Original Research Article

Relationship of peri-implant clinical parameters and increased probing depth in dental implants: a cohort study

.

ABSTRACT

|  |
| --- |
| **Aims:** The gradual increase in probing depth makes it more difficult to keep the subgingival region healthy, patients should be instructed on how to clean the areas rehabilitated with dental implants, and most professionals still have doubts about the diagnosis and treatment of peri-implantitis.  **Study design:** Cohort study  **Place and Duration of Study:** Sample: Department of Dentistry University Santo Amaro, São paulo, Brazil, between June 2019 and July 2021.  **Methodology:** Initially, 208 patients who underwent oral rehabilitation with implants between 2011 and 2012. After defining the eligibility criteria, 73 patients with one unitary external hexagon implant in function for 10 years were included in the study. Participants underwent complete peri-implant examination and were evaluated: probing depth, plaque index, bleeding index and suppuration. Periapical radiographs were taken to verify the current bone level.  **Results:** Peri-implantitis was diagnosed in 37 implants (50.7%) and 36 (49.3%) were healthy. The 37 implants diagnosed with peri-implantitis were influenced by the plaque index and the interaction between probing depth and suppuration (P < .001). The bone loss for implants diagnosed with peri-implantitis, the average was 4.0 mm (P < .001). For plaque index the average was 3.6 mm (P < .001) and average for suppuration as 4.0 mm. The implant diagnosed with peri-implantitis, and presence of biofilm have affected the PD.  **Conclusion:** Within the limitations of this cohort study, increased plaque index and suppuration were significantly associated with peri-implantitis. Prospective studies with baseline measurements should be performed to elucidate the role of biofilm in peri-implantitis. |

*Keywords:* *Dental Implants, Single-Tooth, Peri-implantitis, Risk factors, Periodontal index*

1. INTRODUCTION

The number of rehabilitations carried out with dental implants grows exponentially, thousands of implants were installed. Simultaneously, it is expected an increase in the biological complications resulting from the growing number of dental implants and their rehabilitations [1]. There are several studies discussing the prevalence of peri-implant diseases, with various types of methodological definitions, and literature has reported an average prevalence of peri-implantitis of 22%, varying from 1% to 47% [2].

Peri-implantitis has been defined as an inflammatory lesion of the mucosa surrounding an endosseous implant and with progressive loss of supporting peri-implant bone. The peri-implant health consists of the absence of visual signs of inflammation and the absence of bleeding and/or suppuration after gentle probing, with no increase in the probing depth in comparison to prior exams [3, 4, 5]. The correct diagnostic is key to define the measures to control the peri-implant disease. In the absence of prior exams, the following criteria can be used: presence of bleeding and/or suppuration after gentle probing, probing depth equal to or higher than 6 mm, bone level of 3 mm or more, apical to the most coronary part of the intraosseous portion of the implant. Thus, the development of peri-implantitis is related to an inefficient plaque control, due to the difficult access to the site for hygiene and maintenance, the position of the implant and the presence of keratinized tissue. The plaque index has a dominant role in the prevalence of peri-implantitis, as well as bleeding on probing [6, 7].

Patients must be assessed in regular intervals to monitor their peri-implantitis status, as well as the condition of the prostheses supported by the implant and the control of biofilm. The principles of maintenance must include the regular assessment of the implants and their surrounding prostheses and tissues; occlusal exam; review and reinforcement of the oral hygiene; removal of plaque; treatment or diseases or repair in the prostheses, as needed; and definition of personalized preventive measures [8]. Regular routine and frequent maintenance appointments to motivate patients to professionally control the biofilm may prevent the start or increase of a gingival inflammation in dental implants with mucous membrane-supported prosthesis [9].

The gradual increase in probing depth makes it more difficult to keep the subgingival region healthy, patients are not properly instructed about cleaning sites rehabilitated with dental implants, and most professionals still have doubts about the diagnosis and treatment of peri-implantitis.   
Monitoring the status of dental implants over long periods is important. Relating conditions, habits, and characteristics after years of use can help elucidate some situations such as the appearance of peri-implant disease, marginal bone loss, and constant local inflammation. The objective of the present study was to evaluate the peri-implant clinical condition of implants installed 10 years ago, associating the probing depth found with the clinical status, the presence or absence of disease and the performance of maintenance consultations over these years.

2. material and methods

**2.1 Study design**

This study is in accordance with Resolution no. 196, of October 16th, 1996, by the National Health Council of Brazil, and the Odontology Professional Ethics Code (Resolution CFO No. 042/2003). All recruited individuals received a verbal and a written explanation of the objectives, methodology, benefits and eventual risks related to the participation in the project. Therefore, the individuals who accepted to participate in the study have signed the Free and Informed Consent Term, previously assessed and approved by the Research Ethics Committee for research with humans of the Universidade Santo Amaro no. 7611/2012.This is a longitudinal prospective cohort study which has the main objective of clinically and radiographically analyzing dental implants installed 10 years ago. Its secondary objective is relating the plaque index, bleeding on probing, probing depth, bone loss and annual maintenance with the health/disease status of the implants.

**2.3 Definition of disease**

For this study, the incidence of peri-implant disease has been calculated using the consensus of the 2017 World Workshop for Classifying Periodontal and Peri-Implant Diseases and Conditions. Peri-implantitis is defined as of 2017 as a pathological condition associated with plaque which occurs on the tissues around dental implants; it is characterized by an inflammation in the peri-implant mucous membrane and subsequent progressive loss of the supporting bone. Areas with peri-implantitis presents clinical signs of inflammation, bleeding on probing and/or suppuration, increase in probing depth and/or recession in the mucous membrane margin, as well as radiographical bone loss. Data from previous exams were not available, therefore the diagnosis of peri-implantitis was based on the combination of: bleeding and/or suppuration on gentle probing; probing depths ≥ 6 mm; bone levels ≥ 3 mm apical of the most coronal portion of the intraosseous part of the implant [10, 11].

**2.4 Eligibility criteria**

This study included individuals of both genders, from 40 to 60 years old, with unitary external hexagon implant, and surface treated with acid, with screw-retained or cemented crowns, the presence of teeth adjacent to the implant.

Individuals who had implants diagnosed with peri-implant mucositis, had more than one implant or smokers were excluded from the study, as well as those individuals who, for any reason, had to suspend the use of systemic medication for clinical evaluation, and individuals in need of antibiotic prophylaxis for carrying out the clinical examinations.

Patients were assessed for annual maintenance and its relationship with peri-implant disease. A regular annual visit to each patient's personal dentist was accepted as maintenance. The patients included in the study had implants installed at the same time and returned after 10 years for this evaluation. Patients who reported not going to the dentist every year were assessed as not having annual maintenance.

**2.5 Clinical data**

Participants underwent complete peri-implant examination and all implants were evaluated: probing depth, plaque index, bleeding index and suppuration presence. Probing depth (PD) was measured in millimeters with the help of a periodontal probe (Millenium/Golgram, São Paulo, Brazil) from the edge of the mucosa to the bottom of the sulcus, and measurements were taken manually at four different points in all presented implants (buccal, mesial, lingual and distal). Plaque index and bleeding on probing index measurements were performed on 4 sides same as PD and the presence or absence of biofilm and bleeding on probing were evaluated based on a binominal standard, being 0 = absence of plaque and 1 = presence of visible plaque. The clinical exam comprised: probing depth (PD) - 6 points per implant; plaque and bleeding index - 4 dichotomous points [12].

Each clinical parameter has been obtained by two blinded examiner previously calibrated. As a means of assessing inter- and intra-examiner agreement, PD measurements were performed and repeated at one-week intervals in 12 randomly selected individuals from the initial sample group. The data were submitted to the non-parametric Kappa test for intra-examiner agreement of the measurements. A dichotomous criterion at the cutoff point of PS ≥ 4 mm was used to establish the presence or absence of periodontal alteration. The results showed satisfactory weighted Kappa values ​​for PS and NCI of 0.83 and 0.82, respectively (α = .05).

**2.6 Radiographic data**

For all participants, full periapical radiographic exams were carried out, with 14 x-rays in order to verify the height of the bone cortical and support the periodontal diagnosis. The periapical technique applied was the parallelism with the use of a holder to obtain the most isometric image possible. After digitalizing all x-rays, the bone loss was measured on both sides of the implant (mesial and distal sides) by a previously calibrated probe with the support of an image analysis software (version 3.7.0 Digimizer, Medical Software Brolkstraat, Belgium). To correct dimensional distortions in the x-ray, the software was calibrated with the real diameter and length of the implant. Due to the absence of previous exams, the periapical exam served to aid in the diagnosis and was carried out with this objective.

**2.7 Statistical analysis**

The R software was used for analysis. The observed means were compared using Student's t-test. To assess the relationship between the study variables and the disease variable, we used the Wilcoxon test because the variables presented data without normal distribution. In order to compare patients with different characteristics regarding the odds of having disease, we calculated the Odd Ratio, which is the result of dividing the odds of a patience in a certain category of a categorical variable to have the disease by the odds of a patience in the reference category. Besides Odd Ratio, we showed the Trust Interval of 95% and the p-value of Fisher’s Exact Test, which tests if the Odd Ratio is statistically different from one.

3. results

Initially, 208 patients were selected. Out of them, 62 patients were excluded from the study because they were diagnosed with peri-implant mucositis, 32 patients were excluded with rehabilitation of fixed prosthodontics, 10 patients did not show up to the scheduled exams, 7 patients for needing pre-medication for the clinical exams and 24 patients for being smokers. The samples were analyzed to assess the behavior of the implants related to the peri-implant disease, more specifically, peri-implantitis, bone loss and probing depth.

A total of 73 single implant and screw-retained or cemented crowns were assessed. The average age of the patients was 36.1, with the minimum being 29 and maximum being 56. The frequency of the variable gender in the sample was 45 (61.6%) men and 28 (38.4%) women. Peri-implantitis was diagnosed in 37 implants (50.7%) and 36 (49.3%) of the implants were healthy.

Initially, the main effects of the independent variables, as well as the interactions between them, were evaluated. and thus it was verified that gender, position of the implant and bleeding on probing did not influence the implant to present or not the disease. The 37 implants diagnosed with peri-implantitis were influenced by the plaque index and the interaction between probing depth and suppuration (P < .001). Going to the dentist for maintenance appointments or not attending, showed no statistical difference in terms of having peri-implantitis (Table 1).

Table 1: Variables analyzed according to health status and peri-implantitis (p≤0,05)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Healthy (%) | Peri-implantitis (%) | Total | p value |
| Male | 24 (66.7%) | 21 (56.8%) | 45 (61.6%) | (P = .47) |
| Female | 12 (33.3%) | 16 (43.2%) | 28 (38.4%) |  |
| Age | 35.9 | 36.2 |  | (P = .71) |
| Position |  |  |  |  |
| Superior | 14 (38.9%) | 14 (37.8%) | 28 (38.4%) | (P = 1) |
| Inferior | 22 (61.1%) | 23 (62.2%) | 45 (61.6%) |  |
| Anterior | 15 (41.7%) | 8 (21.6%) | 23 (31.5%) | (P = .08) |
| Posterior | 21 (58.3%) | 29 (78.4%) | 50 (68.5%) |  |
| Plaque index |  |  |  |  |
| No | 25 (69.4%) | 5 (13.5%) | 30 (41.1%) | **(P < .001)** |
| Yes | 11 (30.6%) | 32 (86.5%) | 43 (58.9%) |  |
| Bleeding on probing |  |  |  |  |
| No | 22 (61.1%) | 22 (59.5%) | 44 (60.3%) | (P = 1) |
| Yes | 14 (38.9%) | 15 (40.5%) | 29 (39.7%) |  |
| Suppuration |  |  |  |  |
| No | 36 (100%) | 23 (62.2%) | 59 (80.8%) | **(P < .001)** |
| Yes | 0 (0%) | 14 (37.8%) | 14 (19.2%) |  |
| Maintenance |  |  |  |  |
| No | 17 (47.2%) | 25 (67.6%) | 42 (57.5%) | (P = .1) |
| Yes | 19 (52.8%) | 12 (32.4%) | 31 (42.5%) |  |
| bone loss | 2.3 ± 0.5 mm | 4 ± 0.5 mm |  | **(P < .001)** |
| probing depth | 4.1 ± 0.5 mm | 5.7 ± 0.8 mm |  | **(P < .001)** |

**3.1 Bone Loss**

The bone loss was higher in posterior implants, with an average of 3.3 mm, minimum 1.7 mm and maximum 5.0 mm (P = .03). For implants diagnosed with peri-implantitis, the average was 4.0 mm, minimum 3.2 mm and maximum of 5.0 mm (P < .001). For presence of biofilm, the average was 3.6 mm (P < .001) and average for suppuration as 4.0 mm.

The plaque index was positive for 43 implants out of the 73 implants. The average bone loss for 43 implants, with presence of plaque, was 3.6 mm, minimum of 1.6 mm and maximum of 5.5 mm (P < .001). From the implants that presented suppuration, a total of 14, the average of bone loss was 4.0 mm (P < .001). It is possible to observe on table 2 that bleeding on probing and maintenance did not present statistical differences regarding bone loss. However, bone loss was associated with position, posterior implants, and the presence of biofilm and suppuration, presenting statistical significance level of 5%, which show a correlation between bone loss and the respective previously mentioned variables.



**3.2 Probing Depth**

When assessing the variables individually, and not together, the superior or inferior positions, and bleeding on probing seem not to affect PD (probing depth), while anterior and posterior positions and plaque index do. Therefore, PD seems to be higher in posterior teeth in comparison to anterior ones, and lower when there is no plaque index, when compared to the occurrence of these index respectively. The implant diagnosed with peri-implantitis, and presence of biofilm have affected the PD. With a positive plaque index, the probing depth was 5.3 mm, minimum of 3.5 mm and maximum of 7.0 mm (P < .001). Bleeding on probing was not statistically significant for this group. (Table 3)

In order to compare patients with different characteristics regarding the odds of having disease, the odds ratio were calculated, which is the result of dividing the odds of a patience in a certain category of a categorical variable to have the disease by the odds of a patience in the reference category. Besides Odd Ratio, the Interval of 95% and the p-value of Fisher’s Exact Test, which tests if the Odd Ratio is statistically different from one. According to the obtained results, it is expected that the odds for peri-implantitis when there is plaque index (PI = 1) 14.545 (P < .001 and CI = [4.472;47.313]) times the odds of having peri-implantitis when there is no plaque index (PI = 0) (table 4).





4. discussion

Since 2017, two risk factors for peri-implantitis have been established: the prior history of periodontal disease and the inefficient daily biofilm control. Smoking and diabetes as potential risk factors are considered inconclusive [10, 11]. Host factors are equally important in the event or severity of the disease, since it is a multifactorial disease. Although the prognostic of dental implants in edentate patients is favorable in longitudinal studies, there are several evidences indicating that the installation of implants in patients with a history of periodontal problems may bring an increased risk of implant failure in the long term [13, 14, 15, 16].

With the objective of verifying the influence of clinical and variables in bone loss for implants with peri-implantitis and healthy ones, this study with 73 unitary implants has observed the prevalence of 50.7% and 49.3% respectively. A similar study - although without the established classification of peri-implant disease - has found a percentage of 54% of implants with peri-implantitis [17]. Another study has assessed the influence of clinical variables in the peri-implant condition in 75 patients and 269 implants; and it has diagnosed 115 implants with peri-implantitis (42.75%) [18]. In other studies, the prevalence of peri-implantitis was 28% [19], 9.1% [20], and 5% [21]. In these last two studies with low indicators of peri-implantitis, the patients were part of a strict maintenance program.

The position of the implant can be considered a predisposing factor to peri-implantitis due to the main factors below: (1) inadequate access to perform the correct oral hygiene; (2) excessive physiological bone remodelling when the safe distance between two adjacent implants or one implant and adjacent dentition is not respected; (3) the implant’s diameter; (4) the shape of the prosthetic crowns; (5) immediate loading; (6) bone defect; and (7) insertion torque [22, 23]. Thus, the prostheses must be projected in a way to facilitate the access to regular probing diagnosis, as well as personal and professional hygiene practices [24, 25]. In this study, from the implants inserted in the posterior areas, most were diagnosed with peri-implantitis, even though it did not represent a statistical difference. In agreement with our study, implants in posterior positions were more susceptible to peri-implantitis, with a higher plaque index, bleeding and probing depth [6, 18, 26, 27]. Nonetheless, literature shows, in other studies, that the position of the implants would be a risk factor; however, with a higher risk for the anterior implants [22, 28, 29, 30].

The peri-implant bone loss has been reported as the most important predictive criterion for the success of the treatment with osseointegrated implants [1, 31, 32]. Immediately after the installation of the implants and for several months, a series of cellular and molecular events takes place. The bone remodelling mechanism for a strange body (osseointegrated implant) is induced by RANKL, which promotes the activation of the macrophages in osteoclasts. Therefore, when an early bone loss occurs, the microstructures of the implants are exposed and there is a contamination with bacteria and their subproducts (4). In this study, we assessed the distance between the bone crest and the implant’s platform. The average values for bone loss in healthy and ill implants were 2.3 and 4.0 mm, respectively, with a significant difference (p < 0.001). In a study with 142 implants, the bone loss was 4.29 mm for the implants diagnosed with peri-implantitis [30]. When assessing the 68 implants, amongst the ones diagnosed with the disease, the bone loss was ˃ 4.0 mm [27].

In this study, the average probing depth was 5.7 mm for implants with the disease and 4.1 mm for healthy ones. In the study with 262 implants, the probing depth was 2.61 ± 1.21 mm for healthy implants and 4.58 ± 1.71 mm for those with peri-implantitis. In other studies, the probing depth was 4,2 ± 1,31 mm [23], and 4.91 mm for implants diagnosed with peri-implantitis [18]. When assessing 75 patients with 269 implants, 63 of them were diagnosed with peri-implantitis, and their probing depth was 4.91 mm [33].

Bleeding on probing was not associated with the presence of peri-implantitis, bone loss and probing depth in this study. However, the literature reports that bleeding on probing is a way to early diagnose peri-implantitis. Implants presenting bleeding had a likelihood of 24.1% to be diagnosed with peri-implantitis [25, 34]. We have observed that 40.5% of the implants diagnosed with peri-implantitis presented bleeding. In a study with 482 implants assessed during 10 years, the index of bleeding on probing was 93.9% [19]. In a multi-centric study with 117 patients and 295 installed implants, the bleeding in probing index was 54.9% [35]. Similarly to our results, a randomized clinical study with 41 patients with the absence of a dental element in the posterior region of the upper maxilla did not present statistical differences between the bleeding index and the other clinical variables assessed [17].

In the study, out of the 37 implants (50.7%) diagnosed with peri-implantitis 32 of them (86.5%) presented positive for plaque index in the clinical evaluation. The positive plaque index was statistically significant with the disease’s variables of bone loss and probing depth. In other studies, that percentage was 82.8% [19], 61% [30], 83.3% [35]. The literature reports substantial evidences to indicate the accumulation of biofilm as an etiologic factor for peri-implant diseases [4, 16, 36, 37, 38].

On the other hand, it is widely discussed that the lack of oral hygiene and the poor adhesion to the maintenance therapy may lead to peri-implant diseases [39]. Biofilm is the most important etiological agent to start and progress the peri-implant diseases. However, studies have not yet identified the level of biofilm control compatible with the maintenance of the peri-implant health. As seen in this study, there are evidences of an increased risk to develop peri-implantitis when patients have low capacities to control bacterial plaque and lack regular maintenance after the implant therapy [40]. This suggests that it is important to carefully monitor changes that may occur around dental implants in the early post-restorative phase, with focus on bleeding on probing/suppuration and in combination with radiographic evidence of bone loss [8].

The study has some limitations, such as the absence of baseline radiographic and probing data, and the certainty of carrying out maintenance consultations on the implants, as it was dependent on patient responses, factors that limit generalization.

Based on our results, the annual maintenance has not been statistically significant; and a possible explanation is that there may be an uneven distribution of patients who go to the maintenance appointments regularly and those who do not. Although no major changes were observed between patients who perform annual maintenance and those who do not perform annual maintenance, maintenance consultations are essential for a favorable prognosis of dental implants. Biofilm control is essential for the preservation of peri-implant tissues and, depending on the microorganisms involved, host response and other factors such as smoking, diabetes, and inadequate hygiene, we may have the development of disease. Another reported hypothesis is that the oral hygiene maintenance is not influenced just by the patient’s adhesion, but also by the qualifications and the experience of the dental professionals that provide the preventive treatment [41]. Another factor to be considered is that there is no evidence-based guideline or protocol about preventing peri-implant diseases [42]. Patients often think that by going to the maintenance appointments, the maintenance will be duly performed, but that is not usually the case. Most of the time, the dentist only visually examines the patient, believing that everything is fine and making the patient believe this too without performing peri-implant probing or imaging exams.

5. Conclusion

Within the limitations of this cohort study, increased plaque index and suppuration were significantly associated with peri-implantitis. Prospective studies with baseline measurements should be performed to elucidate the role of biofilm in peri-implantitis.

Consent (where ever applicable)

All authors declare that ‘written informed consent was obtained from the patient (or other approved parties) for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editorial office/Chief Editor/Editorial Board members of this journal.

Ethical approval (where ever applicable)

All authors hereby declare that "Principles of laboratory animal care" (NIH publication No. 85-23, revised 1985) were followed, as well as specific national laws where applicable. All experiments have been examined and approved by the appropriate ethics committee”

All authors hereby declare that all experiments have been examined and approved by the appropriate ethics committee and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki.”

References

1. Windael S, Collaert B, De Buyser S, De Bruyn H, Vervaeke S. Early peri-implant bone loss as predictor of peri-implantitis: A prospective cohort study of Ten years. Clin Implant Dent Relat Res 2021,1-11.
2. Salvi, G, Cosgarea R, Sculean A. Prevalence of Periimplant Diseases. Implant Dentistry 2019, 28 : 100-102.
3. Derks J, Schaller D, Hakansson J, Wennstrom JL, Tomasi C, Berglundh T. Peri-implantitis – onset and pattern of progression. J Clin Periodontol 2016,43:383–388.
4. Insua A, Monje A, Wang H-L, Miron RJ. Basis of bone metabolism around dental implants during osseointegration and peri-implant bone loss. J Biomed Mater Res 2017,105A: 2075–2089.
5. Caton J, Armitage G, Berglundh T, Chapple ILC, Jepsen S, S Kornman K, L Mealey B, et al.. A new classification scheme for periodontal and peri-implant diseases and conditions - Introduction and key changes from the 1999 classification. J Clin Periodontol 2018, 45 , 20: S1-S8.
6. Farina R, Filippi M, Brazzioli J, Tomasi C, Trombelli L . Bleeding on probing around dental implants: a retrospective study of associated factors. J Clin Periodontol 2017, 44:115–122.
7. Roccuzzo M, Layton DM, Roccuzzo A, Heitz‐Mayfield L J. Clinical outcomes of peri-implantitis treatment and supportive care: A systematic review. Clin Oral Impl Res 2018, 29 (16); 331–350 .
8. Renvert S, Persson GR, Pirih FQ, Camargo PM. Peri-implant health, peri-implant mucositis, and peri-implantitis: Case definitions and diagnostic considerations. J Periodontol 2018, 89 (1); S304–S312 .
9. Roman-Torres CVG, Pasquinelli F, Pimentel AC, Melo MP, Rego, Sendyk, WR. The Effects of Annual Maintenance on Peri-implant Health in Patients Rehabilitated with Overdentures: A Retrospective Cohort Study. Int J Oral Maxillofac Implants 2019 ,34 (1); 159-164.
10. Berglundh T, Armitage G, Araujo MG, Avila-Ortiz G, Blanco J, Camargo PM, et al.. Peri-implant diseases and conditions: Consensus report of workgroup 4 of the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions. J Periodontol 2018, 89 ; S313–S318.
11. Slagter KW, Raghoebar GM, Hentenaar DF, Vissink A, Meijer HJ. Immediate placement of single implants with or without immediate provisionalization in the maxillary aesthetic region: A 5-year comparative study. J Clin Periodontol 2021, 48;272–283.
12. French D, Grandin HM, Ofec R. Retrospective cohort study of 4,591 dental implants: Analysis of risk indicators for bone loss and prevalence of peri-implant mucositis and peri-implantitis. J Periodontol. 2019 Jul;90(7):691-700.
13. Al Amri M D, Kellesarian S V. Crestal Bone Loss Around Adjacent Dental Implants Restored with Splinted and Nonsplinted Fixed Restorations: A Systematic Literature Review. Journal of Prosthodontics 2016, 26(6); 495–501,doi:10.1111/jopr.12556.
14. Schwarz F, Derks J, Monje A, Wang H-L. Peri-implantitis. J Periodontol 2018, 89(1); S267–S290.
15. Bunk D, Eisenburger M, Häckl S, Eberhard J, Stiesch M, Grischke J. The effect of adjuvant oral irrigation on self-administered oral care in the management of peri-implant mucositis: A randomized controlled clinical trial. Clin Oral Implants Res 2020,31(10);946-958.
16. Diaz P, Gonzalo E, Villagra LJG, Miegimolle B, Suarez MJ. What is the prevalence of peri-implantitis? A systematic review and meta-analysis. BMC Oral Health. 2022 Oct 19;22(1):449.
17. Gurgel BCDV, Montenegro SCL, Dantas PMC, Pascoal ADB, Lima K C, Calderon PDS. Frequency of peri-implant diseases and associated factors. Clin Oral Impl Res 2016, 1–7.
18. Ramanauskaite A, Becker K, Schwarz F. Clinical characteristics of peri-implant mucositis and peri-implantitis. Clin Oral Impl Res 2018, 29 (6); 1–6.
19. Fransson C, Wennström J, Berglundh T. Clinical characteristics at implants with a history of progressive bone loss. Clin. Oral Impl 2008, 19; 142–147.
20. Velasco-Ortega E, Jiménez-Martin IDR, Moreno-Muñoz J, Núñez-Márquez E, Rondón-Romero JL, Cabanillas-Balsera D, et al.. Long-Term Treatment Outcomes of Implant Prostheses in Partially and Totally Edentulous Patients. Materials (Basel). 2022 Jul 14;15(14):4910.
21. Cecchinato D, Parpaiola A, Lindhe J. Mucosal inflammation and incidence of crestal bone loss among implant patients: a 10-year study. Clin Oral Implants Res. 2014 Jul;25(7):791-6.
22. French D, Grandin HM, Ofec R. Retrospective cohort study of 4,591 dental implants: Analysis of risk indicators for bone loss and prevalence of peri-implant mucositis and peri-implantitis. J Periodontol 2019, 90; 691–700.
23. Dalago HR, Schuldt Filho G, Rodrigues MA, Renvert S, Bianchini MA. Risk indicators for Peri-implantitis. A cross-sectional study with 916 implants. Clin Oral Implants Res. 2017 Feb;28(2):144-150.
24. Aloy-Prósper A, Peñarrocha-Oltra D, Peñarrocha-Diago M, Hernández-Alfaro F, Peñarrocha-Diago M. Peri-implant Tissues and Patient Satisfaction After Treatment of Vertically Augmented Atrophic Posterior Mandibles with Intraoral Onlay Block Bone Grafts: A Retrospective 3-Year Case Series Follow-up Study. Int J Oral Maxillofac Implants. 2018 Jan/Feb;33(1):137-144.
25. Hashim D, Cionca N, Combescure C, Mombelli A. The diagnosis of peri-implantitis:A systematic review on the predictive value of bleeding on probing. Clin Oral Impl Res 2018,29;276–293.
26. Lombardo G, Signoriello A, Marincola M, Nocini PF. Assessment of Peri-Implant Soft Tissues Conditions around Short and Ultra-Short Implant-Supported Single Crowns: A 3-Year Retrospective Study on Periodontally Healthy Patients and Patients with a History of Periodontal Disease. Int J Environ Res Public Health 2020, 14,17(24);9354.
27. Kim DM, Badovinac RL, Lorenz RL, Fiorellini JP, Weber HP. A 10-year prospective clinical and radiographic study of one-stage dental implants. Clin Oral Impl. Res. 2008,19; 254–258.
28. Rodrigo D, Sanz-Sánchez I, Figuero E, Llodrá JC, Bravo M, Caffesse RG, et al.. Prevalence and risk indicators of peri-implant diseases in Spain. J Clin Periodontol 2018 ,45(12)1510-1520.
29. Song X, Li L, Gou H, Xu Y. Impact of implant location on the prevalence of peri-implantitis: A systematic review and meta- analysis. J Dent. 2020 Dec;103:103490.
30. Fischer K, Stenberg T. Prospective 10-year cohort study based on a randomized controlled trial (RCT) on implant-supported full-arch maxillary prostheses. Part 1: sandblasted and acid-etched implants and mucosal tissue. Clin Implant Dent Relat Res. 2012 Dec;14(6):808-15.
31. Pamato S, Honório HM, Costa JAD, Traebert JL, Bonfante EA, Pereira Jr. The influence of titanium base abutments on peri-implant soft tissue inflammatory parameters and marginal bone loss: A randomized clinical trial. Clin Implant Dent Relat Res 2020 , 1–7.
32. Sordi MB, Perrotti V, Iaculli F, Pereira KCR, Magini RS, Renvert S , et al.. Multivariate analysis of the influence of peri-implant clinical parameters and local factors on radiographic bone loss in the posterior maxilla: a retrospective study on 277 dental implants. Clinical Oral Investigations 2021,25;3441–3451.
33. Monje A, Caballé-Serrano J, Nart J, Peñarrocha D, Wang H-L, Rakic M. Diagnostic accuracy of clinical parameters to monitor peri-implant conditions: A matched case-control study. J Periodontol 2018, 89, 4;407-417.
34. Heitz-Mayfield LJ, Aaboe M, Araujo M, Carrión JB, Cavalcanti R, Cionca N, et al.. Group 4 ITI Consensus Report: Risks and biologic complications associated with implant dentistry. Clin Oral Implants Res. 2018 Oct;29 Suppl 16:351-358.
35. Lopez-Piriz R, Morales A, Giménez MJ, Bowen A, Carroquino R, Aguilar L, et al.. Correlation between clinical parameters characterizing peri-implant and periodontal health: A practice-based research in Spain in a series of patients with implants installed 4-5 years ago. Med Oral Patol Oral Cir Bucal 2012,17;893-901.
36. Koldsland OC, Scheie AA, Aass AM. The association between selected risk indicators and severity of peri-implantitis using mixed model analyses. J Clin Periodontol 2011, 38;285–292.
37. Kadkhodazadeh M, Amid R, Amirinasab O, Amirbandeh O, Moscowchi A. Risk Indicators of Peri-Implant Diseases in Public and Private Clinics: A Multicenter Study. Int J Dent. 2024 Aug 17;2024:7061682.
38. Carra MC, Blanc-Sylvestre N, Courtet A, Bouchard P. Primordial and primary prevention of peri-implant diseases: A systematic review and meta-analysis. J Clin Periodontol. 2023 Jun;50 Suppl 26:77-112.
39. Jepsen S, Berglundh T, Genco R, Aass AM, Demirel K, Derks Jet al.. Primary prevention of peri-implantitis: managing peri-implant mucositis. J Clin Periodontol 2015, 42(16);152-157.
40. Meyle J, Casado P, Fourmousis I, Kumar P, Quirynen M, Salvi GE. General genetic and acquired risk factors, and prevalence of peri‐implant diseases – Consensus report of working group 1. International Dental Journal 2019 69(S2); 3–6.
41. Greenstein G, Eskow R. High Prevalence Rates of Peri-implant mucositis and Peri-implantitis Post Dental Implantations Dictate Need for Continuous Peri-implant Maintenance. Compend Contin Educ Dent. 2022 Apr;43(4):206-213.
42. Perussolo J, Donos N. Maintenance of peri-implant health in general dental practice. Br Dent J. 2024 May;236(10):781-789.