



Peri-implantitis: The disease of the future

We have a new disease! A man-made disease with no current gold-standard treatment. In the last decade we have been exposed to a dramatically increasing number of reported cases of peri-implant disease. The increase in reporting can be attributed to better diagnostic guidelines and criteria as well as to actual increase in the prevalence of the disease due to the dramatic rise in the use of dental implants.

Each and every one of us who is involved in implant dentistry should be well aware and concerned about this emerging disease. The reported prevalence in the literature reaches almost 30 to 50% of implant patients. This means that one out of two or three of our implant patients might present with peri-implant disease at some point. This is also an important aspect of informed consent for our patients.

The most essential issue to remember regarding this entity (as in many other diseases) is how to prevent and avoid peri-implant disease. Various risk factors have been identified, such as smoking, diabetes, and periodontal disease; but the most important risk factor that increases the risk for peri-implant disease by almost 15 fold is poor oral hygiene. Oral hygiene is a risk factor that can and should be controlled. Plaque control should be perfectly achieved before placing the implant. Patients should win the opportunity to have implants by proving that they can control the plaque effectively over time. Otherwise, both the patient and the dentist will have to pay the consequences and deal with the troublesome situation of peri-implant disease. Again, this should be done

beforehand and not after the disease is already established. The, sometimes, self-limiting process with a "protective" connective tissue capsule in periodontitis lesions is probably lacking in peri-implantitis lesions, so once established, the lesion might be very difficult to resolve.

Another troubling issue with regards to peri-implantitis is the lack of appropriate, well-documented gold-standard treatment. There are many suggested treatment options described in case reports and case series in the literature; none of them seems to provide a predictable long-term resolution of the disease. Our role as researchers during the next years will be to produce good evidence for the "right" treatment in cases of peri-implantitis. This is not an easy task. Providing a treatment that will save the implant, prevent further bone loss, eliminate inflammation, and preserve the esthetics is very challenging.

Taking all this into consideration, until the miracle treatment is found we had better adhere to stricter prevention programs, trying to avoid the disease rather than having to fix its damage. We should attempt to preserve more and extract less, treat the disease first and establish a stable situation before placing an implant or augmenting the bone, establish the best environment for our implants, and control better the known risk factors.

Prevention is, and will always be, better than the best treatment.

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