The single-tooth restoration has become one of the most widely used procedures in implant dentistry. In the posterior region of the oral cavity, bone volume and density are often compromised. Occlusal forces are greater in this region and, with or without parafunctional habits, can easily compromise the stability of the restorations (Fig. 1). 2-3

The single molar implant-supported restoration has historically presented a challenge in terms of form and function. The mesiodistal dimensions of a molar exceed that of most standard implants (3.75 to 4.0 mm), creating the possibility of functional overload resulting in the failure of the retaining components or the failure of the implant (Figs. 2 & 3). 4 Wider-diameter implants have a genuine use in smaller molar spaces (8.0 to 11.0 mm) with a crestal width greater than or equal to 8 mm (Fig. 4 a). 5 Clinical parameters governing the proposed restoration should be carefully assessed in light of the availability of implants and components that provide a myriad of options in diameter, platform configurations and prosthetic connections. Many of the newer systems for these restorations are showing promising results in recent clinical trials. 6 It has further been suggested by Davarpanah and others, 7 Balshi and others, 2 English and others 6 and Bahat and Handelsman 10 that the use of multiple implants may be the ideal solution for single molar implant restorations (Figs. 4 b & c).

Most standard implants and their associated prosthetic components, when used to support a double implant molar restoration, will not fit in the space occupied by a molar unless the space has been enlarged (12 mm or larger). Moscovitch suggests that the concept of using 2 implants requires the availability of a strong and stable implant having a minimum diameter of 3.5 mm. Additionally, the associated prosthetic components should ideally not exceed this dimension. 2

Finite element analysis (FEA) is an engineering method that allows investigators to assess stresses and strains within a solid body. 10-15 FEA provides calculation of stresses and deformations of each element alone and the net of all elements. A finite element model is constructed by breaking a solid object into a number of discrete elements that are connected at common nodal points. Each element is assigned appropriate material properties that correspond to the properties of the structure to be modeled. Boundary conditions are applied to the model to simulate interactions with the environment. 14 This model allows simulated force application to specific points in the system, and it provides the resultant forces in the surrounding structures. FEA is particularly useful in the evaluation of dental prostheses supported by implants. 13, 16 Two models were subjected to FEA study.
to compare between a wide implant restoration versus the two implant restoration of lower first molar.

**Material and Methods**

Three different parts were modelled to simulate the studied cases: the jaw bones, implant/abutment assembly, and crown. Two of these parts (jaw bone and implant/abutment) were drawn in three dimensions by commercial general purpose CAD/CAM software “AutoDesk Inventor” version 8.0. These parts are regular, symmetric, and its dimensions can be simply measured with their full details.

On the other hand, crown is too complicated in its geometry therefore it was not possible to draw it in three dimensions with sufficient accuracy. Crown was modelled by using three-dimensional scanner, Roland MDX-15, to produce cloud of points or triangulations to be trimmed before using in any other application.

The second phase of difficulty might appear for solving the engineering problem, is importing and manipulating three parts one scanned and two modelled or drawn parts on a commercial FE package. Most of CAD/CAM and graphics packages deal with parts as shells (outer surface only). On the other hand the stress analysis required in this study is based on volume of different materials.5 Therefore set of operations like cutting volumes by the imported set of surfaces in addition to adding and subtracting volumes can ensure obtaining three volumes representing the jaw bone, implant/abutment assembly, and crown.6 Bone was simulated as cylinder that consists of two parts. The inner part represents the spongy bone (diameter 14mm and height 22mm) that fills the internal space of the other part (shell of 1mm thickness) that represents cortical bone (diameter 16mm and height 24mm). Two implants were modelled one of 3.7mm diameter and the other of 6.0mm. The implants/abutment design and geometry were taken from Zimmer dental catalogue (Fig. 5).

Linear static analysis was performed. The solid modelling and finite element analysis were performed on a personal computer Intel Pentium IV, processor 2.8 GHz, 1.0 GB RAM. The meshing software was ANSYS version 9.0 and the used element in meshing all three dimensional model is eight nodes Brick element (SOLID45), which has three degrees of freedom (translations in the global directions). Listing of the used materials in this analysis is found in Table 1. The two models

---

**Fig 5**

**Fig 6a**
were subjected to 120 N vertical load equally distributed (20 N on six points) and one in all directions as a boundary condition.19,20

Results and Discussion

Results of FEA showed a lot of details about stresses and deformations in all parts of the two models under the scope of this study. Figures 6a & b showed a graphical comparison between the crowns of the two models which are safe under this range of stresses (porcelain coating, gold crown, and implants showed the same range of safety). No critical difference can be noticed on these parts of the system. All differences might be found are due to differences in supporting points and each part volume to absorb load energy (equation 2).**

Generally a crown placed on two implants is weaker than the same crown placed on one implant. This fact is directly reflected on porcelain coating and the two implants that have more deflections. Comparing wide implant model with the two implants from the geometrical point of view it is simply noted that cross sectional area was reduced by 45.3 per cent while the side area increased by 6.5 per cent. Using one implant results as a reference in a detailed comparison between the two models by using equation (1) resulted in Table 2 for porcelain coating, gold crown, implant(s), spongy and cortical bones respectively.

Difference % = [One implant Result - Two implants Result]/100

Conclusion can be taken that, under axial loading. Starting from Figure 7 & 8, slight differences can be noticed on spongy bone between the two models results. The stresses on the spongy bone are less by about five per cent in the two implants model than the one wide diameter implant. The exceptions are the relatively increase in maximum compressive stresses and deformations of order 12 per cent and 0.5 per cent respectively.

The bone is known to respond

Conclusions

This study showed various results between cortical and spongy bone. It was expected that the maximum stresses in the cortical bone was placed in the weak area between the two implants. In addition to be higher than the case of using one wide implant. Although the middle part of spongy bone was stressed to the same level in the two cases, using two implants resulted in more volume of the spongy bone absorbed

Table 1

<table>
<thead>
<tr>
<th>Material</th>
<th>Poisson’s ratio</th>
<th>Young’s modulus MPs</th>
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</thead>
<tbody>
<tr>
<td>Coating (porcelain)</td>
<td>0.3</td>
<td>67,200</td>
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<tr>
<td>Restoration (gold)</td>
<td>0.3</td>
<td>99,000</td>
</tr>
<tr>
<td>Implants (Titanium)</td>
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<td>110,000</td>
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<tr>
<td>Spongy bone</td>
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<td>150</td>
</tr>
<tr>
<td>Cortical bone</td>
<td>0.26</td>
<td>1,500</td>
</tr>
</tbody>
</table>
the load energy** which led to reduction of stress concentration and rate of stress deterioration by moving away from implants. That is considered better distribution of stresses from the mechanics point of view, which may result in longer lifetime. Porcelain coating showed less stress in case of two implants, longer life for the brittle coating material is expected.

Contrarily more stresses were found on the gold crown placed on two implants due to its volume reduction (less material under the same load). That is clearly seen in increasing stresses on the two implants, that more load effect was transferred through the weak crown to the two implants. That showed maximum stresses in the area under the crown, while the wide implant showed maximum stresses at its tip. Looking to energy** absorption and stress concentration on whole system starting from coating to cortical and spongy bone, although the stress levels found was too low and far from cracking danger, the following conclusions can be pointed out: the total results favour the two implants in spongy bone and the wide implant in the cortical layer, but the alveolar bone consists of spongy bone surrounded by a layer of cortical bone. It’s also well known that according to the degree of bone density the alveolar bone is classified to D1,2,3,4 in a descending order.

So, provided that the edentulous space after the molar extraction permits, it’s recommended in the harder bone quality (D1,2) to use one wide diameter implant and in the softer bone (D3,4) quality two average sized implants. Therefore more detailed study to compromise between the two implants size/design and intermediate space can put this stress values in safe, acceptable, and controllable region under higher levels of loading.

*The area under the _- curve up to a given value of strain is the total mechanical energy per unit volume consumed*Table 1

<table>
<thead>
<tr>
<th>Differences %</th>
<th>Porcelain coating (1mm)</th>
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<tr>
<td>UcL</td>
<td>-17.86</td>
<td>-18.70</td>
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<td>-0.28</td>
<td>-18.57</td>
</tr>
<tr>
<td>UcL</td>
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<td>-0.03</td>
<td>-19.62</td>
</tr>
<tr>
<td>S1</td>
<td>31.59</td>
<td>-17.99</td>
<td>-6.72</td>
<td>5.96</td>
<td>-37.17</td>
</tr>
<tr>
<td>S2</td>
<td>0.71</td>
<td>-33.44</td>
<td>-310.74</td>
<td>-11.24</td>
<td>-70.43</td>
</tr>
<tr>
<td>S3</td>
<td>-1.26</td>
<td>-18.08</td>
<td>-166.39</td>
<td>4.75</td>
<td>-31.82</td>
</tr>
<tr>
<td>S4</td>
<td>0.25</td>
<td>-10.22</td>
<td>-196.66</td>
<td>4.00</td>
<td>-38.17</td>
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The stresses and displacements on the cortical bone are higher in the two implant model due to having two close holes, which results in weak area in-between. The spongy bone response to the two implants was found to be better considering the stress distribution (energy absorbed by spongy bone**). Therefore, it was concluded that, using the wide diameter implant or two average ones as a solution depends on the case primarily. Provided that the available bone width is sufficient mesio distally and buccolingually, the choice will depend on the type of bone. The harder D1,2 types having harder bone quality and thicker cortical plates are more convenient to the wide implant choice. The D3,4 types consist of more spongy and less cortical bone, are more suitable to the two implant solution.

**The area under the __-__ curve up to a given value of strain is the total mechanical energy per unit volume consumed**Table 1

Table 2

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In 1892, Julius Wolff, a German surgeon, published his seminal observation that bone changes its external shape and internal, cancellous architecture in response to stresses acting on it (Wolff’s law of bone modelling and remodelling). Therefore, it is a significant engineering challenge to design a short implant that biocompatibly transfers occlusal forces from its prosthetic restoration to the surrounding bone. It requires the understanding and application of many basic biological, mechanical, and metallurgical principles. It is paramount that the entire design of a SHORT™ implant optimizes the effectiveness of each of its features within the implant’s available surface area and length. Clinical success cannot be met by any single implant design feature such as surface area, but rather requires the appropriate integration of all of its features.

Since an implant’s design dictates its clinical and mechanical capabilities, it is scientifically approved that bone healing around a plateau-designed implant is different than the appositional bone (the bone that is formed by osteoblasts after cell mediated interfacial remodelling) around threaded implants. The plateaued, tapered and root-formed implant body provides for 30 per cent more surface area than comparably-sized threaded implants. But more importantly, the plateaus provide for an intra-membranous-like and faster bone formation (20–50 microns per day), resulting in a unique Haversian bone with clinical capabilities different from the slower forming (1–5 microns per day) of appositional bone around threaded implants. Additionally, the plateaus provide for the transfer of compressive forces to the bone throughout the entire implant.1,2

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proven short implant on the market that was called the Driskol Precision Implant in the early 1980s, than Stryker and the Bicon Dental Implant from 1993 (Boston, USA).

The Bicon implant has a bacterially-sealed 1.5° locking taper (galling or cold welding) connection between the abutment and implant, with the ability for 360° of universal abutment positioning. Having a bacterially-sealed connection eliminates the bacterial flux associated with clinical odours and tastes and reduces inflammation and bone loss consistently.

Another unique characteristic is the sloping shoulder that facilitates the appropriate transfer of occlusal loads to the bone when positioned below the bony crest. But more practically, the sloping shoulder facilitates aesthetic implant restorations, for it provides space for the interdental papillae with bony support even when an implant is contiguous to another implant or tooth. The sloping shoulder design has been, since 1985, the basis of a sensible biological width and the origin of platform switching.

The 360° of universal abutment positioning provides for the extra-oral cementation of crowns; the use of the cementless and screwless Integrated Abutment Crown (IAC™), the intraoral bonding of fixed bridges, which eliminates the need for cutting, indexing and soldering of bridge frameworks, multiple and easy removal of abutments over time; and the slight aesthetic rotational adjustments during and prior to the seating of a restoration.

Clinical long-term results

In the following long-term case description we can observe the stability of the crestal bone around the sloping shoulder of the plateau implant. Clinically, the soft tissue contour around the Integrated Abutment Crowns indicates a healthy and stable epithelial tissue.

The single-tooth implant is a viable alternative for single tooth replacement. Single-tooth replacement with endosseous implants has shown satisfactory clinical performance in different jaw locations.

Minimal or no crestal bone resorption is considered to be an indicator of the long-term success of implant restorations. Mean crestal bone loss ranging from 0.12-0.20mm has been reported one year after the insertion of single-tooth implant restorations. After the first year, an additional 0.01mm to 0.11mm of annual crestal bone loss has been reported on single-tooth implant restorations. Some implants demonstrate no crestal bone loss and/or crestal bone gain after insertion of definitive restorations.

Crestal bone gain has been documented on immediate and early loaded implants with a chemically modified surface after one year of follow up. A six-year prospective study reported that 45.8 per cent of splined Morse taper implants experienced some bone gain. Crestal bone gain has been documented around immediately loaded Bicon implants. The factors that lead to peri-implant bone gain in different
Implant designs have not been investigated. It would be beneficial for the dental practitioner to understand what factors are associated with crestal bone gain on single-tooth implants after crown insertion. Radiographic long-term control also as a clinical observation of the soft tissue structures surrounding the abutment emergence profile can provide the clinician with a better understanding of an implant’s bone/soft tissue stability (Figs 1–12).

The ideal scenario in modern implant dentistry would be the implant replacement for every missing single tooth (Figs 15&14). The single tooth replacement guarantees good aesthetics, consequently to the fact that a single crown that follows all criteria of a natural-looking soft tissue emergence profile can support the soft tissue in order to recreate papillae anatomy.

Another important aspect of single crown restorations on implants is that the patient can follow a better oral hygiene compared to bridgeworks. Nevertheless, bridgeworks are commonly used as alternatives to single tooth replacement. The reasons are multifactorial, with the cost benefit factor at first place (Figs 15&16). Another significant facet is the atrophic bone situation of the patient, were complicated and expensive bone graft procedures are needed before even thinking of placing single implants.

Alternatively to sophisticated and expensive bridge works (Figs 17&18), cost-effective and simple prosthetic techniques were developed in the last years. One of these techniques, the Fixed on SHORT™, allows to provide the patients with bone atrophies or partial bone deficiencies with a fixed, metal free prosthetic that can be supported by four to six short implants (Figs 19–22).

Conclusion
In this short and synthetic article, the authors like to show the variety of treatment options when implants and prosthetic materials are used with the criteria of long-term crestal bone preservation, recreation and long-term stabilisation of the biological width around the implant/crown and the use of short- and ultra-short implants in all clinical situations. The proper selection of an ultra-short or short implant depends strictly on the implant design, which dictates the implant’s function.

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Stem cells in implant dentistry

Dr André Antonio Pelegrine

The human body contains over 200 different types of cells, which are organised into tissues and organs that perform all the tasks required to maintain the viability of the system, including reproduction. In healthy adult tissues, the cell population size is the result of a fine balance between cell proliferation, differentiation, and death. Following tissue injury, cell proliferation begins to repair the damage. In order to achieve this, quiescent cells (dormant cells) in the tissue become proliferative, or stem cells are activated and differentiate into the appropriate cell type needed to repair the damaged tissue. Research into stem cells seeks to understand tissue maintenance and repair in adulthood and the derivation of the significant number of cell types from human embryos.

It has long been observed that tissues can differentiate into a wide variety of cells, and in the case of blood, skin and the gastric lining the differentiated cells possess a short half-life and are incapable of renewal. Not only can stem cells be isolated from both adult and embryo tissues; they can also be kept in cultures as undifferentiated cells. Embryo stem cells have the ability to produce all the differentiated cells of an adult. Their potential can therefore be extended beyond the conventional mesodermal lineage to include differentiation into liver, kidney, muscle, skin, cardiac, and nerve cells (Fig 2).

The recognition of stem cell potential unearthed a new age in medicine: the age of regenerative medicine. It has made it possible to consider the regeneration of damaged tissue or an organ that would otherwise be lost. Because the use of embryo stem cells raises ethical issues for obvious reasons, most scientific studies focus on the applications of adult stem cells. Adult stem cells are not considered as versatile as embryo stem cells because they are widely regarded as multi-potent, that is, capable of giving rise to certain types of specific cells/tissues only, whereas the embryo stem cells can differentiate into any types of cells/tissues. Advances in scientific research have determined that some tissues have greater difficulty regenerating, such as the nervous tissue, whereas bone and blood, for instance, are considered more suitable for stem cell therapy. In dentistry, pulp from primary (milk) teeth has been thoroughly investigated as a potential source of stem cells with promising results. However, the regeneration of an entire tooth, known as third dentition, is a highly complex process, which, despite some promising results with animals remains very far from clinical applicability. The opposite has been observed in the area of jawbone regeneration, where there is a higher level of scientific evidence for its clinical applications. Currently, adult stem cells have been harvested from bone marrow and fat, among other tissues.

Bone marrow is haematopoietic, that is, capable of producing all the blood cells. Since the 1950s, when Nobel Prize winner Dr E Donnall Thomas demonstrated the viability of bone marrow transplants in patients with leukaemia, many lives have been saved using this approach for a variety of immunological and haematological conditions.

Research into stem cells seeks to understand tissue maintenance and repair in adulthood and the derivation of the significant number of cell types from human embryos.
Implant Tribune

January 2014

United Kingdom Edition

Bone marrow contains more than just hematopoietic stem cells (which give rise to red and white blood cells, as well as platelets, for example); it is also home to mesenchymal stem cells (which will become bone, muscle and fat tissues, for instance; Fig 3).

Bone marrow harvesting is carried out under local anaesthesia using an aspiration needle through the iliac (pelvic) bone. Other than requiring a competent doctor to perform such a task, it is not regarded as an excessively invasive or complex procedure. It is also not associated with high levels of discomfort either intra or post-operatively (Figs 4a & b).

Bone marrow harvesting is a challenge in dentistry (also in orthopaedics and oncology) because rebuilding bony defects caused by trauma, infections, tumours or dental extractions requires bone grafting. The lack of bone in the jaws may impede the placement of dental implants, thus adversely affecting patients’ quality of life. In order to remedy bone scarcity, a bone graft is conventionally harvested from the chin region or the angle of the mandible. If the amount required is too large, bone from the skull, legs or pelvis may be used. Unlike the process for harvesting bone marrow, the process involved in obtaining larger bone grafts is often associated with high levels of discomfort and, occasionally, inevitable post-operative sequelae (Figs 5a-e).

The problems related to bone grafting have encouraged the use of bone substitutes (synthetic materials and bone from human or bovine donors, for example). However, such materials show inferior results compared with autologous bone grafts (from the patient him/herself), since they lack autologous proteins. Therefore, in critical bony defects, that is, those requiring specific therapy to recover their original contour, a novel concept to avoid autologous grafting, involving the use of bone-sparing material combined with stem cells from the same patient, has been gaining ground as a more modern philosophy of treatment. Consequently, to the detriment of traditional bone grafting (with all its inherent problems), this novel method of combining stem cells with mineralised materials uses a viable graft with cells from the patient him/herself without the need for surgical bone harvesting.

Bone reconstruction is a challenge in dentistry (also in orthopaedics and oncology) because rebuilding bony defects caused by trauma, infections, tumours or dental extractions requires bone grafting.

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Until recently, no studies had compared the different methods available for using bone marrow stem cells for bone reconstruction. In the following paragraphs, I shall summarise a study conducted by our research team, which entailed the creation of critical bone defects in rabbits and subsequently applying each of the four main stem cell methods used globally in order to compare their effectiveness in terms of bone healing.1

- fresh bone marrow (without any kind of processing)
- a bone marrow stem cell concentrate
- a bone marrow stem cell culture
- a fat stem cell culture (Figs 6&7).

In a fifth group of animals, no cell therapy method (control group) was used. The best bone regeneration results were found in the groups in which a bone marrow stem cell concentrate and a bone marrow stem cell culture were used, and the control group showed the worst results. Consequently, it was suggested that stem cells from bone marrow would be more suitable than those from fat tissue for bone reconstruction and that a simple stem cell concentrate method (which takes a few hours) would achieve similar results to those obtained using complex cell culture procedures (which take on average three to four weeks; Figs 6&7).

Similar studies performed in humans have corroborated the finding that bone marrow stem cells improve the repair of bony defects caused by trauma, dental extractions or tumours. The histological images below illustrate the potential of bone-sparing materials combined with stem cells for bone reconstruction (Fig 9). It is clear that the level of mineralised tissue is significantly higher in those areas where stem cells were applied (Figs 10a&b).

Evidently, although bone marrow stem cell techniques for bone reconstruction are very close to routine clinical use, much caution must be exercised before indicating such a procedure. This procedure requires an appropriately trained surgical and laboratory team, as well as the availability of the necessary resources (Figs 11a–h, taken during laboratory manipulation of marrow stem cells at São Leopoldo Mandic dental school in Brazil).

All images courtesy of Células Tronco em Implantodontia.2

References

About the author
Dr André Antonio Pelegrine is a specialist dental surgeon in periodontology and implant dentistry (CFO) with an MSc in Implant Dentistry (UNISA), and a PhD in clinical medicine (University of Campinas). He completed postdoctoral research in transplant surgery (Federal University of São Paulo). He is an associate lecturer in implant dentistry at São Leopoldo Mandic dental school and coordinator of the prosthodontics-implant dentistry team at the University of Campinas in Brazil. He can be contacted at pelgrineandre@gmail.com.