Histologic Evaluation of 2 Human Immediately Loaded and 1 Submerged Titanium Implants Inserted in the Posterior Mandible and Retrieved After 6 Months

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Immediate loading can be successfully used in implant dentistry. Many factors are thought to be of importance in obtaining mineralized tissues at the interface. One such factor is the implant surface characteristics. The authors retrieved, after a 6-month loading period, 2 immediately loaded implants and 1 submerged implant, each of which had been inserted in posterior mandibles. Histology showed that, in both immediately loaded implants, mineralized tissue was present at the interface, and the bone-implant contact percentage was about 65% to 70%. No gaps, fibrous tissue, or inflammatory infiltrates were present at the interfaces. In the submerged (control) implant, the bone-implant contact percentage was much lower (about 35%). Our results showed that immediate loading of dental implants, even in the posterior regions of the jaw bones, hadn't caused untoward effects on the formation of mineralized tissues at the interface, producing, on the contrary, a higher bone-implant contact percentage than in the control implant, and thus, immediate loading can be a possible alternative procedure in implant dentistry.

INTRODUCTION

A stress-free healing period was thought to be a prerequisite for successful osseointegration and for the presence of a mineralized tissue interface around dental implants.1,2 A functional rest of 3 to 4 months in the mandible and 6 months in the maxilla was thought to be necessary, and it was believed that an early loading of dental implants could produce a fibrous-tissue encapsulation.3-5 More recently, several clinical and histological reports have appeared in the literature, showing that, in man and experimental animals, immediate loading shows promising clinical results.6-46 Moreover, the...
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necessity for not loading the implants was empirically based and not experimentally ascertained. The classic 2-stage protocol is associated with long treatment time and high treatment costs, and elimination of the healing period offers advantages in terms of cost of treatment and convenience to patients, and avoiding the need for complete dentures while undergoing implant therapy can be a distinct advantage. Complete dentures may create functional and psychological problems. It has been reported that, with immediately loaded implants, patients resumed function quickly and that masticatory function was uniformly judged to be superior to pretreatment time. Any reduction in the number of the surgical procedures necessary or a decrease in the healing period is certainly very well welcomed by clinicians and patients. Chow et al reported a 1-year follow-up with a 98.3% overall implant survival rate in 115 immediately loaded implants. In Buchs et al series, the implant survival rate was 93.7%. In the Chiapasco et al series, the cumulative success rate of immediately loaded implants was 97.5% after 2 years of functional loading. Randow et al found that Branemark implants can be successfully used in the interforaminal mandibular area even when immediately loaded; moreover, they reported that bone resorption is similar to that observed around 2-stage implants. No failures were reported by Ericsson et al in early loaded implants and all implants were working successfully after 5 years. Brannemark et al recently reported on a method for implant therapy of the edentulous mandible: in 50 patients, followed 6 months to 3 years, there was an overall survival rate of 98% and a prosthetic survival rate of 98%. Jaffin et al reported an overall survival rate of 95%, while in a series by Ganeles et al, the clinical success rate at the time of final abutment placement was 99.4%. In a Gatti et al series, the success rate was 96%. Grunder reported an overall success rate of 92.31%. Other important factors are the characteristics of the implant surfaces. Occlusal force transmission schemes differ and a simple transposition of healing patterns from animal to man is not warranted and should be avoided, and moreover, it cannot be assumed that immediately loaded implants will have identical bone healing and bone-implant interfaces. In the posterior areas of the jaws, and especially in the maxillae, several demanding preconditions require considering insufficient bone volume, poor bone quality, and high functional forces. Glauser et al believe that the posterior maxilla should be considered as a risk area. The aim of the present study was an evaluation of the peri-implant tissues, in man in 2 immediately loaded implants and 1 submerged implant inserted in the posterior mandible and retrieved after 6 months.

Materials and Methods

Two patients participated in this study. One patient was a 53-year-old female, while the other was a 45-year-old male. The protocol was approved by the Ethics Committee of our University, and both patients gave their written informed consent. In the first patient, 8 XiVE implants (Friadent, Mannheim, Germany) were inserted in the edentulous mandible (Figures 1 and 2). It was planned to remove the most distal implants (mandibular left 2nd molar region and mandibular right 2nd molar region) with a 5-mm trephine after a 6-month loading period. Both implants were 3.8- × 9.5-mm implants. The last drill used for both implants had a diameter of 3.8 mm and the insertion torque had been 35 N. After a 6-month healing period, this implant was retrieved.

Processing of specimens

The implants and the surrounding tissues were fixed by immediate immersion in 10% buffered formalin and processed to obtain thin ground sections with the Precise 1 Automated System (Assing, Rome, Italy). The specimens were dehydrated in an ascending series of alcohol rinses and embedded in a glycolmethacrylate resin (Technovit 7200 VLC; Kulzer, Wehrheim, Germany). After polymerization, the specimens were sectioned longitudinally along the major axis of the implants with a high-precision diamond disk at about 150 μm and ground down to about 30 μm. Three slides were obtained for each implant. The slides were stained with acid fuchsin and toluidine blue. A double staining was done with von Kossa’s and acid fuchsin to evaluate the degree of bone mineralization, and after polishing, 1 slide per implant was immersed in AgNO₃ for 30 minutes and exposed to sunlight; the slides were then washed under tap water, dried, immersed in basic fuchsin for 5 minutes, and then washed and mounted.

Histomorphometry

Histomorphometry of bone-implant contact percentage was done using a light microscope (Laborlux S; Leitz,
FIGURES 1–7. FIGURE 1. Postoperative panoramic radiography; 8 implants have been inserted in the mandible for an immediate temporary restoration. FIGURE 2. Postoperative view of the implants inserted in the mandible. FIGURE 3. The immediate restoration (frontal view). FIGURE 4. The immediate restoration (occlusal view). FIGURE 5. Periapical X ray (immediately postoperatively). Radiopaque cement is in close contact with the bone. FIGURE 6. Periapical X ray (6 months later). A crestal bone of about 2 mm is visible. FIGURE 7. One of the retrieved implants.
RESULTS

Implant 1 (immediately loaded)—right 2nd mandibular molar region

At low-power magnification, bone was present around the implant (Figure 8). At higher magnification, the bone presented wide marrow spaces, with a few of these abutting on the implant surface. In some areas, newly formed bone was present at the interface. At the level of the crestal bone, on 1 side of the implant, there was no evidence of vertical bone resorption, while on the other hard, a 1.3-mm (±0.2) crestal...
Bone resorption was present. Resorption signs were present in the most coronal bone, while no resorption was seen in the bone at the interface with the implant. Newly formed bone tended to grow down into the bottom of the threads of the implant (Figure 9). The bone-implant contact percentage was 61% (±2.9%). No gaps or fibrous tissue were present at the interface, nor where there any inflammatory cells (Figure 10), foreign body reaction, or epithelial downgrowth. Bone lamellae parallel to the threads were found between the threads: in the crestal and middle part of the implant, a higher deposition of new bone was found.

**Implant 2 (immediately loaded)—left 2nd mandibular molar region**

The bone was more trabecular, with large marrow spaces (Figure 11). The bone-implant contact percentage was 61% (±4.2%). A vertical bone resorption of about 2.3 mm (±0.3) was present on both sides of the implant. No inflammatory cells or fibrous gaps were present at the interface (Figures 12 and 13). At the apical portion of the implants, only a few very thin bone trabeculae covered the metal surface of the implants.

**Implant 3 (submerged control implant)—left 2nd mandibular molar region**

At low-power magnification, it was possible to observe that the bone-implant contact percentage was lower than that observed around both loaded implants (Figure 14): a value of 35.5% (±3.9%) was recorded. No bone contact was observed in a large portion of the implant perimeter (Figure 15).

**Discussion**

When immediately loaded implants reach a state of osseointegration clinically, they have a long-term predictability similar to those of conventionally loaded implants. Moreover, immediate loading shortens the total rehabilitation time, with increased patient satisfaction and the avoidance of delays in the final rehabilitation with the accompanying difficulty of wearing a conventional denture during the healing phase. Immediate loading has been used in totally edentulous patients in order to improve the patient treatment acceptance and to increase their comfort, eliminating the need for removable dentures in the healing period. Immediate loading has been used mostly with implants inserted between the mental foramina and supporting fixed prosthetic restorations in totally edentulous mandibles. Imediately loaded implants have also been used to support successfully implant-retained overdentures. In the anterior mandible, the bone quality is usually sufficient to achieve primary stability. The role of bone quality is important for successful implant placement, and most of the implant failures tended to occur in the posterior jaw quadrants. Glauser et al reported a higher failure rate in implants inserted in posterior maxilla and in implants inserted in bone quality 3 and 4. Thirty-four percent of the implants inserted in the posterior maxilla failed, compared with 9% of the other implants inserted in other portions of the jaw. Grander found that, in his series, all failed implants were the most distal, and both implants placed in bone quality 4 failed, while 5 failures occurred in bone quality 3. A histologic evidence of osseointegration is needed for each different implant surface, and this can be obtained only by histologic analysis of immediately loaded implants retrieved from man. Only rarely, however, have human-retrieved immediately loaded implants been reported in the literature.

Our histologic data show that osseointegration can be obtained in very demanding situations, such as implant insertion in the posterior jaws, and that bone response was not disturbed by the stresses transmitted at the interface under these mechanical conditions and was comparable with that found around conventional delayed-loaded implants. Implant splinting decreases the amount of micromotion during the healing phase, giving to the implant a higher tolerance to deleterious micromotion. Rigid splinting and minimal lateral forces are critical factors for success. Primary stability is a key factor in the success of immediately loaded implants because a high primary stability helps to resist micromotion, that is, the relative movements between the implant surface and surrounding bone during functional loading. Glauser et al reported that primary implant stability is influenced by sufficient implant length, insertion torque, and bone quality as well as bicortical anchorage and modified surgical techniques. Moreover, the intimacy of initial fit and the percentage of implant surface in direct contact with bone influences the capability to withstand functional loads in early healing situations. In our implants, we found the presence of a crestal bone resorption radiographically and histologically. It must be considered, however, that Szmulker-Moncler et al have pointed out that the authors studying early loading did not evaluate the postloading bone remodeling phase. The previously reported differences in bone resorption around early loaded and nonloaded implants must be viewed in light of this remodeling and, probably, they do not necessarily need to be attributed to the early loading of the implants. It must also be pointed out that, in one of the implants (Figures 5 and 6), the margin of the crown was probably positioned in a too low position (this is shown by the presence of the radiopaque cement) and very near to the bone. At last, also, the surface plays a relevant role in implant long-term success, particularly in very demanding situations like in immediate loading in posterior jaw regions, and the roughened surface of the implants as described in this report probably helps to stabilize the initial blood clot and wound against the titanium surface, and that results in enhanced bone formation on the surface. Moreover, this surface may stimulate cell differentiation of osteoblast-like cells, and the
larger dimensions of roughness created by the sandblasting may provide pockets of bony ingrowth that may function as a series of miniretention grooves. Striking is the fact that both loaded implants presented a higher bone-implant contact percentage than the submerged (control) implant. Our results are similar to those reported recently by Testori et al, who found a bone-implant contact percentage of 38.9% in submerged healing and of 64.2% in immediately loaded implants. These results could be explained by the fact that functional loading stimulated bone apposition. Wolff formulated his theory according to the idea that there is a direct link between mechanical loading and bone formation; Wolff’s law would imply that increased stress—loading and bone formation; Wolff’s law would imply that increased stress—

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