The preservation of the natural dentition is the prerequisite in daily patient care. In advanced periodontal disease, the successful realisation of implant therapy requires knowledge in patient expectations, clinical diagnostics, proper surgical skills and delegation of basic services to dental hygienists. Implant treatment in severe periodontitis demands a two-step, time-tested approach, evaluating the outcomes of basic periodontal therapy before implant placement.

Integrated dentistry: Success

The successful positioning of dental partnerships in the fast-growing health market implicates predictable treatment strategies to save permanent teeth. According to orthopaedic, cardiac or vascular medicine, an on-time decision-making protocol for implant therapy is recommended to counterbalance functional and aesthetic discomfort in advanced endodontic and periodontal breakdown settings. Patient’s current and future expectations drive our practices into the necessity to provide synergistic periodontal and implant treatment solutions. The advantages are:

- Optimising implant success by proceeding with periodontal therapy
- Enhanced economic profit due to by-effects from delegated scaling and root planing
- Promotion of oral and body health of both dental patients and staff members

The need to preserve healthy teeth and gums, the ever-expanding influences of web, TV and magazines and an increase in low-cost implant treatment render implant dentistry internationally attractive. The transition of dental practices into the implant market is reasonable, especially for growing dental partnerships. The capital investment and running costs for a surgical implant setting are redeemed by more than 30 implants a year. Because of the economic commitment, a careful financial strategy is needed not to neglect challenges and developing concepts preserving and salvaging compromised teeth from conservative and periodontal dentistry.

Decision-making

Classical implant therapy protocols comprise must-indications resulting in an immediate treatment plan. According to patient preferences, clinical settings and insurance plans, these must-indications with an ad-hoc implant placement recommendation are, in order of precedence:

- Long-term missing bridgeworks or prosthesis, edentulous mandible
- Advanced endodontic damage
- Trauma (tooth fracture)
- Oral cancer surgery

Periodontal diseases represent can-indications. Treatment planning is running more complex. The decision-making comprises a time-tested therapeutic approach. In advanced periodontal settings of more than 50 per cent bone loss with furcation involvement level III, patients suffer from oral discomfort. The tooth prognosis becomes less positive, the frequencies of follow-up visits increase (Fig 1). Periodontal therapy ‘before’ implant planning is aimed at saving doubtful (not hopeless) teeth with a grace period of at least three to six months to evaluate for periodontal treatment outcomes. Thorough scaling and root planing frequently results in a mid-term improvement (two years) up to a long-term stabilisation (five years) of preliminary affected teeth.

The decision to maintain the periodontally compromised dentition undergoes the following criteria (Fig 2):

- Patients with no preferences to comfort, aesthetics and costs
- Patients willing to accept enhanced tooth mobility, occasional
food impaction and frequent professional tooth cleaning.

- Individuals with chronic diseases and autoimmune disorders

The recommendation to replace affected teeth with implants is indicated in the following clinical situations and should be planned on-time after completion of periodontal therapy (three to six months):

- Patients running a demanding business striving for fixed teeth
- Enhanced masticatory and clearance
- Long-term rehabilitation without input in time, effort and expenses

Currently, the items above are effective at implant placements within the local bone, minor lateral hard and soft tissue deficiencies, following sinus floor elevation, in settings with sufficient implant abutment distances of 3mm and after periodontal therapy. Extended surgical protocols enhance treatment time (Fig 5), render the case prognosis uncertain and may aggravate long-term success.

Implant therapy in advanced periodontal disease

The survival rates of teeth with severe periodontal damage published in evidence-based studies are rarely valid for patients inquiring treatment in dental offices (Fig 6). Shortcomings in oral hygiene, lack in supportive care, oral dysfunctions, stress, smoking and general disorders abbreviate the function times of periodontally compromised teeth sustainably.

The advice to replace affected teeth with implants in advanced periodontal settings within the maxilla implicates on-time patient information of the second and third molar removal: implant placement and prosthetic bridge works are scheduled in the functional masticatory area until to the first molar. In the mandible, the second molars can be preserved due to their beneficial root anatomy. They should be restored, but not included in implant planning. Following the removal of the first molar in the maxilla, the implant therapy is often preceded (if the supporting bone is less than 4mm) or accompanied by a sinus floor elevation, in settings with sufficient lateral hard tissue deficiencies. The best protection against surgical therapy prolongs treatment time, renders case prognosis unsafe and may aggravate long-term success.

In advanced periodontal disease, the function times of periodontally compromised teeth are contraindications for short implants in both aesthetic and functionally less demanding situations as an alternative to surgical augmentation (Fig 8).

Low bone quality (D3/D4), lateral hard-tissue deficiencies and increased mechanical loading are contraindications for short implants. According to conventional implant rehabilitation, the horizontal width of the alveolar bone crest is the standard for functional stability, vascularisation and nutrition, thus for implant survival and clinical success (Fig 9).

Inflammation and hygiene

Clinical healthy and stable implants are completely covered within the alveolar bone by osseointegration. They also are attached to the peri-implant gingiva and thereby become functionally included into the body’s metabolism. This explains the high overall survival rates of oral implants between eight and more than 15 years. The combination of:

- A thin biotype gingiva with lack of soft tissue protection
- Functional overload due to chewing for a missing front-canine equilibration
- Loss of biofilm protection by periodontal diseases often causes mid-term damages (two years after functional loading) of the implant-to-bone interface. Like periodontally affected teeth with lack of hygiene access and enhanced biofilm accumulation, implants develop a potential risk of inflammation when bacteria enter the implant-to-bone interface (Fig 10). If the close hard and soft tissue sealing disappears irreversibly, foreign-body infections that are more harmful for the body health than periodontal diseases.

Summary

In advanced periodontal diseases, the network between medical progress and ever-expanding patient’s expectations requires a time-tested schedule with a grace period of three to six months to evaluate the affected dentition for periodontal treatment outcomes. If patients anticipate immediately fixed and aesthetic restorations, on-time implant therapy with minimal augmentative solutions is recommended. Preservation of periodontally compromised natural teeth is advised when patients display no preference for further comfort and aesthetics. Periodontal therapy is continued, supplemented with surgery in advanced intra-bony settings where oral hygiene is impaired. The long-term success for the natural dentition and implants similarly depends on patient’s medical and local risk factors that cannot be forecasted with any genetic or susceptibility test for sale.

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