The use of the Er:YAG in laser-assisted broken abutment screw treatment

Dental implants are a functional and aesthetic solution to partial and total edentulism. Although the overall success rate of implant dentistry is very high, more than 90 per cent of the treatment modality is not free of complications and dental implants occasionally fail. The chronic loosening or fracturing of implant screws continue to be a problem in restorative practices and generally are challenging to remove. This report describes and demonstrates the management and technique used for the removal of fractured screw fragments and the successful utilisation of the Er:YAG laser as an important auxiliary tool.

Introduction - the problem

Success in implant-supported prosthetic replacement of teeth will be due to a combination of appropriate placement criteria (receptor site quality, implant stability, osseo-induction), appropriate (non-excessive) loading and prevention of bacterial contamination.

The failure of dental implants is due not only to biological factors, such as unsuccessful osseo-integration or the development of peri-implantitis, but it may also result from technical complications. Dental implant complications may be considered under the following main categories:

Early
- Failure/inadequate surgical preparation
- Failure of osseo-integration
- Peri-surgical infection

Late
- Implant overloading, leading to bone loss
- Peri-implantitis
- Soft tissue complications
- Fracture of mechanical components and aesthetic/phonetic considerations

Failures of implant-supported restorations result from technical problems and can be divided into two groups: those relating to implant components, and those relating to the prosthesis. Technical problems related to implant components include abutment screw fracture.

The abutment screw fracture presents a rare, but quite unpleasant failure and can be a serious problem, as the fragment remaining inside the implant may prevent the implant from functioning efficiently as an anchor. The primary reason for screw fracture is undetected screw loosening which can be due to bruxism, an unfavorable superstructure, overloading, or malfunction.

Fractures of the implant abutment or of the abutment screw have been observed as a consequence of screw loosening and undetected micro-movements of the abutment under functional loading and consequently, it is advised that the repeated loosening of an abutment screw should alert the clinician to possible significant contributing causes.

However, the behaviour of the implant/abutment joint components with respect to critical bending force is still unclear. Studies show that implant abutment failure occurs when lateral forces exceed 570 Newtons for abutment with a joint depth of at least 2.1 mm and 530 Newtons with a joint depth of at least 5.5 mm.

Recommendations

The number, position, dimension and design of implants, as well as the design of the prosthesis are critical factors to be considered during the treatment planning phase. To withstand high bending stresses, implants should be as long and as wide as possible, used in adequate numbers, and be positioned such as to allow axial loading. Implant components are known to fracture...
A team including Peter Fairbairn, the principle implant dentist at the Scarsdale Dental Clinic in Kensington, South West London was indulging in its favourite pastime with the help of DIO Implants (UK) and Biocomposites Ltd. The two companies supported the racing team which took part in the Britcar 24-hour race at Silverstone, held on Saturday and Sunday 2/3 October, 2010.

Peter has been racing in motor sport for many years although this was the first time he’d taken part in a grueling 24-hour event. Akin to the Le Mans 24-hour race, this was the fifth Britcar GP event at Silverstone and James Tucker, the event organiser, said that it was becoming more popular each year.

In addition to all the engineers and pit crew in the team, Peter was accompanied by his fellow drivers: Paul McLain who set the car up; Tony Littlejohn who works for Porsche; and Mike Quinn, a seasoned racing driver whose grandfather founded luxury car manufacturer Porsche; and Peter Fairbairn’s relationship as a regular speaker for the Association of Dental Implantology (ADI). He has lectured at Kings College in London on the use of synthetic bone grafting materials, he has lectured at the Bioclinic in Kensington, South West London was indulging in its favourite pastime with the help of DIO Implants (UK) and Biocomposites Ltd. The two companies supported the racing team which took part in the Britcar 24-hour race at Silverstone, held on Saturday and Sunday 2/3 October, 2010.

When the Sebring 1000km race was an underlying connection to the Britcar GP collaboration, I certainly can’t wait for next year’s event!”

Over the last 22 years Peter has been on the world stage speaking about implants and synthetic graft materials and regularly contributes to dental journals. He has lectured at the Royal College of Cosmetic Dentistry annual forum (2005 and 2006) and the European Society of Cosmetic Dentistry Forum (2006) and is a regular speaker for the Association of Dental Implantology (ADI).

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The objective is to have the spinning bur’s blades contact the metal surface of the screw so that the screw will spin itself out of the hole. When repeated several times, the screw can be backed out and retrieved easily with forceps. If this technique fails, a slot can be created using a surgical drill, on the head of the fractured screw, and then a screwdriver is used to back out the broken abutment screw. Sometimes just a gentle touch with the drill to the head of the broken screw will be enough to back it out. If the head of the screw is stripped, it should be filed away completely using a round carbide bur or heatless stone, the head of the implant should be straightened, and a new abutment may be rotated into the implant.

**Case study**

This clinical report describes a situation in which a fractured implant abutment screw was successfully retrieved by using the Er:YAG laser as an auxiliary tool, and the advantages of this 2840 nm wavelength versus conventional methods.

**DIO Implants (UK) and Biocomposites Support Racing Team at Silverstone**

Peter has performed implant surgery for the last 20 years and has particular expertise in the use of 2nd generation synthetic materials such as Fortoss VITAL from Biocomposites which implant surgeons worldwide are now recognising as a reliable alternative to traditional human or animal derived bone-grafts. He has lectured at Kings College in London on the use of synthetic bone grafting materials and says that he has a success rate in excess of 99%. "I am particularly impressed with the usability and implant coatings of DIO implants," he explained. "They are perfectly compatible with calcium derived synthetics and complement my techniques very well.”

Iain Forster admitted that he was delighted to have the opportunity of supporting Dr Fairbairn and the team in his favourite sport, motor racing. "Silverstone is a special track - exhilarating but very rewarding time for all of us. After everything we went through, I really feel like a member of the team now.”

It was a pertinent opportunity for its founder Dr Fairbairn’s Porsche team. “The German engineered Porsche seemed relevant to DIO and Peter Fairbairn’s relationship as DIO’s RBM-surface implants are sent to Germany for the electrochemical implantation process (called Biotite-H),” Iain explained. “Peter favours using these biomechanical calcium phosphate-enhanced implants with his pioneering technique, so there was an underlying connection to the Britcar GP collaboration, I certainly can’t wait for next year’s event!”

The methods employed to grasp the broken fragments or screw, are determined according to the location of the fracture abutment above or below the head of the implant. If an abutment screw fractures above the head of the implant, an exploder, a straight probe or haemostats might be successful. The tip of the instrument is moved carefully in a counter-clockwise direction over the surface of the screw segment until it loosens.

If the screw fracture occurs below the head of the implant, other methods are required. There are several available implant repair kits:

- DIO Implant System (Institut Straumann AG, Switzerland), consists of drills, two drill guides and six manual tapping instruments. (fig 8)
- IMZ® TwinPin Implant System (DENTSPLY Friadent, Germany)
- Certain®-Screw Removal Kit (Biomet Sp*, Florida, USA)

The application of these systems is to permit a hole to be drilled into the centre of the broken screw and drive a removal wedge into the hole that engages the broken fragments where a reverse torque is applied by removing the instrument.

If no thread damage has occurred and the screw has not “bottomed out” or torqued into a seating stop, then the force necessary to remove the screw may be minimal. If none of these systems is available, another method for broken screw retrieval involves the following procedure: after the prostheses or abutment is removed, the screw hole is vigorously flushed with an air/water spray from a 5-way syringe. Pressurised air is applied to dry the screw hole, and a drop of mineral oil (delivered on the tip of an explorer) is introduced into the screw hole. A sharp 4-round bur in a high-speed hand piece is activated and lightly applied to the exposed side of the fractured screw.

**Fragment retrieval**

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Examination
A 36-year-old male presented for treatment, reporting the detachment of an implant-supported crown in the region of the upper left central incisor. The patient stated that the implant and crown had been placed four years earlier and that looseness of the crown had occurred on two occasions during this period. On both occasions, the screw had been retightened with no further investigation.

Clinical examination of the patient revealed a missing tooth at the surgical site with no sign of an implant (Fig 1). The patient brought the abutment, crown and broken screw with him (Fig 5). Radiographic examination of the area showed the presence of a root-form cylindrical implant, consistent in appearance with a 15mm long, 5.75mm diameter abutment with an internal hex. The apical part of the screw remained threaded into the implant, but had fractured at the level of the hexagonal neck. Although the implant was osseointegrated, there were radiographic signs of peri-implantitis with some crestal bone loss having occurred (Fig 2).

Treatment options
The treatment options available were: 1) retrieve the fractured screw, or 2) remove the old implant and insert a new implant in one sitting. Following discussion with the patient and evaluation of the possibilities for success, it was decided to try and retrieve the fractured screw. Treatment would involve the use of the Er:YAG laser to perform the procedure, based upon accepted research:

- The flap incision
- Ablation of granulation tissue around the implant
- Remodelling, shaping and ablation of the bone
- Detoxification of the infected surfaces of the implant

An associated osteogenic (GBR) procedure to prevent soft tissue in-growth and maintain the form of the alveolus treated for the various surgical stages were as follows:

- Flap Access: Wavelength: 2.940nm (Er:YAG), 200 micro-sapphire tip, in contact mode; 450ml per pulse at 20Hz. Total power: 9 Watts.
- Granulation Tissue Removal: Wavelength: 2.940nm (Er:YAG), 1,500 micro-sapphire tip, in non-contact mode; 700mJ per pulse at 12Hz. Total power: 8.4Watts.
- Bone Surgery: Wavelength: 2.940nm (Er:YAG), 1,500 micro-sapphire tip, in non-contact mode; 450mJ per pulse at 20Hz. Total power: 9Watts.
- Detoxification of the implant: Wavelength: 2.940nm (Er:YAG), 1,500 micro-sapphire tip, in non-contact mode; 150mJ per pulse at 20Hz. Total power: 3W.
- Decortication for GBR technique: Wavelength: 2.940nm (Er:YAG), 1,500 micro-sapphire tip, in non-contact mode; 500mJ per pulse at 17Hz. Total power: 8.5Watts.

A V shape incision was made with the Er:YAG laser. An intrasulcular incision was made (after anaesthesia) at the buccal and palatal side of the implant, together with two vertical relieving incisions: one at the mesial side of tooth # 8 and the second at the mesial side of tooth # 11 (Figs 4, 5).

The buccal and palatal flaps were lifted and the area explored (Fig 6); there was granulation tissue around the neck of the implant. The granulation tissue was ablated using the laser (Fig 9). Vaporisation of granulation tissue (if any exists) after raising a flap is efficient with the Er:YAG laser, offering a lower risk of overheating the bone than that posed by the current diode or CO2 lasers; and often obviates the need for hand instruments. Results from both controlled clinical and basic studies have pointed to the high potential of the Er:YAG laser and its excellent ability to effectively ablate soft tissue without producing major thermal side-effects to adjacent tissue has been demonstrated in numerous studies.

The broken hexagon slot was straightened, using a round diamond bur and the head of the fractured screw, and a screwdriver was successfully used to unscrew the broken abutment screw (Figs 7, 8). The Er:YAG laser was aimed at the surface of the exposed implant for the purpose of decontaminating the infected exposed surfaces, without damaging them. Studies have shown that Er:YAG laser energy effects on bone include bacterial reduction. Follow ing this, all accessible bone surfaces were exposed to laser energy to ablate necrotic bone and to shape and remodel the surface, in accordance with established clinical protocols. Decortication of the buccal bone was then performed (Fig 10).

The purpose of decontamination is to encourage bleeding, providing progenitor cells to the site. A new abutment was then inserted into the implant (Fig 11). All spaces between implant and existing osteotomy site were filled with a xenograft bone substitute (Bio-Oss®, Geistlich Biomaterials) and covered with an absorbent bilayer membrane (Bio-Gide®, Geistlich Biomaterials), (Figs 12, 15). The mucoperiosteal flap was re-positioned and sutured with silk 5-0, paying particular attention to primary closure of the flap (Fig 14).

Post-operative instructions
The patient was prescribed Clindamycin 150mg x 50 tabs to avoid infection. He was also given Motrin 800mg x 15 tabs for pain. Instructions were given to rinse with Chlorhexidine 0.2% per cent, starting the next day for two weeks x three per day.

Management of complications and follow-up care
The following day the patient reported moderate pain and moderate swelling. There was no tissue bleeding and the site was closed. The flap was showing signs of attachment and was healing nicely. At ten days postop the patient returned for inspection and removal of sutures. The swelling had resolved, there were no signs of fistula and healing was progressing well. After five months the soft tissue was completely healed without complications (Figs 16, 17). The soft tissue had healed over the bone and there were no bony projections observed under the soft tissue. The prognosis is excellent.

Conclusion
The use of osseo-integrated implant-supported prostheses in the replacement of missing natural teeth has become an accepted clinical protocol in dentistry. Success in this area is enhanced through correct diagnosis, treatment planning and maintenance; however, complications often occur, which may be significant and compromise the long-term success of the implant abutment and associated prosthesis. The management of such complications has given rise to several techniques to address failings, such as component fracture and bacterial contamination.

The Er:YAG (2.940nm) laser can be employed as an auxiliary tool for the purpose of decontamination of infected implant surfaces and it has been shown to be effective and safe. The use of the 2.940nm wavelength for these procedures presents many advantages: a) conventional methods, including enhancing the surgical site and less bleed-
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References available on request to Lisa@dentaltribunuk.com