The aim of the present study was to conduct a systematic review of the literature to compare soft tissue aspects of immediate and delayed implant placement in esthetic areas. This review of literature was conducted in the following databases: MEDLINE (PubMed), Lilacs, Scielo, EMBASE, and Cochrane Central Register of Controlled Trials (CENTRAL). For those studies that met the inclusion/exclusion criteria, the results were analyzed and summarized according to the treatment protocol used for implant placement. The primary parameters taken into consideration were papilla level (PL) and marginal mucosa level (MML) around implants. Four randomized controlled trials (RCT) were selected for analysis, but all were deemed as being of poor quality according to quality assessment. No studies reported any statistically significant differences concerning the soft tissue esthetic parameters analyzed around immediate or delayed implants at any follow-up periods reported. However, PL results seemed to be more reliable than were MML results, due to the PL standardization of the method of analysis, which showed a tendency for poorer results around immediately placed implants. In conclusion, although the results are based on only a few poor quality RCTs, both treatment options for implant placement demonstrated similar outcomes in the esthetic area, especially when PL was considered.

Key Words: dental implant; immediate implant; delayed implant; esthetics; soft tissue
intervention as the dental extraction; (2) early implant placement (type 2), when implants are placed in the early stages of healing (from 4–8 weeks); and (3) delayed implant placement (types 3 and 4), when implants are placed once the alveolar ridge has completely healed (>12 weeks after extraction). In this systematic review, implants placed up to 15 days after tooth extraction were considered as immediate implants, while implants placed after at least 8 weeks after tooth extraction were regarded as delayed implants.

Outcomes measured

Soft tissue morphology around implants was evaluated based on papilla level (PL) and marginal mucosal level (MML).

Inclusion Criteria

This systematic review included only RCTs that fulfilled the following inclusion criteria: (1) human studies, (2) comparison of soft tissue alterations around immediate and delayed implants, (3) evaluation of the morphologic soft tissue alterations (at buccal and interproximal sites) after implant placement, (4) follow-up period of at least 6 months after implant placement, (5) single implants, and (6) presence of natural teeth adjacent to implants.

Exclusion criteria

Studies presenting any of following characteristics were excluded from the review: (1) patients with implants adjacent to implant sites; (2) implants placed in areas previously submitted to osteogenesis distraction, bone block grafting, or soft tissue grafting; (3) implants placed in the molar region; and (4) implants placed in patients with previous periodontal disease, uncontrolled systemic disorders, and smokers.

Search strategy

An electronic search was conducted via MEDLINE (PubMed), Lilacs, Scielo, EMBASE, and Cochrane Central Register of Controlled Trials (CENTRAL). Randomized clinical trials, performed only in humans and published until December 2012, were selected. MeSH terms, key words and other free terms were used with Boolean operators (OR, AND) to combine searches. Studies published in any language and any journals were considered for analysis. The search terms used were:

#1 (“implant” OR “implants” OR “dental implant” OR “implant placement” OR “delayed implantation” OR “delayed implant” OR “delayed implant placement” OR “delayed implant installation”)

#2 (“immediate implant” OR “immediate implant placement” OR “post-extraction implant placement” OR “immediate implant installation” OR “early implant placement” OR “early implant installation”)

#3 (#1) OR (#2)

#4 (“papilla” OR “papillae” OR “marginal soft tissue” OR “mucosal level” OR “marginal mucosa” OR “soft tissue stability” OR “soft tissue”)

#5 (“aesthetic” OR “esthetic”)

#6 (#4) OR (#5)

#7 (#3) AND (#6)

Study selection

Two independent reviewers (A.B., C.S.D.) screened the titles, abstracts, and finally the full texts of the articles identified in the search according to the inclusion and exclusion criteria. Reviewers then selected the abstracts and finally full texts of all eligible articles for possible inclusion. In case of disagreement, a joint decision was taken.

Other sources of data

A hand search was also carried out in the reference lists and journals that were considered relevant for implant dentistry. Unpublished data were searched listing unpublished studies, abstracts, and supplement editions of important journals.

Data extraction

Two reviewers (A.B., C.S.D.) independently recorded the data from the selected studies. The data were extracted and compiled, summarizing the main characteristics and results for comparisons. The following data were recorded: (1) total number of patients included; (2) patients’ mean age and gender; (3) number of implants placed; (4) implant surface, design, length, and diameter; (5) healing protocol (submerged or non-submerged); and (6) follow-up period. Patients’ treatment protocols were also recorded: (1) time of implant placement after tooth extraction (immediate or delayed); (2) loading protocol; and (3) type of bone-grafting or membrane used for ridge preservation or GBR.

Validity assessment and methodological quality

The methodological quality of the interventional studies selected was assessed using Cochrane’s Collaboration quality measurement tool.14 The risk of bias was categorized according to the following classification: (1) low risk of bias (plausible bias that is unlikely to seriously change the results) when all criteria are met; (2) moderate risk of bias, when one or more criteria are partially met; and (3) high risk of bias, when one or more criteria are not met.

Results

Search results

Using the search strategy aforementioned, 420 potential articles were found and separated for title and abstract analysis. A total of 12 full-text articles were selected for more detailed analysis. From these, 5 texts fulfilled all the inclusion/exclusion criteria,15–19 while the remaining 7 studies were excluded (Appendix A). However, the information contained in 2 of those 5 studies reported data from the same sample15,17 in two different follow-up periods. After contacting the authors, it was decided to include only the most recent article,17 which reported data from both follow-up periods (2 and 5 years). Thus, finally, a total of 4 studies were included and considered for this review. Figure 1 has a Flow Diagram illustrating the study selection process.

A total of 122 patients (ages 21–69 years) and 126 implants were included in the analysis. The follow-up period ranged from...
from 6–60 months (Table 1). The characteristics of the studies included in this review—such as the number of patients treated, gender, mean age, implant system, surface, length, diameter, healing time, and loading protocols—are shown in Table 1. Other characteristics—such as bone grafts, method of PL and MML analyses, and assessment time—are displayed in Table 2.

**Implant restoration type and loading protocol**

Implant restoration type and loading time varied among studies. One study used provisional restorations 2 days after implant placement, but neither centric relation occlusal contacts nor protrusive and lateral movements were reported. Two studies reported only the later placement of final restorations, 7 to 9 months and 6 months after implant placement, respectively. Finally, one study did not report any type of restoration (provisional or final).

**PL analysis**

In three studies, changes in PL were clinically evaluated using the Jemt Papilla Index. The scores ranged from 0–4 (score 0 = no papilla; score 1 = less than half of space filled by proximal papilla; score 2 = at least half of space filled by proximal papilla; score 3 = all the space filled by proximal papilla; and score 4 = hyperplastic papilla). Figure 2 shows the results of these studies summarized for comparison (descriptive analysis only). In one study, however, PL was measured, in millimeters, from the most apical point of the mucosa margin to the apical coronal position of the midbuccal marginal mucosa and a reference line crossing the CEJ of adjacent teeth.

In the study by Schropp and Isidor, clinical crowns in IG at baseline was adequate (score 3) in 77% of the cases; in DG, clinical crowns were adequate in only 50% of the cases. At the 2-year follow-up, 82% of IG and 75% of DG were classified as adequate (P < .05). These values remained stable at the 60-month follow-up. It seems important to point out that all unsatisfactory crowns in IG and only half in DG occurred due to high crowns (score 1).

In another trial, no statistical analysis was performed. However, the descriptive data showed that only 61% of immediate vs 84% of delayed implants presented ideal MML. In addition, IG presented 9% of at least 2-mm recession (score 3) compared to no cases in DG. In the study by Palattela et al, mean MML alteration from the beginning of the treatment to the 2-year follow-up was −0.8 ± 0.7 mm for IG and −0.6 ± 0.6 mm for DG, indicating a slightly displacement of mucosal margin to the apical position in both groups but with no significant differences between them (P > .05). Finally, in the study by van Kesteren et al, MML analysis was carried out before (baseline) and at 6 months after tooth extraction (follow-up). Before tooth extraction, mean MML for DG and IG were 0.49 ± 0.57 mm and 0.20 ± 1.04 mm coronally to the reference line, respectively. There was a loss of 0.13 mm and 0.26 mm for IG and DG at 3 months; between 3 and 6 months, DG lost only 0.01 mm while IG gained 0.08 mm, indicating that most of the recession occurred within the first 3 months. Nonetheless, no significant differences between groups were found at any timepoint (P = .170) (for details, see Table 2).
Quality assessment of included studies

None of the studies included in this review were considered as having low risk of bias.\textsuperscript{16–19} The reasons for the poor quality of the studies found were mainly due to unclear allocation and concealment, and lack of examiner blinding (for details, see Table 3).

DISCUSSION

Only four studies fulfilled the inclusion/exclusion criteria established by this review in contribution to answer the research question. In summary, the results indicated that no differences in the esthetic outcomes (PL and MML) were found when immediate and delayed implant placement were compared at any of the follow-up periods reported.\textsuperscript{16–19} However, the results obtained in this review have to be analyzed with caution for the following reasons: (1) very few studies were included in the review; (2) there were important methodological differences among the studies; (3) PL results seemed to be more consistent than the MML results due to a lack of standardized procedures and a slight tendency of immediate implants to present poorer MML outcomes.\textsuperscript{16}

Recent systematic reviews have been conducted to compare peri-implant clinical parameters, success and survival rates among immediate, early, and delayed implants.\textsuperscript{21–25} In these studies, soft tissue modifications have also been evaluated but as a secondary outcome. In contrast, the present systematic review focused only in the comparison of soft tissues alterations around immediate and delayed implants.

A recent systematic review\textsuperscript{25} reported that early implant placement, compared to delayed placement, may offer advantages in terms of soft tissue stability. However, the study focused on all peri-implant clinical aspects, and soft tissue was analyzed secondarily. Esposito et al\textsuperscript{23} also reported lack of sufficient evidence for an unequivocal conclusion but suggested that esthetic outcomes might be better when implants are placed immediately after extraction. In another review,\textsuperscript{22} the results demonstrated that immediate placement of implants showed more recession in the buccal aspect and poorer esthetic results when compared to early and delayed implant placement.

There are some clinical studies suggesting that immediate implant placement is the best approach to prevent papilla loss in single tooth replacement.\textsuperscript{26,27} This review found no differences between IG and DG in terms of PL (Figure 2). However, considering all individuals in both groups, different outcomes were found among the studies.\textsuperscript{16–18} The prostheses used may be a possible explanation for the different results obtained,\textsuperscript{20,28,29} as this variable may be difficult to control. The prosthesis is an important factor that can affect the soft tissue around implants,\textsuperscript{20,28,29} as the emergence profile may lead to soft tissue apical displacement. The papilla will fill the interproximal areas according to the height of the contact point of the crown.\textsuperscript{29} A distance of $<5$ mm from the contact point to the bone crest is crucial to obtain the interproximal area entirely filled by soft tissue.\textsuperscript{30,31} The results obtained in this review reinforce the hypothesis that interproximal papilla seems to be influenced by the prosthesis,\textsuperscript{29} tooth-to-implant distance,\textsuperscript{12} and interproximal bone level of adjacent teeth.\textsuperscript{33,34}

Concerning MML, two studies included in this review\textsuperscript{18,19} reported that early implant placement compared to delayed placement showed more recession in the buccal aspect and poorer esthetic results when compared to early and delayed implant placement.

![FIGURE 2. Graphic showing the individuals’ distribution (percentage) of papilla level according to Jemt Papilla Index score\textsuperscript{20} of immediate and delayed implant placement among three studies included.](http://www.joi.or.jp/index.php/joi/article/download/10000511)
reported no difference in MML between groups (for details, see Table 2). Moreover, one study did not report the use of bone graft in any of the groups.18 Considering the inability of immediate implants to preserve buccal bone, a possible explanation for MML stability in this case is soft tissue gain (2.1 mm), which would replace the hard tissue modeling after tooth extraction.35 However, MML stability around implants with no buccal bone is controversial, once more recession has been observed in the long-term (7 years).

In the study by Lindeboom,16 delayed implants presented more ideal MML when compared to immediate implants (9% with ≥2 mm of recession). These results are in agreement with other studies that evaluated MML around immediate implants after 136 and 3 years.37 The authors observed >1 mm of mucosal recession in 8.3% and 8% of the patients, respectively.36,37 Thus, MML stability seems to be related to factors such as thin, damaged, or absent buccal bone, position of implant placement,22 and gingival biotype.10,22

This review of the literature found only a few randomized controlled studies. Furthermore, there was a lack of standardization in the procedures, type of esthetic analysis, characteristics of implant supported crowns, use of bone grafts, and description of gingival biotype. However, despite these limitations, the data assessed from the literature suggested that no differences in esthetic outcomes between immediate and delayed implants exist, with more consistent outcomes observed for PL than for MML.

### Implications for Practice

Although no differences in soft tissue esthetic outcomes were found between immediate and delayed implant protocols, clinicians should expect that soft tissue esthetic alterations will occur to some extent after tooth extraction and the subsequent implant placement. Hence, prior identification of individual risk factors that may lead to negative results could help the clinician choose the most adequate technique for implant placement.

### Table 2

<table>
<thead>
<tr>
<th>Study</th>
<th>Bone graft</th>
<th>Method of analysis</th>
<th>Time of evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindeboom et al16</td>
<td>Particulate AB in the buccal aspect of all implants</td>
<td>PL: Jemt Papilla Index</td>
<td>PL and MML: 12 mo after implant placement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MML: difference with the buccal gingival outline of the adjacent teeth (scores)</td>
<td></td>
</tr>
<tr>
<td>Schropp and Isidor17</td>
<td>Particulate AB: only with delayed implants in case of fenestrations or dehiscence</td>
<td>PL: Jemt Index, by clinical photography</td>
<td>PL and CCH: One wk after restoration, 24 mo and 60 mo of follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MML: by CCH in relation to adjacent teeth gingival level (scores)</td>
<td></td>
</tr>
<tr>
<td>Palattella et al18</td>
<td>NR</td>
<td>PL: Jemt Papilla Index</td>
<td>NP: 24 mo (follow-up)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MML: The distance from the most apical point of the gingival margin to the implant shoulder measured (in mm)</td>
<td>MML: at the moment of the provisional restoration delivery (baseline) and 24 mo (follow-up)</td>
</tr>
<tr>
<td>van Kesteren et al19</td>
<td>DG: Ridge preservation with FDBA + collagen membrane</td>
<td>PL: Distance between the level of CEJ of adjacent teeth and the most coronal point of the papilla</td>
<td>PL and MML: before tooth extraction (baseline), 3 and 6 mo after implant placement</td>
</tr>
<tr>
<td></td>
<td>IG: FDBA filling the gap between the buccal bone and the implant surface when the HDD ≥ 2 mm without membrane</td>
<td>MML: Distance between the apical position of the midbuccal mucosa and the adjacent teeth marginal gingiva</td>
<td></td>
</tr>
</tbody>
</table>

*AB indicates autogenous bone; FDBA, freeze-dried bone allograft; HDD, horizontal dimension defect; CEJ, cement-enamel junction; Sco., score; PR, papilla recession; MR, mucosa recession; CCH, clinical crown height; NR, not reported.*
analyses. The identification of causal factors of negative results would also be important, especially when MML is evaluated. Additional information—such as horizontal defect size in immediately placed implants, type of bone grafts used, prostheses (contact point height), gingival biotype, and tomographic analysis for the presence or absence of adjacent buccal bone—adds some variables to be evaluated. Other patient-centered variables could also be analyzed and associated

### Implications for research

In future studies, it would be important to focus on high quality, well-designed RCTs with larger samples, long-term follow-up periods, and standardization in the methods of analyses. The identification of causal factors of negative results would also be important, especially when MML is evaluated. Additional information—such as horizontal defect size in immediately placed implants, type of bone grafts used, prostheses (contact point height), gingival biotype, and tomographic analysis for the presence or absence of adjacent buccal bone—adds some variables to be evaluated. Other patient-centered variables could also be analyzed and associ-
ated to soft-tissue alterations, such as oral hygiene, trauma due to brushing, and tooth-brushing instruction.

ABBREVIATIONS

CCH: clinical crown height
CEJ: cementoenamel junction
DG: delayed group
GBR: guided bone regeneration
IG: immediate group
MML: marginal mucosa level
PL: papilla level
RCT: randomized controlled trials

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APPENDIX A: LIST OF EXCLUDED STUDIES. MAIN REASON FOR EXCLUSION IS SHOWN IN PARENTHESES