



## GUIDELINES FOR CASE REPORTS FOR FELLOW MEMBERSHIP\*

### General Information

Each Fellow candidate must submit ten (10) cases as specified in the *Requirements for Fellow Membership*. 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 beginning of the examination period.

The case reports must be submitted in electronic format. Each report must conform to these guidelines. Submit all case reports online at the links provided by the AAID in your application and confirmation letter.

**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. (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) permucosal 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 II) or bilateral (Kennedy Class I) 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.**

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\* Approved by the Admissions and Credentials Board, September 1997; last revision, May 2016.

Three (3) of the ten (10) cases must have been completed within one year of the examination date and seven (7) of the ten (10) cases must have been in function for at least two (2) years by the examination date. All cases presented for the examination must include implants that are at least 3 mm in diameter and 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 memory stick (USB flash drive) or by online submission. 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.

Each electronic case report must include a folder for each case type, labeled as appropriate, e.g. edentulous arch and include the candidate's examination number. 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 ten (10) reports, provide a file that contains a 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 in a separate file.)

## Photographs

Post-completion photographs that meet the criteria listed in this section and show clearly the views listed below are required for each case. These photographs must clearly depict the soft tissue relationship to the implant prosthesis. The tooth (teeth) of interest must be shown in each of the photographs.

All photographs must be of good quality (diagnostic value) and should be made with a digital camera with a SRL lens of the macro type and a ring flash. (You may use a digital camera without an SRL lens and a ring flash; however, such photos often are not of diagnostic value.)

Cheek retractors must be used for all intraoral photos, and a high quality side view mirror must be used for all posterior views.

**All visual images presented in the photographs must be in their natural state and must not have been altered by a graphics editing program such as Adobe Photoshop.**

**I. STANDARD PHOTOGRAPHS.** Post-completion photographs that clearly show the views listed below are required for each case:

1. Centric occlusion, right
2. Centric occlusion, left
3. Anterior Centric
4. Anterior Protrusive
5. Lateral view of left working
6. Lateral view of right working
7. Occlusal maxillary
8. Occlusal mandibular

**II. ADDITIONAL PHOTOGRAPHS REQUIRED** (by case type)

- A. Single tooth
  - i. Standard photographs only
- B. Edentulous segment of two or more adjacent teeth
  - i. Standard photographs only
- C. Immediate placement of one or more implants in the maxillary anterior segment cases (*13 photos total*)
  - i. Standard photographs
  - ii. Plus five additional photographs:
    1. Frontal view of proposed immediate site in the aesthetic zone prior to extraction.
    2. Occlusal view of the proposed immediate site prior to immediate implant placement.

3. Frontal view of the proposed immediate site prior to immediate implant placement.
  4. Occlusal view of the immediately placed implant.
  5. Frontal view of immediate provisional.
- D. Edentulous cases (8 – 11 photos total)
- i. Standard photographs
  - ii. *Cases that include a removable prosthesis, three additional photographs are required*
    1. Occlusal view of the superstructure without the removable prosthesis in place.
    2. Frontal view of the superstructure without the removable prosthesis in place.
    3. View of the intaglio (tissue side) surface of the removable prosthesis
- E. Graft cases (14 photos total)
- i. Standard photographs
  - ii. Plus six additional photographs
    1. Pre-surgical occlusal view showing the atrophic ridge Pre-surgical facial (lateral) view showing the atrophic ridge
    2. Immediate post-surgical occlusal view
    3. Immediate post-surgical facial (lateral) view
    4. Occlusal view of healed site, typically 4 - 6 months after ridge augmentation and pre-implant placement
    5. Facial (lateral) view of healed site, typically 4 - 6 months after ridge augmentation and pre-implant placement

**All photographs must comply with applicable patient privacy laws.**

*Do not submit any photographs that are not required.*

## 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.

1. Presurgical panograph or a full-mouth radiographic series.
2. Post-surgical (within one week of surgery) panograph or a post-surgical periapical radiograph for a single-tooth-implant.
3. Post-prosthetic (on the day of final insertion) with prosthesis or bar superstructure in place; either panographic or periapical radiographs are acceptable.
4. Completed case radiograph, taken within 12 months of the candidate's oral/case examination date. Either a panograph or a full-mouth radiographic series is acceptable.

For Grafting case, two additional radiographs are required:

5. Cross sectional cone beam radiograph of the augmentation site both BEFORE the augmentation's placement.
6. Pre-prosthetic cross sectional cone beam radiograph of augmentation site that shows
  - a. 3 mm gain in bone for onlay grafts
  - b. 5 mm gain in bone for sinus grafts

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.

## INSTRUCTIONS FOR SUBMISSION OF ELECTRONIC CASE REPORTS

**General Information**

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

Submit all three (3) written reports in electronic format, which includes a folder for each case type, labeled as appropriate, e.g., edentulous case. Each electronic case report must include the following three files: written report, photographs and radiographs.

Provide a file for each of the seven (7) cases documented with radiographs and label each as appropriate. A template for each file is posted on the Academy's website ([www.aid.com](http://www.aid.com)) in the Credentialing/Fellow/Case Report Resources section. These templates are also available on a CD upon request to the Headquarters Office.

**Include the candidate's examination number in the name of each case file.** As noted in the *Guidelines for Case Reports for 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, convert the final file into an adobe pdf document. Label it using your candidate number, case type, and Written Report and save in the appropriate case folder in your files. (e.g. 9F001 Unilateral Written Report).

**Template for Photographs**

Use Microsoft PowerPoint to open the photograph template. For each case, type the information specified in the bracketed text. All of the photo views required for each case are listed on slides 1 – 4. On slide 5, insert the candidate's examination number, the patient's initials, and the case type. Slide 6 provides the template for each view. In either the slide sorter view or the side bar on the left, click on Slide 6, then edit > copy, edit>paste, and repeat until you have inserted slides for each of the required photos. On slide 6 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.

Label the file using your candidate number, case type, and Photographs and save in the appropriate case folder in your files. (e.g. 9F001 Unilateral 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, all the radiographs that are required for each case are listed. In slide 2, insert the candidate's examination number, the patient's initials, and the case type. 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.

Name the file by candidate number, case type and "Radiographs" and save in the appropriate case folder in your files (e.g. 9F001 Unilateral 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.**