

## Uncementing relations

**C**ement is driving me crazy. Not the road kind, the implant kind.

It happened again 2 weeks ago, a patient was returned to my office by her dentist. His concerns were the clinical signs of inflammation and bone loss seen on radiographs around one of the patient's implants. My records showed that the implant had been healthy following the healing stage 6 months before when I had released her for her restoration. The radiographs exposed at that time showed normal bone levels on the mesial and distal, the implant was clinically stable, and the soft tissues had normal probing depths and were clinically free of signs of inflammation. A radiograph taken at her most recent visit had radiolucency on the distal, with no apparent marginal discrepancy. At this visit, there was a 6-mm probing depth (6 months before it was 3 mm with no bleeding upon probing), and there was suppuration. The occlusion was normal, and the patient reported that she routinely wore her maxillary hard acrylic habit device when she slept. Her self-reported oral hygiene was acceptable, and the remaining periodontal and peri-implant probing depths were within normal limits.

As is our custom in these cases, we anesthetized the area and explored it with a dental endoscope. Vision was difficult because of the inflammation, but there on the distal was a large white mass in the area adjacent to the juncture of the crown and the implant. Cement. As is our habit, we used a special tip on a sonic device along with the scope to remove the offending material. The area was lesion-free and clinically normal 4 weeks later.

The next week, another patient presented with the same problem. This gentleman had been too busy to return for a radiograph of the restoration following crown cementation and had also forgotten his yearly (free) checkup in my office for the last few years. In his case, the bone loss had progressed to the point that the implant was symptomatic and was removed. Not a good outcome for any of us.

Back in the good old days we had to deal with broken implants and loose screws but not cement. So why the move to cementation? Economics.

Yes, money. It is far less expensive to have the laboratory fabricate a crown for cementation than one that will be screw retained. In addition, cementing a crown requires less chairtime than screw retaining the restoration. It also takes fewer parts to make the impression when you cement. All this adds up to savings for the dentist and the patient. And leads to more cement.

As to the solution, I could propose only screw-retained crowns, or outlaw cement, but that would be counterproductive and would not work anyway, since the average dentist is no more compliant than the average patient. Besides, there is nothing wrong with cementation as long as one follows the rules.

I would argue that if one cements, remember that cement is a foreign body and if left in contact with the peri-implant soft tissues, will create problems. If we just followed the basics we were all taught in dental school, these patients would fare better. First, it makes sense to have the cement margin just below the gingival margin in esthetic areas and just coronal to it in nonesthetic zones (Remember that for some, especially in the US, there is no such thing as a nonesthetic zone). Next, spend adequate time and effort to clean off the cement at the seating appointment, and take radiographs following cementation. And last, but far from least, remind patients that implants need periodic examination and maintenance just like teeth.



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