Peri-Implant Treatment Options

Implant care depends on the severity of disease, the home care of the patient, as well as the general health of the patient. The more plaque because of poor home care or the worse health because of smoking or uncontrolled diabetes, the tighter the recall should be on such patients. The patient side of the implant will be discussed in more detail later.

With regard to implant disease severity alone, the following strategies apply:

Peri-Implant Mucositis (gingival inflammation, bleeding on probing, suppuration on palpation, but no radiographic bone loss or probings over 6mm):

-Mechanical debridement (implant safe cavitron/piezo).

-Adjunctive irrigation (Chlorhexidine, Peroxide, Iodine).

-Adjunctive laser (Nd:YAG, CO2, Diode, Erbium).

-Antibiotics (systemic or local).

Peri-Implantitis (now includes radiographic bone loss) can be managed surgically in the following ways:

-Flap access with surface debridement chemically or mechanically, possible thread reduction; bone grafting if remaining bone topography is favorable; gingival grafting if there is lack of keratinized tissue.

-Explantation (when there is 50% or greater bone loss and/or non-responsive to all prior therapy).

Peri-Implant Disease

Implants face disease states just as teeth can. When a tooth has succumb to bacterial invasion and only the gingiva is involved such that there is no bone loss, we call this gingivitis. Once the bone is affected, we call this periodontitis. Similarly, when an implant succumbs to bacterial invasion and only the soft tissue is involved, this is called Peri-Implant Mucositis. But once the bone is affected, it is called Peri-Implantitis.

Because dental implants are being placed in higher numbers each year especially in the general dental setting, knowing not only how to manage implant disease, but more importantly, how to prevent implant disease is very much worth understanding.

As a generalist, management of severe Peri-Implantitis in terms of surgical intervention or even explantation may be something that is referred out. But management of initial issues with the hygienist can help prevent or delay the need for surgical treatment. Additionally, understanding how implant position as well as patient systemic factors affect the long term outcome of the implant is also very relevant.

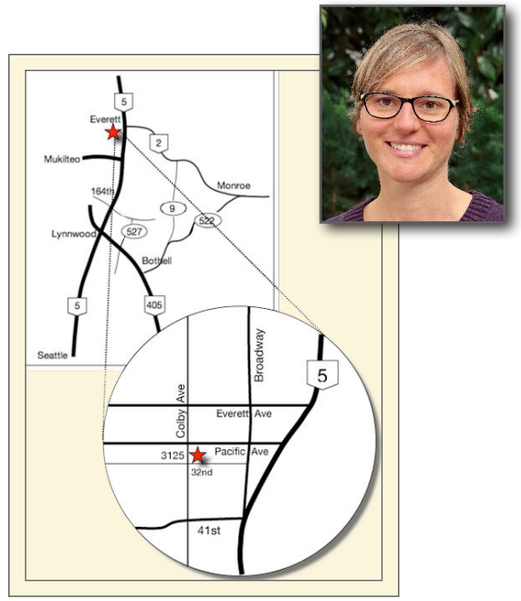
This **ProbeTips** newsletter will briefly review surgical care of ailing and failing implants, but **will focus primarily on ideal implant placement and restoration as well as implant maintenance procedures** to help ensure the best long term outcomes for your patients and keep you sleeping soundly at night.

Pamela A Nicoara DDS MSD PLLC

PERIODONTOLOGY IMPLANTOLOGY ORAL MEDICINE

Pamela Nicoara is a Board Certified Periodontist practicing in Everett since 2007. She is a UW Perio graduate, and a transplant from Dallas, Texas.

She is driven to achieve esthetic and predictable outcomes, particularly for anterior implant cases, and is always looking to improve processes and results. You can email her directly below with questions, comments, or suggestions for future newsletters.



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Probe Tips

A Quarterly Periodontal Newsletter

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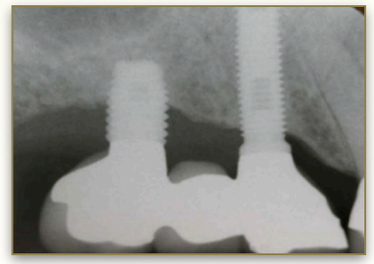
Peri-Implant Consensus AO/AAP 2025



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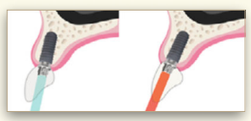
Peri-Implant Consensus AO/AAP 2025

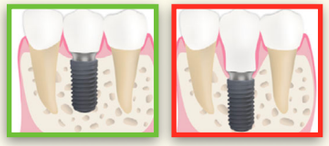
Implant Placement Factors

Prosthetically driven implant positioning is highly important for long term implant success. Although it is possible to correct for lack of ideal implant position with a restoration, this does not reduce the risk for higher or faster failure rates of the implant because of lack of access for hygiene or the inability of the soft tissues to maintain themselves over time. It is a misconception that implants maintain soft tissue and bone as teeth can. Not only do soft tissues and bone shrink over time around implants, but because the implants are integrated in the bone, they do not move with the face as it continues to grow and change with time. We don't consider facial change to occur after puberty, but this must also be factored into implant positioning, particularly in younger patients who have more risk for change with time compared to older patients. The face generally grows downward and forward, making the implant seem to intrude and move backwards with time. Four main implant malpositions are shown below.

1. Implant too Facial



2. Implant too Proclined



3. Implant too Deep
>6mm below adjacent CEJ

4. Implants too Close
<3mm inter-implant distance

Consideration of hard and soft tissue topography is also important. If there is thin buccal bone or soft tissue, or a lack of keratinized tissue, these should should be modified surgically with bone and soft tissue grafting.

Patient Considerations (Local and Systemic)

Patients are also responsible for the long term outcome of their implants. Any patient exhibiting the factors listed below should not be expected to maintain implants long term, and may be better served with other tooth replacement solutions as failed implants can decimate bone and prevent traditional tooth replacement.

1. Poor home care and/or Poor recall compliance.
2. Excess alcohol consumption (>7u and 14u per week for women and men respectively).
3. Current or former smoker (>10 cigarettes per day, <10 years since having quit).
4. History of periodontitis or Active periodontitis.
5. Obesity or metabolic syndrome or uncontrolled diabetes.

Implant Maintenance Strategy

Six weeks after non-surgical debridement with possible adjunctive irrigation, laser or antibiotics, maintenance frequency is determined by the response to this initial care. The better the response in terms of reduced bleeding or suppuration, and the healthier and more compliant the patient, the less frequent the recall needs to be, such as every 6 months or once per year. When bleeding or suppuration does not improve and the patient is non-compliant, maintenance every 2-3 months is requisite with continual adjunctive irrigation or local antibiotics, and surgical intervention may be necessary.

References

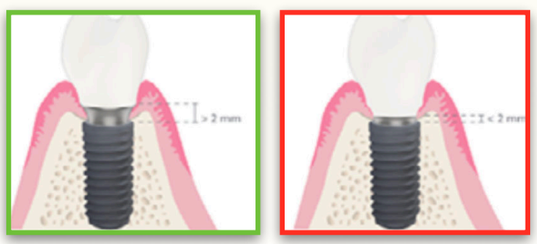
Int J Periodontics Restorative Dent *Fiorellini, et al.* 2025

Clin Adv Periodontics *Kumar, et al.* 2025

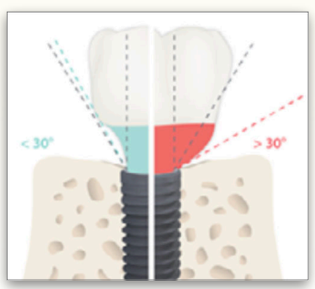
Complete References Available on Request.

Implant Restoration Factors

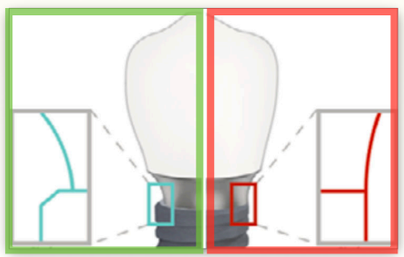
Of greatest relevance to the generalist is realizing that how the implant is restored affects the long term outcome of the implant. Below are key factors that are important to AVOID when restoring titanium dental implants.



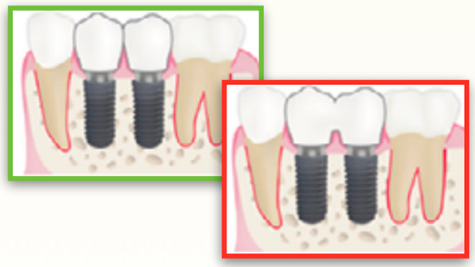
1. Short Transmucosal Height
Use height of 2mm or more, Use Custom Abutment and Avoid Ti-Base to bring crown-abutment junction where bacteria reside as far away from implant platform as possible.



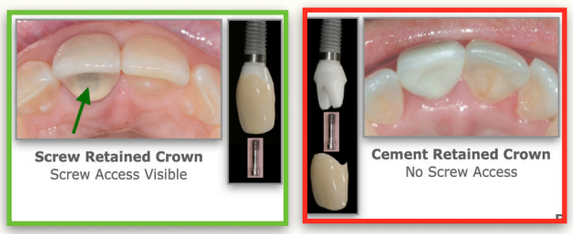
2. Convex Emergence Profile
Use Straight or Concave profile, Avoid >30 degree emergence.



3. Non-Platform Switch
Use inset of abutment to implant platform to give buffer for bone loss if there is micro-movement or bacterial contamination.



4. Splinted Crowns
Use individual crowns, Splinting risk reduces as implants are further spaced from each other as with bridge scenario with pontic present.



5. Cemented Crowns
Use screw retention to eliminate risk of sub-gingival cement extrusion which harbors bacteria causing bone and soft tissue loss. Screw retention also provides retrievability for repair.