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By Irena Sailer, Stefan Fickl and Tommie Van de Velde

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Who's who

**Stefan Fickl (Germany)** received his dental degree from the University of Erlangen in Germany in 2003. He has been Clinical Associate Professor in the Department of Periodontology, University of Wuerzburg, Germany since 2009. Stefan is an acclaimed speaker in the field of periodontology and implant dentistry and has written more than 50 publications and book chapters. In his youth he wanted to be a professional tennis player. Today he prefers to play doubles!

**Jaime Jiménez Garcia (Spain)** received his DDS and PhD degrees from the Complutense University of Madrid, Spain. He gained his certificate in Periodontology and Implant Dentistry, under the guidance of Professor Dennis Tarnow at New York University (NYUCD). He is currently Chairman of the Implant Department at the European University of Madrid. He also holds an Adjunct Associate Professorship at the New York University (Perio & Implant dentistry), USA. He loves sports – water, sky and soccer – and is a big Real Madrid fan!

**Ailsa Nicol (UK)** is a Specialist in Restorative Dentistry, Periodontics and Prosthodontics. She is a Consultant in Restorative Dentistry at James Cook University Hospital, Middlesborough, UK, and also works as a Consultant in Restorative Dentistry at Newcastle Dental Hospital and School, as well as in private practice in Newcastle upon Tyne. She completed her PhD at the University of Glasgow in 2006. Ailsa has been a member of the EAO since 2007. She played Water Polo for Scotland for many years and keeps pet chickens!

**Irena Sailer (Switzerland)** is Professor and Chairwoman of the Clinic of Fixed Prosthodontics and Occlusion, School of Dental Medicine, University of Geneva, Switzerland. She also holds an Adjunct Associate Professorship at the University of Pennsylvania, USA. Her clinical work focuses on the comprehensive treatment of complex, partially edentulous patients. She loves street photography and regularly strolls around big cities in search of interesting subjects to capture!

**Alberto Sicilia (Spain)** is Professor of Periodontology and Co-Director of the Master's Degree in Periodontology, University of Oviedo, Spain, and Medical Director at Clinica Sicilia in Oviedo. He was elected to the EAO's board of directors in 2010 and currently serves as treasurer. He also chairs the EAO Communication Committee, where he has been responsible for a wide range of activities including redesigning the EAO website. He loves surfing, but the older he is the taller the surfboard seems to become!

**Tommie van de Velde (Belgium)** received his master's degree in periodontology and fixed prosthodontics in 2001 from the University of Ghent, Belgium. He obtained his PhD in 2009. He owns a private practice at the Medipolis medical centre in Antwerp and specialises in periodontology, implantology and aesthetic oral reconstruction. He is currently Vice-President of the Belgian Society for Periodontology. When Tommie is not working, he shaves his legs to compete in bike races and triathlons!
Welcome to the first edition of *Inspyred*, the alternative EAO voice; a new project that will surprise and delight you! We will keep you company twice a year through the publication, but all year round through our sister website, www.eao.org/inspyred. The articles you read here will be linked to the website, along with much more. The link will give you access to ongoing clinical cases that are updated continuously, along with news and more!

- *Inspyred* will find the experts and ask them the unusual questions other journals don’t. It will have the courage to shout out loud what it is sometimes difficult to say
- *Inspyred* will introduce you to new faces from within our world. It will provide sneak previews of the most sophisticated or innovative technology available for use in our daily practice
- *Inspyred* will bring you the low-down on social events at the EAO annual meeting. It will also introduce you to the city where the annual meeting is taking place, with tips on cool places to stay and what to see
- *Inspyred* will have VIP access to lectures and courses, ensuring that you receive exclusive information and tip-offs
- And last but not least, *Inspyred* will bring you REAL clinical cases: the complications, the problems we are faced with every day when treating individuals, and the tips and tricks that can overcome or avoid them. *Inspyred* is not interested in publishing the one ‘perfect’ case we all have performed. Instead it will illustrate what REALLY happens in daily practice

Our aim is to make sure you enjoy following us and we promise you will be mesmerised!

Isabella Rocchietta and David Nisand

David Nisand (France) received a DDS degree from the University of Paris V along with a specialty training in periodontics and implant dentistry at the University of Paris VII. He is currently a member of the scientific board of the French Society of Periodontology and a board member of the EAO Communication Committee. He owns a private practice in Paris limited to Periodontology and Implantology. When David is not working, he loves to travel and sample food and wine from around the world.

Isabella Rocchietta (UK) is affiliated with the Department of Biomaterials, Institute for Clinical Sciences, The Sahlgrenska Academy at the University of Gothenburg, Sweden and performs clinical work limited to periodontics and implant dentistry in London, UK. She was Chairman of the EAO’s Junior Committee from 2007 to 2011 and is a member of the Experts Council of the Osteology Foundation and the Academy of Osseointegration. If you see a Vespa speeding around London it’s probably Isabella rushing to work!
One of the hottest topics in implant dentistry at the moment is the issue of bacterial-induced peri-implantitis. This affects a substantial number of dental implants worldwide.

Peri-implantitis in this context means progressive marginal bone loss, together with infection signs which could jeopardise implant survival. There have been a substantial number of consensus conferences, systematic reviews, trials, human and animal studies on this topic over the last few years. This article asks whether we can trust all their findings.

The major areas of research into peri-implantitis can be broadly grouped into four themes:

1. **Incidence and prevalence of peri-implantitis with its associated etiological factors.** The ideal study designs to explore these aspects are cross-sectional surveys and, even better, prospective cohort studies. While there are several epidemiological studies in this field, only a few properly designed prospective cohort studies have been conducted. Researchers should use the most reliable study designs to achieve reliable results. Knowledge of the principal factors associated with peri-implantitis, based on reliable epidemiological data, would represent a very useful tool in developing effective preventative measures.

2. **Diagnostic tests.** This interesting line of research looks at the development of reliable diagnostic tools for screening specific populations to identify peri-implantitis as early as possible. Ideally, these tests should be both valid (capable of providing accurate results) and reliable (capable of delivering accurate results consistently). If the disease is identified sooner, less treatment will be required and the prognosis of the affected implants will be better. Unfortunately, no reliable diagnostic test has been identified so far.

3. **Prevention of peri-implantitis.** This line of research is concerned with how to effectively prevent peri-implantitis. If effective solutions can be found, it is arguably the most important theme. It would involve focusing research on several areas:
   - designing implants with surfaces that are less prone to peri-implantitis. For instance, it is widely believed (and there is also some supporting evidence) that implants with surfaces that are too ‘rough’ (e.g., titanium plasma-sprayed) lead to a higher risk of peri-implantitis
   - controlling those factors associated with peri-implantitis (poor oral hygiene; prosthetic design; smoking; residual submucosal cement etc.)
   - identifying effective maintenance programmes

The best way to answer these questions would be to compare alternative solutions using randomised controlled trials (RCTs). Unfortunately, no such trials have been conducted so far.

4. **Treatment of peri-implantitis.** Many different therapeutic protocols have been presented for the treatment of peri-implantitis and some have also been evaluated with RCTs. However, the results (for instance as summarised in a recent Cochrane review) suggest that none of the tested therapies have shown convincingly better results than a simple conventional debridement of the plaque biofilm present on the implant surface. More properly conducted research is needed in this area, though there are several ongoing projects.

When reviewing research data relating to peri-implantitis there are a number of additional factors to take into account:

1. **The role of animal studies.** Scientific journals are literally flooded with animal studies which have been conducted using insignificant sample sizes (4 to 8 animals). They involve creating completely artificial diseases around non-loaded implants in a few healthy animals. Some authors speculate wildly using data which may be based on one implant failing in a single dog. The role of animal studies is very slight and can be extremely misleading, particularly if there is a ‘secret agenda’ to extrapolate data to the clinical situation. Unfortunately these types of studies are widely abused in an attempt to extrapolate data to the human situation.

2. **Trial duration.** Peri-implantitis is a chronic disease which can develop many years after implantation. Its recurrence is common even after repeated treatments.
3. Commercial sponsorship. The great majority of the RCTs so far conducted to evaluate the effectiveness of therapies for the treatment of peri-implantitis were sponsored by companies willing to test their products (ie to show how good they are). Examples of products tested include local antibiotics, lasers and sophisticated devices for mechanical debridement. Companies that are serious about advancing scientific research will also publish any data that shows no effect. Those that are less serious may try to stop publication of data or sabotage the continuation of the trial. We have already experienced this when the largest ever multicenter RCT to be conducted failed to show any clinical relevant effect using light activated therapy as adjunct therapy to mechanical debridement, to the point where contracts were revisited. We really need more independent trials and companies that are prepared to act as serious partners if we want to understand the best way to deal with peri-implantitis (as with any other disease).

I wish to conclude by citing DG Altman, who in 1994 elegantly summarised what was required: ‘We need less research, better research, and research done for the right reasons’. In 2013 very little has changed and we still have exactly the same needs. What should we do to finally improve our knowledge? It is very simple. We need to demand high-quality research, and we should not waste our time in either conducting or reading about poorly conducted and misleading research. Is this possible? The answer depends on us.
**Case presentation**

Management of an implant prosthetic complication

*Irena Sailer¹, Bertrand Thièvent²*

This case presentation demonstrates the stepwise procedures used to solve a major prosthetic complication, ie malpositioned implants. The treatment encompassed thorough pre-treatment diagnostics in collaboration with the dental technician in order to analyse whether or not the osseointegrated implants could be used for a fixed reconstruction; the use of angulated and customised components to compensate for the misalignment of the implants; and the fabrication of resin-veneered screw-retained fixed implant bridges in the upper and lower jaws.

The male patient (1937, Figure 1) was referred to the Clinic of Fixed Prosthodontics and Material Sciences, University of Zurich, for final prosthetic treatment. The implants had been placed in a private practice several months earlier, and a screw-retained implant provisional was already in situ. The patient complained about the aesthetics of the provisional, along with difficulties cleaning it. A close-up view of the patient’s smile (Figure 2) revealed the screw access holes on the buccal side of the provisional, indicating that both the implant positions and axes were prosthetically compromised.

The severely compromised positions of the implants (Branemark, Nobel Biocare, Sweden) is illustrated in Figures 3 and 4. Note the different diameters of the implants placed in the anterior and posterior regions, and the ‘sleeping’ implants. The patient’s main desire was a fixed reconstruction with good aesthetics and function. He was not willing to accept a removable alternative.

Lateral and occlusal views of the implant provisional (Figures 5–8) illustrate the over-contouring, which made it difficult to clean the provisional adequately. Plaque accumulation is evident. After the removal of the provisional the severely inflamed peri-implant mucosa were clearly visible (Figures 9 and 10).

In order to evaluate whether or not a fixed reconstruction was possible at all, fixture-level impressions of both jaws were made (Figures 11 and 12), and the axes of the implants were analysed in collaboration with the dental technician. Thereafter a set-up of the ideal prosthetic position of the teeth was made (Figure 13). Note the position of the implant in region 31, which was too lingual (Figure 14).

A try-in of the set-up and extraoral aesthetic analysis of the planned tooth positions in upper and lower jaws (Figure 15) illustrated that he set-up achieved a harmonious smile line. However, the intraoral analysis of this ‘ideal’ set-up exposed problems: note the intermediate and buccal positions of most of the implants (Figure 16).
In order to accomplish the desired prosthetic outcome, customised cast metal frameworks had to be fabricated, modifying the prosthetic positions (Figures 17 and 18). Furthermore, in the maxillary anterior region 15–30° angled abutments (multi-unit, Nobel Biocare, Sweden) were used in combination with the customised framework. In order to overcome the difficulties with the transfer of the respective angled abutments from the master cast to the clinical situation a positioning stent was made by the technician (Figures 19 and 20). Note the correction of the bucco-oral axis accomplished by means of the angled abutment (Figure 21). Figures 22 and 23 show a detailed view of final screw-retained metal-resin bridges 17–15, 13–23, 25–27, 37–31, 41–47.

The critical areas of the final reconstructions (Figure 24) were designed to be as easy to clean as possible while maintaining the aesthetics. The interdental regions made cleaning straightforward, as shown in these lateral views (Figures 25 and 26).

Smile line with final reconstructions. The use of angled abutments and a customised framework support meant the screw access holes could be located on the palatal/lingual side of the reconstructions, thereby avoiding impairing the aesthetic outcome. This optimised the smile line when the final reconstructions were in place (Figure 27).

Patient reference portraits (Figures 28 and 29) show the natural teeth and the implant supported reconstructions. A night-guard (Figure 30) was provided after finalisation to protect the reconstructions from the high biting forces.

Discussion

This case demonstrates one approach for prosthetically solving the problem of critically positioned implants. The clinical situation presented highlights the importance of carrying out thorough pre-treatment prosthetic diagnostics prior to implant surgery.

Pre-treatment diagnostics should encompass the fabrication of a wax-up/set-up of the desired outcome, a clinical try-in and the analysis of the individual anatomy in combination with the patient’s main desires. This first treatment phase determines the individual prosthetic goal, which is then used to establish the optimal placement of the implants for the prosthesis.

By using the clinically approved wax-up/set-up to fabricate surgical stents, the prosthetic goal should transfer accurately to the implant surgery.

More recently, computerised technology has enabled planning of the prosthetically ideal implant position within a virtual environment (guided surgery software). Information obtained from this process can be transferred to the clinic by means of surgical stents, enabling a guided surgical procedure.

The need to compensate for non-prosthetically oriented implant positions frequently leads to compromises of the final outcome.

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improvements in the field of implantology have led to a broadening of treatment indications. In particular, modern augmentation procedures or the use of short implants allow implant placement in areas where in earlier times dental implants were impossible. However, soft tissue management is still a challenge in these advanced cases, as the quantity and quality of soft tissue might play a role in the long-term maintenance of the implants.

The case depicts a clinical scenario following sinus-floor grafting and simultaneous implant placement (Figures 1–2). At the time of second stage, peri-implant problems are evident. Punching the soft tissue and connecting the implant-restored reconstruction might be followed by shortfalls in oral hygiene and possible inflammation of soft and hard tissues. Therefore, at this time the correction of the soft tissue architecture should be considered. In this case a free gingival graft was used in combination with a vestibuloplasty to apical position the muco-gingival junction and established fixed keratinized tissue around the implant (Figure 3). Furthermore, a resective approach was used in the palatal aspect in order to avoid pseudo pocketing due to increased tissue quantity. At the time of final reconstruction attached keratinized tissue is clearly visible circular around the implant fixture (Figures 4–5).

Figures

1. Buccal view of soft tissue dehiscence at the time of abutment installation
2. Occlusal view showing the soft tissue problems.
3. Correction with free gingival graft and resective technique in the palatal aspect.
4. Circular attached keratinized tissue at the time of insertion of final prosthesis.
5. Final reconstruction.
Clinical cases

Single implant tooth replacement: a minimally invasive surgical and prosthodontic approach

Tommie Van de Velde

There is a growing demand among patients for implant restorations that provide a high-quality, long-lasting aesthetic outcome that mimics the natural dentition. Many surgical and prosthodontic techniques can contribute to achieving harmony between pink and white aesthetics. However, there is no ‘cookbook’ that describes one ideal technique for restoring a lost tooth. Instead, it is vital to fully assess each patient and draw up a case-specific treatment plan.

If a tooth has been lost or must be extracted, the primary aim is to preserve or restore as much of the surrounding hard and soft tissue as possible. A range of factors contribute to the achievement of long-term tissue stability following the loss of a tooth. However, a minimally invasive approach during every stage of treatment is likely to make an aesthetically successful restoration easier to achieve. This case report describes the treatment protocol that was followed to provide an optimal combination of function and aesthetics using an implant restoration to replace an upper right central incisor with a vertical root fracture.

In this case, procedures for tissue preservation and augmentation were combined to optimise the peri-implant tissues early in the treatment sequence. Following implant surgery a provisional restoration was placed to create the ideal soft tissue architecture. When the desired soft tissue profile had been achieved, the final crown was duplicated using the temporary restoration.

Initial situation. The upper right central incisor (Figure 1) had a vertical root fracture and persistent infection. The patient presented with a very high smile line, medium-thick gingival biotype and a small excess of gingival tissue, compared with the contralateral central incisor. The cone-beam CT images (Figures 2 and 3) revealed a small vertical bone defect around the root fracture. Bone was present on the mesial and distal aspect of the root (arrow).

Initial treatment. A careful extraction of tooth 11 was performed (Figure 4) with preservation/ augmentation of hard and soft tissues. Bovine bone hydroxyapatite (Endobon, Biomet 3i, Palm Beach, USA) and a collagen membrane (Osseoguard, Biomet 3i, Palm Beach, USA) were used to augment the bone defect (Figure 5). A large connective tissue graft, harvested from the palate, was inserted and sutured with 6-0 monofilament sutures (Seralene, Serag Wiessner, Naila, Germany) in a buccal and palatal pouch to cover the socket and augment the soft tissues (Figure 6).

Implant placement. After 3 months, a 4x15 mm implant (NT Osseotite, Biomet 3i, Palm Beach, USA) was inserted using a flapless approach (Figure 7). Pre-operative evaluation revealed an adequate quantity of bone and soft tissue. Additional steps were taken to fulfil all requirements for immediate implant placement as the bovine bone substitute was still immature. A definitive abutment was prepared to install immediately after implant surgery (Figure 8). The outline of the abutment and the biocompatible material were optimised to act as a scaffold encouraging the soft tissue to heal. Additional soft tissue corrections were achieved by adapting the shape of the acrylic provisional crown (Figure 9).

Outcome. Figures 10 and 11 illustrate the final result with definitive crowns on the implant and neighbouring central incisor. Note the excellent soft tissue volume at the buccal side of the implant. At a follow-up of three years, the peri-implant bone level remained stable (Figure 12). (Prosthodontist: Erik Van den Bogaert)
Questions by Dr Martin Brient, Paris, France, with responses from Tommie Van de Velde

How did you manage the membrane placement in the extraction socket? Would you choose the same surgical approach with a larger bony defect of the buccal bone?

The membrane was positioned on the buccal bone wall after careful elevation of the periosteum around the bone defect. The size of the defect was narrow but deep, and allowed for this minimal approach. In cases where we find larger bone defects, a larger extension of the buccal flap is necessary to position and stabilise the membrane. We understand that the bone substitute was still immature after three months. How did you manage to obtain sufficient primary stability for immediate provisionalisation?

Primary stability of the implant was obtained using a similar protocol to immediate implant placement (anchorage apically and palatally; under-preparation; tapered implant design).

How do you design the marginal shape of your tailor-made zirconia abutment with respect to the final soft tissue level and shape?

The design of the final abutment was based on the level and profile of the neighbouring tissues. As the peri-implant tissues were augmented after extraction, an ideal implant bed was created. The excess in height and width of the soft tissues allowed for a minimal flap design during implant placement. An ideal profile was designed for the final abutment allowing the soft tissues to heal around the biocompatible Zr02 abutment, which acted as a scaffold. The buccal margin of the abutment was placed 0.5 mm apically from the future gingival outline. By adding acrylic to the provisional crown, additional changes to the gingival architecture were accomplished. In this case, this was mainly necessary at the buccal level to shift the gingival zenith in an apical and distal direction.

You used a zirconia abutment for the implant-supported restoration. Did you also use zirconia as a prosthetic framework for the two crowns?

Yes, the crowns were made by the referring dentist, Erik Van den Bogaert. A glass fibre reinforced post was placed to build up the 21. Two separate Zirconia crowns were made on the implant-abutment and the natural tooth.

How would you disassemble the cemented crown if a reintervention was required (for example as a result of ceramic chipping or screw loosening)? How would you control the removal of the excess cement?

The implant crown was cemented with a provisional cement enabling it to be retrieved in the case of technical complications such as ceramic chipping or screw loosening of the abutment. During the cementation process, a retraction cord was used to prevent cement inclusion at the submucosal level of the abutment. This is a very delicate procedure and is often done under local anaesthesia. A duplicate (die) of the abutment can be used to remove excess cement prior to placement intraorally.

Would you be able to show us a 3 year follow-up X-ray?

X-rays taken three years post-operatively show excellent marginal bone preservation, as well as the presence of biomaterial in what is presumed to be newly-formed bone.
Highlights of Dublin 2013

Ailsa Nicol talks to David Harris about highlights of the EAO’s forthcoming scientific meeting in Dublin

Which five topics do you think participants will most look forward to?

1. The plenary and parallel sessions have been carefully chosen to appeal to a wide variety of interests, with content for generalists, specialists, researchers and academics. They all have an emphasis on sharing practical clinical information that can be applied in every day practice. The aim is to help clinicians provide optimum patient care and manage the challenges involved in delivering successful outcomes. Five of the ten plenary and parallel sessions focus exclusively on practical topics.

2. The sessions on emerging technologies in tissue regeneration and computer-assisted implant rehabilitation will provide a valuable update on new treatments and trends. They will feature future practical applications in these exciting areas.

3. The EAO’s Junior Committee, who always have an eye on the future, will present a session on ‘Learning and sharing clinical dentistry in a virtual world’. This will cover topics including the future of dental education; privacy and e-health; and digital platforms.

4. The master-class entitled ‘Extended defects in the aesthetic zone: dreams, nightmares, reality’ will address one of the most difficult clinical situations for implant-based rehabilitation.

5. The session on implants in an ageing population will deal with the challenges facing the future delivery of dental care as the global population ages.

What are the five best reasons to attend the 2013 EAO Annual Congress?

1. In my opinion one of the most important aspects of EAO meetings is the quality and independence of the scientific programme. There is always a clear distinction between industry presentations and the main scientific programme, which is carefully chosen by a broad-based scientific committee. There is no crossover between commercial interests and science. This transparency means participants can make informed judgments on the information provided, confident that it is independent of industry influence.

2. The quality of the faculty is a very important. All the speakers are acknowledged experts in their field and are talented presenters. At the Dublin meeting there will be a mixture of established names and some new faces. All have been carefully chosen to address the pertinent issues of their topics, based on the most compelling scientific evidence.

3. Over the coming decades the ageing global population will pose unprecedented treatment challenges. As far as I know, the EAO’s Dublin meeting will be the first international forum to consider the delivery of dental implant treatment in this environment of increasingly complex needs.

4. The opportunity to meet and exchange views with colleagues from all over the world is a key benefit of attending. Delegates will be able to renew old friendships and establish new ones during this unique educational forum.

5. The EAO holds several prestigious research competitions during its annual meeting. All those who are shortlisted for a prize have the opportunity to give a short oral presentation. This is an incredible platform for publicising research and attaining recognition as a researcher.

Can you provide five good reasons to come to Dublin?

1. **The city.** Ireland is often referred to as ‘The Emerald Isle’ and the capital, Dublin, is the jewel. The congress will take place in the heart of the city with stunning views across Dublin Bay.

2. The nearby **countryside** offers many opportunities for walking, fishing and golf, as well as sightseeing in the beautiful Wicklow area.

3. Ireland is famous for its **culture**, especially its literary, traditional and modern musical and dance traditions. You will sample some of this excitement first-hand at the opening ceremony.

4. **2013 is the year of the ‘Gathering’**, a year-long celebration of Ireland and all things Irish. It will feature numerous festivities, exhibitions and events celebrating all aspects of Ireland’s vibrant culture.

5. **The people.** Their friendliness, humour and celebratory spirit will leave a lasting impression on you. You can be assured of ‘Céad Míle Fáilte’ (Irish for ‘100,000 welcomes’).
Dublin city gems

Here is our pick of stylish destinations for visitors to Dublin this October

Brown Thomas
Grafton Street landmark and Dublin’s premiere fashion lifestyle destination.

The Dylan
Victorian-era boarding house converted into a 44-room boutique hotel.

The Indigo Lounge
Bohemian-chic bar with café-style dining in Contarf Castle Hotel.

The Clarence
Cutting-edge style looking over the River Liffey in the Temple Bar district.

The Loft Market
NYC-style boutique design collective with the next-big-things in Dublin fashion.

The Merrion
18th century elegance meets modern luxury, with award-winning spa Tethra.

Restaurant FortyOne
Flavourful and imaginative dining with maximum taste and minimal fuss.

Gallery of Photography
Temple Bar gem featuring monthly exhibitions from Irish and international artists.

Chapter One Restaurant
Michelin-starred restaurant located in the Dublin Writers Museum on Parnell Square.

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