
Ich bedanke mich bei den unten aufgeführten Kolleginnen und Kollegen für ihre wertvolle Mitarbeit, die sie in den vergangenen zwei Jahren geleistet haben.

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Peri-implantitis prevalence and treatment in implant-oriented private practices: A cross-sectional postal and Internet survey

Keywords: Peri-implantitis; Mucositis; GBR; survey

This survey aimed to estimate the subjective prevalence of peri-implantitis and its management in the private practice of dentists with and without board certified specialization. For this purpose, a cross-sectional postal and internet survey of 521 dentists, representing all members of the Swiss Society of Oral Implantology (SGI) was conducted (year 2010). The questionnaire consisted of four sections assessing 1) general information regarding the practice setting and education, 2) general questions regarding implantation profile and 3) specific questions regarding the prevalence and experience with the management of peri-implantitis. In the fourth section, therapy options of three exemplary cases were assessed. The data were separately evaluated and compared for specialists (S) and non-specialists (N–S).

A total of 253 questionnaires could be included in the present study. The results revealed that specialists placed significantly more implants than non-specialists. The subjective prevalence of cases with peri-implantitis was 5–6 and 7–9% after 5 and 10 years, respectively. The polled dentists perceived periodontitis (N–S: 72%; S: 80%), smoking (N–S: 71%; S: 77%) and bad compliance (S: 53%; N–S: 61%) as the most important risk factors for peri-implantitis. Chlorhexidine was the most frequently used antiseptic agent for disinfection. A surgical approach to treat peri-implantitis was reported by more than 80% of all dentists. Specialists used significantly more resective or regenerative approaches than non-specialists.

Introduction

The insertion of dental implants has become a routine procedure to replace one or more missing teeth. With the implant survival as the main criterion for success, the majority of clinical studies showed impressive success rates for dental implants, even in combination with cantilever extensions (Blanes et al. 2007, Aglietta et al. 2009). However, there is evidence of chronic inflammation of peri-implant soft and hard tissues in the range of 8.6%–9.7% (Pjetursson et al. 2004, Jung et al. 2008) after 5 years and peri-implantitis is a frequent clinical finding 10 years after implantation (Roos-Jansaker et al. 2006). The pathologic conditions termed “mucositis” and “peri-implantitis” are considered the major complication in today’s dental implantology (Jung et al. 2008). The clinical manifestations of peri-implantitis are gingival bleeding and/or pus secretion, swelling and bone loss which highly resemble periodontal inflammation. A number of studies showed a bacterial etiology with a similar spectrum of pathogens for both diseases (Mombelli 1993, Pontoriero et al. 1994, Meffert 1996). It is...
therefore not surprising that, after 10 years, implants in peri-
odontally compromised patients yield lower survival rates and higher mean marginal bone loss rates when compared with implants placed in healthy subjects (Matarasso et al. 2010). However, this issue remains controversial, because studies also found that a previous history of periodontal disease may not have a significant impact on implant failures up to 5 years after loading (Gianserra et al. 2010).

Due to the background and evidence of potential biological risks, a broad variety of different treatment modalities have been proposed for the prevention and treatment of this disease entity and several mechanical, physical and chemical approaches were suggested to fight peri-implantitis in non-surgical as well as in surgical treatment concepts based on current periodontal therapy (Schwarz et al. 2005; Esposito et al. 2008). However, neither laboratory nor clinical investigations were able to elaborate consensus and evidence supporting predictable and stable healing by a specific treatment protocol, especially in regenerative approaches (Sahrmann et al. 2009).

Lambrecht and co-workers published a cross-sectional survey on the status of implantology in Switzerland in 2006. Compared to a study undertaken 12 years ago, the number of dentists engaged in implantology has doubled and an increasing willingness of implantologists to extend the therapeutic range of implant dentistry with the risk of potential complications was reported (Lambrecht et al. 2010). Nevertheless, long-term prognosis was still a crucial factor when planning and placing implants.

No data on the prevalence and management of biological complications, i.e. mucositis peri-implantitis in private practice are available to date. Therefore, the purpose of this study was to evaluate the subjectively estimated prevalence of peri-implantitis and its management in the private practice of dentists with and without board certified specializations.

Materials and Methods

Study design and participants

A cross-sectional postal and Internet survey of 521 dentists practising in Switzerland was conducted. The sample included all members of the Swiss Society of Oral Implantology. Four-hundred-and-twenty-nine structured questionnaires in German and 92 in French language were dispatched in winter 2009/2010. There was also an opportunity to fill out the questionnaire in electronic form. All questionnaires returned within 3 months were included in the analysis.

Questionnaire

The questionnaire consisted of 4 sections (Tab. I–IV).

Most of the questions had multiple choices of answers. The first section addressed the profile of the dentist and the practice, more specifically the dentist’s age, number of years since graduation, working area (urban versus rural area), speciality (periodontics, prosthodontics, maxillofacial and/or oral surgery or other) and the employment of dental hygienists or prophylaxis assistants. The second section asked about the implant systems used, the number of implants placed per year, the main contraindications and clinical limitations (e.g. smoking and periodontitis), immediate implant placement, augmentation techniques and materials used in primary surgery and for the retention of the suprastructure, i.e. cementation or screw-retention of single crowns or bridges. The third section consisted of questions regarding the occurrence and the management of peri-implantitis, e.g. the subjective prevalence of peri-implantitis cases in the office and the preferred treatment options: e.g. mechanical instruments, use of antisepsics and antibiotics, GBR techniques as well as observed potential risk factors believed to be associated with peri-implantitis. In the fourth section 3 clinical cases were presented: 3 radiographs of osseo-integrated implants with moderate to severe bone loss were shown (Fig. 1–3). The dentists were asked to indicate their treatment choice among the following treatment options: supragingival cleaning and oral hygiene re-instruction and motivation, non-surgical mechanical therapy or surgical intervention with and without regenerative techniques. The latter modalities could be chosen with or without systemic antibiotics. The final option was explanation.

Statistical analysis

Data were coded in Excel and analysed in PASW Version 18.0. Descriptive statistics such as mean and standard deviation for continuous variables and relative frequencies for discrete variables separately for specialists and non-specialists were computed. Dentists were rated as specialists, if it was clearly stated that they were board certified by one of the following organizations officially approved by the Swiss Dental Association SSO: Periodontology (Swiss Society of Periodontology), Reconstructive Dentistry (Swiss Society of Reconstructive Dentistry) and Oral Surgery (Swiss Society of Oral Surgery).

In order to investigate differences in means of continuous variables between specialists and non-specialists a two-sample Student’s t-test was computed. In order to find an association between two discrete variables Chi2-test ($r \times c$) and the Fisher’s

| Tab. I Dentist profile and practice setting (mean values±standard deviations where appropriate) |
|---|---|---|
| **Population**<br>| **Specialist n=81** | **Significance** | **Non-Specialist n=172** |
| **Age (years)** | 49.8±9.4 | 0.151 | 51.6±9.2 |
| **Gender (male, %)** | 92.6 | 0.812 | 90.6 |
| **Professional experience (years)** | 23.1±9.6 | 0.103 | 25.2±9.2 |
| **Implantation experience (years)** | 17.3±7.2 | 0.878 | 17.1±7.0 |
| **Practice for implant referrals (%)** | 48.1 | 0.007 | 30.8 |
| **Location of the office (%)**<br>(global 0.215) | | | |
| – Countryside | 12.3 | 0.882 | 11.7 |
| – Agglomeration | 18.5 | 0.046 | 30.4 |
| – City | 71.6 | 0.054 | 59.1 |
| **Occupation (%) of**<br>| | | |
| – Dental hygienist | 95.0 | 0.090 | 88.2 |
| – Prophylaxis assistant | 52.6 | 0.325 | 45.8 |
Exact test (2 × 2 contingency tables) were applied. The Chi2-test was applied in order to find the association between a specialist and a non-specialist (r = 2) and location or implants per year (c > 2) as they are factors which exhibit more than 2 levels.

In order to find out which features are common to specialists and non-specialists, a multiple regression model was used. First, we evaluated the features that were significant or showed a tendency (p < 0.1) in the univariate analyses using a univariate logistic regression. The best multiple model has been found by applying the forward and backward model choice techniques for binary regression provided by PASW. For the final multiple model we calculated the adjusted odds ratios (OR) with the corresponding 95% confidence intervals (CI) and conducted a receiver operating characteristic analysis (ROC). Area under the curve (AUC) estimates the chance of correct distinction between the specialist-group and the non-specialist-group given the predictors in the model.

Results of the statistical analysis with p-value < 0.05 were interpreted as statistically significant.

**Results**

A total of 429 German and 92 French questionnaires were sent to all members of Swiss Society of Implantology. Two-hundred-and-fifty-three questionnaires were completed (response rate 49%).

The results of the survey are presented in Tables I to III. Multiple answers were possible.

Table I shows the dentist profiles of specialists (n = 81) and non-specialists (n = 172). The mean age of both groups was comparable with 49.8 ± 9.4 versus 51.6 ± 9.2 years. The mean professional experience was somewhat more than 20 years for both groups, as was the mean experience in implant therapy with 17 years. Specialists received more referrals for implant insertion than non-certified dentists (p < 0.05). There was a tendency for specialists to have their practice in a more urban environment. The collaboration with dental hygienists in the practice is well established in Switzerland as about 90% of the dentists reported to employ a professional in this field. About...
50% also reported to employ in their team a prophylaxis assistant working exclusively in the supragingival area.

Table II depicts the implant profile of the polled dentists. The most frequently used implant system among the participants of this survey was that of Straumann (almost 70%), followed by Biomet 3i and Thommen Medical implant systems (around 20%, each).

Specialists placed significantly more implants than non-specialists: about 50% of the specialists reported to perform more than 100 implantations per year, whereas more than 50% of the non-specialists placed less than 50 implants in the same time period. Twenty-five to 30% of the respondents placed “up to 100 implants” per year in both groups.

Primary indication for implants was the replacement of single missing teeth (around 50% in both groups). Fixed bridges and removable prostheses were equally distributed (around 25% each). Immediate implants were placed by around 30% of the dentists. The fixation type, i.e. screw-retained versus cemented, was almost equally distributed.

Upon the question, whether implants are also placed in periodontally compromised patients with residual bleeding pockets of ≥ 5 mm, 41.8% of the non-specialists and 51.9% of the specialists n = 81 Significance Non-Specialist n = 172

Peri-implantitis experience
– within 5 years
  Percentage 5.1 ± 5.9 0.435 6.0 ± 8.0
  Numbers 14.7 ± 32.3 0.192 4.8 ± 7.0
– within 10 years
  Percentage 7.3 ± 7.3 0.261 8.9 ± 10.6
  Numbers 18.8 ± 46.8 0.167 4.5 ± 4.6

Suggested reasons for peri-implantitis (%)
– Periodontitis
  79.7
– Smoking
  76.9
– Bad compliance
  53.2
– Parafunaction
  20.3
– Smooth implant surface
  24.4
– Rough implant surface
  31.6
– Short implants
  17.7
– Reduced diameter
  16.5
– After Sinuslift
  10.1
– After Augmentation
  21.5
– After immediate loading
  31.6

Knowledge of CIST (%)
61.5 0.001 39.8

Debridement modality (%)
– Conventional (hand instruments/ultrasonic)
  55.6 0.862 54.4
– Special implant inserts
  75.3 0.452 70.8
– Air abrasion
  22.2 0.029 11.7
– Laser
  22.2 0.280 28.7
– Photodynamic therapy
  21.0 0.254 15.2

Antimicrobial therapy (%)
– Systemic antibiotics
  82.7 0.005 65.5
– local antibiotics
  47.5 0.984 47.4
– Chlorhexidine
  93.8 0.106 86.9
– Iodine
  19.7 0.182 12.7

Use of a bacterial test (%)
31.6 0.222 24.2

Surgical techniques (%)
– Open flap debridement
  86.3 0.394 81.9
– Resective
  68.4 0.002 47.0
– Regenerative
  78.8 0.001 56.0

Regenerative approach (%)
– Filler only
  11.3 0.214 6.6
– Filler and membrane
  57.5 0.058 44.6
– EMD
  18.8 0.205 12.7
– EMD and filler
  12.5 0.810 11.4
– EMD and filler and membrane
  22.5 0.004 9.0

Regenerative materials (%)
– Filler material
– alloplastic
  21.3 0.633 18.7
– xenogenic
  75.0 0.005 56.4
– autogenous
  25.0 0.166 17.5
– Membrane
– alloplastic
  7.5 0.802 8.4
– xenogenic
  76.3 0.001 54.8

Tab. III Experience and management of peri-implantitis (mean values ± standard deviations where appropriate)
Articles published in this section have been reviewed by three members of the Editorial Review Board.

Table III reports on the experience and management of peri-implantitis, which was defined by the presence of bone loss, increased probing pocket depth and bleeding upon probing and/or suppuration. The subjectively self-estimated prevalence of cases was around 5–6% after 5 years and 7–9% after 10 years, respectively, in both groups. There was a wide range of the number of cases, probably depending on the great variations of implants placed in the individual practice settings. Most reported possible etiological factors for peri-implantitis were periodontitis (N-S: 72% and S: 80%), smoking (N-S: 71% and S: 77%) and bad compliance (S: 53% and N-S: 61%). Potential risk factors related to implant form and surface or surgical techniques or methods (augmentation, immediate placements) were also mentioned and varied between 6 to 32%.

The knowledge about the Cumulative Interceptive Supportive Therapy (CIST) (Lang et al. 2000) as a published guideline for peri-implantitis was more frequent in specialists than non-specialists (p < 0.001). Debridement of contaminated implants was mainly performed by mechanical means using conventional or modified hand and ultrasonic instruments and tips in both groups. Other modern methods reported for surface decontamination were hard lasers (S: 22% and N-S: 29%), air-abrasion (S: 22% and N-S: 12%) or photodynamic therapy (S: 21% and N-S: 15%). Chlorhexidine was the most frequently used antiseptic agent for disinfection (S: 94% and N-S: 87%). Specialists were using systemic antibiotics more frequently than non-specialists (83% and 66%, respectively, p = 0.005). About 50% stated applying locally administered antibiotics. Less than one third of the dentists performed microbiological testing before antibiotic use.

Surgical techniques to treat peri-implantitis were reported by more than 80% of the dentists in both groups. Resective or regenerative approaches were more frequently applied by specialists than non-specialists (68 vs. 47% and 79 vs. 56%, respectively). Classical GBR techniques using filler materials and membranes were reported. Almost one fifth of the specialists reported to use solely enamel matrix derivatives (EMD) to regenerate peri-implantitis defects. A combination of filler material, EMD and membrane was used by 22.5% of the specialists as compared to 9% of the non-specialists (p = 0.004). Xenogenic materials were the most frequently applied filler and membrane materials, but were more frequently applied by specialists than non-specialists (p = 0.005 and 0.001, respectively).

In summary, multiple logistic regression analysis revealed that the specialists used more frequently the Thommen Medical implants (SPI) (OR = 2.5 with 95%CI [1.1, 5.6]), inserted more than 100 implants in one year (OR = 3 with 95%CI [1.5, 5.7]), used more frequently systemic antibiotics (OR = 3 with 95%CI [1.3, 4.6]) and conducted more resective and regenerative surgical techniques than non-specialists (OR = 2.4 with 95%CI [1.3, 4.5] and OR = 2.2 with 95%CI [1.1, 4.4], respectively).

With regard to the presented cases, specialists and non-specialists had, with some variations, the same treatment strategies. In case one (Tab. IV), non-surgical therapy was considered by only 3% of the non-specialists and 5% of the specialists. The two most favoured therapeutic options were completely antibiotics. About one third chose a regenerative approach with systemic antibiotics whereas another third preferred an explanation of the affected implant.
As to the second clinical example (Tab. V), almost 50% of the respondents proposed to treat the implant with a regenerative approach with systemic antibiotics, while 18 to 26% favoured a surgical intervention in combination with antibiotics. Exploration and resective therapy were chosen by a minority of the respondents only (less than 10%).

In the third case (Tab. VI), almost 50% of the respondents considered it irrational to treat the implant and advocated explantation. Thirteen to 18% aimed to do a resective approach and about 10% selected a watchful waiting approach with non-surgical therapy.

**Discussion**

This cross-sectional postal and Internet survey aimed to evaluate the experience and practice of peri-implantitis cases among active members of the Swiss Society of Implantology (SGI). The overall response rate was 49%, despite the fact that no reminder was sent. Thus, the rate of response was equal or higher than in other recent Swiss surveys, which used a reminder. Lambrecht and co-workers had a response rate of 47.3% in their survey on the status of implantology in Switzerland in 2006, which was sent to all SSO (Swiss Dental Association).
A recent systematic review aimed to assess the available literature for regenerative treatment of peri-implantitis using bone graft substitutes and membranes (SÄHRMANN ET AL. 2009). Again, a large heterogeneity concerning disinfection protocols and regenerative materials used was found. As an overall finding, complete fill of the bony defect using GBR seemed not to be predictable with regard to the outcome.

Conclusions

From the present cross-sectional survey it can be concluded that implant oriented Swiss private practitioners reveal a subjective prevalence of cases with peri-implantitis of 5–6% (S) and 7–9% (NS) after 5 and 10 years. The polled dentists considered periodontitis (72–80%), smoking (71–77%) and bad compliance (S3–61%) as the most important risk factors for peri-implantitis. In terms of treatment, chlorhexidine was the most frequently used antiseptic agent for disinfection and surgical techniques to treat peri-implantitis were reported by more than 80% of all dentists. Resective or regenerative approaches were more frequently applied by specialists than by non-specialists. Despite a relatively low subjective prevalence of peri-implantitis in private practices in Switzerland, there is an urgent need for safe and predictable treatment modalities and protocols to master future problems in this field and a great need for research and technical improvements.

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La présente enquête, auprès de dentistes suisses, a étudié la prévalence de la péri-implantite diagnostiquée de façon subjective et de son traitement chez des dentistes spécialisés et non spécialisés. Pour ce faire, un questionnaire en allemand et en français a été envoyé par la poste ou via internet à 521 membres de la Société Suisse d’Implantologie (année 2010). Le questionnaire était divisé en quatre sections, lesquelles évaluent: 1.) des informations générales sur la pratique, la formation et la formation continue des dentistes, 2.) des questions sur la nature et la fréquence d’implantations réalisées et 3.) des questions spécifiques sur la prévalence de la péri-implantite diagnostiquée de façon subjective et de l’expérience faite lors du traitement. Dans la quatrième section, les dentistes ont été interrogés sur les options de traitement en montrant trois cas exemplaires. L’analyse des réponses a été effectuée séparément pour les spécialistes (S) et «non-spécialistes» (NS).


La fréquence de péri-implantite subjectivement diagnostiquée variait entre 5–6% (S) et 7–9% (NS) après cinq respectivement dix ans après l’implantation. Les principaux facteurs de risque de péri-implantite étaient la parodontite (80% S, 72% NS), le tabagisme (77% S, 71 NS%) et le manque de collaboration venant du patient. En ce qui concerne le traitement de la péri-implantite, 80% des dentistes optaient pour des techniques chirurgicales. Les spécialistes utilisaient significativement plus souvent une approche de thérapie résective ou régénératrice. La combinaison des charges et des membranes xénogéniques a été le plus fréquemment utilisée. En ce qui concerne la thérapie anti-inflammatoire, la chlorhexidine était la plus souvent utilisée. Les spécialistes administraient plus souvent des antibiotiques de façon systémique (83% S, 66% NS).

En conclusion, la plupart des dentistes interrogés avec expertise en implantologie employaient des hygiénistes dentaires. La prévalence de la péri-implantite (7–9%) diagnostiquée de façon subjective dix ans après l’implantation était plutôt faible.

Zusammenfassung


Insgesamt fanden 253 beantwortete Fragebögen Einzug in die Studie. Spezialisten und Nichtspezialisten praktizierten im Schnitt seit 25 respektive 25 Jahren und verfügten über eine im Mittel 17-jährige implantologische Behandlungserfahrung. Spezialisten implantierten signifikant häufiger als Nichtspezialisten, wobei für beide Gruppen gesicherte Risikofaktoren wie parodontale Resttaschen und Rauchen nur eine relative Kontraindikation für eine Implantation darstellten. Dentalhygienikerinnen waren in 95% bzw. 88% der Praxen beschäftigt, und in jeder zweiten Praxis war ferner eine Prophylaxeeassistentin angestellt. Die Häufigkeit subjektiv diagnostizierter Periimplantitisfälle bewegte sich zwischen 5–6% (S) bzw. 7–9% (NS) respektive 10 Jahre nach Implantation. Als wichtigste Risikofaktoren für die Periimplantitis nannten die Befragten Parodontitis (80% S, 72% NS), Rauchen (77% S, 71% NS) und schlechte Mitarbeit des Patienten. Bezüglich der Therapie der Periimplantitis ergab sich, dass diese von 80% der Zahnärzte mittels chirurgischer Techniken behandelt wurde, wobei Spezialisten signifikant häufiger einen resektiven oder regenerativen Therapieansatz wählten. Dabei fand die Kombination aus xenogenen Füllern und Membranen am häufigsten Verwendung. Bezüglich der anti-inflammatorischen Therapie wurde Chlorhexidin als das am häufigsten eingesetzte Antiseptikum genannt, wobei von den Spezialisten signifikant häufiger (83% S, 66% NS) Antibiotika systemisch verabreicht wurden.

Zusammenfassend lässt sich sagen, dass bei den befragten implantatorientierten Praxen zumeist Dentalhygienikerinnen beschäftigt waren und die berichtete Prävalenz für Periimplantitis mit 7–9% 10 Jahre nach Implantation subjektiv als eher gering empfunden wurde.
References


