Editorial Predisposing Peri-implantitis: An Archetype of a Burden

It has been four decades since contemporary implant dentistry was accepted as a viable alternative for rehabilitation of both partially and completely edentulous patients, thanks to the efforts of two of the most relevant pioneers, Per-Ingvar Brånemark and André Schroeder. Since then, a myriad of pertinent refinements in clinical skills and surface technologies have been developed to enhance and accelerate the process of osseointegration. Likewise, sophisticated implant macro-designs that are tailored for use in challenging case scenarios, such as postextraction immediate implant placement or immediate prosthetic loading, have been introduced. These developments resulted in high predictability of the procedures, and clinicians have shifted their focus to improving esthetic results.

The new millennium contemplates implant dentistry as a highly successful therapy to restore a failing dentition. Unfortunately, patients in need of periodontal therapy have been prematurely guided to replace their natural dentition with implants. Peri-implantitis, an uninvited plaque-associated chronic condition, has become a threat to implant success. Existing evidence suggests that the microbial profile associated with peri-implantitis is not induced by specific bacterial phenotypes, and lesions found with infraosseous defect morphologies may differ from those seen with periodontitis, where a generalized loss of support may occur, but circumferential defects are seldom sighted for teeth. Here, the infraosseous defects are associated with local contributing factors, such as faulty restorations, excess subgingival prosthetic cements, food impaction, or malposition of the implants negating oral hygiene.

The current high prevalence of peri-implantitis reported with long-term unsatisfactory therapeutic outcomes may relate to biofilm accumulation on the implant or prosthetic surface. Other predisposing factors include smoking, hyperglycemia, history of periodontitis, implant malposition, and faulty prosthetic designs.

The width and thickness of keratinized mucosa appear to contribute to long-term tissue stability, especially for erratic compliers and noncompliers of oral hygiene maintenance programs. Thus, there is a need for certain soft tissue morphologic characteristics to facilitate a patient's good oral hygiene performance.

In light of this, local predisposing factors should be assessed when assigning prognoses to peri-implantitis implants. As such, treatments are modifiable to accommodate the prognoses and encourage patients to perform efficient plaque control. In these cases, the most predictable therapy might include implant retrieval to avoid the endless recurrence of disease.

It would appear appropriate to eliminate periodontal disease before placing implants and to provide a well-constructed maintenance program to monitor the health of the implant prostheses. It has been demonstrated that implants can exist in health for decades when all of these thoughts are executed. When successful, implant dentistry is a great process to improve not only the mastication and nutrition of the patient, but their self-esteem as well.

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