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International Journal of Periodontics & Restorative Dentistry

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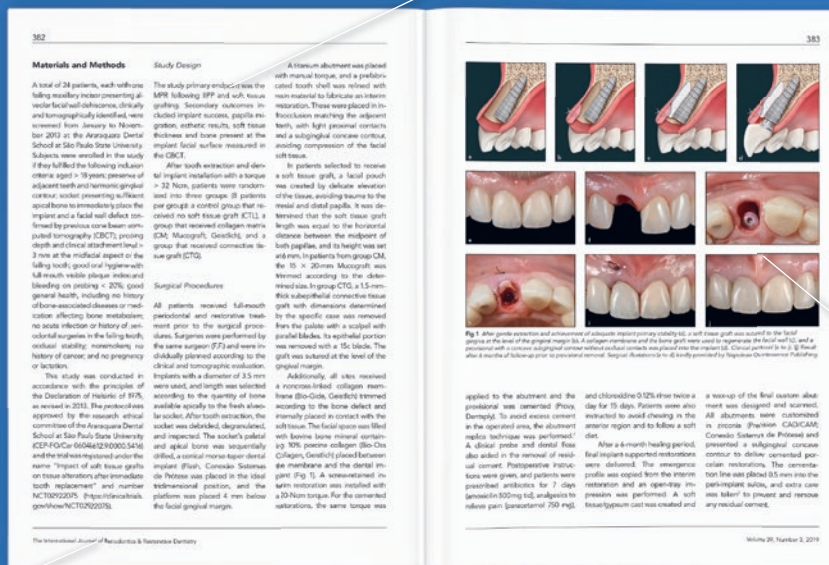
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One aim of the journal is to provide the reader with knowledge that can be used directly in daily practice.

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Materials and Methods

Study Design

A total of 28 patients, each with one failing maxillary incisor presenting at the facial wall of the incisor, clinically and tomographically identified, were recruited from January to November 2013 at the Aesthetic Dental School at San Paulo State University. Subjects were enrolled in the study if they fulfilled the following inclusion criteria: aged > 18 years; presence of adjacent teeth and harmonious gingival contour; no other periodontal or systemic diseases; no previous orthodontic treatment; and a facial wall defect confirmed by previous cone-beam computed tomography (CBCT), probing depth and clinical attachment level > 3 mm at the midfacial aspect of the failing tooth; good oral hygiene with 18-month recall period; no periodontal bleeding on probing < 20%; good general health, including no history of bone-associated diseases or medication affecting bone metabolism; no acute infection or history of localized systemic or localized allergic diseases; no history of cancer; no pregnancy or lactation.

This study was conducted in accordance with the principles of the Declaration of Helsinki of 1975, as revised in 2013. The protocol was approved by the research ethics committee of the Aesthetic Dental School at San Paulo State University (CEP/FORC/6040642/2010/0035476) and the trial was registered under the name "Impact of soft tissue grafts on tissue alterations after immediate tooth replacement" and number NCT02020295. Ethics (ethicsprotocol.gov.br/NCT02020295).

Study Design

The study primary endpoint was the MRG following 300 and 600 days post-grafting. Secondary outcomes included implant success, papilla recession, esthetic results, soft tissue thickness and bone present at the implant facial surface measured in the CBCT.

All patients received full-mouth periodontal and restorative treatment prior to the surgical procedures. Surgeries were performed by the same surgeon (FJ) and were individually planned according to the clinical and tomographic evaluation.

Implants with a diameter of 3.5 mm were used, and length was selected according to the quantity of bone available apically to the fresh alveolar socket. After tooth extraction, the socket was debrided, degranulated, and irrigated. The socket's palatal and apical bone was sequentially drilled, a conical Morse taper dental implant (Fujin, Conical System on, Pofree was placed in the ideal subperiosteal position, and the platform was placed 4 mm below the facial gingival margin.

A titanium abutment was placed with manual torque, and a prefabricated tooth shell was fitted with resin material to fabricate an interim restoration. These were placed in 10–15 hours, matching the adjacent teeth with light pressure, verticals and a subgingival concave contour, avoiding compression of the facial soft tissue.

In patients selected to receive a soft tissue graft, a facial pouch was created by delicate elevation of the tissue, avoiding trauma to the mesial and distal papilla. It was determined that the soft tissue graft length was equal to the horizontal distance between the midpoint of both papillae, and its height was set equal to 10% of the crown height of the 15 × 20-mm Maxgraft, was trimmed according to the determined length (Fig. 1). A 5-mm-thick subepithelial connective tissue graft with dimensions determined by the specific case was removed from the palate with a scalpel with parallel blades. Its epithelial portion was removed with a 15° blade. The graft was placed at the level of the gingival margin.

Additionally, all sites received a collagen-based collagen membrane (Bio-Gide, Geefick) trimmed according to the bone defect and manually placed in contact with the soft tissue. The facial space was filled with bone using mineral granules (90% porous collagen (Bio-Gide, Geefick) placed between the membrane and the dental implant (Fig. 1). A uniaxiated polyethylene membrane was installed with a 0.5-mm torque. For the coronal restorations, the same torque was



Fig. 1 After tooth extraction and achievement of adequate reparatory stability, a soft tissue graft was sutured in the facial portion of the gingival margin (A). Grafting membrane and the tooth graft were used to regenerate the facial wall, and a facial abutment with a conical subgingival concave contour was placed into the implant (B). Clinical pictures (C–E). Final aesthetic result of follow-up prior to permanent removal. Source: Adapted from 8, kindly provided by Quintessence Publishing.

applied to the abutment and the prosthesis was cemented (Phos-Dempral). To avoid excess cement in the operated area, the abutment replica technique was performed. A clinical probe and dental files also aided in the removal of residual cement. Postoperative instructions were given, and patients were prescribed antibiotics for 7 days (amoxicillin 500-mg t.i.d., analgesics to relieve pain [paracetamol 750 mg]

and chlorzoxidine 0.125) twice a day for 15 days. Patients were also instructed to avoid chewing in the anterior region and to follow a soft diet.

After a 6-month healing period, facial implant-supported restorations were delivered. The emergence profile was copied from the interim restoration and an open-top impression was performed. A soft tissue gypsum cast was created and

a wax-up of the final custom abutment was designed and scanned. All abutments were customized in zirconia (Phenix – CAD/CAM; Conexao; Selenia de Pirovetti) and presented a subgingival concave contour to define optimal papillary restorations. The ceramic top line was placed 0.5 mm into the periimplant sulcus, and extra care was taken to prevent and remove any residual cement.

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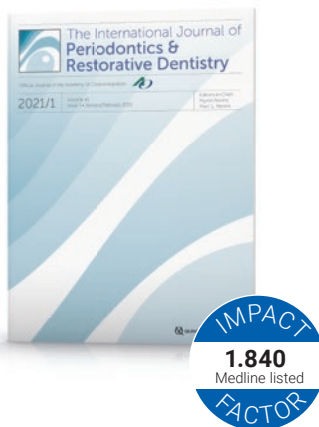
Contact person:

Markus Queitsch

queitsch@quintessenz.de

Tel.: +49 (0)30 76180-644

Fax: +49 (0)30 76180-621



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