

CYTOFLEX®

TEF-GUARD®

Microporous ePTFE Membrane

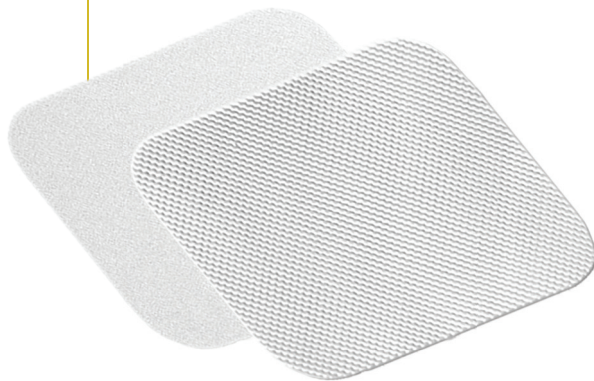
“I generally achieve good bone regeneration after 4-5 months of healing... I like the ease of use and would recommend Tef-Guard® products for socket grafting.”
- Dr. David Kao, Los Angeles, CA - 600+ Cytoflex® Tef-Guard® membranes

The Cytoflex® Tef-Guard® microporous ePTFE membrane is designed to resist the penetration of fibroblasts and bacteria, while allowing the exchange of interstitial fluids through the membrane. The microporous design enhances gingival tissue attachment and provides a favorable habitat for guided tissue regeneration. The flexible membrane conforms to the grafted site, and is easily retrieved as one piece after completion of bone growth. Cytoflex® Tef-Guard® ePTFE membranes are recommended for less invasive socket grafting technique.



Available in 12m x 24mm & 25mm x 30mm sizes

Available as smooth or textured



Micro Pore Advantages

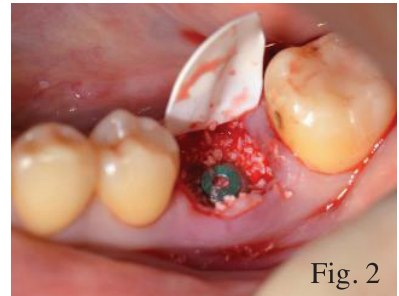
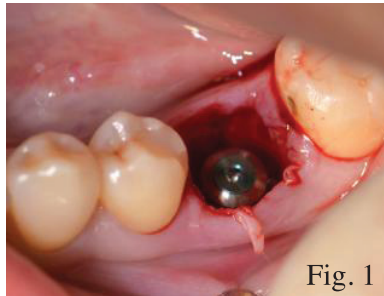
- Better barrier for bone regeneration
- Better host tissue attachment
- Soft and easily conformable

Cytoflex® Tef-Guard® - Clinical Case Review

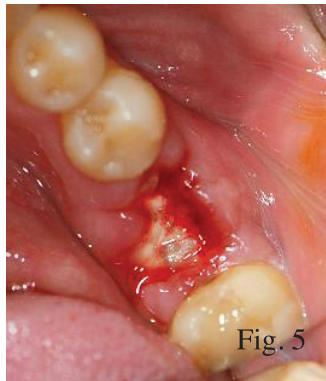
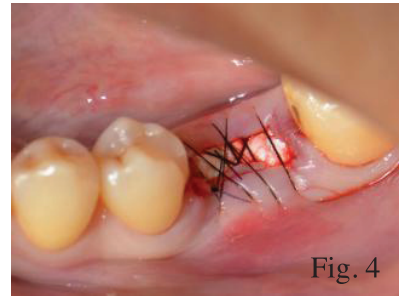
MINIMALLY INVASIVE IMPLANT SITE GRAFTING TECHNIQUE *Jenchun Chen DDS*

This is a 38 year-old female who presented a crown-root fracture of the mandibular first molar and a thin gingival biotype. An immediate implant placement following tooth extraction was planned. A flapless, minimally invasive extraction and implant placement combined with guided tissue regeneration was employed to minimize soft and hard tissue recession.

The tooth root was extracted with an intrasutural incision and a periosteal elevator. The extraction socket was curetted to remove all soft tissue remnants. After an implant was placed into the extraction site, the gap between the implant and the socket wall was filled with bone graft particles (Figures 1 & 2).



A Tef-Guard® ePTFE membrane was trimmed to extend 3 mm beyond the socket walls and then tucked subperiosteally under the lingual flap, the buccal flap and underneath the interdental papilla using a curette. The membrane was allowed to rest passively over the socket (Figure 3), and was stabilized with a criss-cross absorbable PGA monofilament suture without primary closure (Figure 4).



After one-week post operation, the graft site was uneventful, and the suture was removed (Figure 5). At three-week post-operation, the soft tissue overlying the exposed membrane demonstrated healing without signs of inflammation. An inadvertent fold in the membrane (introduced during membrane placement) was found at the distal buccal corner (Figure 6).

The decision was made to remove the membrane early to prevent potential complications as a result of the folding of the membrane. After applying topical anesthetic, the membrane was easily removed by grasping with a tissue forcep. A dense, vascular connective tissue matrix was found underlying the membrane in the extraction socket upon membrane removal. Figure 7 shows the site at one week after membrane removal.



Following membrane removal, keratinized gingiva formed over the grafted socket. At six-week post-operation, the soft tissue was stable with preserved interproximal papillae and natural mucogingival architecture (Figure 8). This case demonstrates the effective use of a less invasive grafting technique using a micro porous ePTFE barrier.