

# FOCUS ON PRAMA

**VOL.1**

*Guidelines for the positioning and  
rehabilitation of PRAMA implants.*

**SINGLE CROWNS**

  
sweden & martina

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# Prama: an overview on its first **DECADE OF CLINICAL USE**

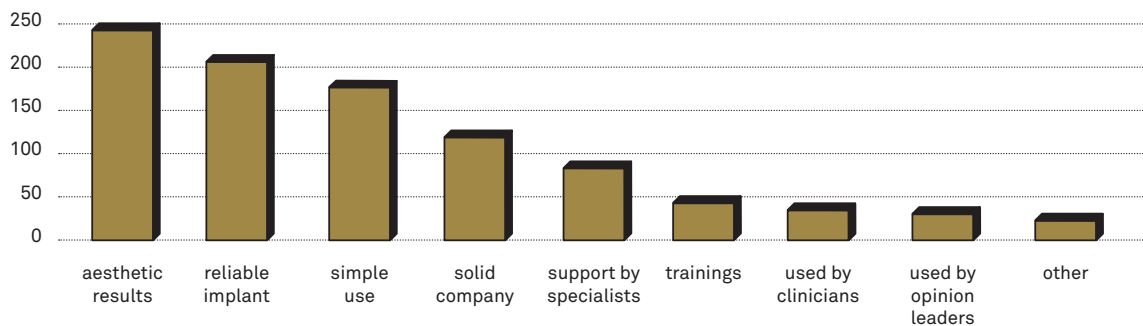
Among the many advantages of Prama there are the freedom of positioning and prosthetic approach. In these 10 years of clinical history, simple and predictable operating protocols have been consolidated from the experience of thousands of users all over the world. This first booklet was created precisely to share with all of you the main indications for positioning and use regarding rehabilitations on single implants; further volumes will follow, which will deal with multiple rehabilitations, conometric prosthesis, the use of the implant in context with regenerative procedures, and more. This is a summary of some of the data collected through interviews with users who we asked to describe their experience in different clinical conditions, also to the advantage of those who are approaching this very versatile implant for the first time.

*“It is important to systematically analyze data on clinical use in years to understand how experience shapes the use of a versatile device.”*

**Cristiano Tomasi**  
Coordinator of the statistical analysis of users' responses to the interview on Prama



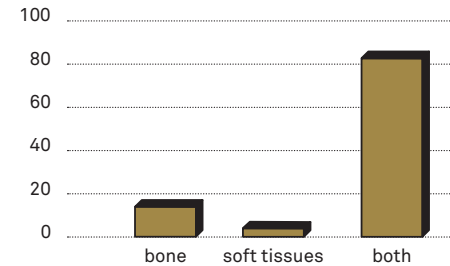
## Why do users choose Prama?



Prama is chosen because it is a reliable system that allows for excellent aesthetic results with simple use.

The solidity of the company has a bearing on the choice of the system to use.

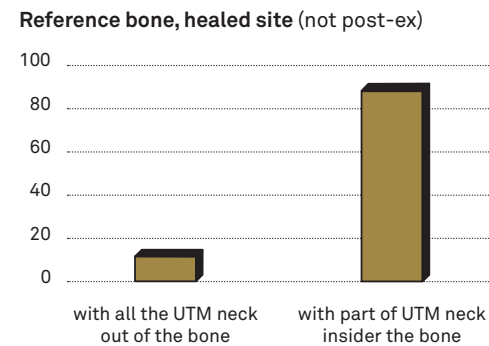
## What reference do users adopt to position Prama?



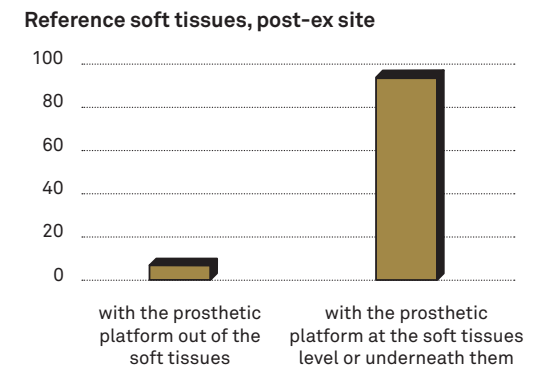
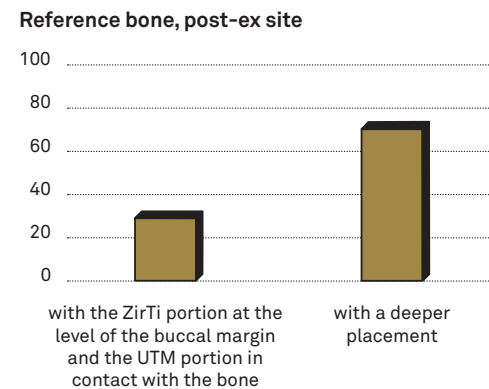
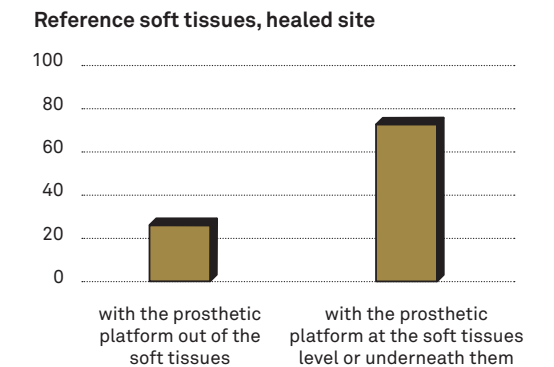
The positioning of Prama is planned considering both the bone level and the thickness of the soft tissues.

## How do users position the neck when

taking the bone as a reference?



when taking the soft tissues as a reference?



Intramucosal positioning is always preferable.

# The one and only **INTRAMUCOSAL IMPLANT**

Prima is an intramucosal implant, composed by an endosseous body with ZirTi treatment and a neck with UTM surface.

The implant is characterized by  
3 different areas:

## Neck

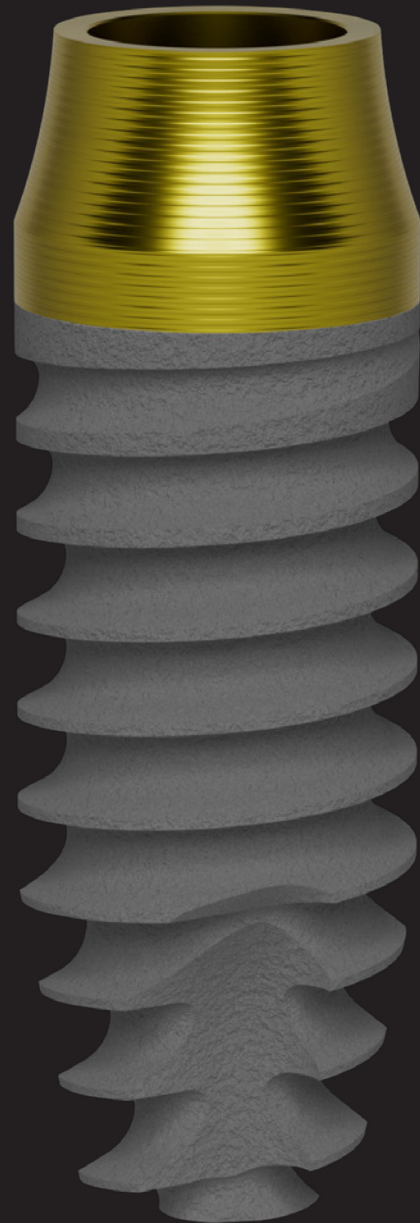
Convergent portion with UTM surface

## Neck

Cylindrical portion with UTM surface

## Body

with ZirTi surface



## Neck

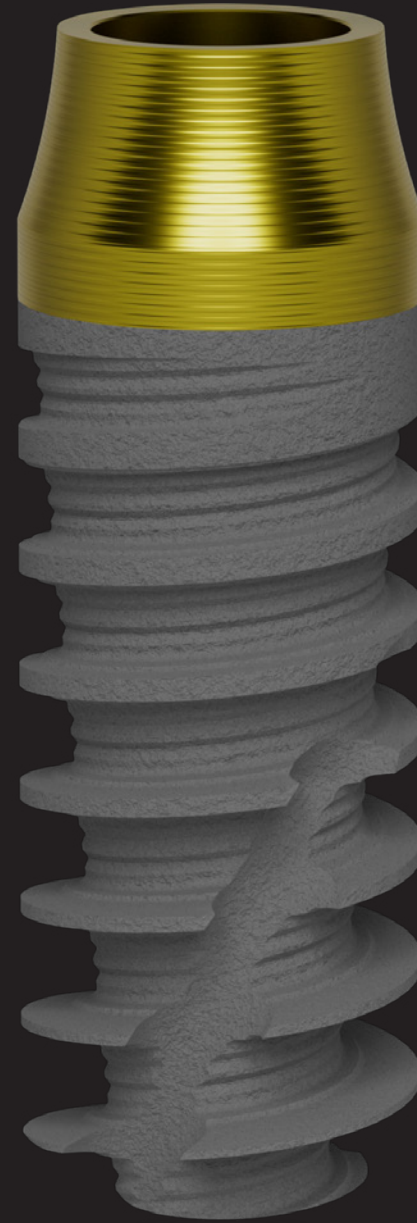
Convergent portion with UTM surface

## Neck

Cylindrical portion with UTM surface

## Body

with ZirTi surface



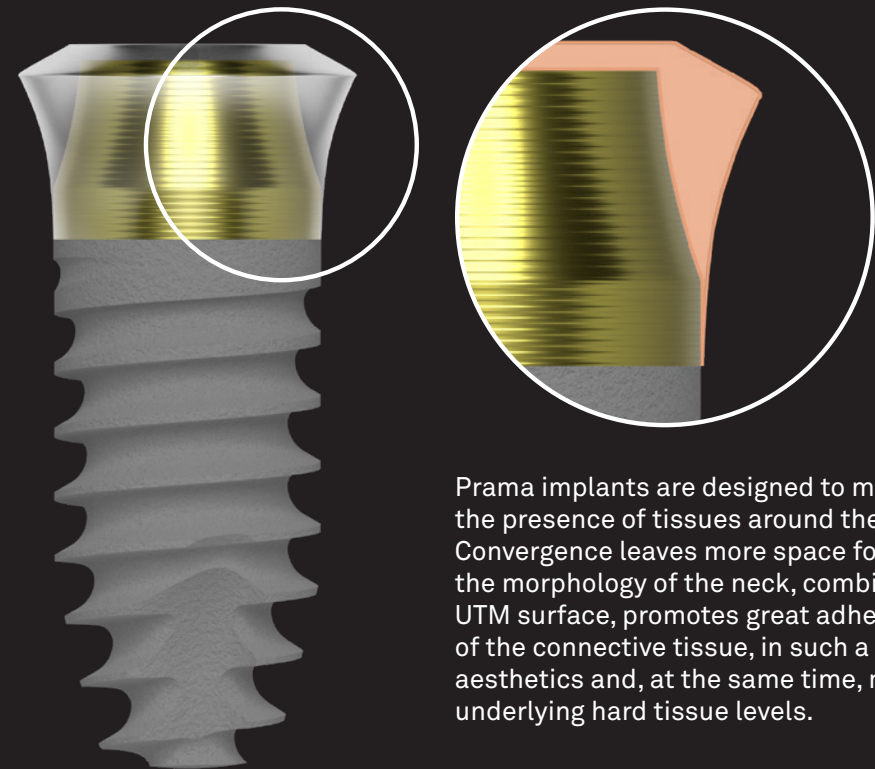
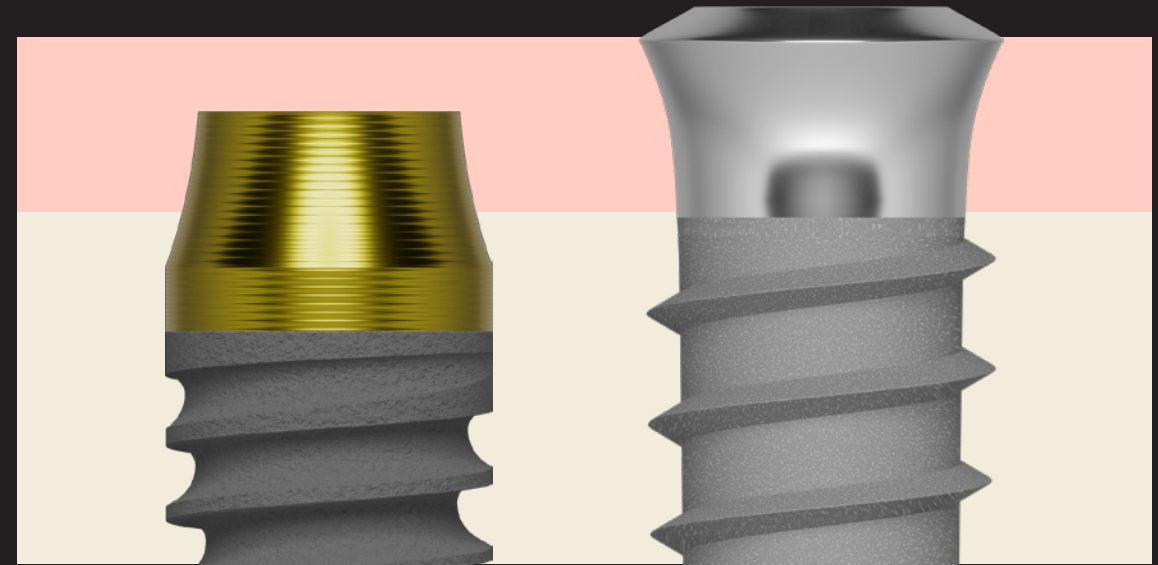
# What does INTRAMUCOSAL mean?

Given their morphology, these implants do not have intrinsic stops that prevent deeper insertion, as normally happens with all transmucosal implants with the characteristic divergent neck, thus allowing the positioning of the connection platform within the soft tissues.

This feature of Prama offers great clinical freedom and many biological possibilities and advantages. The volumes around the coronal portion of the implant are filled, after placement, with the clot and by important regrowth factors, which will turn into thick and functional soft tissues.



Prama implants have the advantages of traditional tissue level implants, as the junction point between implant and prosthesis (the so-called "implant platform") is far from the bone, with all the related and widely known biological benefits. However, the real advantage and distinctive feature of Prama lies in being INTRAMUCOSAL.



Prama implants are designed to maximize the presence of tissues around the implant neck. Convergence leaves more space for soft tissue, and the morphology of the neck, combined with the UTM surface, promotes great adhesion and stability of the connective tissue, in such a way as to favor aesthetics and, at the same time, maintaining the underlying hard tissue levels.

# Guidelines for the insertion of PRAMA with **INTRAMUCOSAL** **PROTOCOL**

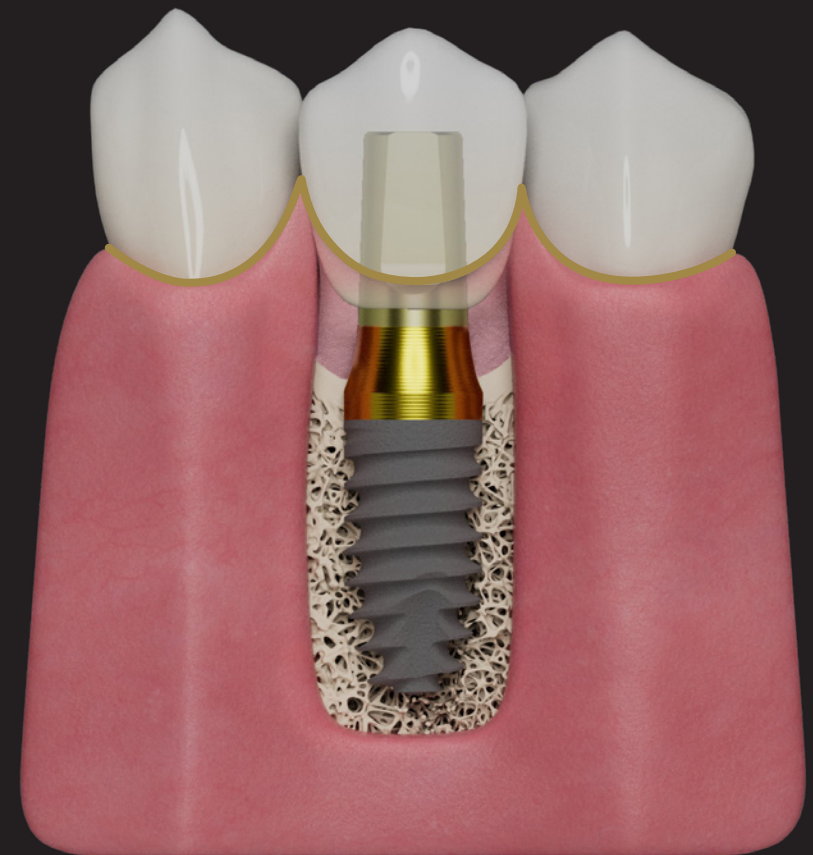
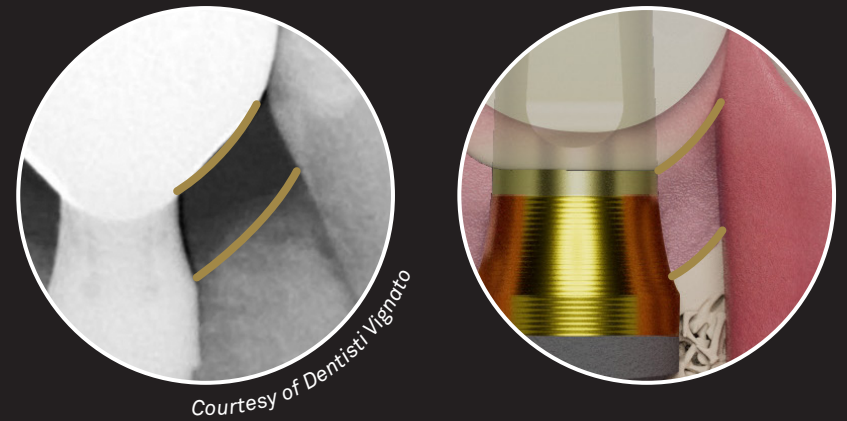
## PRE-OP SITUATION

The insertion of Prama implant should be planned starting from the prosthesis. The desired profile of the parabola is to be taken as a reference, which must be harmonious with the festooning of the adjacent elements or of the contralateral element.



## FINAL SITUATION

Literature and clinical experience show that after the healing a bone remodelling occurs, that is parallel to the emergence profile of the prosthetic crown, approximately 3 mm from the latter. Therefore, the positioning of the implant should be such as to maximize the biological space available for the connective tissue. The use of a vertical post will allow the crown to close at the desired level, with its zenith positioned at least 1 mm below the gum margin. Bone remodeling and regrowth of the soft tissues will take place in an optimal manner and maximizing the aesthetic and functional results of the rehabilitation.

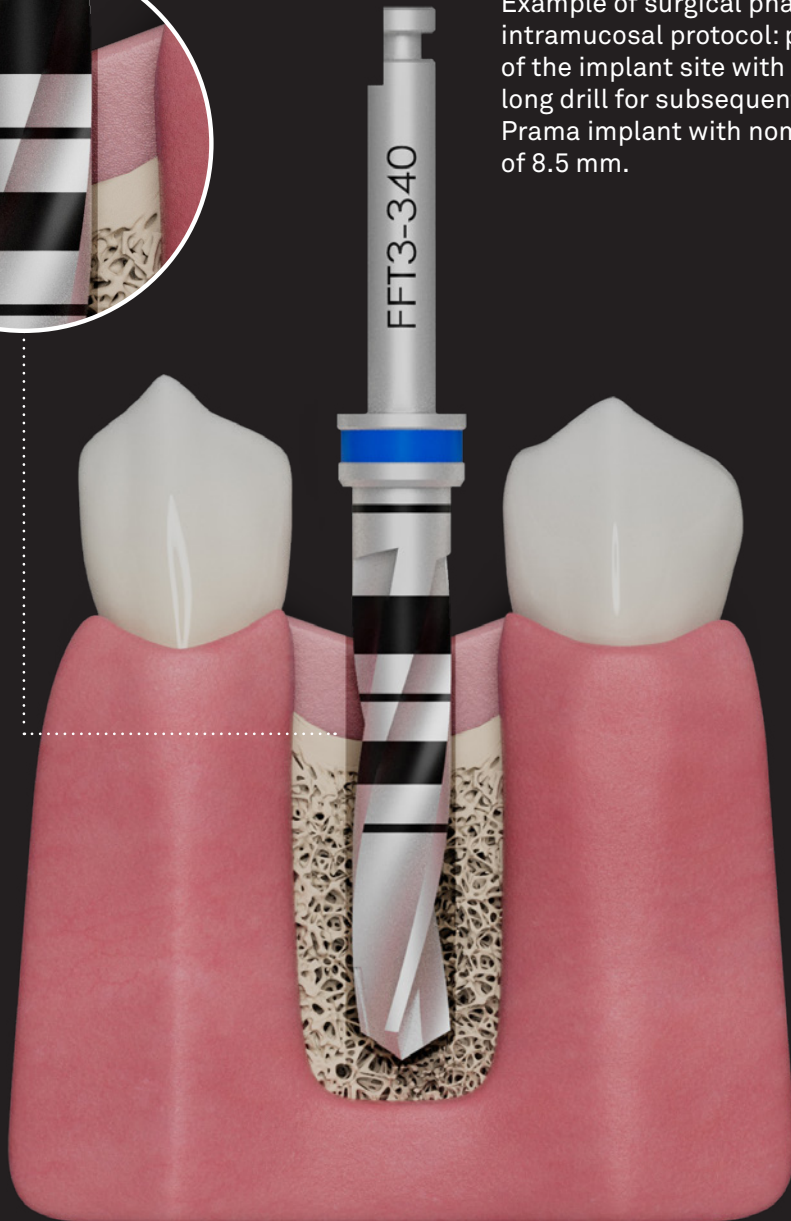


## Surgical phase

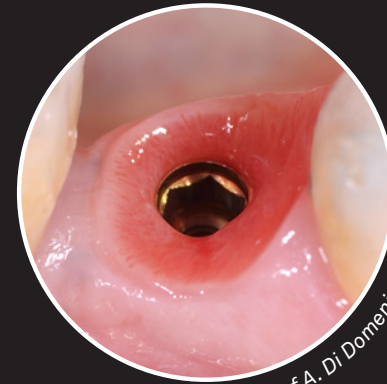
In light of what we have just seen, the implant should be placed sufficiently deep. Therefore, the advice is to choose the implant at least one length shorter than the depth of the prepared site. For example, if the available bone allows the insertion of a 10 mm implant, a 10 mm long hole will be prepared, but a 8.5 mm implant will be placed, and the insertion depth will be modulated up to the level in such a way as to take advantage of the intramucosal potential of the Prama neck.



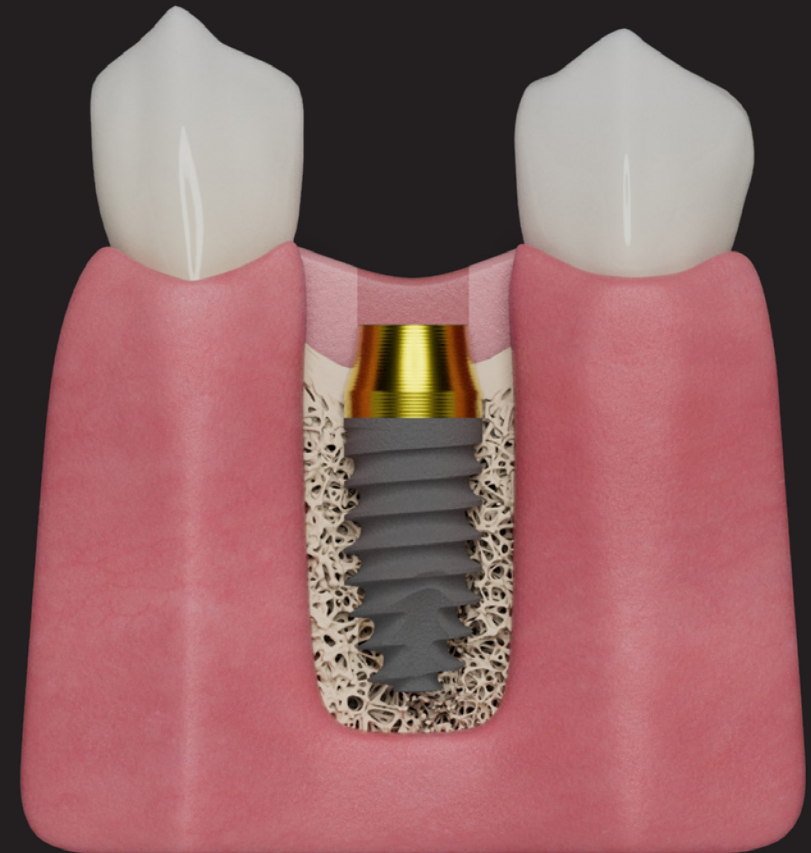
Example of surgical phase with intramucosal protocol: preparation of the implant site with a 10.00 mm long drill for subsequent insertion of Prama implant with nominal length of 8.5 mm.



By inserting Prama implant with the intramucosal protocol, a part of its UTM neck will go inside the bone and a part will be in the soft tissues, in order to fully take advantage of the benefits of the UTM micromorphology and convergent macromorphology.



Courtesy of A. Di Domenico



**Do you know why the synergy between UTM micromorphology e convergent macromorphology of the Prama neck has a significant impact on the quality of peri-implant soft tissues?**

Read the complete article published on the Clinical Oral Implants Research



# What if the patient has a **VERY THIN GINGIVAL BIOTYPE?**



## PRE-OP SITUATION

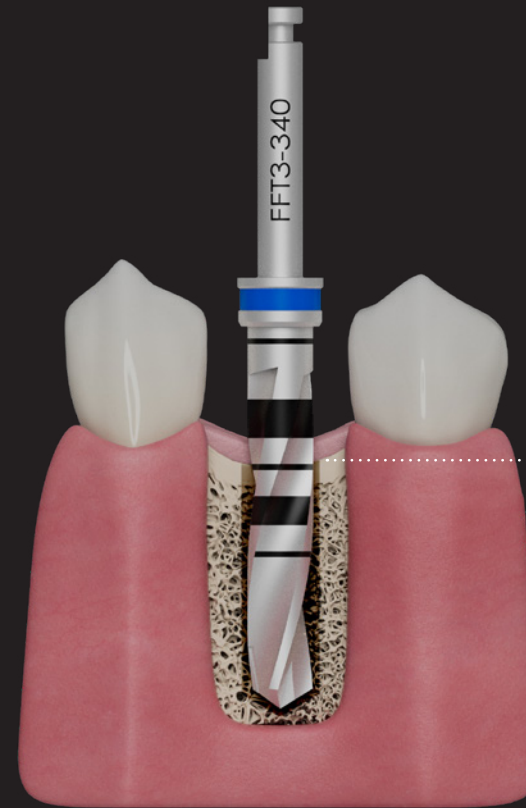
In case of particularly thin gingival biotype (approximately 1 mm of gum), the protocol for intramucosal insertion and for subsequent rehabilitation of a Prama implant does not change. Just further deepen the level of insertion of the implant into the bone, procedure possible thanks to the UTM surface of the Prama neck that works in an excellent way also in contact with hard tissues.

## FINAL SITUATION

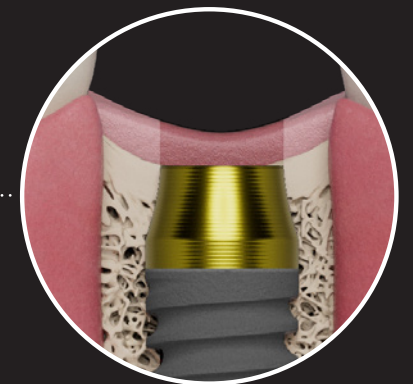
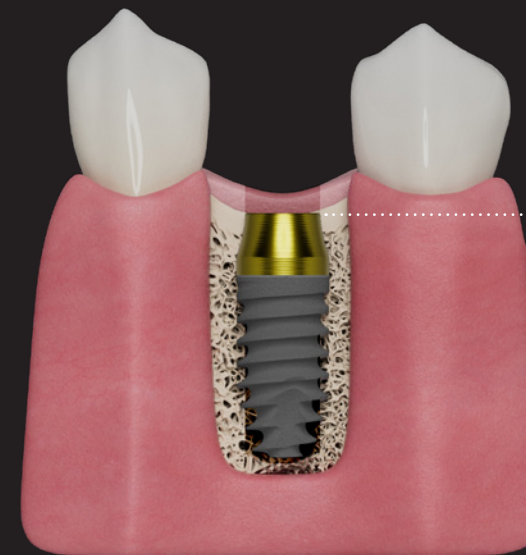
Planning always should start from the prosthesis: once designed the position of the prosthetic crown, whose zenith will always go assumed approximately 1 mm below the gingival margin, the insertion of the implant follows the protocol described in the previous pages.



## Surgical phase



In case of thin biotype, since a deeper placement is needed, it is recommended to choose a shorter implant length. In the example on the left, the drill is used at the depth of 11.5 mm for the insertion of a 8.5 mm long implant.

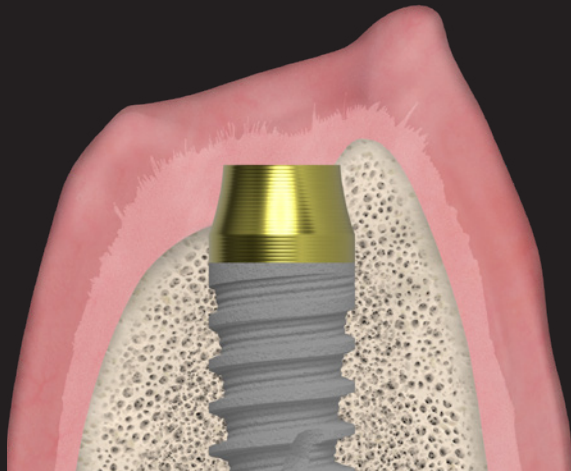




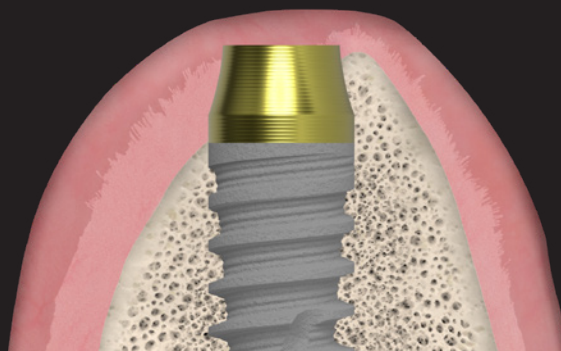
# Insertion in case of POST-EXTRACTION PROTOCOLS

In the case of post-extraction protocols, there is always a discrepancy between the height of the buccal bone and that of the lingual or palatal bone. In some cases, the buccal wall it may also have defects of a certain extent. In these cases, the ideal positioning of Prama implants is to place the platform at the level of the lingual or palatal bone, leaving the UTM surface exposed vestibularly, making sure that the entire ZirTi portion is in the bone. **The recommendation is to always place the ZirTi surface entirely in contact with the bone.**

Placement in post-extraction socket



Healing



Alternatively, in the case of a post-extraction socket an implant with long neck can be used (PRAMA LONG NECK) in cases where the difference in height between the buccal bone and lingual or palatal bone is excessive and the standard neck is too short to compensate for the difference in height.

X-ray follow up of a Prama Long Neck placed in a post-ex socket.



Courtesy of Guillermo Cabanes Gumbau

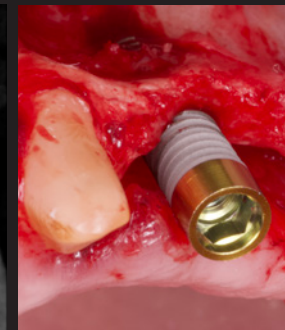
# Insertion in case of THIN RIDGES

In case of particularly thin crests, or with a knife-edge conformation (in which the most coronal part of the crest is very thin, and then widens widely after a few millimeters) the use of Prama SLIM implants allows you to face this type of clinical challenge with greater predictability and confidence.

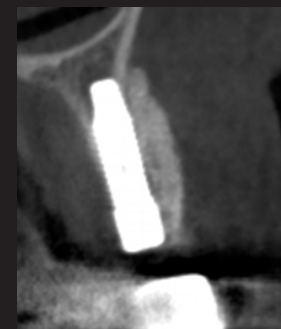
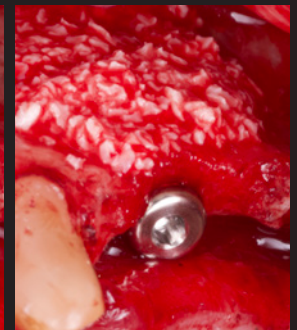
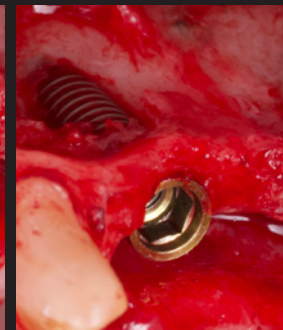
With Prama even surgery in very thin ridges is simpler and safer thanks to the Slim implant, with a constant diameter of 3.3 mm along the entire implant length. The presence of such a thin ZirTi treated portion allows you to make the most of the scarce amount of bone available and the UTM neck maintains the cylindrical geometry of the implant and exploits the benefits that its particular micro-threaded surface brings both in contact with the bone and with soft tissues.



Pre-op situation.



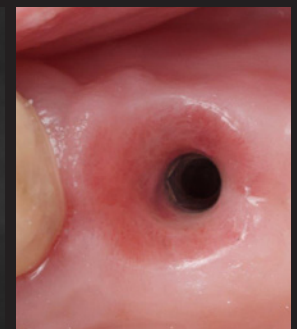
Insertion of the Prama Slim implant, which thanks to its geometry make the most of the scarce bone availability. Compensation of the defect with deproteinized bovine bone mineral particles.



After surgery CBCT.



Clinical and radiographic healing 13 months after surgery.



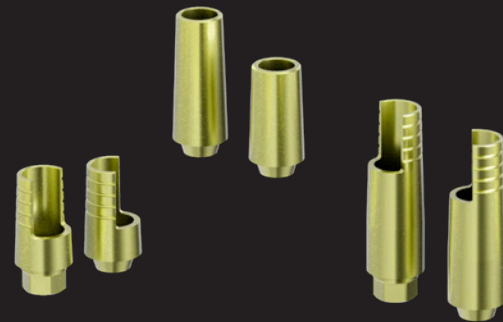
Clinical healing 15 months after surgery.

Courtesy of Andrea Di Domenico

# The choice of the PROSTHETIC COMPONENT

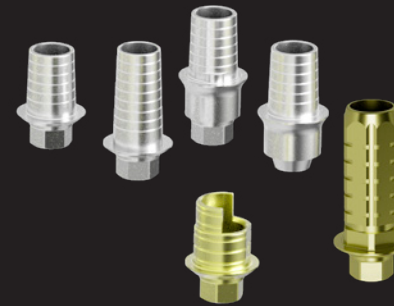
Prama's philosophy is to leave more space for soft tissues. Prama implants offer a rich selection of prosthetic components that allow you to rehabilitate single crowns, bridges and full arch in all situations, with digital workflow. Marginless and with margin options are available, and leave to the clinician the decision on where to close the prosthetic margin, either posts or bases with a predefined support base for luting the crown. Both cemented and luting options are available, for digital and traditional workflows. It is possible, in the case of a screw-retained prosthesis, to choose an angled screw hole.

Convergent shoulderless solutions or without base are available, with narrow or convergent profile, in which the crown can be positioned at different levels (L-MD or L-MDT). These solutions promote soft tissue thickening because they leave more space for connective tissue.



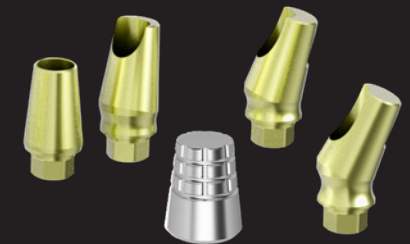
When single rehabilitation concerns a last molar element, an option is to use a "Prama IN" prosthetic solution which closes around the implant neck, allowing greater robustness to the rehabilitation, also in light of the important typical chewing loads of that area. The "Prama IN" prosthetic solutions may also represent a valid option in cases where, due to factors related to the patient's immune system response, bone and tissue remodeling was not the desired one.

Standard or cuttable T-Connects for straight or angled screw hole.



## CONICO prosthetic system:

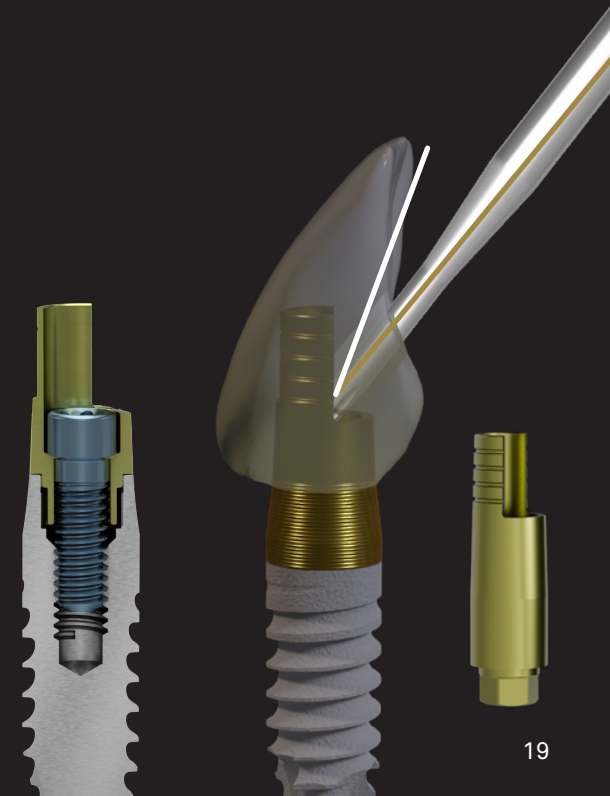
- fixed prosthesis without screws or cement;
- easy to remove: at any time the clinician can remove the prosthesis to perform a follow up and/or the hygiene;
- the conometric technique allows restorations from single elements to entire arches;
- biological seal and healthy and stable tissues over time.



## ANGLED SCREW HOLE

In the case of implants in the aesthetic area, which need an angulation between the implant and the post axis, it is recommended to place the implants deeper in order to be able to use bases or posts for luting with angled screw hole, so that the screw has a palatal access, consistent with the aesthetic needs.

Solutions for luting are available with support base for the crown, the so-called "Interphases", and without a base of support, the so-called L-MDT, which leave the clinician free to choose where to close the crown.

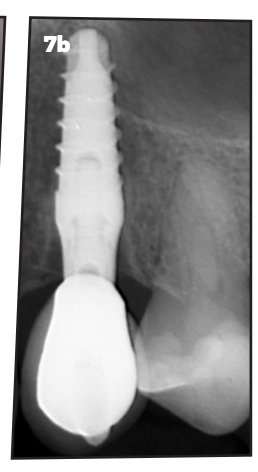
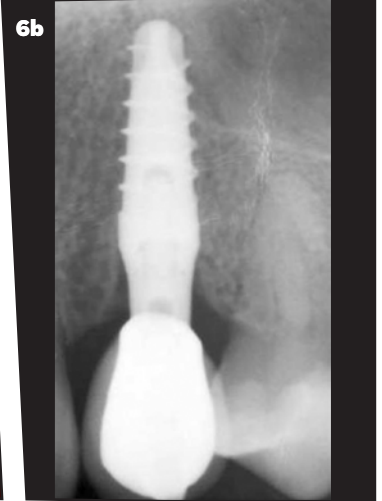
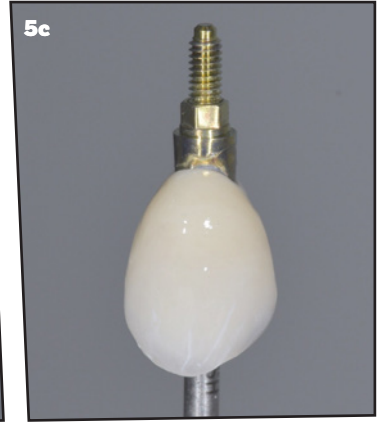
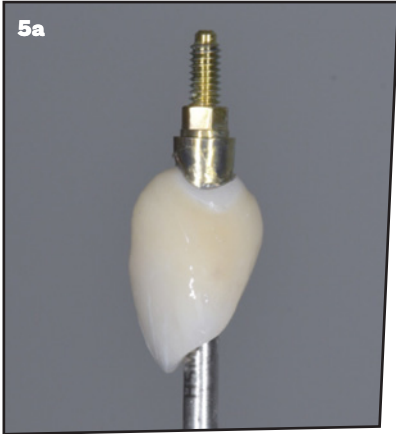


Do you know why cuttable T-Connects represent a versatile and easy-to-use tool?

Watch the video and find it out!







- 5. Details of the final prosthesis.
- 6. Clinical images and radiograph at final crown delivery.
- 7. Clinical and radiographic follow up at 2 years.













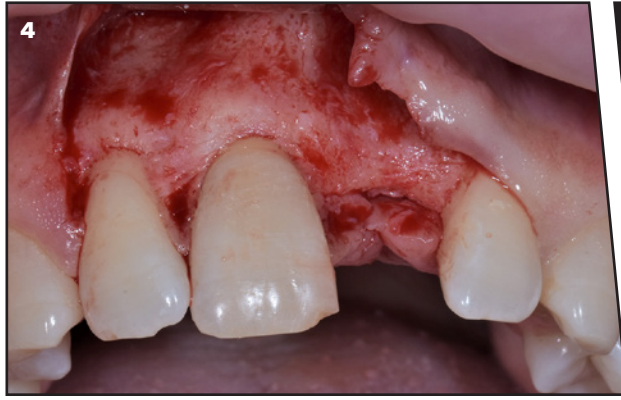








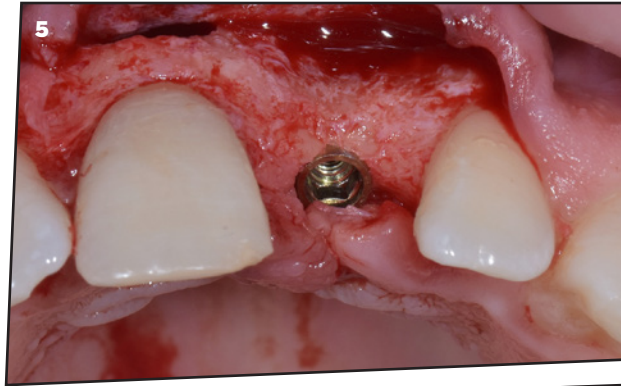




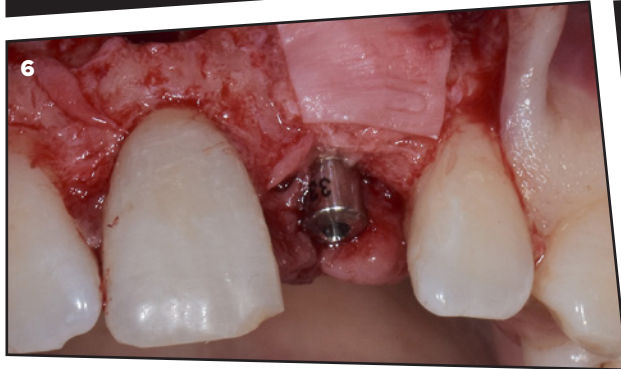
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After incision we raised a full thickness flap to see the bone because the direction of the implant was very important in order to make a screw retained crown.

The implant was inserted into a palatal position as we planned.



5



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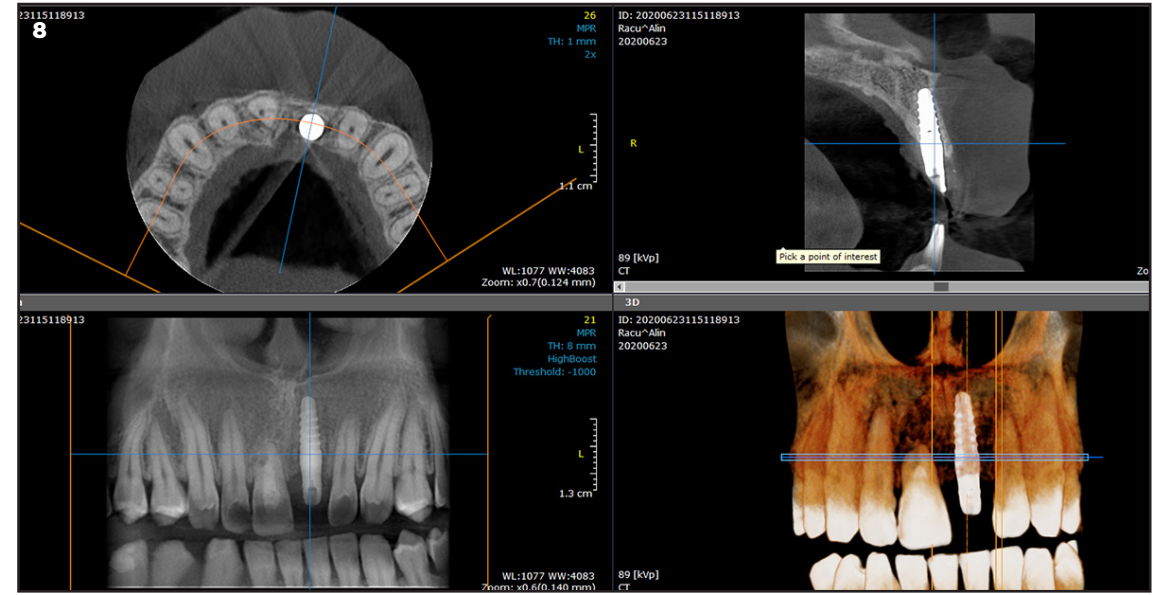
After insertion, a bone graft was added vestibularly, using deproteinized bovine bone covered by a collagen membrane.

No CTG was needed because we managed to restore the vestibular volume. In the same surgery an apical resection on tooth 1.1 was done.

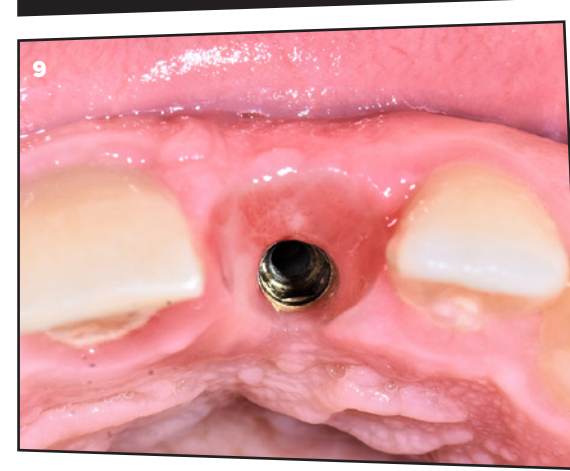
The provisional restoration had no contact with the lower jaw and was out of any guidance. However, the esthetic outcome of the provisional was not the desired one.



7



After 6 month the patient came back to the clinic for the final restoration. We performed a control CBCT to evaluate the peri-implant bone.



9



10

We used a custom impression technique that helped us to maintain the same emergence profile, being it stable. The dental technician made the zirconia crown over a straight repositionable abutment.

Afterwards the vestibular part was layered with ceramic. We corrected the zenith of the crown to make it look more natural. The part of the crown which is in contact with gingiva is just manually polished and not glazed. After the try in, we fastened the crown at 25 Ncm. The hole was filled with composite material.



Final restoration try in.



Final result.



Two years follow up.

The Prama implant have the proprieties to support immediate loading. Insertion torque was above 50 Ncm witch in great. The converging neck had a big impact on soft perimplant tissues stability, avoiding any bleeding during disconnections and connections of the provisionals, like a One abutment-one time approach.



## Bicortical anchorage to the maxillary sinus with **IMMEDIATE LOADING.**

 Diego Torralba García



Dental implantology has undergone a significant revolution with the introduction of advanced techniques such as guided surgery and immediate loading. In particular, the maxillary sinus lift has proven to be a crucial procedure to overcome anatomical limitations and provide a solid foundation for implant placement. This case explores the spectrum of guided surgery as a tool to plan the sinus lift, aiming to achieve bicortical

anchorage to facilitate sufficient stability for immediate implant loading. The strategic combination of these practices not only offers significant aesthetic and functional advantages but also presents an advanced approach to improving the effectiveness and predictability of outcomes in oral rehabilitation. Clinical cases like this support the synergy between guided surgery and prosthetic design, outlining a path towards a paradigm capable of transforming modern implantology.

The maxillary sinus lift, or anchoring to its cortical bone with minimal invasion, is a predictable and widely used procedure to facilitate the placement of dental implants in the posterior region of the atrophic maxilla. However, the immediate loading of the implant after the sinus lift remains a significant clinical challenge, particularly in terms of implant stability and long-term success. In this context, guided surgery emerges as a promising tool that optimizes the precision and safety of the procedure, while also improving clinical outcomes.

Guided surgery technology allows detailed three-dimensional planning and precise implant placement, reducing surgical invasiveness and minimizing the risks associated with the maxillary sinus lift. However, the feasibility of immediate loading depends not only on the surgical technique but also on the minimum torque required to stabilize the implant in compromised maxillary bone, whether due to height deficits or bone quality, as described in this case.



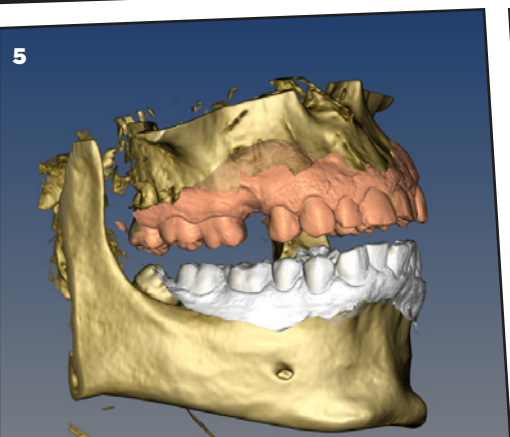
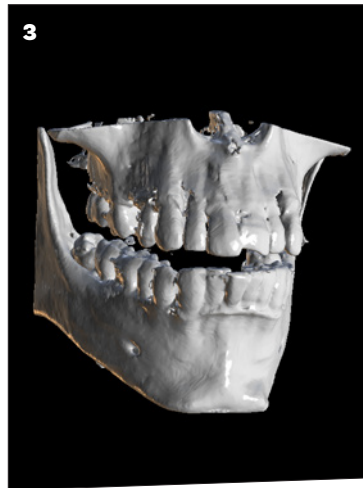
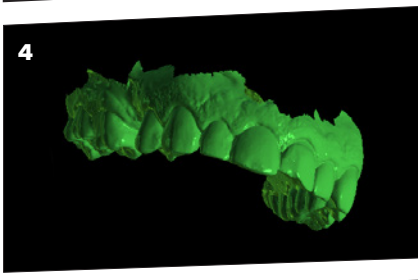
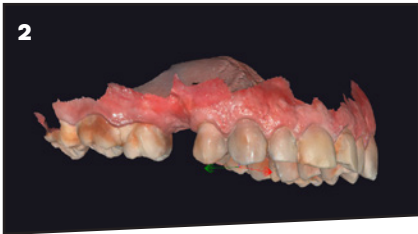
Watch the video  
MY PRAMA by dr. Torralba

57-year-old patient, with no significant medical history, presents at clinical examination with the absence of tooth 1.5, which was extracted due to a vertical fracture. Alveolar preservation was performed using particulate bone, presumably a xenograft, the manufacturer of which is unknown as the procedure was carried out in another dental clinic.

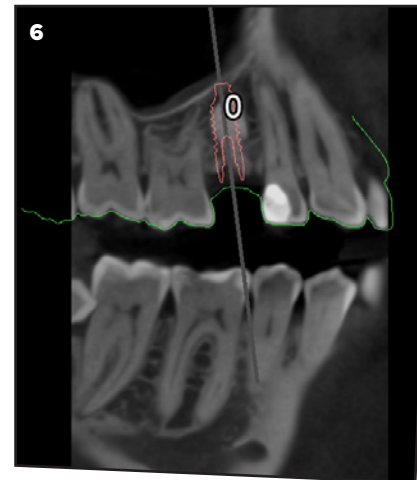


The patient states that more than 12 months have passed since healing. In the CBCT, we can observe that the particulate bone seems to have integrated with the soft tissue without achieving clear bone remodeling of the socket.

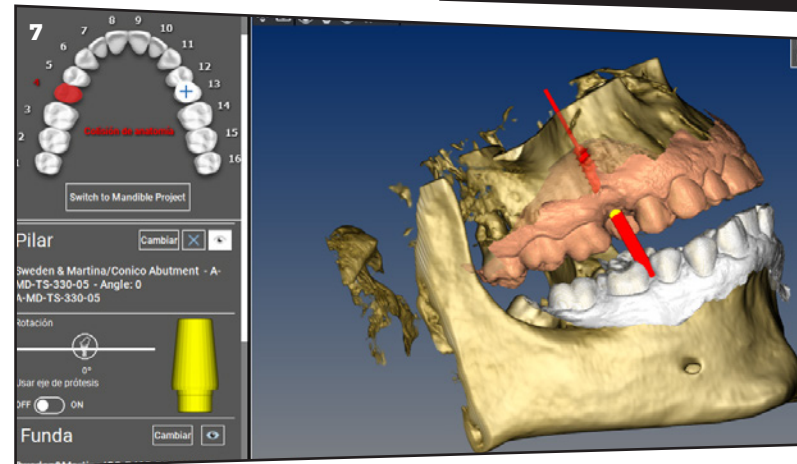
Scanning the patient's with a intraoral scan, we obtain the PLY and STL files, necessary to merge the different meshes.



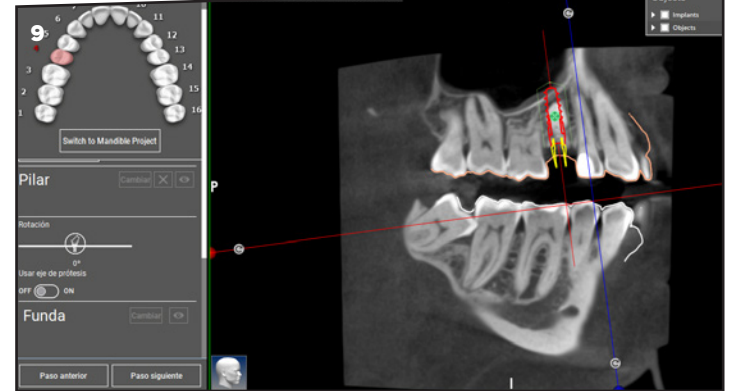
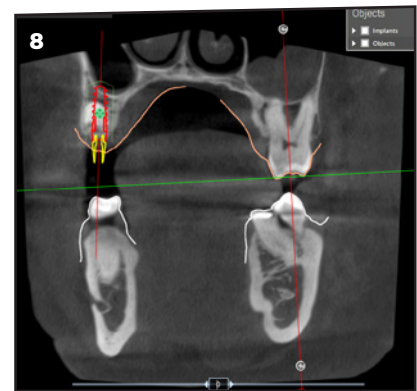
We then merged the meshes obtained from the CBCT files and those from the scanner. This allows us to verify both the bone tissue and the soft tissue, to make a prediction about the type of abutment to use in terms of both height and diameter.



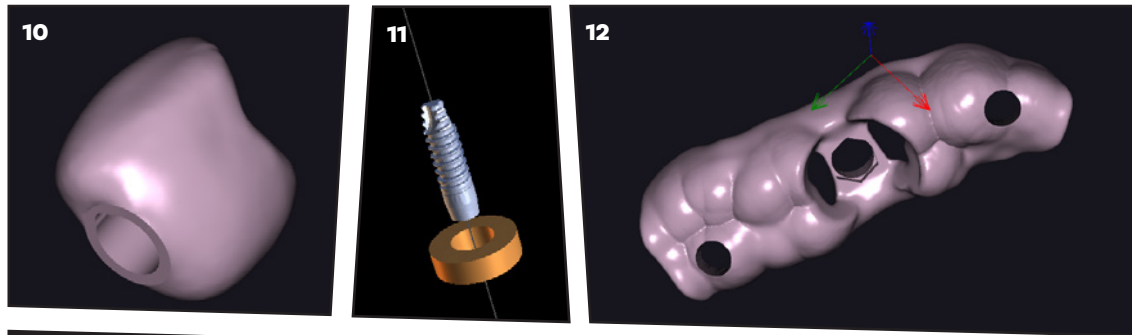
We planned the implant positioning using the Archiplan planning software (Sweden & Martina, Italy). In this case, we decide to place a Prama implant with a length of 11.5 mm and an intramucosal neck height of 2.8 mm, providing a total length of 14.3 mm. The RF SL body features a wider thread compared to a conventional Prama RF implant, which is ideal for providing higher primary stability and torque, required for immediate loading cases.



Thanks to the versatility of the libraries included in the Archiplan software, we can calculate the ideal prosthetic component for the crown, taking into account the thickness of the soft tissues and the gingival biotype.



Once our project is completed, the software automatically generates a milling protocol as established by the manufacturer Sweden & Martina. This ensures that the milling is as effective as possible for the selected implant model, adjusting the diameter and length of the drills to the characteristics of the implant body. We utilize the guided surgery kit specifically designed for Prama implants.



We create the crown design using a design software based on the exports of the meshes created in the Archiplan planning software. We draw the position of the abutment and the surgical guide.



We perform the segmentation of the maxillary CBCT to obtain a 3D printed bio-replica in polyamide to achieve a sensation as close as possible to the bone texture. This enables us to conduct a more realistic simulation of the surgery before performing it on the patient.



For further verification, we have 3D printed a crown in transparent acrylic, allowing us to see through it and check all the adaptations we had planned in the design. The final crown (fig. 14) will exactly replicate this morphology.

**SURGICAL PHASE**  
After a successful virtual and physical simulation of the patient and the surgical process, we can proceed with our guided surgery through immediate load prosthetics.



We apply the surgical template to the patient (fig. 16) and, using a circular scalpel, we make the mucosal incision and remove the tissue cleanly. We then proceed with the milling sequence established in the initial design.

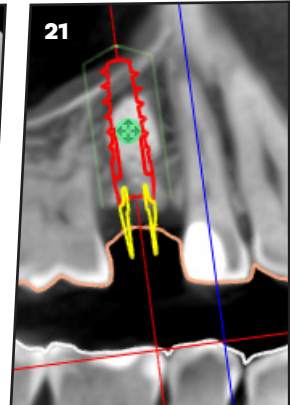


We mount the Prama implant using the mouter, which serves as a guide through the abutment inserted into the surgical template to achieve the correct angulation, easily observing the coincidence of the intended hex position. This phase is the most critical of the surgery as even a slight deviation of the implant hex could result in the inability to place the crown in its position. We adjust the final degrees of position manually using the carrier attached to the ratchet, which shows us an insertion torque of 50Ncm.



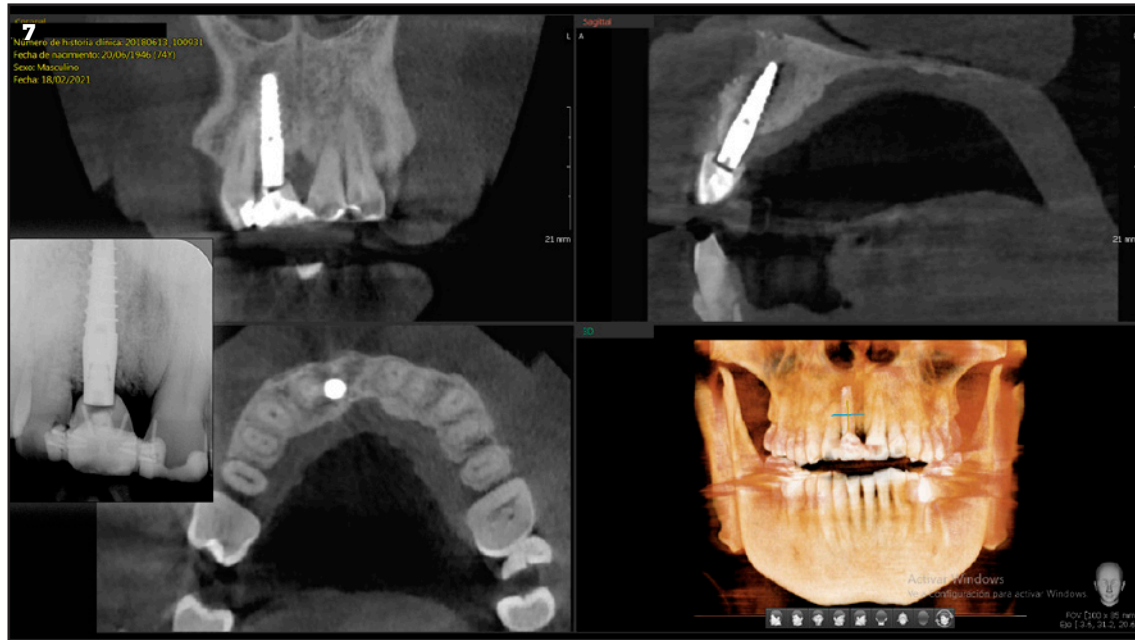
The position of the implant head remains subgingival, just as we had planned when overlaying the meshes from the intraoral scanner with those from the CBCT. After tightening, we observe that the position of the crown, both at the gingival and occlusal levels, is identical to the digital simulation we used for the design.

After placing our Teflon cap and verifying that the occlusion is as light as previously planned, we perform a follow-up radiograph. We then observe that the result is 100% overlapping with what was virtually planned and confirmed in the biomodels.

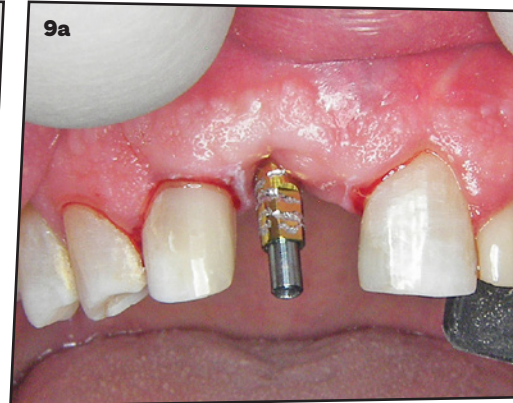


Two weeks follow up. Once again, it is demonstrated that preoperative planning is the foundation for the success of our surgeries.

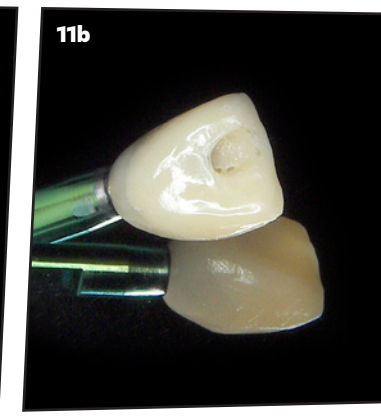
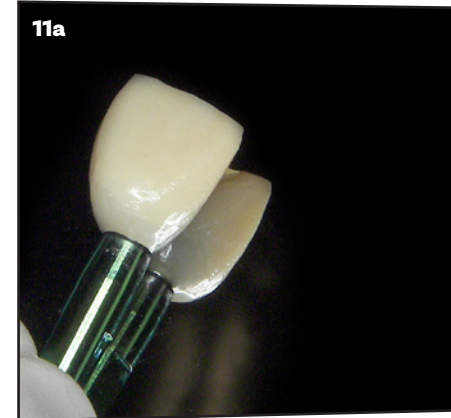
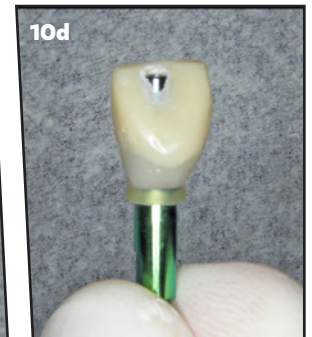
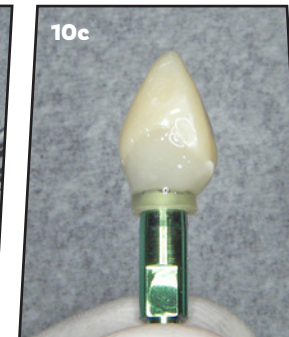
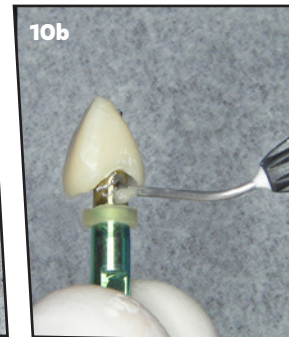




Intraoral xray and tomographic sections showing the three-dimensional position of the implant and the biomaterial used for regeneration.

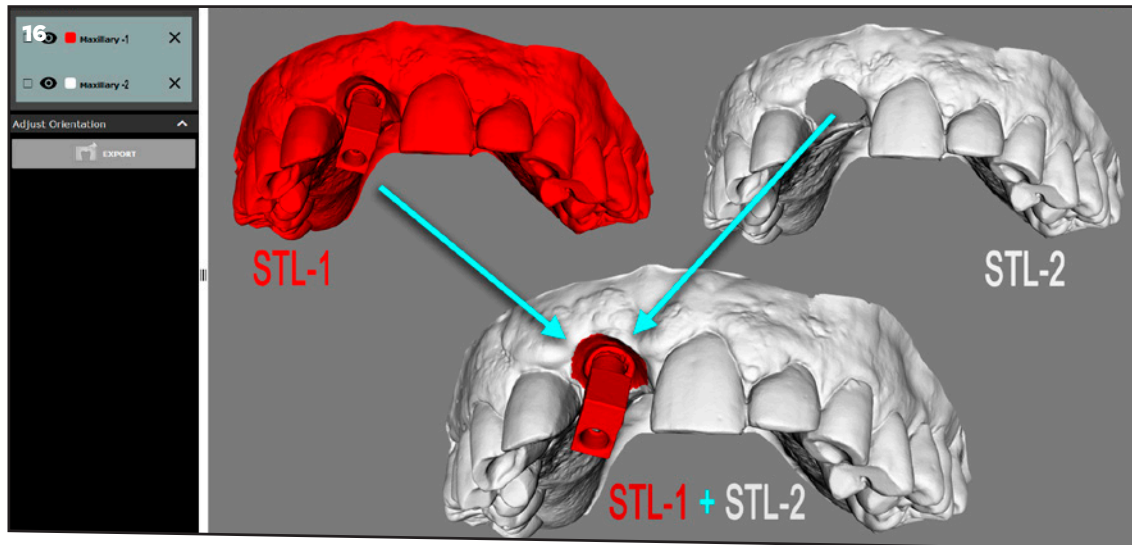
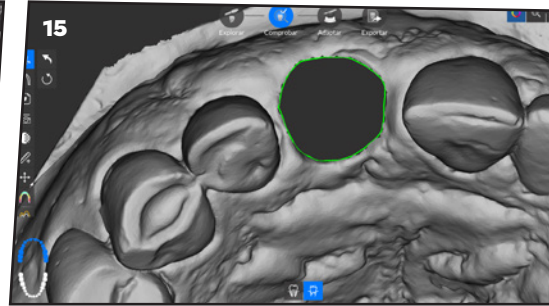
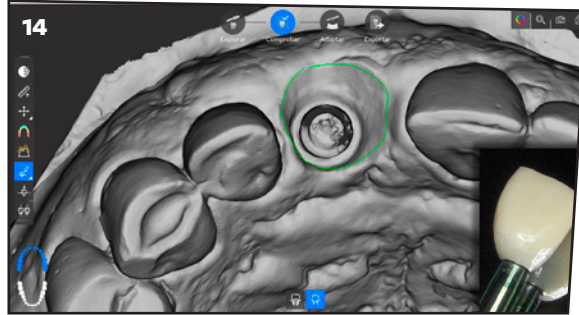
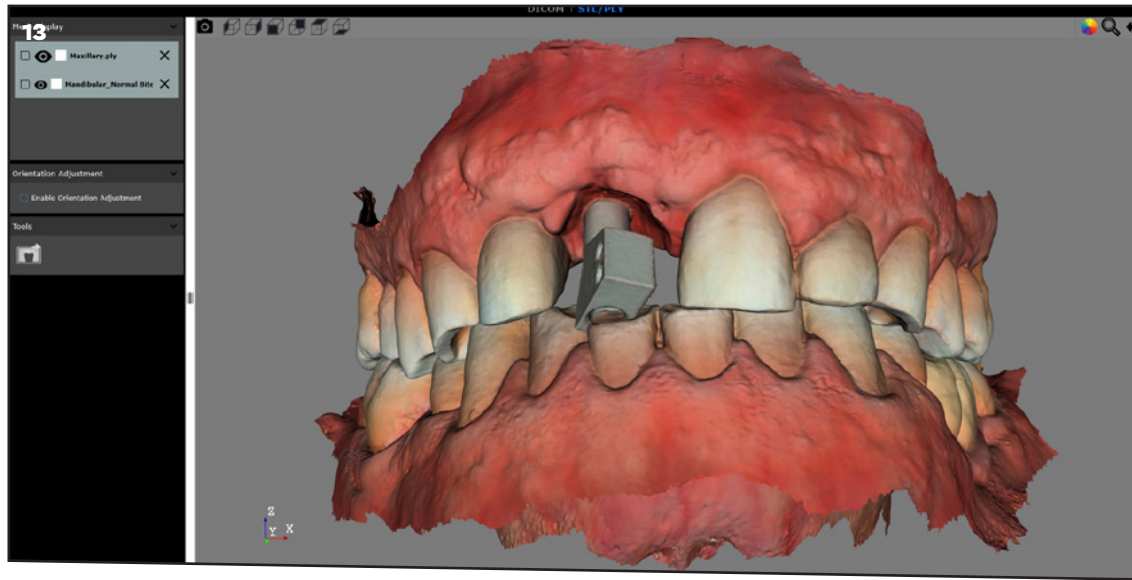


Maturation of the soft tissues around the healing abutment and its replacement with a chairside-adapted, cement-retained provisional crown.

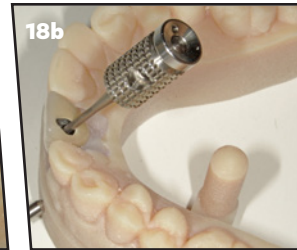


Chairside adaptation of a screw-retained provisional resin crown. After positioning the abutment inside the crown through relining with autopolymerizing resin, the emergence profile is created extraorally using a flowable photopolymerizable composite, applied conveniently and precisely with the use of a rubber guide on the implant analog. Proper final polishing of the generated emergence profile is essential for the correct evolution and adaptation of the peri-coronal mucosa.

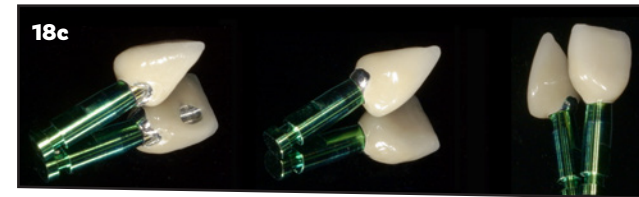




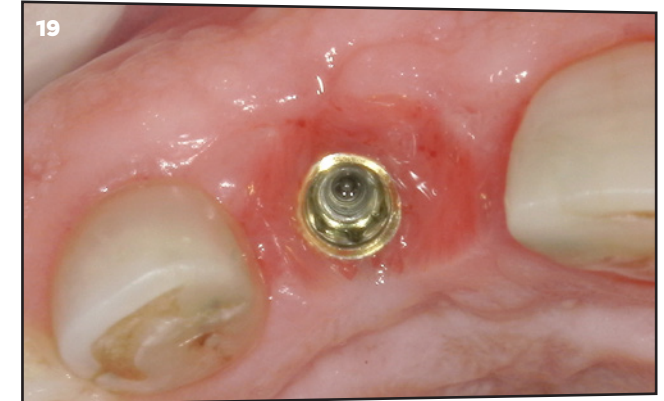
The impression-taking process is performed digitally using an intraoral scanner. Then, the desired cervical design is indicated to the laboratory using the software integrated into the intraoral scanner.



A metal coping with a customized morphology of the interproximal festooning is positioned on the Prama abutment for angled screw channel. The luted ceramometallic crown is placed on the prototyped model.



Maturation of the peri-implant soft tissues and frontal view of the definitive luted crown with a dynamic screw.



# SCREW RETAINED CROWN

on Prama implant in aesthetic area.

Paolo Nardinocchi and  
Laboratorio Camaioni Odontotecnici



The patient came to the clinic with a deep fracture of the 2.1 element that had affected the buccal wall. The tooth had a very short root but was mobile as it ankylosed. The restoration started from the extraction of the fractured element and the insertion of a Prama implant in a prosthetically ideal position: the emergence of the neck is positioned at the level of the apical margin of the adjacent teeth, being careful not

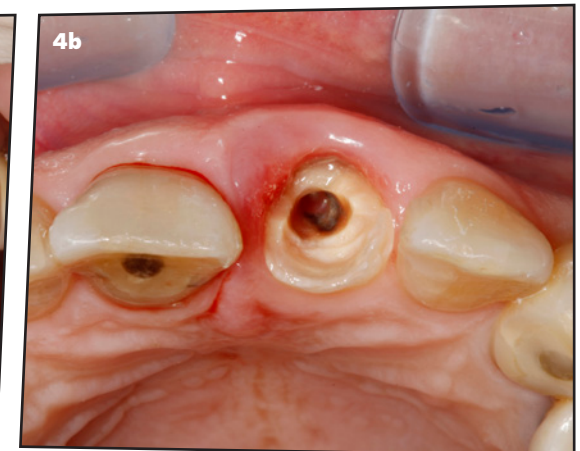
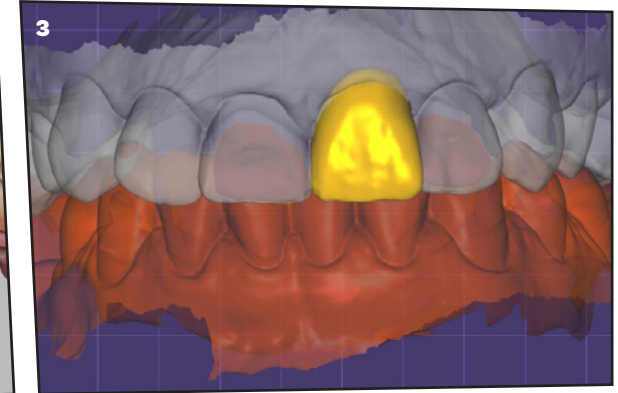
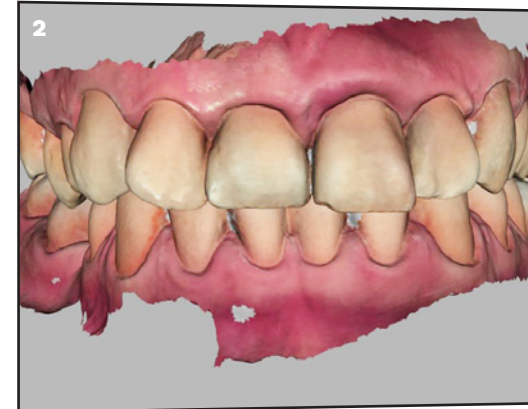
to come in contact with the buccal bone plate. This type of positioning is contraindicated when using tissue level implants with divergent or cylindrical neck because, being inserted in a more palatal position to avoid future recession of hard and soft tissues, they would force a prosthesis with a horizontal over-contour that could negatively influence the elimination of plaque by the patient, thus precluding the possibility of a cemented prosthesis due to the difficulty of removing excess cement. In this case, thanks to this positioning, it would have been possible to realize a definitive crown both screw retained or cemented. A screw retained crown was chosen, taking advantage of the benefits of the angulation offered by the Interfase Dinamica supports.

“The Prama implant allowed me to plan an ideal rehabilitation from the prosthetic point of view, positioning the emergence of the convergent neck at the level of the coronal edge of the adjacent teeth. This way it was possible to create a screw retained crown in the aesthetic area with an ideal and very natural emergence profile, also thanks to the possibility of realizing an angled prosthesis using the Interfase Dinamica.”

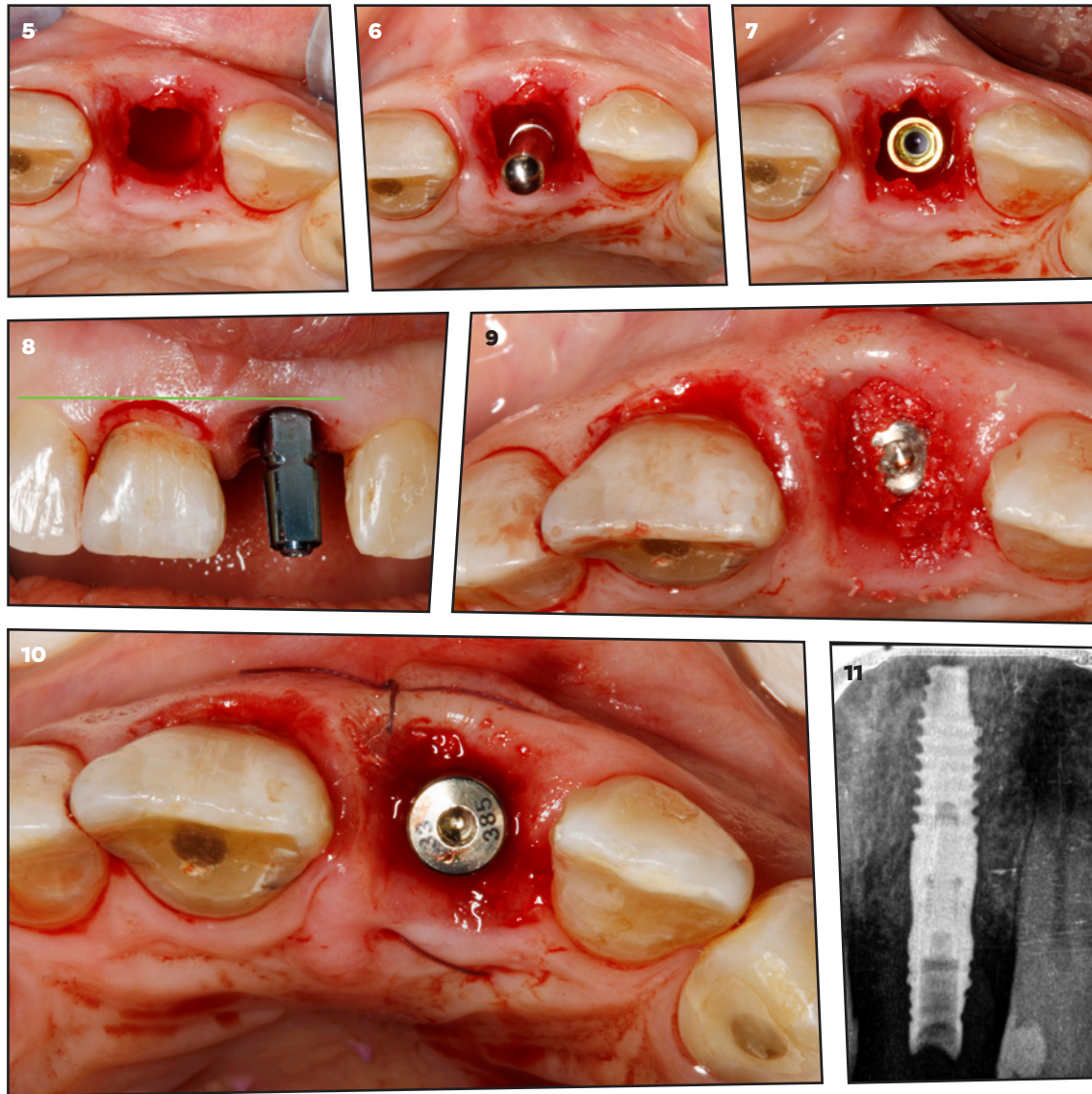
(cit. Dr. Paolo Nardinocchi and Laboratorio Camaioni Odontotecnici)



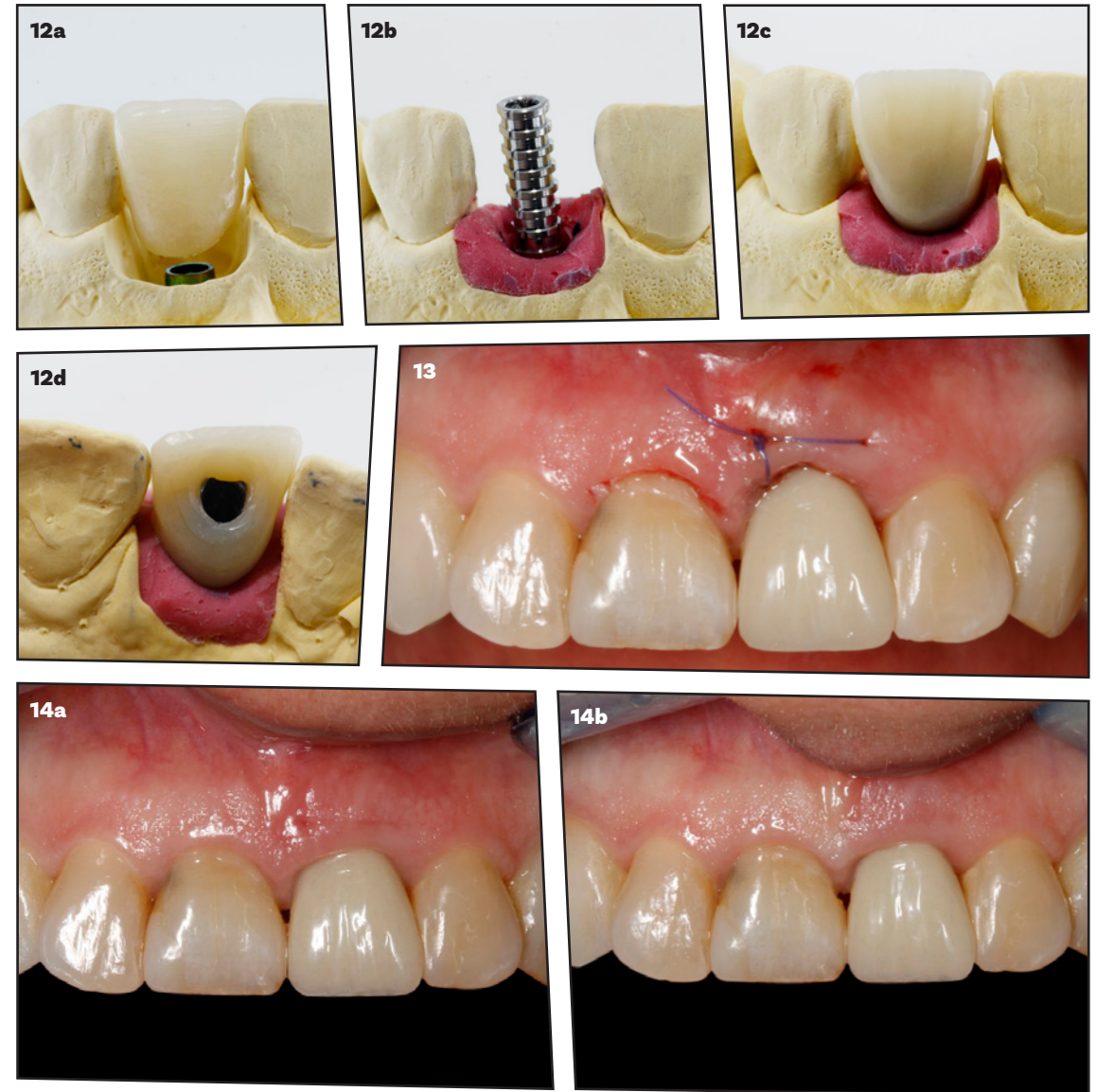
Find out dr. Nardinocchi point of view on Prama



1. Clinical image and initial radiograph: the fractured on the element 2.1 is noted.
2. Before the extraction of the fractured element, an intraoral scan is performed for the digital design of the temporary prosthesis, which will be delivered the same day of the surgery.
3. Design of the temporary crown with CAD software.
4. Occlusal and frontal view of the radicular residue.

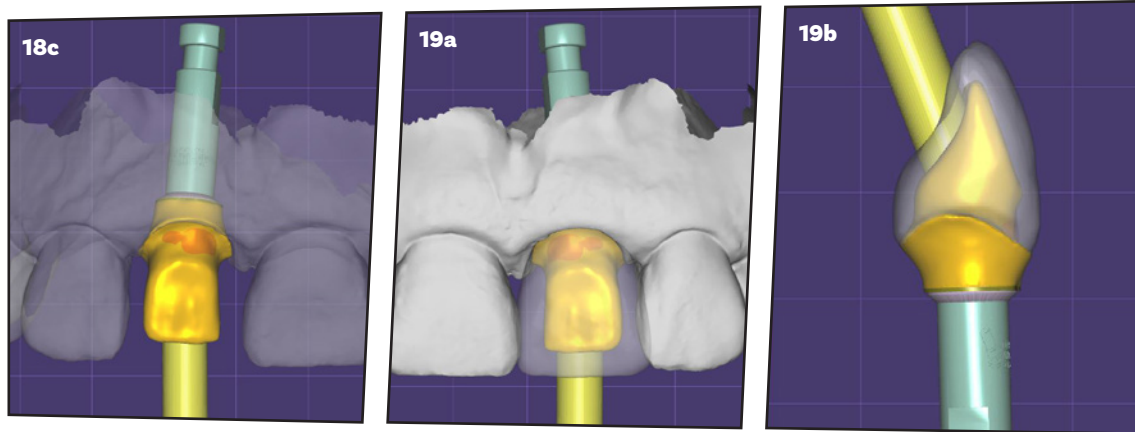
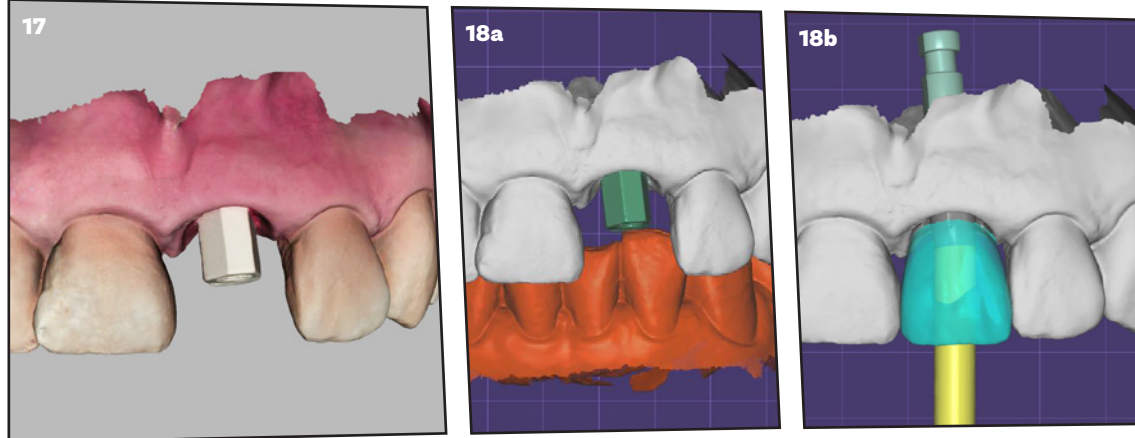
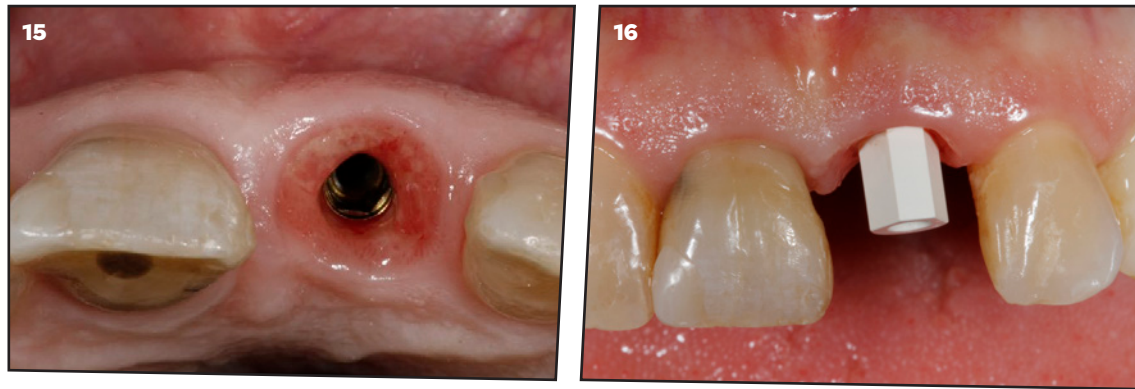


5. Occlusal view of the post-extraction socket.
6. Insertion of a parallelism pin to verify the insertion axis of the implant.
7. Prama implant in situ.
8. At the same time as the impression is taken, a gingivectomy is planned on the element 1.1 to normalize the incisor parabola and thus obtain a better aesthetic result. The 4 mm sulcus allows us to intervene without having to resort to a surgical crown lengthening.
9. After the impression is taken, the alveolar sockets are filled with bovine bone mineral based biomaterial in particles.
10. Positioning of a healing abutment and sutures.
11. Post-surgery intraoral radiograph.

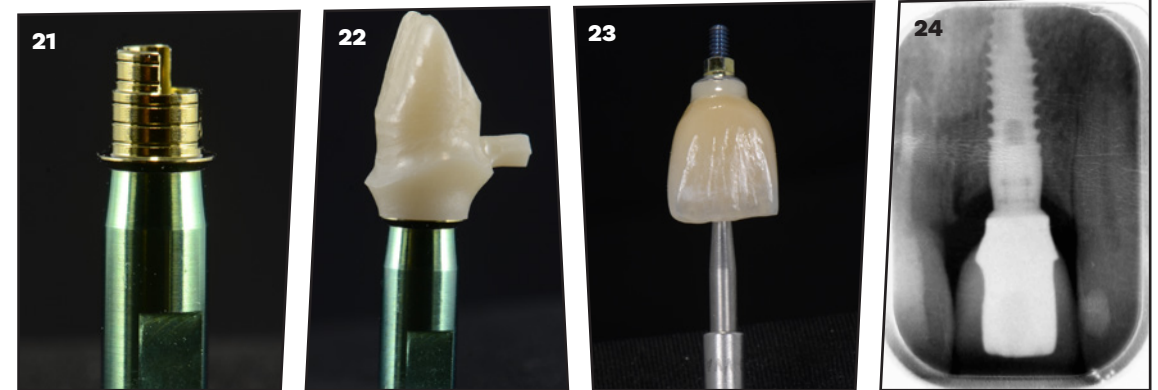
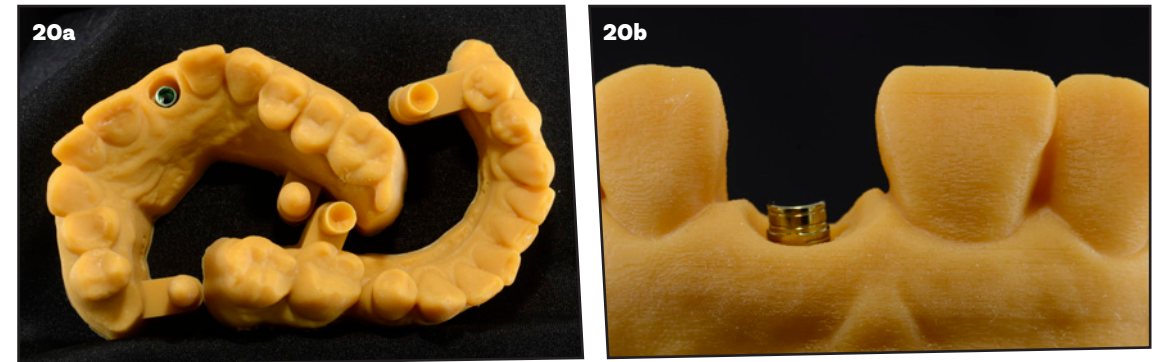


12. Laboratory phases for the realization of the temporary crown.
13. Positioning of the temporary crown in PMMA, designed before surgery with CAD software.
14. Clinical situation after 1 and 2 weeks from the insertion of the provisional crown: the tissues appear healthy and the healing process is progressing favorably, even if the papillae have not yet fully occupied the interproximal spaces.





15. 3 months after implant insertion it is possible to appreciate the healing progression of peri-implant soft tissues.  
 16. A digital impression is taken with an intraoral scanbody in PEEK.  
 17. Intraoral impression acquired by software.  
 18. The crown design on the Interfase Dynamica support, which allows the realization of a screw retained crown with palatal displacement of the screw hole, in favor of the final aesthetics.  
 19. Final phases of the planning of the definitive crown.



20. Print of the 3D model with the Interfase Dynamica support inserted on the analogue.  
 21. Interfase Dynamica support onto the analogue: note the peculiar structure that allows to angle the prosthesis thanks to the tilted screw hole.  
 22. Definitive crown luted on the Interfase Dynamica support.  
 23. Layered zirconia screw retained crown.  
 24. Final radiograph.  
 25. Clinical photo 4 months after surgery: parabolas are harmonized, and soft tissues are stable and healed.



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