

Zygomatic Implants

Implant-prosthetic solutions
for treating cases of severe
maxillary atrophy.

**Total
Approach
Concept**

SURGICAL MANUAL

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IMPORTANT NOTE

For the latest updates and information, visit: www.aonimplants.it

This manual provides dentists and other dental specialists with general information on the use of dental implant systems for severe atrophy of the upper jaw.

For detailed information on other specific implant lines and related prosthetic procedures, please refer to the relevant manuals, specific literature, or the AoN Implants website.

Participation in specific training is recommended before using these products to ensure the long-term success of dental restorations on implants.

T.A.C. Zygomatic Implant

The TAC Zigo implant is used in cases of **severe partial and/or total maxillary atrophy** and is therefore placed in a system composed of multiple implants, where the loads are distributed.

This type of approach involves the use of **long implants, from 28 to 60mm**, bilaterally at the latero-posterior level, approximately in the premolar area, in order to obtain anchorage both at the crestal level and at the zygomatic bone level.

In the immediate loading protocol, the zygomatic implant is mechanically anchored thanks to the threaded portion that finds retention exclusively in the malar bone, due to its particular morphology. In the case of a rehabilitation in two surgical stages, the completion of osseointegration is awaited in the part in contact with the bone.

Whenever possible, it is preferable to adopt an extrasinusal technique for the placement of TAC Zigo implants. This approach avoids perforation of the sinus membrane, as the implant is inserted along the external wall of the maxilla, thus preserving the integrity of the membrane.

Before proceeding with the surgery, a thorough preoperative study is strongly recommended, including radiographs, CT images, and possibly a stereolithographic model of the maxilla.

For the placement of the zygomatic implant, **AON Implants** has provided the **patented ZTA (Zygomatic Telescopic Approach) technique**, the **newest surgical technique** with short telescopic burs.

The rehabilitation of severe maxillary atrophy involves a mixed implant approach; there is no single solution.

Cases may be encountered where it will be appropriate to insert two zygomatic implants in the maxilla in the posterior area (one per half-arch) and an additional two or four implants in the anterior region. In the most extreme cases, it may be necessary to place two zygomatic implants per half-arch, a combination known as QUAD. Furthermore, we also recommend the placement of 2 pterygoid implants for optimal load distribution.



SMOOTH DESIGN

The most gentle and safe implant morphology ever!

The **OsteoPore** surface treatment, with double acidification, **only affects the threaded part**.

The new "**Smooth Design**" thread profile is designed to respect hard tissues to the fullest, offering top performance. The reduced apical part adapts perfectly to the **minimally invasive** preparation of the implant site.

The objective is to leave the quality of the patient's bone as unaltered as possible, aiming to achieve maximum stability while maintaining an adequate insertion torque.

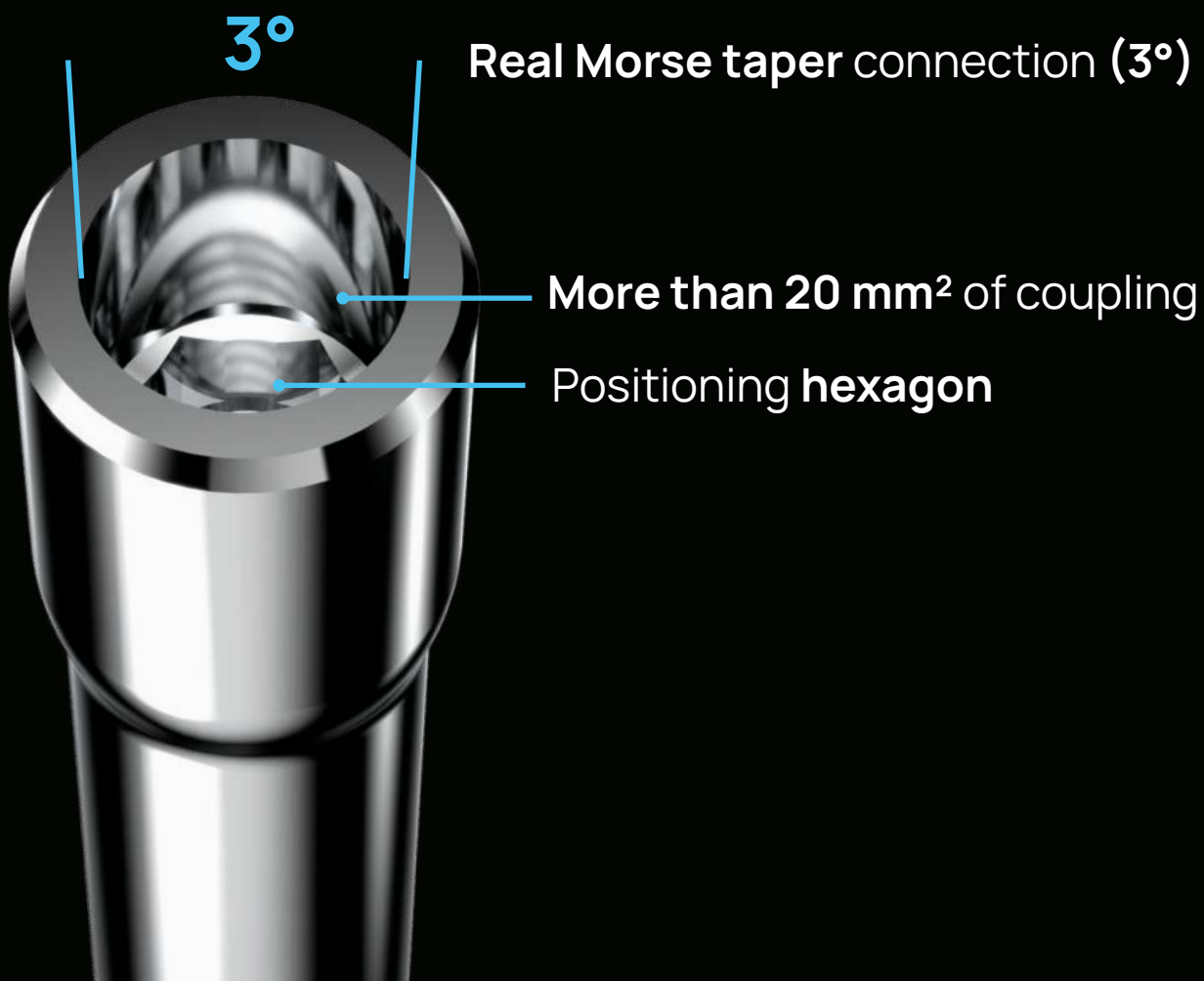




SELF-LOCKING MORSE TAPER CONNECTION

The new **Self-Locking Morse Taper** connection by AON Implants. With this system, we want to rewrite the concept of conometry in dentistry, bringing innovation, simplification, and versatility to a prosthetic system that has proven to be one of the **most reliable and durable over time**.

The **REVCON** prosthetic system has been designed to meet all the needs of the dentist in terms of implant-prosthetic rehabilitation. **REVCON** supports all prosthetic techniques: screwed, cemented, combined, telescopic, accommodating any clinical approach required by the operator. All this is thanks to a **complete range of implant morphologies**, studied with extreme care, to offer the pluses that all great implantologists currently seek in an implant line.



Introduction

The rehabilitation of edentulous patients with dental implants has proven to be a long-term successful solution in various clinical scenarios.

However, in cases of severe bone resorption, especially in the posterior maxilla, the lack of sufficient bone volume poses significant therapeutic challenges. Advanced alveolar resorption, combined with the pneumatization of the maxillary sinus, often leaves little bone for the insertion of conventional implants.

In recent decades, bone grafting techniques, such as maxillary sinus floor augmentation and onlay grafting, have been commonly used to increase bone volume and facilitate implant placement.

However, these procedures have significant limitations, including prolonged treatment times, increased donor site morbidity, and post-operative complications, prompting the search for more predictable and less invasive alternatives. In this context, zygomatic implants have emerged as a valid therapeutic option for the rehabilitation of severely atrophic maxillae. These long implants anchor in the zygomatic bone, providing a stable foundation for prosthetic rehabilitation without the need for bone grafts.

Since their introduction, the indications for zygomatic implants have expanded, now covering not only severe maxillary atrophy, but also maxillary defects resulting from oncological resections and failures of previous bone grafting procedures. The development of various surgical techniques has optimized the use of zygomatic implants, improving clinical outcomes and minimizing complications. The new ZTA technique, conceived by Dr. Prada in collaboration with the AON Implants team, aims to rewrite the conventional drilling protocol adopted by most companies.

The current classic technique with long burs is quite invasive and not easily controlled by the surgeon.

To facilitate clinical procedures, a set of short rotary instruments has been created in collaboration with Dr. Prada, which can be extended at the clinician's discretion according to anatomical needs with the help of special extenders.

Advantages of the ZTA (Zygomatic Telescopic Approach)



Extrasinusal approach:
no complications for the
maxillary sinus.



Complete Dedicated
Surgical Kit.



Short drills with
morphologies dedicated to
each step of the preparation.



Patented
System

Graduated extenders
of 3 lengths with
graduated notches.



Angled placement of posterior
zygomatic implants.
More freedom of movement,
allowing for variation in
implant angulations.



The division into three
surgical steps increases
precision and simplicity.

Preoperative evaluation and planning

Many factors must be taken into account during the therapeutic planning phase.

These must be based on a thorough evaluation of the patient's clinical and radiological examination results.

The following issues should be considered in the clinical examination:

- Medical history
- Intra- and extra-oral clinical examination
- Lack of teeth, bone, gum.
- Type of bone defects.
- Smile line and its impact on rehabilitation.
- Interdental relationships.
- Parafunctional habits.
- Intermaxillary relationships
- Occlusal plane
- Possible opposing dentition
- Instrumental examinations
- Photographic documentation

In order for the doctor to rule out any pathology and plan the number and positions of the implants, the radiological examination must be performed on radiographs and CT scans that include all relevant information.

From the CT scan, through processing with special software, it is possible to obtain stereolithographic models of the upper jaw bones, useful for virtually planning the surgery.

Considerations

The position of the zygomatic implants must be defined before the surgery, through guided surgical planning based on the type of prosthesis decided upon.

These implants must be rigidly connected to each other and stabilized with any other implants (at the premaxilla level) to prevent occlusal forces from transmitting the entire load to the zygomatic fixtures, especially during the healing period.

This type of rehabilitation is performed in most cases with an immediate loading technique.

It is therefore appropriate to pay attention to the following:

- Eliminate cantilevers
- Decrease cusp height and inclination
- Create a balanced occlusion.

The most suitable prostheses for this type of rehabilitation are made of acrylic with internal metal frameworks.

If the conditions for immediate loading are not met, a delayed loading is performed.

Indications

The technical indication is when the bone volume at the premaxilla level is sufficient for the insertion of standard implants, but the posterior alveolar crest is so resorbed that it requires bone grafts

- Total and partial edentulism
- Failures of previous regenerative surgeries
- Post-traumatic defects
- Post-oncological resections
- Cases where additive surgery therapies are not possible.

Post surgery Care

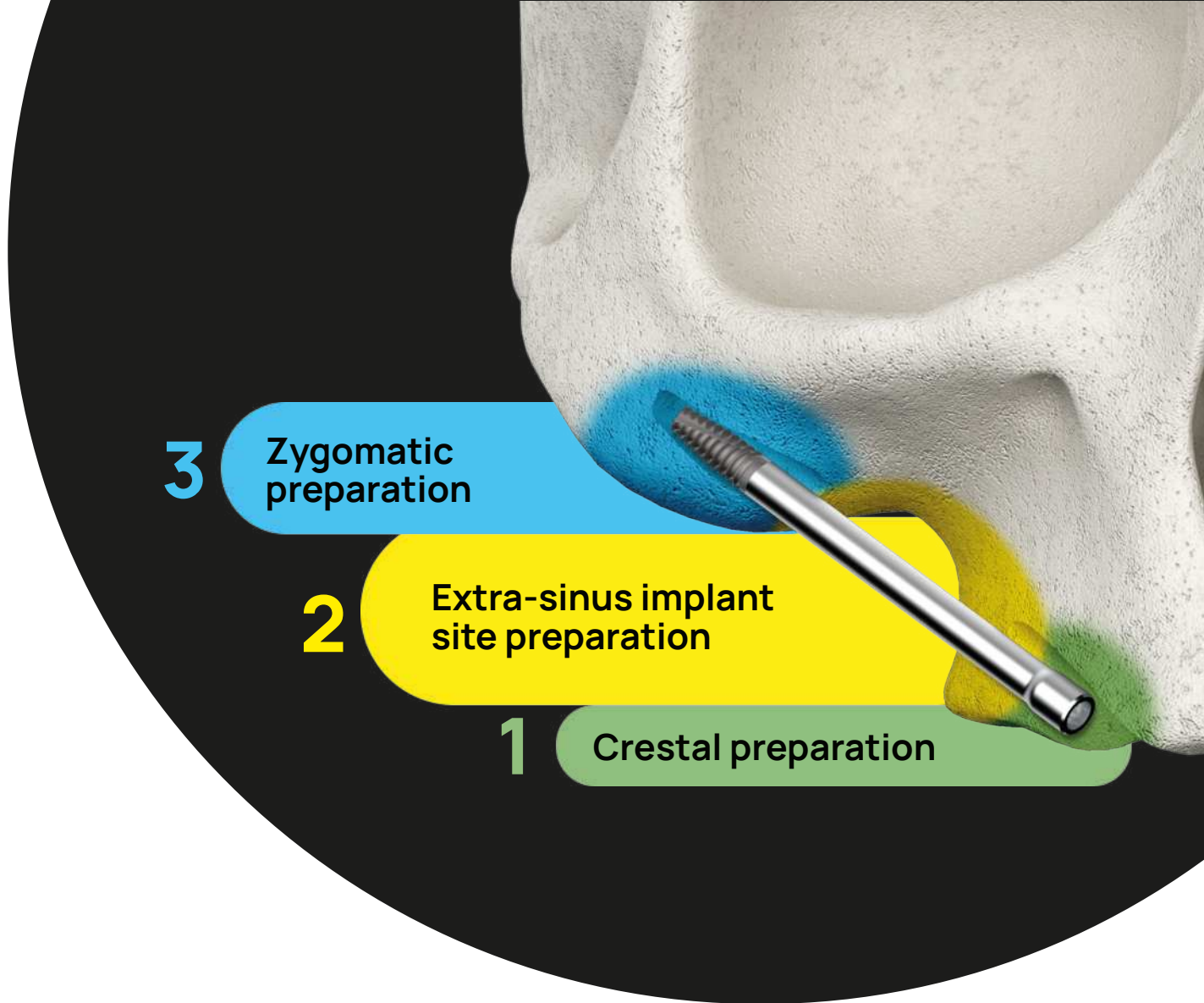
- Soft food diet and supportive medical therapy.
- The post-operative instructions are similar to those for a maxillary sinus lift operation..
- Oral hygiene and periodic check-ups to be carried out.
- Six months after the surgery, the final restoration can be performed.

Possible immediate complications

- Invasion into the infratemporal fossa and/or orbit
- Lip laceration
- Nasal bleeding
- Fracture of the zygomatic bone

Late complications

- Periorbital hematoma
- Edema
- Paresthesia
- Sinusitis
- Oro-antral communications
- Loss of implant osseointegration
- Peri-implantitis



Z.T.A. Surgical Protocol

To increase its precision, AON Implants has devised a protocol that divides the preparation of the osteotomy site into three different steps:

1 Crestal bone preparation

2 Maxillary bone preparation

3 Zygomatic bone preparation

The technique consists of creating a bed of a few millimeters along the chosen axis (the long axis along which the implant will meet the zygoma) on the outer wall of the maxillary sinus without ever invading it. The goal is to transform an implant technique used mainly to solve extreme clinical cases into a much more precise technique, easily performable by many, and with lower operative risks.

Clearly, it is mandatory to emphasize the need for adequate training by the operator who wishes to approach this technique.

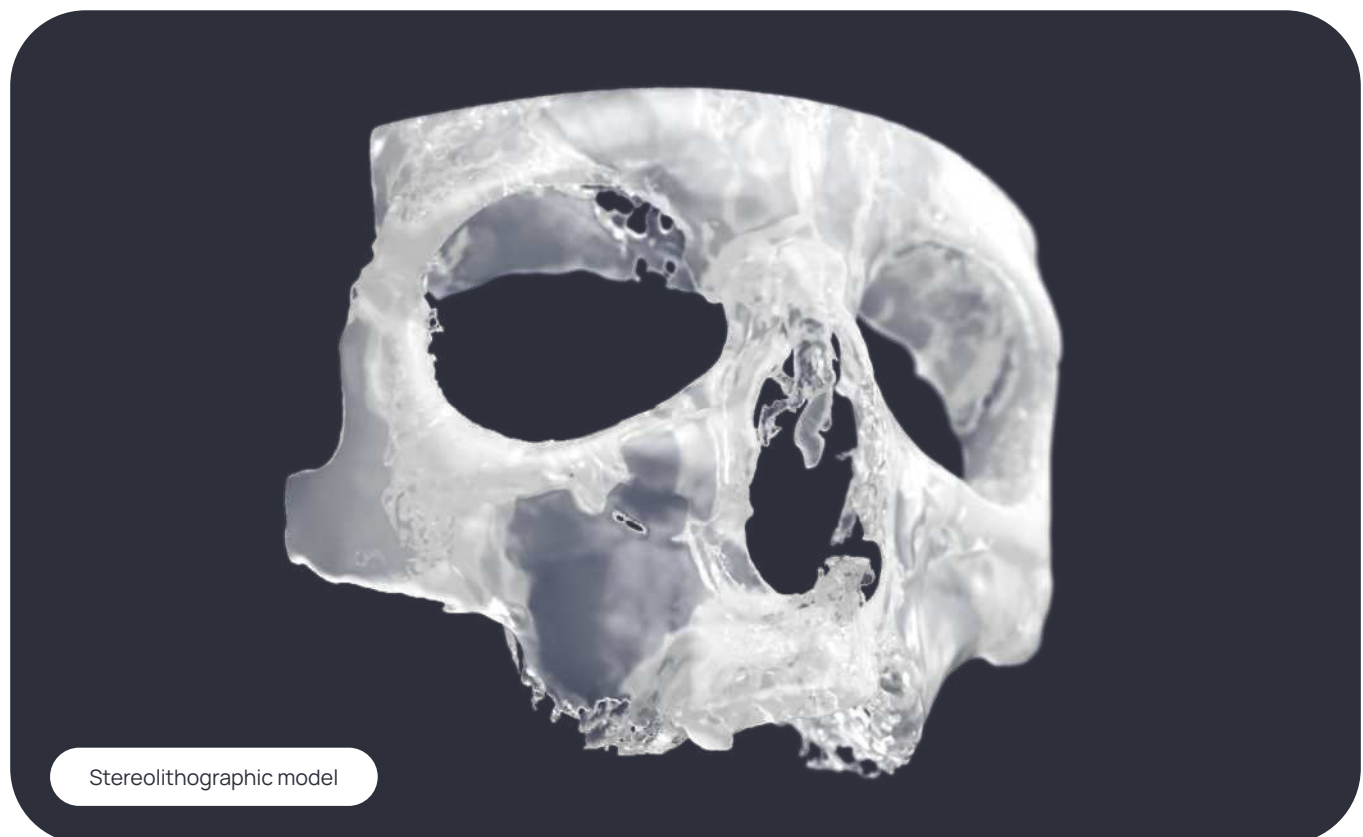
Advanced Pre-Operative Planning

The pre-operative evaluation includes a comprehensive analysis through computed tomography (CT) imaging, which allows for a detailed assessment of the anatomy of the zygomatic bone, maxillary sinus, orbital floor, and residual alveolar crest structures.

The data obtained from the CT scan are used to create custom 3D models, which allow for precise pre-surgical measurements and simulations of the procedure.

The use of 3D models allows for the determination of the ideal dimensions and angles for the implant with high precision, reducing the risk of intra-operative modifications.

The pre-operative simulation also provides essential information on anatomical variations, supporting the optimal selection of the implant in terms of length, diameter, and angulation.



Optimized Surgical Access

Surgical access is performed by elevating a full-thickness mucoperiosteal flap, which allows for exposure of the alveolar crest and the lateral maxillary wall, offering complete visibility of the surgical area.

This approach directly exposes the lateral wall of the maxillary sinus and the zygomatic bone, facilitating a clear visualization of the vestibular and palatal regions.

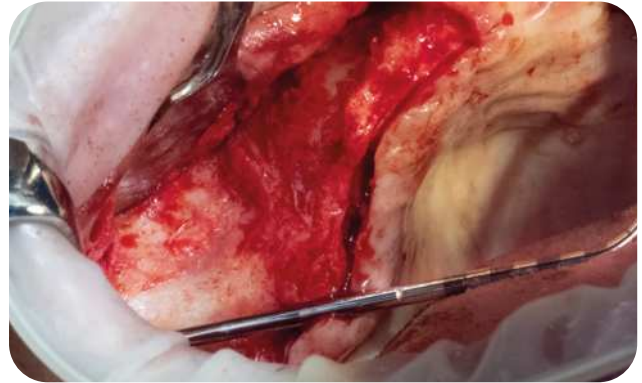
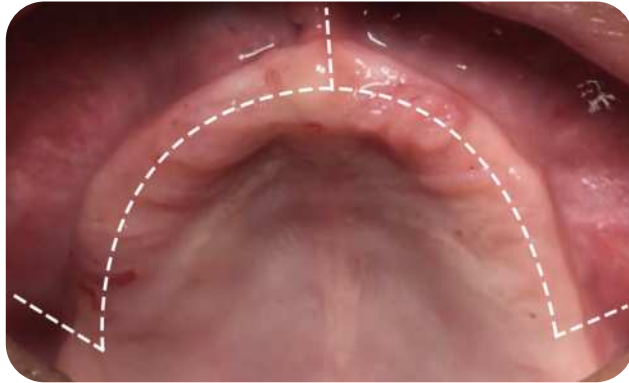
Adequate exposure of these structures is fundamental for precise drilling and implant placement, allowing for monitoring of depth and trajectory with minimal obstruction, ensuring high precision throughout the surgical procedure.

Once the detachment of the soft tissues is completed, they are stabilized to facilitate the operative part of the drilling. In this phase, it is recommended to trace the concerned anatomical points with a pencil, which have been previously highlighted on the stereolithographic model.

Marking the points allows for the subsequent operations to be performed more safely.

THE FLAP

Full-thickness incision of the soft tissues, elevation of a muco-periosteal flap that allows for a wide view of the piriform aperture, the emergence of the infraorbital foramen, and subsequently the surface of the body of the zygomatic bone where a retractor must be placed to keep the operating area clearly visible.



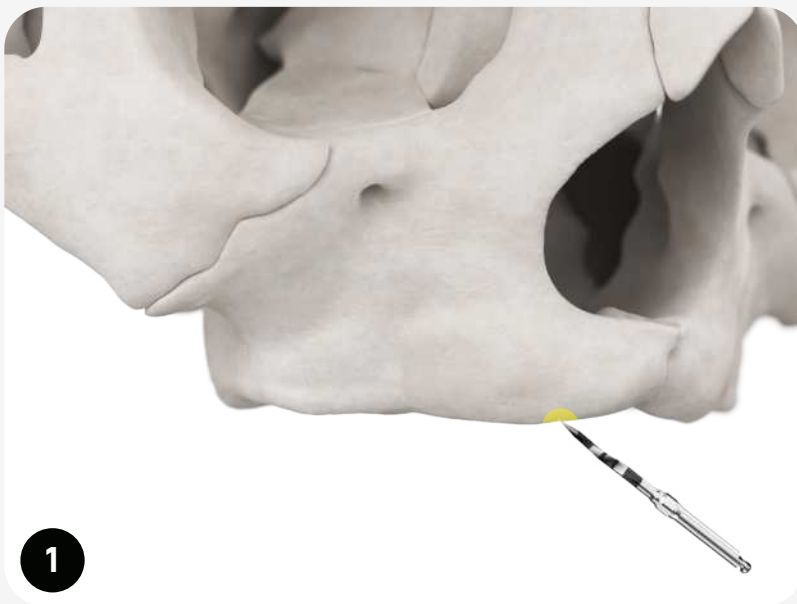
Surgical procedure

- 1 A vestibular incision according to Le Fort 1 or a full-thickness crestal incision is made, extending from the nasal spine to the distal area of the first molar; then, bilateral release incisions are made towards the zygomatic process.
- 2 The maxillary bone is skeletonized, paying attention to the Stensen's duct.
- 3 The alveolar crest is exposed, including the palatal side, and dissected until the infraorbital foramen is highlighted to facilitate anatomical orientation.
- 4 Identification of the alveolar support point and, where possible, try to preserve the bone structure of the alveolar region for greater stability of the future implant.
- 5 In the case of an intrasinusal approach, it is possible to design an opening of about 10 mm×5 mm on the lateral wall of the maxilla until the sinus mucosa is carefully exposed and mobilized to proceed with the implant osteotomy.
- 6 The possible trajectory of the implant is identified by placing the measurement probe over the lateral wall of the maxilla.
This must rest on the lateral wall of the maxilla, starting from the alveolar region and inserting into the zygomatic bone until it reaches its outer cortex.
- 7 In the case of an extrasinusal approach, it is important to design an implant bed from the residual alveolar crest to the malar bone.

STEP 1 Crestal preparation

The initial drilling is performed through a sequence of progressively larger burs, following a strictly controlled protocol to create a stable implant bed. The incremental process involves the use of pilot and intermediate burs, designed to gradually remove bone, minimizing tissue trauma.

The use of increasingly larger burs allows for precise monitoring and control of the drilling trajectory, ensuring that the crestal bone is adequately prepared. This approach reduces the risk of bone fractures and optimizes the interface for osseointegration, ensuring a stable and long-lasting result.

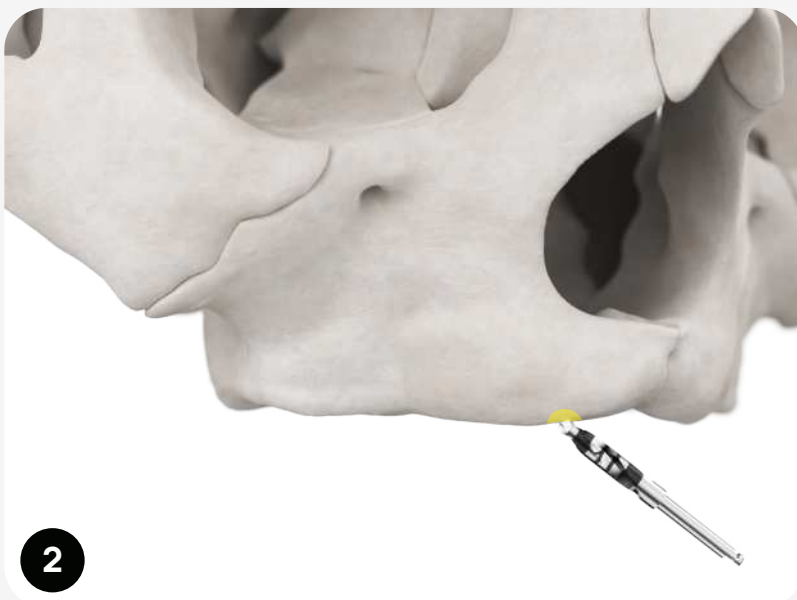


STEP 1 involves the preparation of the crestal bone, starting with the 2.0 mm lance-shaped bur, up to a maximum diameter of 3.5 mm.

Lance drill Ø 2,0 mm



Drill usage:
1000 rpm and abundant irrigation



The preparation is suspended once this diameter is reached, to allow the extenders (which have an external diameter of 3.5mm) to be guided into the newly created hole.

Lance drill Ø 2,2 mm



NB: after using the first 2.2 bur, it will be possible to use the depth gauge

Lance drill Ø 2,8 mm



Lance drill Ø 3,2 mm



Lance drill Ø 3,5 mm

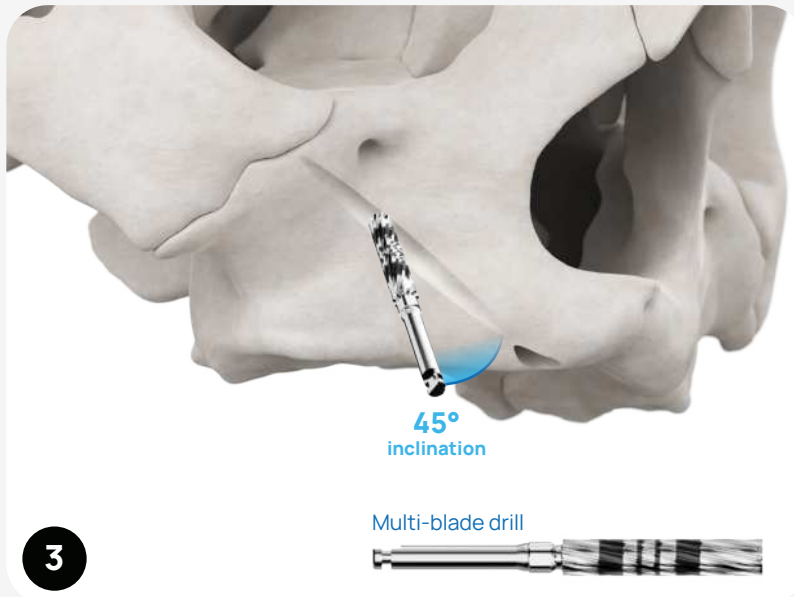


Drills usage:
150 rpm-standard protocol*
70 rpm-THC protocol
*Abundant irrigation is recommended.

The distinctive feature of the ZTA technique lies in its unique approach to creating a frustoconical-shaped telescopic cavity that copies the shape of the zygomatic implant.

This preparation enhances implant stability by generating a perfect fit that closely adapts to the implant structure, reducing micromovement and increasing primary stability.

STEP 2 Maxillary preparation I extra-sinus



The initial cavity serves as a guide for defining the trajectory, which orients the subsequent drilling phases.

The entry point is precisely selected to ensure an optimal path, avoiding excessive access to the maxillary sinus cavity while ensuring adequate bone contact.

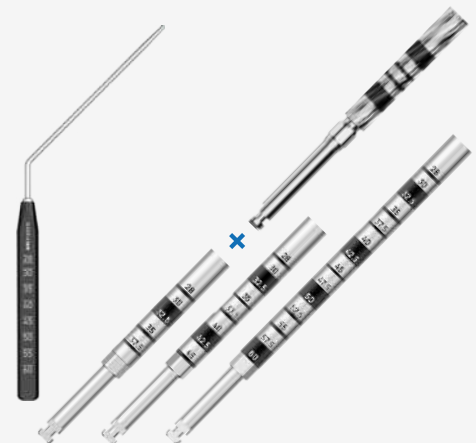
In this preparatory phase, the section connecting the crestal area to the implant insertion point in the zygoma is shaped.

After identifying the two reference anatomical landmarks, the multi-blade bur included in the surgical kit is used.

Initially, the bur is used directly on the handpiece, with controlled movements, to trace the trajectory between the two identified points.

Drill usage:
400 rpm and abundant irrigation

Once the implant site is outlined, the axial preparation is carried out by inserting the multi-blade bur onto an extender.



Guided by the crestal drilling performed in the previous step, the action is extended axially until it reaches the base of the planned insertion point in the zygomatic bone. In this phase, the implant bed is rectified, defining the site for the subsequent preparation of the malar bone.

STEP 3 Zygomatic preparation



The preparation of the malar bone is performed using a lance-shaped bur mounted on extenders, with the aim of shaping the implant site according to the required morphological specifications. The depth of the site is controlled through the use of specific gauges, with reference to the measurements previously determined using the stereolithographic model.

Lance drill Ø 2,0 mm



Graduated extender



Drill usage:
1000 rpm and abundant irrigation



Once the planned depth is reached, the final bur is used, characterized by a specific geometry for shaping the threaded portion of the implant.

Final drill Ø 3,5 mm (for Ø 3,5 implant)



OR

Final drill Ø 4,0 mm (for Ø 4 implant)



Graduated extender



Drills usage:
150 rpm-standard protocol*
70 rpm-THC protocol
*Abundant irrigation is recommended.



In order to verify the adequacy of the preparation and to correctly select both the implant size and the prosthetic component size, it is necessary to finish the crestal area. This operation is carried out using a 4 mm diameter bur, limited to the crestal portion of the implant site.

Final drill Ø 4,0 mm (crestal only)

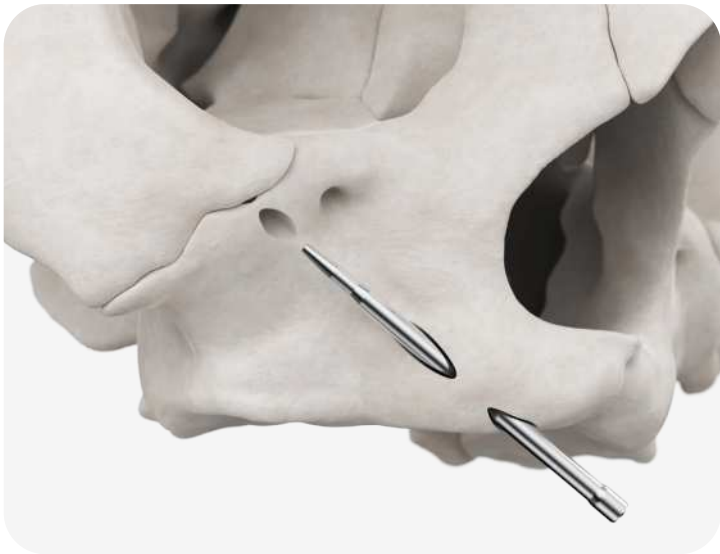


Drills usage:
150 rpm-standard protocol*
70 rpm-THC protocol
*Abundant irrigation is recommended.

Pre-Insertion Simulation with DEMO Implants

Once the implant site preparation is complete, the demonstration implants included in the surgical kit can be used to perform operational simulations. This phase allows for the verification of the correct depth and direction of the preparation, facilitating the selection of the most appropriate implant length and the identification of the most suitable prosthetic component.

Lengths included in the kit



Implant Placement

The implant placement is carried out by progressive screwing, with continuous control of the axis and depth to ensure constant contact with the zygomatic bone along the entire length of the implant. This method allows for the minimization of any micromovements and the maximization of primary stability, creating favorable conditions for effective osseointegration.

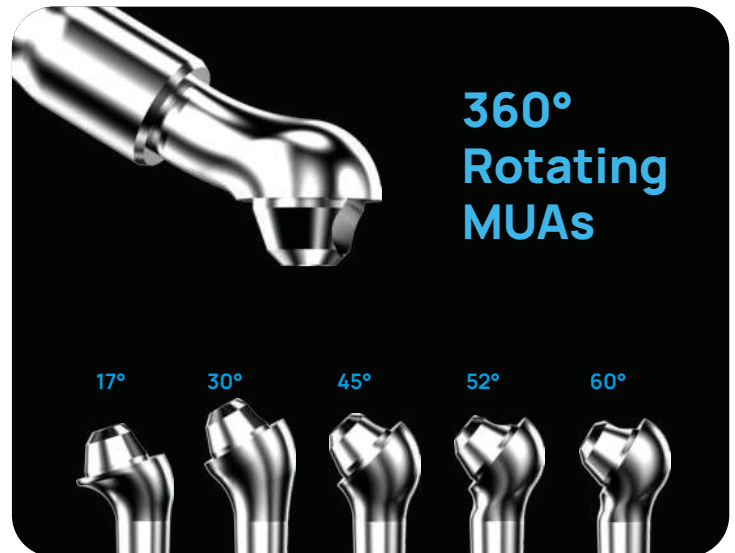


Stability Check and Abutment Selection

Following implant placement, primary stability is carefully assessed to confirm the adequate mechanical integration of the device.

In case of minor discrepancies, final adjustments are made to optimize placement accuracy. Subsequently, the previously chosen abutment is positioned.

In cases where implant stability is satisfactory, the protocol allows for immediate functionalization of the system with a first therapeutic prosthesis, contributing to greater treatment efficiency and a reduction in overall rehabilitation times.



360° rotating MUAs

The new REVCON Multi Utility Abutments offer a modern design, extremely suitable for clinicians who pay particular attention to soft tissues.

Their fully curved design is ideal for recreating the correct biological spaces. Thanks to their innovative shape, even at the most extreme angulations, the screw hole is closed by the placement of the prosthesis. The wide range of sizes and angulations, combined with the ability to rotate the abutment 360°, makes the product extremely versatile and easy to position and parallelize.

Site Closure and Post-Operative Management

The closure of the surgical site is performed with resorbable sutures to promote controlled healing of the soft tissues.

The post-operative protocol includes the administration of antibiotics (amoxicillin/clavulanic acid 875 mg/125 mg, for 7 days) for infection prophylaxis, associated with an anti-inflammatory treatment (ibuprofen 600 mg, for 5 days) for pain and inflammation management.

Patients are recommended a soft diet for a period of two weeks, with scheduled clinical follow-ups to monitor healing progress and promptly identify any complications.

NB: the data recommended by AON Implants for pain and inflammation therapy are generic and must be adapted for each individual patient.

Packaging opening

To handle the dental implant safely, follow the steps shown below.



1

Bi-phasic vial with a 5-year warranty. It is supplied already sterilized.



2

Remove the top cap by prying sideways with your thumb.



3

Extract the inner blister containing the dental implant.



4

Remove the red safety cap.



5

Use the mounter key included in the dedicated kit. It has a retention o-ring that ensures a perfect grip with the connection.



6

Insert the key into the connection until it is fully seated. NB: The o-ring must disappear into the connection.



7

Gently remove the implant.

Surgical kit **Implant sizes** **Prosthetic components**

List and product codes



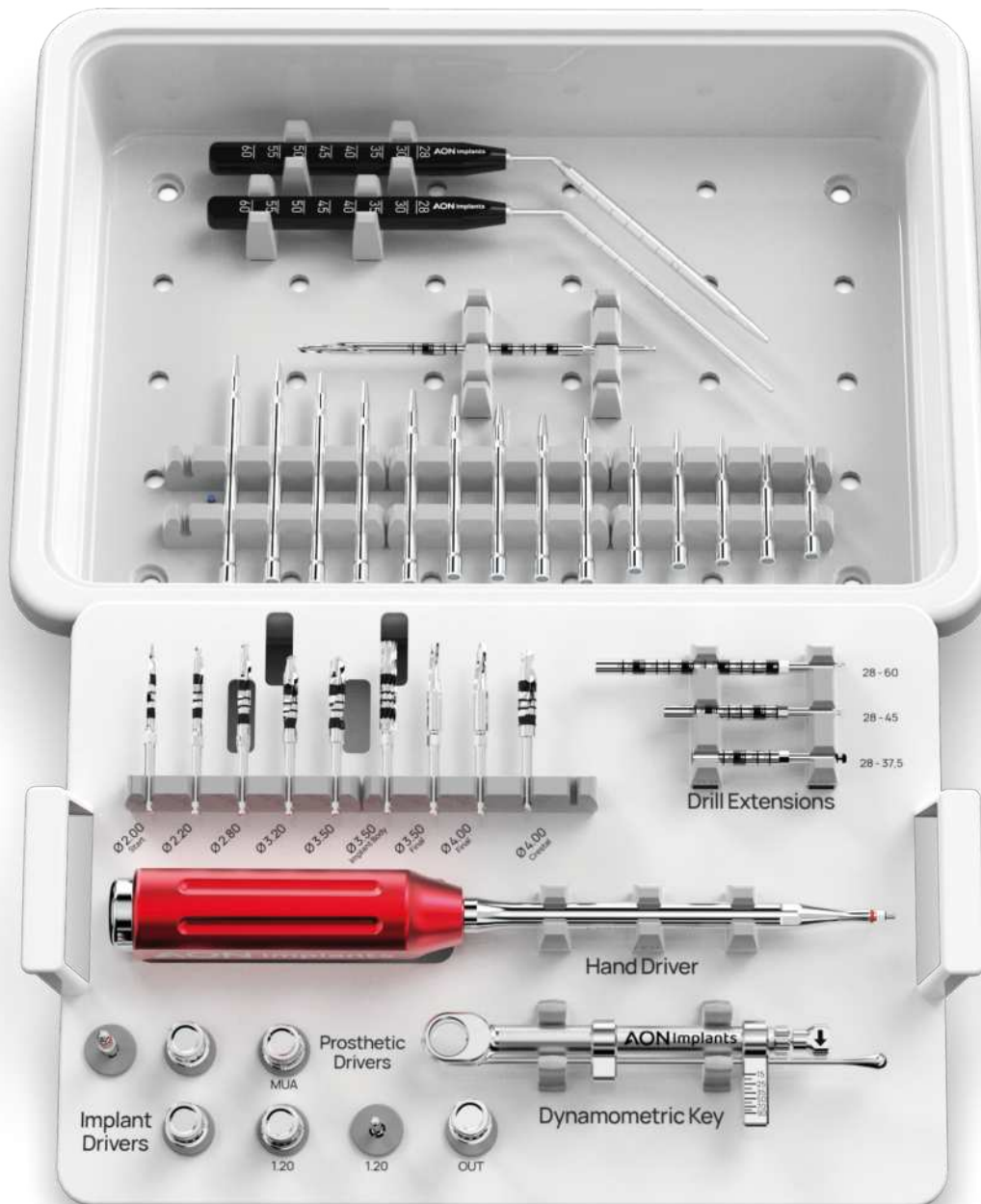
Kit with telescopic drills

The TAC ZYGO surgical kit is essential yet complete with all the instruments to tackle maxillary surgeries with the Z.T.A. technique.

The layout has been designed to neatly contain all the contents and includes the new short burs and bur extenders, equipped with practical millimeter markings.

With the depth gauges and Demo implants (with a polished, non-treated surface), it is possible to prepare the site with precision, checking it without risks and proceeding step by step.

It also contains the practical implant and prosthetic handling keys, as well as a precise dynamometric ratchet and a manual screwdriver.



	Length	Ø Tip	Ø Platform	Ø Coronal	Product Code
 Ø 3,5	28 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35280N200C
	30 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35300N200C
	32,5 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35325N200C
	35 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35350N200C
	37,5 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35375N200C
	40 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35400N200C
	42,5 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35425N200C
	45 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35450N200C
	47,5 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35475N200C
	50 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35500N200C
	52,5 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35525N200C
	55 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35550N200C
	57,5 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35575N200C
	60 mm	Ø 2,5 mm	Ø 2,8 mm	Ø 4 mm	ATZ35600N200C

 Ø 4,0	28 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40280N200C
	30 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40300N200C
	32,5 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40325N200C
	35 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40350N200C
	37,5 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40375N200C
	40 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40400N200C
	42,5 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40425N200C
	45 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40450N200C
	47,5 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40475N200C
	50 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40500N200C
	52,5 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40525N200C
	55 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40550N200C
	57,5 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40575N200C
	60 mm	Ø 3 mm	Ø 2,8 mm	Ø 4 mm	ATZ40600N200C

360° rotating MUAs

	Description	Options / Diameters / Heights	Product Code
 DW	Straight NB Multi-utility abutment	Ø platform 4,8 mm	H. 0,7 mm AMUNB007ST00C
			H. 1,5 mm AMUNB015ST00C
			H. 3,0 mm AMUNB030ST00C
			H. 4,5 mm AMUNB045ST00C
			Max torque 35 Ncm
			Prosthetic screw included
 DW	Angled NB Multi-utility abutment	Ø platform 4,8 mm	17° - H. 1,5 mm AMUNB015IN17C
			17° - H. 3,0 mm AMUNB030IN17C
			30° - H. 1,5 mm AMUNB015IN30C
			30° - H. 3,0 mm AMUNB030IN30C
			30° - H. 4,5 mm AMUNB045IN30C
			45° - H. 1,5 mm AMUNB015IN45C
			45° - H. 3,0 mm AMUNB030IN45C
			52° - H. 1,5 mm AMUNB015IN52C
			52° - H. 3,0 mm AMUNB030IN52C
			60° - H. 1,5 mm AMUNB015IN60C
			60° - H. 3,0 mm AMUNB030IN60C
			Max torque 25 Ncm
			Prosthetic screw included

DW → **Digital Workflow:** prosthetic components present in digital libraries.

REVCON Prosthetics

	Description	Options / Diameters / Heights	Product Code
 H. 2	Healing Screw Multi Utility NB Max torque 15 Ncm	H. 3 mm H. 5 mm	AMUNB030CG000 AMUNB050CG000 Prosthetic screw included
 DW H. 10	Bonding Cap Multi Utility NB Max torque 15 Ncm		AMUNB000CL000 Prosthetic screw included
 H. 10	Temporary Abutment Multi Utility NB Max torque 15 Ncm		AMUNB000PT000 Prosthetic screw included
	Castable Abutment Multi Utility NB Max torque 15 Ncm		AMUNB000CA000 Prosthetic screw included
	Analog Multi Utility NB		AMUNB000AD000 Prosthetic screw included
 DW	Analog Multi Utility NB Digital		AAD350000000B Prosthetic screw included
	Transfer Multi Utility NB		AMUNB000TM000 Includes H. 15 screw Optional H. 10 screw
 DW	Direct MUA Scanbody		ASBNB000000TI0 Prosthetic screw included
 DW	Direct Scanbody CC		ASB0000000TIC Prosthetic screw included
 DW H. 4	3POD Link MUA Max torque 15 Ncm	Shoulder H. : 1,3 mm	ALINB000000000 Prosthetic screw included

 → **Digital Workflow:** prosthetic components present in digital libraries.

AON Implants All or Nothing

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Scan the QR CODE
with your smartphone