



WESTSIDEOMS ORAL SURGERY & DENTAL IMPLANT CENTER

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Summer 2016 ~ A Quarterly Update

Dear Colleague:

Each year we continue to see growth and development in our practice accompanied by an increase in treatment success. Through this quarterly newsletter, we wish to share with you some of the latest developments in oral surgery and implant dentistry, as well as open communication with your office.

If we can provide any additional information, or if you would like to see an article on a particular topic in our next issue, please do not hesitate to call. We appreciate the trust you place in us by allowing us to participate in the care of your patients.

Regards,

Dr. Rupi Dhadli

Keratinized Mucosa Around Implants in Partially Edentulous Posterior Mandible

Roccuzzo M, Grasso G, et al.
Clin Oral Implants Res. 2016 Apr;27(4):491-6

The purpose of this research was to investigate the clinical conditions around dental implants placed in the posterior mandible of healthy or moderately periodontally compromised patients, in relation to the presence or not of keratinized mucosa (KT). One hundred and twenty-eight patients who needed an implant in the posterior mandible were consecutively enrolled in a private specialist practice. Only one implant per patient was examined originally placed either within KT or alveolar (AM) mucosa. At 10 years, clinical and radiographic measures were recorded by a calibrated operator. The number of sites treated according to therapy modalities C and D (antibiotics and/or surgery) during the 10 years was also registered.

Ninety-eight patients completed the 10-year study. The absence of KT was associated with higher plaque accumulation, greater soft-tissue recession (REC), and

a higher number of sites that required additional surgical and/or antibiotic treatment. Patient-reported outcomes regarding maintenance procedures presented major differences between the groups. In 11 of the 35 AM cases, additional free gingival graft (FGG) was successfully employed to reduce discomfort and to facilitate optimal plaque control. Implants that are not surrounded by KT are more prone to plaque accumulation and REC, even in patients exercising sufficient oral hygiene and receiving adequate supporting periodontal therapy (SPT). *In selected cases, particularly in the edentulous posterior mandible, where ridge resorption leads to reduced vestibular depth and lack of KT, additional FGG can be beneficial to facilitate proper oral hygiene procedures.*

Open Contacts Adjacent to Dental Implant Restorations

Greenstein G, Carpentieri J, et al.
J Am Dent Assoc. 2016 Jan;147(1):28-34

The purpose of this investigation was to evaluate the potential causes, clinical significance, and treatment of open contacts between dental implant restorations and adjacent natural teeth. The authors searched the dental literature for clinical trials in humans that addressed the incidence of open contacts that develop after implant restorations are placed next to teeth.

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Dr. Dhadli is dual degreed Oral and Maxillofacial Surgeons both a physician and dental surgeon. Dr. Dhadli attended Dental School and Medical School at Case Western Reserve University. She furthered her training and education through a 5 year intensive residency program in Oral and Maxillofacial Surgery and Anesthesia at University Hospitals of Cleveland, OH, Mt. Sinai Medical Center, Rainbow Babies and Children Hospital, and Metrohealth Medical Center in Cleveland, OH.



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Open Contacts...continued

The authors found 5 studies in which the investigators addressed the incidence of open contacts after implant restorations are inserted next to teeth. Results from these studies indicated that an interproximal gap developed 34% to 66% of the time after an implant restoration was inserted next to a natural tooth. This event occurred as early as 3 months after prosthetic rehabilitation, usually on the mesial aspect of a restoration. The occurrence of an interproximal separation next to an implant restoration was greater than anticipated. It appears that force vectors cause tooth movement and an implant functions like an ankylosed tooth. Clinicians should inform patients of the potential to develop interproximal gaps adjacent to implant restorations, which may require repair or replacement of implant crowns or rehabilitation of adjacent teeth. Furthermore, steps should be taken to check the continuity of the arch periodically. *If the clinician detects an open contact, it is prudent to monitor for signs or symptoms of pathosis so that prosthetic repair of the gap can be initiated, if needed. These problems could add to treatment costs and decrease overall patient satisfaction related to implant treatment.*

The Fate of Buccal Bone Around Dental Implants

Merheb J, Vercruyssen M, et al.
Clin Oral Implants Res. 2016 Jan 8

Buccal bone thickness is considered to be an important factor during implant surgery. Its resorption might have an effect on the soft tissue stability and eventually on implant survival. This study was conducted to investigate the resorption of the buccal bone over the first 12 months after implant loading. Twenty-four subjects (47 implants) were included. The buccal bone thickness was measured during implant surgery at several distances from the implant shoulder using a specifically designed device which allows buccal bone thickness measurements without the elevation of a muco-periosteal flap. These measurements were repeated after 12 months of loading. Sixteen implants were placed flapless and 31 with the elevation of a flap. Of the latter, 19 were placed following a one-stage protocol and 12 following a two-stage protocol.

The mean reduction in buccal bone thickness, when all groups pooled, was 0.26, 0.36, 0.35 and 0.27 mm at the shoulder and 2, 4 and 6 mm apically. Implants with initial bone thickness <1mm (thin buccal plate) did not lose

significantly more bone than those with an initial thickness ≥ 1 mm (thick bone plate) except in the 'open-flap, one-stage' group. A flapless procedure leads to less bone resorption compared to an open-flap procedure. However, the number of surgeries (one stage vs. two stages) did not influence the rate of bone resorption. *From the results of this study, the authors questioned the necessity of having a thick bone plate at the vestibular site of the implant.*

Dental Implants in Patients with Oral Mucosal Diseases

Reichart PA, Schmidt-Westhausen AM, et al.
J Oral Rehabil. 2015 Dec 21

The purpose of this study was to reveal dental implants survival rates in patients with oral mucosal diseases: oral lichen planus (OLP), Sjögren's syndrome (SjS), epidermolysis bullosa (EB) and systemic sclerosis (SSc). A systematic literature search identified publications on clinical use implant-prosthetic rehabilitation in patients with OLP, SjS, EB, SSc reporting on study design, number, gender and age of patients, follow-up period exceeding 12 months, implant survival rate.

After a mean observation period (mOP) of 53.9 months, 191 implants in 57 patients with OLP showed a survival rate (SR) of 95.3%. For 17 patients with SjS (121 implants, mOP 48.6 months), 28 patients with EB (165 implants, mOP 38.3 months) and five patients with SSc (38 implants, mOP 38.3), the respective SR was 91.7 (SjS), 98.5 (EB) and 97.4 (SSc). Heterogeneity of data structure and quality of reporting outcomes did not allow for further comparative data analysis. For implant-prosthetic rehabilitation of patients suffering from OLP, SjS, EB and SSc, no evidence-based treatment guidelines are presently available. However, no strict contraindication for the placement of implants seems to be justified in patients with OLP, SjS, EB nor SSc. *Implant survival rates are comparable to those of patients without oral mucosal diseases. Treatment guidelines as for dental implantation in patients with healthy oral mucosa should be followed.*



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