DIO IMPLANT
Renown dental implant in over 70 countries

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DIO 2013 EUROPE MEETING

ROME, Italy | Oct. 11-12

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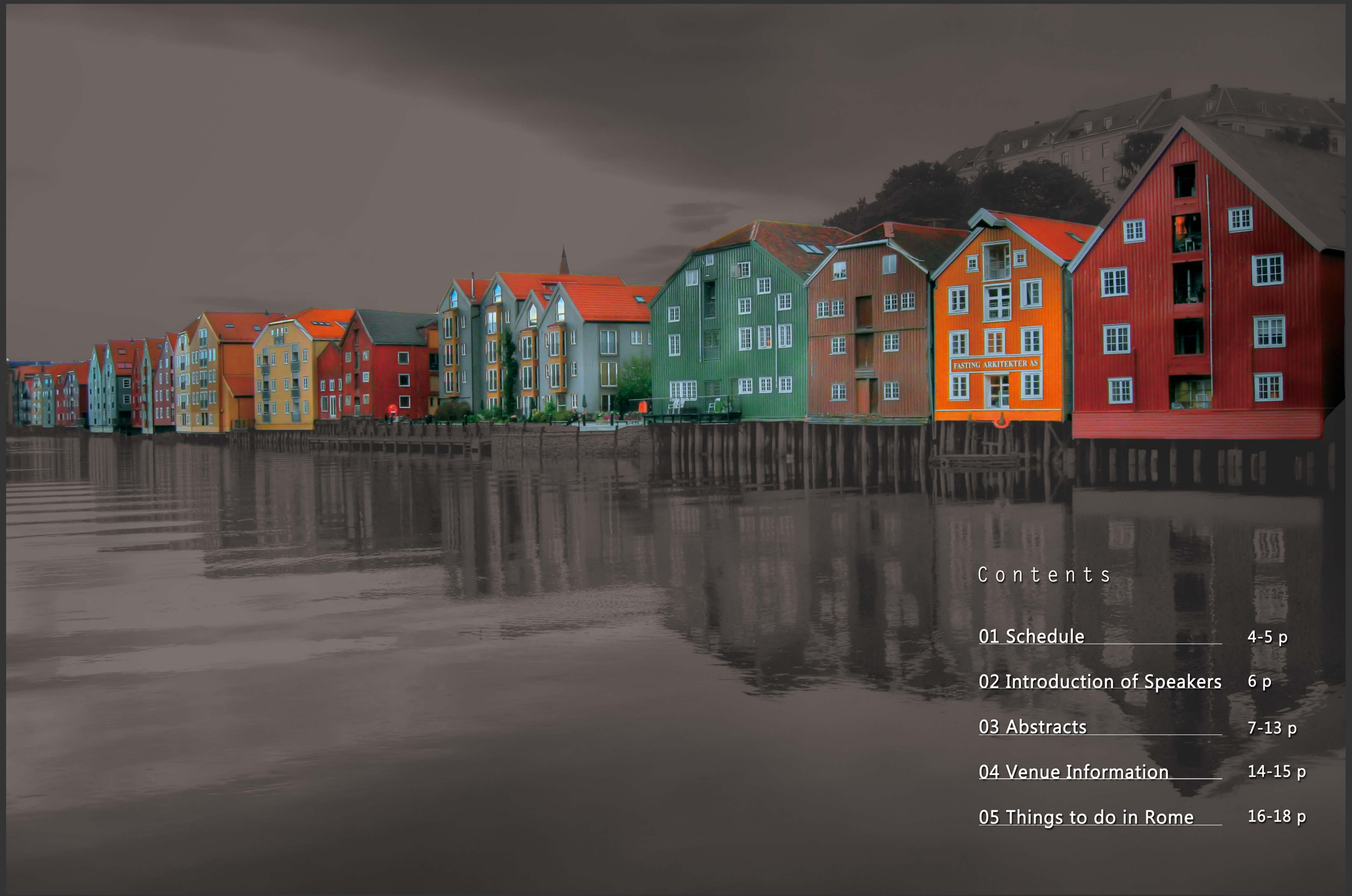

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2	Session 1 _ Seminar	Dr. Chung(DIO CTO)	Digital Solution for dental implant
3	Session 2 _ Seminar	Dr. Saritori(IT)	Homologous bone and PRGF for the regeneration of atrophic maxillae
4	Tea Break	Cafeteria on the Rooftop	
5	Session 3 _ Live Surgery-1	Prof. Pompa(IT)	Computer technology applications in surgical and prosthetic implant dentistry. All in one
6	Lunch	Cafeteria on the Rooftop	
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8	Session 6 _ Seminar	Dr. Fairbairn(UK)	The Use of DIO SM Implants in reduced Bone Cases
9	Garden Party	Villa Piccolomini	

SPEAKERS

From Korea
Dr. DongKeun Chung

C.T.O.(Chief Technology Officer)of DIO,
DDS, PhD, Diploma of ICOI, AO

From Italy
Prof. Giorgio Pompa

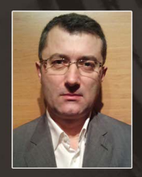
Professor at Sapienza University of Rome.
Professor of Prosthodontics and implant prosthesis at the Graduate Program in Dentistry.
Director Responsible for the surgery unit of implant prosthesis.
Author of international scientific papers and speaker at International Congress regarding issues of implant prosthesis

From Italy
Prof. Felice Roberto Grassi

MD, DMD, PhD, Full Professor
Department of Dentistry and Surgery at University of Bari

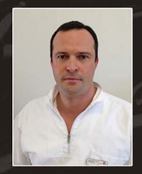
From Portugal
Dr. João Pimenta

DMD, MD, DDS, Founder of the Sociedade Portuguese Society of Dental Esthetics, Founder of the Portuguese Assotiation of Implantology and Biomaterials)



From Bosnia
Dr. Nenad Tanasković

EACMFS Member, BAMFS Member, ITI member, AO Foundation, CMF Group Member, PhD, DDS, MD, Specialist of Maxillofacial Surgery, School of Medicine, University of Banja Luka



From Italy
Dr. Stefano Sartori

Active member of the Italian Academy of Endodontics. Co-founder of the Academy of not-transfusional emocomponents. Speaker at many international meetings: e.g. American Academy of Periodontology and Japanese Society of Periodontology

From Portugal
Dr. Alejandro Vivas Rojo

Oral And Maxillofacial Surgeon
Fellow in Oral and Maxillofacial Surgery
Member American Ass. Oral and Maxillofacial Surgery.
Hospital dos Lusiadas; Oral and Maxillofacial Service. Lisbon-Portugal.

From Slovenia
Dr. Dime Sapundjiev

Works as oral surgeon at the University Medical Centre Ljubljana, Slovenia and is assistant of oral surgery at the Medical University Ljubljana. Works on the fields of atraumatic extractions, management of compromised patients, dental implantology, immediate loading and tissue augmentation. Is a member of the European Association for Osseointegration.

From Poland
Dr. Elzbieta Krezlik

Graduate of Medical University of Lodz, Poland
Member of DGZI, DGOI and ICOI, ICOI Lecturer
Past-president and co-founder of Polish Society of Implantology (PSI)

From United Kingdom
Dr. Peter Fairbairn

Spoken at the BACD, ADI (members), IAAFA, ICOI, BIDM and ESCD annual forums. Regular study club speaker for both the ADI and BACD. Used alloplast graft materials for the last 6 years and refined techniques for improved success.

ABSTRACTS

From Korea
Dr. DongKeun Chung

Digital Solution for dental implant

Implant paradigm is changing.Many efforts are made to have a more convenient, accurate, and swift treatment for the patients.DIO Implant has attempted to develop the Digital Implant System for the last 3 years, and recently by the development of various tools, the clinical trials are showing very good results. Especially by the development of the H-scan body, many processes accompanying before and after the surgery have been simplified, resulting in a more convenient and accurate process.
In a fast changing dental market, the clinical cases regarding the loading time should be looked over by Trione, the Digital Implant system of DIO.

From Italy
Dr. Stefano Sartori

Homologous bone and PRGF for the regeneration of atrophic maxillae

Several techniques can be used to increase bone volume in the upper and lower jaw.
Most of cases in the upper jaw can be treated with the sinus lift. A full thickness flap is performed to access to the buccal plate of the maxilla. Than a corticothomy is achieved using a piezosurgical tecnique. The Shneider membrane is then elevated. The sinus is filled with a mixture of heterologous or homologous bone chips and PRGF. The buccal bone's plate previously removed is now repositioned in it's proprer position. The flaps are than sutured with vycril or gore-tex sutures.
The time to reentry and position the implants varies from 4 to 5 months. Sometimes when the ratio crown/root is unfavorable it's necessary to add an onlay cortical bone graft coronally to the alveolar crest (vertical ridge augmentation).
In some cases, when the sinus lift is performed on a previous failed site, it's impossible to obtain new bone regeneration using bone chips and it's necessary to position and fix a block inside the sinus covered with PRGF membranes. it can be made of homologous or autologous bone. In this case homologous bone has the same predictability than autologous bone.
Several techniques can be used in the mandible to increase bone volume: split crest with ultrasonic osteotomy, autologous and homologous bone blocks, titanium meshes, resorbable and non resorbable membranes, autologous and heterologous bone chips.
All this techniques can be differently combined one with the other depending on the needs of the singolar clinical case.
If the bone is enough to position extrashort implants it would be considered as the first treatment choice because the predictability of this type of fixtures is the same than tarditional implants.
When some implants are positioned and 2 to 5 threads are coronally exposed they can be covered with a mixture obtained from bone colleted during the implant site preparation (without irrigation and at a speed of 50-75 rpm) and PRGF. A second layer made of Biooss and PRGF positioned over the first graft avoids the autologous bone chips resorption.
When the crest is thin but the high is enough the crest can be splited using an ultrasonic device with the simultaneous insertion of implants and "protection" of buccal plate with a mixture of Biooss and PRGF.
When hight and thickness is not enough cortical bone blocks can be fixed to the mandible with screws and covered with PRGF membranes. In this case autologous or homologous bone can be used. Another approach is based on the use of titanium mesh and bone chips added with PRGF. The soft tissue management is very important to ensure graft covering and avoid it's exposition: the releasing of periostium should be performed just after the flap elevation and sutures should be made in double layer (simple interrupted stitch and mattress suture). If bone blocks are used, the angles of the bone graft should be rounded and smoothed.
The time for the insertion of implant in the regenerated bone in the mandible is about 4 months.

ABSTRACTS

From Italy
Prof. Giorgio Pompa

Computer technology applications in surgical and prosthetic implant dentistry.

Technological progress are significantly influencing the implant therapy. Recent improvement in computer technology have made possible the use of computers not only in the planning of surgical implant placement but also in the implant site preparation and implant guided insertion.
The computer guide static and dynamic surgery use of a static surgical template or a surgical navigation system that reproduces virtual implant position directly from computerized tomographic data and allow intraoperative modifications of implant position.
Based on the data analysis of systematic review it is concluded that various systems for computer-guided surgery based implant treatment are available.
Meta-analysis of in vitro, cadaver and clinical studies regarding accuracy revealed mean horizontal deviations of 1.1 –1.6mm, but also considerably higher maximum deviations. The survival rate of implants placed with computer guided technology is comparable to conventionally placed implants ranging from 91% to 100% after an observation time of 12–60 months. Early surgical complications were observed in 9.1%, early prosthetic complications in 18.8% and late prosthetic complications in 12% of the patients. However, limited data and relatively short observation periods are available in literature. Further research should involve clinical studies with long-term follow- up and strive for an improvement of the systems and procedures regarding accuracy, predictability and reproducibility of implant placement as well as surgical and prosthetic outcomes.
The accurancy depends on all cumulative and interactive errors. In case of computer guided dynamic surgery the meta-analysis of all literature studies revealed a total mean error of 0,74 mm at the entry point and 0,85 mm at the apex. Future long term clinical data are necessary to identify additional radiation doses, efforts and costs associated with computer assisted implant surgery. There is not today evidence to suggest that computer assisted surgery is superior to conventional procedures in terms of safety, outcomes, morbidity .

From Portugal
Dr. Alejandro Vivas Rojo

Three main treatment options for severly edentulousatrophiz posterior maxillae & mandible

In this lecture, three main treatment options for severely edentulous atrophic posterior maxillae and mandible —bone augmentation procedure, non grafting solution and zygomatic implant application—are presented. Poor bone quality and insufficient bone volume due to critical jawbone atrophy in the posterior maxillae are addressed as the main factors contribute to the failure of dental implant system. The rationales behind the introduction of each treatment option are discussed and compared for a better understanding. This lecture placed an emphasis on the use of zygomatic implants, a high focus is given to this section covering the specification of zygomatic implants, advantages and disadvantages, indications and contraindications of treatment, types of surgical approach for the implant placement and survival rate of implants. This lecture, provides sufficient information on the treatment of patient with severely atrophic posterior maxillae / mandible specifically via the use of grafting and non-grafting procedure"

From Italy
Prof. Felice Roberto Grassi

Tissuue Engineering in Maxillar Sinus Lifting: A Comparation of Differents Grafts and Confocal Laser Scanning Microscopic Evaluation

This study included 10 (ten) patients that underwent to bilateral sinus lifting surgical procedure for implant placement and prosthetic rehabilitation. Sinus grafting has been performed in both sides in the same surgical procedure, using AMBE technique, following this prothocol: right sinus received only bovine hydroxyapatite (Bio-Oss) as grafting matherial, while left sinus received Bio-Oss and PRF previously obtained by using Choukroun technique [12].
During the stage-two surgery, performer after four months, ten trephine cores were taken, using a trephine bur instead pilot(s) drill, one for each one for each graft site, and sent for histologic examination. Each specimen was first fixed in a buffered solution of 10% formalin and then immersed in an appropriate fixing and decalcifying solution (Mielodec, Bio Optica, Milan, Italy) for 90 min, rinsed in 70% ethyl alcohol for 30 min, and then conventionally processed for histopathologic paraffin embedding, thin sectioning at 5 mm perpendicular to the long axis, and staining with hematoxylin–eosin.
Histological examination was carried out using a Nikon Eclipse E600 microscope (Nikon Corporation, Tokyo, Japan), equipped with argon–ion and helium–neon lasers, emitting at 488- and 543-nm wavelengths respectively, which allows both optical and confocal laser scanning microscopic analyses. The Nikon EZ C1 software (Nikon Corporation, version 2.10, Coord Automatisering) was used for image processing.

From United Kingdom
Dr. Peter Fairbairn

The Use of DIO SM Implants in reduced Bone Cases

The Speaker has placed over 700 Dio SM Implants in the last 2 years often in extreme reduced bone situations and has refined surgical techniques to optimise the benefits of these taper Implants. In the last 9 years and 1,500 grafts the speaker has not used autogenous bone nor a traditional collagen type membrane in the regeneration of bone defects for the placement of Implants. This concept of graft particulate "Bonding " combined with the benefits of the DIO SM Implant system has allowed us to up-regulate the host regeneration of bone even
in the most severe cases of bone loss.

Objectives
To Show these surgical techniques and discuss the use of DIO SM implants and their indexed taper abutment system. To show and explain bone regenerative protocols with core samples and Micro CT results as well as long term outcomes. Using Osstell to discuss earlier loading possibilities and earlier functional re-moddelling

ABSTRACTS

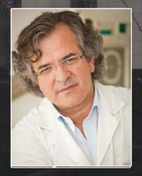
From Slovenia
Dr. Dime Sapundjiev

Medical Issues in Dental Implantology - Where Are The Limits?

Dental implants are intended to replace lost teeth and restore chewing function. Their basic purpose is to improve the quality of life of the patients. As a surgical procedure dental implants are invasive method for restoring lost function. As such there is always of great importance to follow some general rules as indications, contraindications and proper patient selection for these purpose.
Placing dental implants is not an emergency procedure. Those operations are in the group of elective procedures. That means that we usually have time to plan the operation. This planing include patient examination, image diagnostic and planing, treatment planing, hardware choice, patient information and proper documentation. Following these steps we can do proper patient selection and minimize risks for treatment failure.
With rapid improvement and advancement of medicine today the aging of population is growing. That means that more and more elderly patients would need dental implant treatment for restoring normal chewing function not just for cosmetic reasons. Dealing with this kind of patient carries some risks as far as their general medical status is concerned.
To minimize failures with compromised patients implant treatment outcome is very important to recognize and classify the patients general status.
Taking accurate and precise medical history from each patient before treatment is the only way to obtain any useful information to guide the clinician to undergo safely planed dental implant therapy. The clinician can also use any form of written question form to record patient medical history and record all important medical condition and therapies to help him make proper evaluation of the medical status. All those actions can clinician use to get prepared to predict how these medical condition can influence the patients general health, which type of anesthetic solutions could be used and to decide which treatment option is best for each patient individually.
Beside gathering proper medical history is also very important to clearly clarify chief complaints of the patients and to state and evaluate the treatment expectations.
For this purpose to classify general physical status of the patients we can use ASA (American Society of Anesthesiologists) classifications of the general patients health. According to ASA each patient can be classified in the following classes:
ASA I: normal, healthy patient
ASA II: a patient with mild systemic disease or significant health risk factor
ASA III: a patient with severe systemic disease that is not incapacitating
ASA IV: a patient with severe systemic disease that is a constant threat to life
ASA V: a moribund patient who is not expected to survive without the operation
ASA VI: a declared brain-dead patient whose organs are being removed for donor purposes
This classification of the physical status enables clinicians to decide either to routinely and safely perform the planed procedure or to modify the routine treatment plans and to undertake some preoperative consultations, preparations and pre-medications from the specialists of other fields or even to refuse to perform any ambulatory surgical procedures.
The conditions on which we should be careful can be divided in to two groups. The local and systemic conditions that can influence on general status of the patient and affect the treatment outcome success.

From the local conditions that we should have in mind are:
Systemic conditions that we should bare in mind and do precise evaluation and preparation of the patient before any implant surgical procedures are:
1. Cardiovascular conditions. 2. Diabetes mellitus and other metabolic disorders 3. Congenital and acquired hematological conditions 4. Osteoporosis 5. Bone diseases 6. Head and neck cancer 7.Neurologic conditions
8. Pregnancy 9. Psychiatric conditions

When we deal with this kind of patients we should do proper treatment selection and patient preparation. Questions to be answered before starting treatment should be in the direction of providing safe treatment protocol with clearly stated goals of treatment outcome. These can help us minimized unnecessary risks that can lead to worsening of the patient conditions with severe complications that are sometimes hard to menage.
Despite great numbers of consensus statements issued by different implantology societies there are still open questions and controversies on how to menage and prepare patients with impaired general status for dental implant surgery.
Issue in todays dental implantology is not only achieving osseointegration of dental implants but provide long term restoration of chewing function and achieving highly esthetic demands. With modern diagnostic tools for treatment planing, big selection of different implant concepts, lots of different augmentative procedures, highly esthetically improved restorative materials there are unlimited possibilities of achieving successful implant treatment outcomes. On the other hand the general patient status gives us certain limitations to conclude that there are unlimited limitations to achieve proper and successful implant treatment outcome.



From Portugal
Dr. João Pimenta

Implantology and esthetics: imitating nature…

"In the present time the aesthetic is a very important factor in all types of dental restorations, and also in the field of implantology. Patients require restorations with huge quality, not only functional, but specialy needs to look natural. The author will present clinical several clinical cases based on the concept that aesthetics lies in the subtle asymmetries, fashion and the "perfect imperfections" ... "

ABSTRACTS

From Poland
Dr. Elzbieta Krezlik

A bar based on implants and implants with a ball abutment as an ideal solution in case of lack full denture stabilization

The jaw bone atrophy follows every teeth extraction because of the loss of function. The atrophy we can observe is on the highest level of 40% of alveolar bone during three next years after the extraction. This level of atrophy becomes stronger and stronger with time by 0.5 % annually.

According to implantological classification of edentulous jaws by Lekholm and Zaarb the most advanced atrophy concerns D and E groups where it covers the whole alveolar bone as well as basal bone and this bone undergoes the phenomenon of resorption.
In such situations a problem of lack prosthetic stabilization appears which is connected with loss of prosthetic support.
The problem of atrophy represents not only the loss of bone capacity but also all changes in maxilla – mandible space conditions.
The mandible resorption is of centripetal character whereas the maxilla resorption is centrifugal. The defective space condition of atrophic mandible affects in a faulty way the occlusal conditions.

The teeth extractions also cause enlargement of bone maxillary sinus and, as a result it limits the amount of bone for implantation. The bridges supported on implants in extreme atrophy are generally contra-indicated because of causing too big distance between the jaws.
Additionally, in many cases placing bridges is impossible due to the presence of alveolar nerve and maxillary sinus.

All these factors affect the full dentures stabilization, causing that it gets worse and worse. They also directly lead to inferior mastication process, faulty speaking and very often have a negative influence on psychical state of patients.

Thanks to the dentistry implantology development, patients with the advanced maxilla and mandible atrophy can have a stable removable prosthesis.
With the purpose of gaining prosthetics stabilization implants with ball abutment or bars on implants are applied.
In case of one-phase implants with a ball abutment the surgical procedures as well as prosthetic ones are relatively simple in comparison with creating bridges on implants.

There are following advantages of one-phase implants with a ball abutment:
- non-traumatic surgical protocol
- shortened time of treatment for both the doctor and the patient
- simplified surgical and prosthetic procedure
- low cost

Nevertheless, bars on implants are even better solution giving stronger stabilization than the implants with a ball abutment. They can be supported on 2,3 ,4 and even 8 implants.
If the bone condition is good enough for implantation in the molar area, the bar can support the denture only on implants without soft tissue support. It gives a possibility of applying a bigger force of mastication which improves comfort and efficiency of biting. The area of denture can be smaller too, which is relevant especially in the upper denture and is very satisfactory for patients.

The advantages of applying bars:
- a possibility of taking on a stronger occlusal force
- limitation of the denture area
- free palate
- excellent denture stabilization thanks to the presence of retentional elements
- low cost

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The advantages of OVD dentures(in comparison with bridges):
- a very good facial esthetics and phonetic effect
- functional soft tissue
- possibility of applying OVD dentures in extreme atrophy
- faulty occlusal conditions compensation
- simple surgical and prosthetic procedure
- low cost

The disadvantages of OVD dentures:
- negative aspect of a removable denture
- necessity of periodical padding

The lecture describes all above problems and is based on numerous clinical cases and represents surgical and prosthetic part solution.

People with lack of stabilization in complete dentures appreciate implantological development the most because there is no better solution to their problems but implants.
It is a group of a very satisfied and grateful patients. Creating the dentures for them is also a satisfactory job for the doctors who help their patients efficiently and, what is more – effectively.

From Bosnia
Dr. Nenad Tanasković

Narrow fix implants in Piezo-Surgical ridge split osteotomy site

Dental rehabilitation of partially or totally edentulous patients with dental implants has become common practice in the last decades, with reliable long-term results. However, local conditions of edentulous alveolar ridges may be unfavorable for implant placement.
In particular, a relevant horizontal deficit of the alveolar ridge may render the use of dental implants difficult or impossible, because of an insufficient bone volume to harbor implants of adequate dimensions.
Moreover, the reduction in width of the edentulous ridge may render the final prosthetic results non ideal from a functional and esthetic viewpoint, because of the palatal/lingual position of the implants.
To correct this situation, a variety of surgical procedures have been proposed. The Piezo sagittal osteotomy technique with immediate implant placement arose great interest in the last years because of the reduction of morbidity (no bone harvesting, no risk of membrane exposure, no risk of graft loss).
Since the body of the NarrowFix implant is less than 3.5 mm in diameter (narrow implant), wich we always use in this cases, this almost always ensures that it will be placed in good bone with two cortical places for support and immediate immobility.
In situations with limited horizontal space a combination of Piezosurgery preparation of alveolar ridge and using of narrow diameter implant may be the only option to replace a missing tooth and to avoid additional bone augmentation.

Where
you will be

Venues _ Università di Roma (Sapienza)

Sapienza University of Rome, founded in 1303 by Pope Boniface VIII, is one of the oldest extant universities in the world and a high performer among the largest universities in the international rankings.
Since its founding over 700 years ago, Sapienza has played an important role in Italian history and has been directly involved in key changes and developments in society, economics and politics. It has contributed to the development of Italian and European science and culture in all areas of knowledge.

Piazzale Aldo Moro 5, 00185 Roma | http://en.uniroma1.it/
T (+39) 06 49911

Restaurant _ La Taverna de 'Mercanti
1st day dinner

The spacious rooms and two floors of the building allow the Taverna de 'Mercanti welcomes groups and banquet spaces reserved to them entirely, enjoying personalized menus chosen from the classic Roman cuisine.
Durante la stagione estiva, la Taverna de' Mercanti accoglie i suoi ospiti all'aperto sulla piazza e sugli intriganti balconcini, nella splendida cornice di una Roma d'altri tempi. During the summer season, the Taverna de 'Mercanti welcomes its guests outside on the square below and the intriguing balconies, in the splendid setting of an Ancient City.

Piazza de 'Mercanti, 3rd - Trastevere - Rome
Tel. 06-5881693

Garden party _ Villa Piccolomini
2nd day dinner

The Villa Piccolomini is surrounded by a vast park dominated by the Basilica of San Pietro. From the ancient porch around the garden “all'italiana”, surrounded by pines and the greenery of the vegetable gardens, the Michelangelesque dome stands out. Villa Piccolomini lies in the heart of Rome, next to the Colle del Gianicolo.
It's a renaissance building, founded in 1458 by the pope Pio II. The complex also includes the “Rina Morelli and Paolo Stoppa”pavilion theatre and the large “Leo De Berardinis and Perla Peragallo”conservatory.

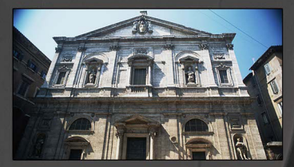
Via Aurelia Antica 164 - 00165 Rome
Tel. +39.3294650743

TOP 9 THINGS TO DO IN ROME + 1 TIP

1. Galleria Borghese

They say the best museum in Rome is the city itself. That may be so, but the Galleria Borghese is still a gem worth seeing. Its collections are housed in a magnificent 17th-century villa and offer a compact course in the Italian aesthetic. In just 20 rooms, you are exposed to antiquities, the Renaissance and the beginnings of baroque art. Visits to the Galleria in the northeast corner of the sprawling Villa Borghese park are by reservation, which allows you the pleasure of seeing the Bernini sculptures from every angle without being crowded out.

2. San Luigi dei Francesi



Once you've gotten a taste of Caravaggio, a late Renaissance master whose work is featured at the Galleria Borghese, you can't leave Rome without seeing what many say is his most powerful work. You'll have to go to church to do it.

The Calling of Saint Matthew hangs in the Contarelli Chapel of the San Luigi dei Francesi church, a reminder that 400-year-old art was provocatively modern when it was first conceived. Two other Caravaggio works — St. Matthew and the Angel and the Martyrdom of St. Matthew — which round out the triptych, are also on permanent display here. Seeing such a renowned work in a church you might otherwise have easily overlooked is proof that Rome really is a living museum.

Like other basilicas, entry is free (come in the morning, since the church closes at lunchtime); you'll have to drop a few coins to light up the paintings in the darkened interior and see how Caravaggio infused his own light into the baroque melodrama.

3. Giorgio de Chirico House-Museum

It's hard to get away from art in Italy. Here's one last solely art-related suggestion, and one that quickly brings us up to the 20th century. The Giorgio de Chirico House-Museum is a chance to get a guided look at some of the signature works of the master of classically fueled surrealism and to get a peek into his sunny attic studio. The pristinely preserved two-level apartment, where De Chirico lived for more than 30 years until his death in 1978, also lets you glimpse how the city's upper crust have lived for centuries. In this case, it's accompanied by about the best view overlooking the splendid Piazza di Spagna. The living area has been left largely as it was during De Chirico's life and displays dozens of his works. Reservations must be made in advance.

4. Via del Governo Vecchio

If you look out ol' Giorgio's living room window (from the Giorgio de Chirico House-Museum) across Piazza di Spagna, you will see the famous Via Condotti, which stacks most of the best-known Italian designers into a 100-m stretch of real estate. For my money, though, I'd go to the other side of downtown for a less well-known, but no less elegant shopping experience on Via del Governo Vecchio, where you can buy everything from fur to bathing suits. It may not exactly be a bargain for American shoppers, but you'll probably find items not yet available in the U.S.

5. Ponte Sisto Stroll

The best way to soak up the city — and to find some of the quainter (and more affordable) shops — is to zig-zag from vicolo to vicolo (alley), piazza to piazza. For a good two-hour stroll, start at the bustling Piazza Navona, then head south through Campo dei Fiori, where you'll find cafés and daily food and flower markets, to the beguiling Piazza Farnese, with its pair of fountains and Renaissance palace. From there, continue toward Ponte Sisto. The ponte (bridge) offers a great perspective on the beauty of Rome, with the Gianicolo hill rising to the west and St. Peter's Basilica to the north. Cross the Tiber to arrive in the utterly charming Trastevere neighborhood, where laundry swings overhead and flowers burst from window boxes; your stroll can continue, and the enchantment (and shops) will keep coming.

6. Pizza al Taglio

By now you're hungry. If you have a lot of ground to cover and don't have time for a sit-down lunch, try some of the best stand-up pizza of your life. Rome is filled with these pizzerie al taglio (sliced), where ordering what you want is as easy as pointing through the glass toward the variety you like, nodding your approval for the width of the serving, then digging in. Feel free to ask for smaller portions of two or three different types. Beside the standard margherita (tomato sauce and mozzarella), most pizzerie will make a mean potato or zucchini pizza, as well as fresh cherry tomatoes and mozzarella.

Two of my favorite places are near the Trevi Fountain. Da Michele serves kosher pizza (meat, but no cheese) cooked to crisp perfection with endless varieties. Try sausage and broccoli, or mushrooms and arugula. My other favorite pizzeria is so small it doesn't have a name. It is on Via del Piè di Marmo, near the corner of Via del Gesù. Try the eggplant. Buonissima!

7. Gianicolo

This is known as the city of seven hills, but actually Rome has more than that. Indeed, the Gianicolo (or Janiculum), the hill that affords the best view of Rome, is west of the Tiber and outside the ancient city, so it's not counted among the ancient seven. Still, it's close to the historic center, just above the Vatican and the Trastevere neighborhood — and the panorama (not to mention the silence) from the top takes your breath away. At noon, the quiet is momentarily broken by the single shot of a cannon, to mark the exact time, a tradition that dates back to the 19th century.

8. Ristorante Al Presidente

You're hungry again? Because of Rome's agreeable climate, lunch and dinner all'aperto is doable up to eight months out of the year. One of the best restaurants with the nicest terraces is Ristorante Al Presidente, flat in the center of town, under the shadow of the Quirinale presidential palace. The indoor dining room is also lovely. I can't help but order the same thing every time: pasta with fresh sardines and pecorino cheese.

9. Gelato

Like pizza al taglio, gelato is not hard to find in central Rome. Most of the gelato around here is high quality, but arguably still the best in town is at the famous Giolitti, nestled between the Pantheon and the Italian Parliament. Ask for up to three flavors on a medium cone to go, or sit down at a streetside table and savor every moment. Try bacio, pistachio and nocciola for a creamy, nutty, chocolate-touched delight.

10. Open Hours

Plenty of Roman shops still partake in the afternoon siesta. To be safe, don't plan your shopping between 1:30 p.m. and 5 p.m (though some shops take shorter breaks). Stores are typically open daily until 8 p.m. and closed on Sunday. Restaurants in Rome, especially in the city center, tend to start serving dinner around 7:30 p.m. to accommodate visitors' dining habits. Romans usually won't sit down at the table at 9 p.m. Or later.

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By Jeff Israely

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