Perio meets implant dentistry

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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 renders 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
- 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

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- 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 cleancess
- Long-term rehabilitation is 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 alveolus 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 inquire treatment in dental offices (Fig 6). Shortcomings in oral hygiene, lack in supportive care, oral dysfunctions, and 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-work is scheduled in the functional masticatory area until 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 simultaneous sinus lift. The current treatment plan in periodontally compromised patients results in a reduced dentition (Fig 5):

- Fixed bridge-works in the maxilla and mandible up to the first molar
- Maxilla: preservation of pre-molars and first molars, tooth removal and implant therapy with sinus floor elevation at furcation involvement level III (Fig 6)
- Mandible: preservation of second molars, restoration, no inclusion into bridgeworks
- Volume thickening with free autogenous gingival grafts in initial thin biotype settings (Fig 7)

Fig. 1 Treatment of advanced periodontal disease with implants replacing the natural dentition is recommended “time tested” 6-12 months following periodontal therapy (SRP).

Implant Therapy should be performed with minimal augmentation. Extended surgical protocols prolong treatment time, render case prognosis uncertain and may aggravate long-term success.

Fig. 2 Exclusion criteria for implants with continuation of saving natural teeth after comprehensive periodontal therapy.

Implant therapy is often preceded (if the supporting bone is less than 4mm) or accompanied by a simultaneous sinus lift. The implant-to-bone interface is indicated in the following clinical situations and should be planned on-time after completion of periodontal therapy (three to six months):

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The survival rates of teeth with severe periodontal damage published in evidence-based studies are rarely valid for patients inquire 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.

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- Short implants in both aesthetically 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 load are contraindications for short implants. According to conventional implant rehabilitation, the horizontal width of the alveolar bone crest is the fundament for functional stabilization, vascularization 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 short implants in both aesthetically and functionally less demanding situations as an alternative to surgical augmentation (Fig 8).

- A thin biotype gingiva with lack of soft tissue protection
- Functional overload due to teeth attached to a missing front-canine equilibration
- Loss of biofilm protection by inflammation

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 enter the implant-to-bone interface. The implant-supporting bone and the body health are affected irreversibly. Foreign-body infections often occur within the oral cavity, which are more harmful for the implant-supporting bone and the body health than periodontal diseases.

The best protection against peri-implant inflammation is not avoiding implants: a careful implant placement strategy with concomitant thickening of the surrounding tissues and relief from functional overload preceded by comprehensive periodontal therapy (Fig 11).

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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