The use of the Er:YAG in laser-assisted broken abutment screw treatment

Dental implants are a functional and aesthetic solution to partial and total edentulism. Although the overall success rate of implant dentistry is very high, more than 90 per cent of the treatment modality is not free of complications and dental implants occasionally fail. The chronic loosening or fracturing of implant screws continue to be a problem in restorative practices and generally are challenging to remove. This report describes and demonstrates the management and technique used for the removal of fractured screw fragments and the successful utilisation of the Er:YAG laser as an important auxiliary tool.

Introduction - the problem

Success in implant-supported prosthetic replacement of teeth will be due to a combination of appropriate placement criteria (receptor site quality, implant stability, osseo-induction), appropriate (non-excessive) loading and prevention of bacterial contamination.

The failure of dental implants is due not only to biological factors, such as unsuccessful osseo-integration or the development of peri-implantitis, but it may also result from technical complications. Dental implant complications may be considered under the following main categories:

Early
- Failure/inadequate surgical preparation
- Failure of osseo-integration
- Peri-surgical infection

Late
- Implant overloading, leading to bone loss
- Peri-implantitis
- Soft tissue complications
- Fracture of mechanical components and aesthetic/phonetic considerations

Failures of implant-supported restorations result from technical problems and can be divided into two groups: those relating to implant components, and those relating to the prosthesis. Technical problems related to implant components include abutment screw fracture.

The abutment screw fracture presents a rare, but quite unpleasant failure and can be a serious problem, as the fragment remaining inside the implant may prevent the implant from functioning efficiently as an anchor. The primary reason for screw fracture is undetected screw loosening which can be due to bruxism, an unfavorable superstructure, overloading, or malfunction. Fractures of the implant abutment or of the abutment screw have been observed as a consequence of screw loosening and undetected micro-movements of the abutment under functional loading and consequently, it is advised that the repeated loosening of an abutment screw should alert the clinician to possible significant contributing causes.

However, the behaviour of the implant/abutment joint components with respect to critical bending force is still unclear. Studies show that implant abutment failure occurs when lateral forces exceed 570 Newtons for abutment with a joint depth of at least 2.1 mm and 530 Newtons with a joint depth of at least 5.5 mm.

Recommendations

The number, position, dimension and design of implants, as well as the design of the prosthesis are critical factors to be considered during the treatment planning phase. To withstand high bending stresses, implants should be as long and as wide as possible, used in adequate numbers, and be positioned such as to allow axial loading. Implant components are known to fracture...
A team including Peter Fairbairn, the principle implant dentist at the Scarsdale Dental Clinic in Kensington, South West London was indulging in its favourite pastime with the help of DIO Implants (UK) and Biocomposites Ltd. The two companies supported the racing team which took part in the Birtcar 24-hour race at Silverstone, held on Saturday and Sunday 2/3 October, 2010.

Peter has been racing in motor sport for many years although this was the first time he’d taken part in a grueling 24-hour event. Akin to the Le Mans 24-hour race, this was the fifth time he’d taken part in a grueling 24-hour event. He has lectured at Kings College in London on the use of synthetic bone grafting materials and says that he has a success rate in excess of 99%. “I am particularly impressed with the usability and implant coatings of DIO implants,” he explained. “They are perfectly compatible with calcium derived synthetics and complement my techniques very well.”

Iain Forster admitted that he was delighted to have the opportunity of supporting Dr Fairbairn and the team in his favourite sport, motor racing. “Silverstone is an exhausting but very rewarding time for all of us. After everything we went through, I really feel like a member of the team now.”

It was a pertinent opportunity for DIO sponsor Dr Fairbairn’s Porsche team. “The German engineered Porsche seemed relevant to DIO and Peter Fairbairn’s relationship as DIO’s RBM-surface implants are sent to Germany for the electrochemical surface modification process (called Biolit®)”, Iain explained. “Peter favours using these biomechanical calcium phosphate-enhanced implants with his pioneering technicians, so there was an underlying connection to the Birtcar GP collaboration, I certainly can’t wait for next year’s event!”

Over the last 22 years Peter has been on the world stage speaking about implants and synthetic graft materials and regularly contributes to dental journals. He has lectured at the British Academy of Cosmetic Dentistry annual forum (2005 and 2006) and the European Society of Cosmetic Dentistry Forum (2006) and is a regular speaker for the Association of Dental Implantology (ADI).

Further editorial information from: Steve Jordan The Words Workshop Ltd Tel: 01908 095500 Fax: 01908 690099 E-mail: steve@thewordsworkshop.co.uk Web: www.thewordsworkshop.co.uk

All dental implant business enquiries to: Iain Forster Managing Director DIO Corporation Ltd (UK) Tel/Fax: 0845 123 5996 E-mail: info@DIOUK.com Web: www.DIOUK.com Web: www.Dental.co.uk

For information on The Next Rejuvenation of fully synthetic materials please contact: Robert Teague Sales Director (Dental) Biocomposites Ltd Tel: 01782 738580 Fax: 01782 535599 E-mail: rmt@biocomposites.com Web: www.biocomposites.com

The application of these systems is to permit a hole to be drilled into the centre of the broken screw and drive a removal wedge into the hole that engages the broken screw and when reverse torque is applied by removing the instrument.

If no thread damage has occurred and the screw has not “bottomed out” or torqued into a seating stop, then the force necessary to remove the screw may be minimal. If none of these systems is available, another method for broken screw retrieval involves the following procedure: after the prosthetic or abutment is removed, the screw hole is vigorously flushed with an air/water spray from a 5-way syringe. Pressurised air is applied to dry the screw hole, and a drop of mineral oil (delivered on the tip of an explorer) is introduced into the screw hole. A sharp #4-round bur in a high-speed hand piece is activated and lightly applied to the exposed side of the fractured screw.

The objective is to have the spinning bur s blades contact the metal surface of the screw so that the screw will spin itself out of the hole. When repeated several times, the screw can be backed out and retrieved easily with forceps. If this technique fails, a slot can be created using a surgical drill, on the head of the fractured screw, and then a screwdriver is used to back out the broken abutment screw. Sometimes just a gentle touch with the drill to the head of the broken screw will be enough to back it out. If the head of the screw is stripped, it should be filed away completely using a round carbide bur or heat and a new abutment may be rotated into the implant.

Case study
This clinical report describes a situation in which a fractured implant abutment screw was successfully retrieved by using the Er:YAG laser as an auxiliary tool, and the advantages of this 2,840 nm wavelength versus conventional methods.

---

DIO Implants (UK) and Biocomposites Support Racing Team at Silverstone

Peter is a recent convert to using DIO dental implants which, he says, are ideally suited to his branch of dentistry. He has performed implant surgery for the last 20 years and has particular expertise in the use of 2nd generation synthetic materials such as Fortoss VITAL from Biocomposites which Implant surgeons worldwide are now recognising as a reliable alternative to traditional human or animal derived bone-grafts. He has lectured at Kings College in London on the use of synthetic bone grafting materials and says that he has a success rate in excess of 99%. “I am particularly impressed with the usability and implant coatings of DIO implants,” he explained. “They are perfectly compatible with calcium derived synthetics and complement my techniques very well.”

Iain Forster admitted that he was delighted to have the opportunity of supporting Dr Fairbairn and the team in his favourite sport, motor racing. “Silverstone is an exhausting but very rewarding time for all of us. After everything we went through, I really feel like a member of the team now.”

It was a pertinent opportunity for DIO sponsor Dr Fairbairn’s Porsche team. “The German engineered Porsche seemed relevant to DIO and Peter Fairbairn’s relationship as DIO’s RBM-surface implants are sent to Germany for the electrochemical surface modification process (called Biolit®),” Iain explained. “Peter favours using these biomechanical calcium phosphate-enhanced implants with his pioneering technicians, so there was an underlying connection to the Birtcar GP collaboration, I certainly can’t wait for next year’s event!”

Over the last 22 years Peter has been on the world stage speaking about implants and synthetic graft materials and regularly contributes to dental journals. He has lectured at the British Academy of Cosmetic Dentistry annual forum (2005 and 2006) and the European Society of Cosmetic Dentistry Forum (2006) and is a regular speaker for the Association of Dental Implantology (ADI).
Examination

A 56-year-old male presented for treatment, reporting the detachment of an implant-supported crown in the region of the upper left central incisor. The patient stated that the implant and crown had been placed four years earlier and that looseness of the crown had occurred on two occasions during this period. On both occasions, the screw had been tightened with no further investigation.

Clinical examination of the patient revealed a missing tooth at the site of the implant (Fig 1). The patient brought the abutment, crown and broken screw with him (Fig 5). Radiographic examination of the area showed the presence of a root-form cylindrical implant, consistent in appearance with a 15mm long, 3.75mm diameter abutment with an internal hex. The apical part of the screw remained threaded into the implant, but had fractured at the level of the hexagonal neck. Although the implant was osseointegrated, there were radiographic signs of peri-implantitis with some crestal bone loss having occurred (Fig 2).

Treatment options

The treatment options available were: 1) retrieve the fractured screw, or 2) remove the old implant and insert a new implant in one sitting. Following discussion with the patient and evaluation of the possibilities for success, it was decided to try and retrieve the fractured screw. Treatment would involve the use of the Er:YAG laser to perform the following, based upon accepted research:

- The flap incision.33,43
- Ablation of granulation tissue around the implant.14,51,53
- Remodelling, shaping and ablation of the bone.32,33,34,37
- Detoxification of the infected surfaces of the implant.30,34,43,51,52

An associated osteogenic (GBR) procedure to prevent soft tissue in-growth and maintain the form of the alveolar treatment alternatives, using a more conventional approach, would include the use of traditional scalpel, curetage, and rotary instruments.

Treatment

A dual-wavelength laser system with operating wavelengths of 2.940nm and 10,600nm (OpusDuo™ AquaLite™, Lumenis, Ltd. Yokneam, Israel) was employed for this procedure. The laser operating parameters employed for the various surgical stages were as follows:

- Flap Access: Wavelength: 2.940nm (Er:YAG), 200-micron sapphire tip, in contact mode; 450 mJ per pulse at 20Hz. Total power: 9 Watts.
- Granulation Tissue Removal: Wavelength: 2.940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 700mJ per pulse at 12Hz. Total power: 8.4Watts.
- Bone Surgery: Wavelength: 2.940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 450mJ per pulse at 20Hz. Total power: 9Watts.
- Detoxification of the implant: Wavelength: 2.940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 150mJ per pulse at 20Hz. Total power: 3W.
- Decortication for GBR technique: Wavelength: 2.940nm (Er:YAG), 1,500-micron sapphire tip, in non-contact mode; 500mJ per pulse at 17Hz. Total power: 8.5Watts.

A V shape incision was made with the Er:YAG laser. An intrasulcular incision was made (after anaesthesia) at the buccal and palatal side of the implant, together with two vertical relieving incisions; one at the mesial side of tooth # 8 and the second at the mesial side of tooth # 11 (Figs 4, 5).

The buccal and palatal flaps were lifted and the area explored (Fig 6); there was granulation tissue around the neck of the implant. The granulation tissue was ablated using the laser (Fig 9). Vaporisation of the granulation tissue (if any exists) after raising a flap is efficient with the Er:YAG laser, offering a lower risk of over-heating the bone than that posed by the current diode or CO2 lasers,41 and often obviates the need for hand instruments. Results from both controlled clinical and basic studies have pointed to the high potential of the Er:YAG laser and its excellent ability to effectively ablate soft tissue without producing major thermal side-effects to adjacent tissue has been demonstrated in numerous studies.30,42,53

The broken hexagon slot was straightened, using a round diamond bur and the head of the fractured screw, and a screw-driver was successfully used to unscrew the broken abutment screw (Figs 7, 8). The Er:YAG laser was aimed at the surface of the exposed implant for the purpose of decontaminating the infected exposed surfaces, without damaging them.30,42,43,51 Studies have shown that Er:YAG laser energy effects on bone include bacterial reduction.44 Follow- ing this, all accessible bone surfaces were exposed to laser energy to ablate necrotic bone and to shape and remodel the surface, in accordance with established clinical protocols.30,42,43 Decortication of the buccal bone was then performed (Fig 10).

The purpose of decortication is to encourage bleeding, providing progenitor cells to the site. A new abutment was then inserted into the implant (Fig 11). All spaces between implant and existing osteotomy site were filled with a xenograft bone substitute (Bio-Oss®, Geistlich Biomaterials) and covered with an absorbent bilayer membrane (Bio-Gide®, Geistlich Biomaterials), (Figs 12, 15). The mucoperiosteal flap was re-positioned and sutured with silk 5-0, paying particular attention to primary closure of the flap (Fig 14).

Post-operative instructions

The patient was prescribed Clindamycin 150mg x 50 tabs to avoid infection. He was also given Motrin 800mg x 15 tabs for pain. Instructions were given to rinse with Chlorhexidine 0.2 per cent, starting the next day for two weeks x three per day.

Management of complications and follow-up care

The following day the patient reported moderate pain and moderate swelling. There was no tissue bleeding and the site was closed. The flap was showing signs of attachment and was healing nicely. At ten days postop the patient returned for inspection and removal of sutures. The swelling had resolved, there were no signs of fistula and healing was progressing well. After five months the soft tissue was completely healed without complications (Figs 16, 17). The soft tissue had healed over the bone and there were no bony projections observed under the soft tissue. The prognosis is excellent.

Conclusion

The use of osseo-integrated implant-supported prostheses in the replacement of missing natural teeth has become an accepted clinical protocol in dentistry. Success in this area is enhanced through correct diagnosis, treatment planning and maintenance; however, complications often occur, which may be significant and compromise the long-term success of the implant abutment and associated prosthesis. The management of such complications has given rise to several techniques to address failings, such as component fracture and bacterial contamination.

The Er:YAG (2.940nm) laser can be employed as an auxiliary tool for the purpose of decontamination of infected implant surfaces and it has been shown to be effective and safe. The use of the 2.940nm wavelength for these procedures presents many advantages v. conventional methods, including enhancing the surgical site and less bleed-
during the operation, providing the practitioner a better field of visibility and reducing patient discomfort during its use. In addition, anecdotal claims have been made that post-operative effects such as pain and swelling are less pronounced.

A summary of possible serious complications associated with implant placement has been given, together with a report of a clinical case in which the use of the Er:YAG laser has been shown to be beneficial in the management of the consequences of a fractured abutment screw.

References available on request to Lisa@dentaltribunuk.com