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GBR membrane for ideal ridge regeneration
Non-resorbable
Guided bone regeneration using a titanium membrane at implant placement: a case report and literature discussion

Howard Gluckman, 1 Jonathan Du Toit2

Abstract
Reconstruction of the oral supporting tissues lost by disease or trauma is essential to tooth replacement with dental implant therapy. This treatment requires evidence based augmentative procedures combined with up-to-date and current techniques. Guided bone regeneration (GBR) aims to initialize this process of alveolar ridge reconstruction by utilizing biologically active and supportive materials best coupled to the body’s healing processes. The use of non-resorbable, titanium membranes can achieve GBR by ensuring graft stability and space maintenance so as to ensure optimal neovascularization. Hereafter is a case report of a ridge defect reconstructed at implant placement, with the rationale and current, evidence-based literature discussed.

Keywords: Guided bone regeneration, titanium membrane, ridge augmentation, dental implant therapy

Background
The management of partially or totally edentulous patients with implant therapy has long since been a literature supported and successful treatment modality.1-3 The implant supported restoration’s survival and success is directly related to the health of its supporting tissues and their orientation circumferential to the implant.4 Guidelines to ensure long-term bone stability exist, namely positioning an implant at minimum 1.5 mm from an existing tooth, as narrow implant diameter as possible in the aesthetic zone, 3 mm inter-implant space, palatal and deeper implant placement in an immediate protocol, 2 - 3 mm of bone buccofacial and palatolingual to the implant, and so forth.5-9 When the tissues to ensure the long term stability of an ideally prosthodontically planned implant placement are deficient, the site should be augmented, by means of soft tissue procedures and guided bone regeneration (GBR).10, 11 Viz the guidelines should not be violated to compensate for the tissue deficit. Alveolar ridge augmentation can be predictably achieved by means of GBR, whereby the clinician constructs a scaffold at the defect site that supports a bone graft or bone substitute material (BSM).12 A variety of GBR techniques are available to the clinician’s augmentation armamentarium, comprising a variety of materials, each with its own properties and clinical indications.

Bone graft materials
These are defined by their osteoinductivity, osteoconductivity and osteogenicity. Albrektsson simply describes osteoinduction as the process by which osteogenesis is induced, the ability of the graft material to actively promote bone formation.13 Osteoconductivity is the property of a surface that promotes bone formation upon it, a characteristic of a scaffold that may facilitate osteoprogenitor cells and neovascularization of its surface.14 Osteogenicity is the property of actual bone forming cells within the graft material, specifically pluripotent bone stem cells to form bone.15 Since autogenous bone contains such undifferentiated mesenchymal cells, precursors for osteoblasts and osteoclasts, monocytes and growth factors, it possesses all these aforementioned qualities and is the literature supported gold standard to promote GBR.16 In consideration of additional surgery, technique difficulty, and patient morbidity,
conform to guidelines for long-term implant tissue stability by using a titanium barrier membrane.

**Case Report**

A 58-year-old female patient was referred by her general practitioner with the request to extract tooth 14 and for further rehabilitative intervention. Additional social history profiled the patient as a non-smoker, and social drinker. The patient reported an uncomplicated medical history. The dental history indicated endodontic treatment of tooth 14 with a post-core-crown restoration completed several years prior. The tooth demonstrated failure of treatment, periapical pathology, and was symptomatic.

Intraoral examination indicated the patient had a thick gingival biotype though with high scalloped, triangular adjacent teeth. Cone beam computed tomography (CBCT) of the site indicated significant pathological resorption of the bony ridge at 14 (Fig. 1). The tooth root was orientated buccally within the ridge and a post-extraction ridge defect was anticipated. Endodontic retreatment was opted against due the large apical pathology in spite of relatively sound looking, previous endodontic treatment, and extraction with dental implant therapy to follow was planned for.
The patient’s preoperative drug regime consisted of Augmentin 1000 mg twice daily 2 days prior to treatment, to progress 5 days following treatment. The operative site was anaesthetized with a 4% articaine solution containing a 1:100,000 concentration of adrenaline, and was the local anaesthetic administered in all subsequent surgical procedures. The tooth was sectioned and removed by a minimally traumatic extraction technique and the periodontal tissues maximally preserved where possible (Fig. 2). A full thickness flap was raised, and with the site fully exposed, apical pathological and inflammatory tissue was debrided from the socket and the site rinsed with a sterile saline solution. The extent of the ridge defect could be appreciated post-extraction (Fig. 3). A screw retained prosthesis had been planned and for its support a conical connection 4.5 x 11.5 mm endosteal implant (MegaGen AnyRidge) was then immediately placed into the site (Fig. 4). A flat abutment screw was fixed in place and a combination graft material consisting of particulate xenograft (Gen-Oss) mixed with A-PRF membranes cut into small fragments was placed onto and around the implant, augmenting the buccal and crestal ridge defect (Fig. 5). With the particulate bone in position, a titanium membrane (i-Gen, Megagen) was then positioned over the graft material and secured in place to the neck of the implant by a healing abutment screwed into the flat abutment (Figs. 6, 7). A-PRF membranes were then positioned over the titanium membrane to assist with soft tissue healing (Fig. 8). The flap was repositioned and passive closure by primary union achieved with 6-0 polypropylene sutures (Fig. 9). A postoperative regime consisting of Myprodol, 2 capsules taken 6 - 8 hourly as required, and a chlorhexidine antiseptic rinse used twice daily was administered for 5 days. A 10 day follow up with suture removal reported healing without incidence, without
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and function re-established with the graft procedure and the final healing (Fig. 17).

Discussion

Soft tissue aesthetics and long-term stability of the peri-implant tissues buccofacial to the implant supporting the restoration are largely dependent on the health and quantity of the bone. Grunder and Spray notably proposed the guidelines of bone ≥ 2 mm buccal and palatally to ensure long-term tissue stability. An alveolar ridge deficient in volume to accommodate the dental implant whilst providing untoward pain, signs of infection, oedema, nor perforation of the soft tissue (Fig. 10). The site was left to heal for a period of 4 months, whereafter the patient was recalled for removal of the membrane. The site was inspected and demonstrated no signs of tissue perforation by the titanium material (Fig. 11). With the site anaesthetized, an incision was made from the healing abutment’s buccal aspect to the membrane’s crestal fold only (Fig. 12), the healing abutment was removed, and the membrane retrieved with micro forceps (Figs. 13, 14). The flat abutment was also removed and a standard healing abutment then repositioned and the site again sutured closed (Fig. 15). An impression was taken of the implant for the fabrication of a lab manufactured provisional which was fitted 2 days later and the site was left to heal for an additional 2 months of soft tissue healing and development.

After the additional 2 months the ISQ readings demonstrated osseointegration of the implant, at 80B and 82P respectively. Postoperative CBCT evaluation demonstrated successful augmentation of the site with abundant bony tissue on the buccal aspect (Fig. 16) demonstrating a buccal ridge augmentation contour consistent with the anterior and posterior ridge and with good tissue stability. The patient was satisfied with the form and function re-established with the graft procedure and the final healing (Fig. 17).
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and populate a graft particulate faster than an immature blood supply can introduce cells that secrete osteoid which then requires significant time to mature and mineralize. Moreover, suturing the mucoperiosteum directly over the graft material without a barrier to achieve primary union may place tension on the underlying material that has increased the ridge volume. This scenario does not maintain space. Moreover, if primary union is not achieved, the graft material may spill from the site, defeating the purpose of the procedure, and as such it could be argued that the use of a barrier membrane is indispensable to maintain space and protect the graft. The use of barrier membranes for GBR around titanium implants has been reported in the literature for more than 25 years. Resorbable membranes, typically of xenogeneic collagenous material could contribute to achieving temporary stability, as a barrier between healing soft tissue and graft material, but do not provide any space maintenance, and the clinician cannot ensure its duration within the tissues and thus is wholly unsure of the procedure's predictability. This is owed to variation in tissue collagenase pH among patients, to variability in material resorbability, and to the membrane strength itself. Jason porcine pericardial membranes (Botiss) for example claim a stability for 12 - 24 weeks, while Altis porcine tendonous membranes (Altis Biogenics) state complete degradation at 16 weeks. These materials are organic and their infiltration by oral microbiota cannot be entirely prevented. Studies show that bacterial adherence to collagen membranes is higher than any other type of membranes, introducing a radical risk of graft infection and failure. By comparison, non-resorbable membranes are biologically inert. The materials may theoretically harbour microbes but...
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do not provide a nutritional source promoting graft infection. Of the more widely known materials, dense polytetrafluoroethylene (dPTFE) can provide separation between soft tissue and the grafted bone, can assist in sealing the wound when primary union will not be achieved, and if secured properly can stabilize the graft to support ingrowth of new vessels. DPTFE is malleable though and has no structural strength. dPTFE membranes modified by titanium for structural resilience are however commercially available and may provide the necessary space maintenance and aid graft stability. Adjunct to these are membranes wholly manufactured of titanium. The case demonstrated here utilized such a membrane of titanium sheeting that was fixed over the graft, secured in place by the implant fixture component itself, and it created the three essential factors needed for the graft’s success. Being structurally the most resilient in the membrane armamentarium the clinician is assured of it protecting the graft, supporting angiogenesis and cell ingrowth, and the maintenance of space is controlled by the clinician until its removal. If the GBR technique is applied correctly and the bone given adequate time to develop, the implant tissues’ stability and ultimately the long term aesthetic stability can be better assured.

The discussion would however be incomplete without noting the material’s disadvantages. These titanium membranes incur increased treatment cost, whereas suturing with the mucoperiosteum for example as a graft membrane incurs none. The material’s greatest advantage being its resilience, is also its greatest disadvantage. There is risk of perforating of the overlying soft tissues. Thus the use of titanium membranes may be best suited in thick gingival biotypes, or their use in thin biotypes should possibly be with an adjunctive connective tissue graft, or with A-PRF as in this case to support the soft tissue healing. As with any technique and material selection, the clinician is to be well informed of each to make best practice clinical decisions.

Conclusions
To achieve predictable long term aesthetic results around restored dental implants, the bone supporting the soft tissues requires volume. GBR when successful can provide the 2 mm or more required. The critical factors for GBR success are graft stability, space maintenance, and supporting the blood supply. Proper case selection coupled with the use of titanium membranes can produce positive results when grafting around dental implants.

Declaration
No conflicts of interest are declared.

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