

Integrating implants with natural teeth in a periodontitis patient with malocclusion: a clinical case report

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Abstract

Dental implants are a reliable solution for tooth loss, particularly in the anterior region, where functionality and aesthetics are crucial. However, challenges such as post-extraction bone loss complicate implant placement. Techniques like socket preservation and partial extraction therapy aim to mitigate bone resorption, but their long-term effectiveness remains uncertain. An alternative approach—connecting implants to natural teeth—has shown potential in preserving bone structure and simplifying treatment. While conventional protocols discourage this method due to biomechanical differences between implants and teeth, recent studies suggest it may offer advantages in some instances.

This article presents a case study of a 57-year-old patient with periodontitis and fractured maxillary central incisors. Implants were placed and connected to the lateral incisors, improving both function and aesthetics. A five-year follow-up showed stable periodontal conditions, no significant bone loss, and high patient satisfaction. Despite risks such as natural tooth intrusion and peri-implantitis, careful planning, regular maintenance, and the absence of systemic risk factors contributed to success. This case highlights the potential benefits of implant-to-tooth connections in anterior regions, emphasizing the need for further research to establish long-term outcomes and refine treatment protocols.

Keywords: implant-tooth connection; anterior implants; bone preservation; periodontal health



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Introduction

Dental implants provide a dependable substitute for lost teeth and are regarded as an efficient and popular remedy (1–15). However, these implants have the additional difficulty of meeting both functional and aesthetic requirements in the anterior region, especially the front teeth (16–30). In addition to fulfilling their essential function as prosthetic replacements in this area, where the teeth are visible, implants must blend perfectly with the surrounding natural dentition to provide a harmonious and natural-looking appearance (31–50). As a result, the cosmetic result of the treatment is crucial. The problems of bone loss after tooth extraction, which can make implant placement more complicated, have been addressed by recent developments in implantology (51–63). Two methods that try to slow down the gradual degradation of alveolar bone following tooth removal are socket preservation and partial extraction therapy (64–76). Sole conservation has been demonstrated to be a viable strategy to slow bone resorption. However, there is currently inadequate scientific data to support its long-term effectiveness (77–87). However, partial extraction therapy is known to be technique-sensitive. It carries its dangers, including the possibility of ankylosis or perforation of the remaining tooth root, even though it can assist in preserving the surrounding tissues (88–98).

Attaching dental implants to natural teeth is an alternate strategy that has attracted interest (99–109). Potential advantages of this connection include lowering the need for tooth extractions, stopping more bone loss, and maintaining the anterior region's cosmetic integrity (110–121). The integrity of the current natural dentition can be preserved by attaching the implant to a regular tooth (122–127). This could lead to superior long-term results, especially in maintaining function and look (128–135). Notwithstanding the benefits, this approach has encountered resistance and criticism, primarily because of the conventional Bränemark protocol, which suggests that implants should operate separately from natural teeth (136–139). Because of the possibility of difficulties, the protocol advises against using the natural tooth to support the implant (140–153).

However, not everyone agrees with this viewpoint (154–158). Lindh and other researchers have taken a more accommodating approach, arguing that, in certain circumstances, maintaining natural teeth and joining them to implants may be a good course of treatment (159–167). According to a 2000 consensus study by Belser et al., connecting implants to natural teeth should only be considered in extreme cases (168,169). Despite this warning, research is still being done to assess the results of this strategy, with differing opinions regarding its advantages and disadvantages (170–183).

According to research by Lang et al., the loss rate for implant placements alone was 0.94%, whereas the loss rate for implant-natural tooth connections was 2.1% (184–203). These results suggest that implants positioned separately and unattached to natural teeth typically fail less frequently (204–213). On the other hand, La Monaca et al.'s meta-analysis revealed no

appreciable variations in the rates of complications between single implants and those attached to natural teeth, including abutment failure, mechanical or biological problems, prosthesis loss, and other difficulties (214–229).

This implies that joining implants to natural teeth might not always lead to worse results. It might be advantageous in some circumstances, significantly if it simplifies the treatment process by lowering the procedure's complexity or related expenses (230–243).

According to another meta-analysis by Alsabeeha et al., the connection between implants and natural teeth was linked to greater preservation of the peri-implant bone, which suggests that such linkages may help achieve better long-term hard tissue outcomes (244–247).

This offers more proof that joining natural teeth with implants may have benefits, especially in terms of preserving bone mass and avoiding excessive tissue resorption (248–251). Though numerous studies have examined the relationship between natural teeth and implants in different areas of the mouth, no systematic review has been done on the subject, and the only research specifically focusing on the anterior region is case reports (252–254).

The functional and cosmetic stability of the periodontal tissues over five years is the subject of a case study presented in this article (255–261). After the maxillary bilateral central incisors were extracted, dental implants were placed and connected to the bilateral lateral incisors as part of the procedure (262–264). Regarding the patient's smile's aesthetic appeal and the long-term stability of the periodontal tissues, the case was linked to positive results (265–267). By using this instance, the authors hope to shed light on the possible advantages of joining implants to natural teeth in the anterior region and show that, with careful planning and execution, this strategy can produce positive results (268–277).

Case Presentation

In January 2016, a 57-year-old woman came to the Namiki-dori Dental Clinic complaining of pain in her maxillary anterior teeth as she chewed. Her maxillary bilateral central incisors had porcelain-fused-to-metal (PFM) restorations placed at another clinic. She didn't seek treatment because she didn't feel any pain, but she did notice some swinging in her teeth over the previous two years. She did not have a history of systemic disease or smoking.

Upon initial examination, the left lateral incisor displayed cavities, and the porcelain restorations on the maxillary central incisors and left lateral incisor were detached (Figure 2). The patient also had crowded teeth and a sinus tract on the buccal side of the right central incisor. Radiographs revealed fractures in the central incisor roots and considerable bone loss surrounding the maxillary incisors (Figure 1. a,b).

The patient was diagnosed with stage 4 periodontitis (grade C), malocclusion (Angle class 1 with crowding), and bilateral maxillary central incisor root fractures (Figure 3).

After discussing treatment options, including implants, fixed partial dentures, and removable dentures, the patient decided on implants as a long-term solution.

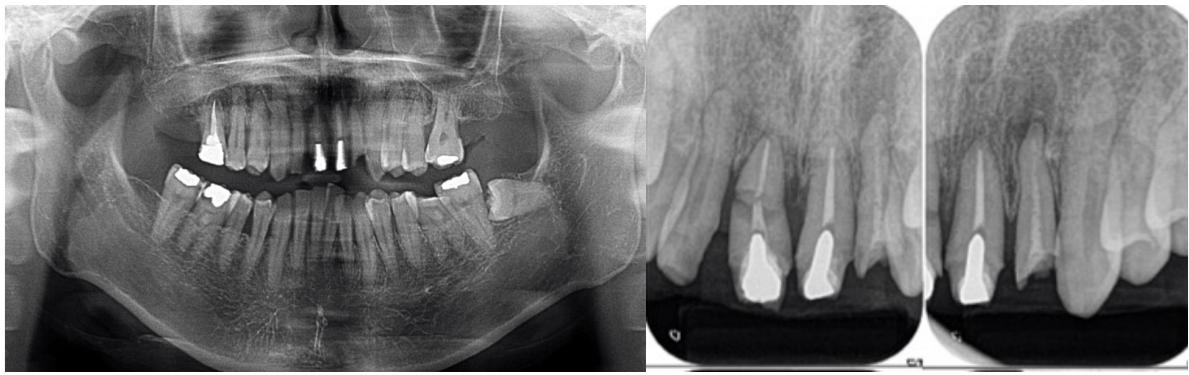


Figure 1. Panoramic radiography before treatment (a) and periapical radiography of teeth 1.1, 1.2, 2.1, 2.2, 2.3, 2.4 (b).



Figure 2. Intraoral photographs at the initial examination.

Removable dentures raised questions regarding functionality and appearance, but fixed dentures would necessitate drilling the nearby canines and lateral incisors. Following the extraction of the central incisors, the patient's maxillary lateral incisors would be less stable if left independent due to their poor crown-root ratio. Attaching them to implants would aid in maintaining functional stability. Digital simulation was used to plan implant placements before orthodontics, allowing implants to act as orthodontic anchors and cutting down on treatment duration (Figure 4).

1. Using lateral cephalometry to ascertain the occlusal plane and incisal edge position was part of the intended method.
2. Aligning the anterior teeth with the McNamara line.
3. Determining implant location by digital wax-ups and preoperative simulation.
4. Using a surgical guide to position the implants.
5. The use of autologous bone and membrane for bone repair.
6. Performing a connective tissue transplant to guarantee sufficient soft tissue thickness.
7. Starting orthodontic therapy (OT).

Mobility		0	1	2	1	1	3	1	1	1	1	1	1	1	1
Plaque	labial	██████	██████	—+—	+++	—-—	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+
	lingual	██████	██████	—+—	—+—	—-—	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+
Bleeding on probing	labial	██████	██████	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—
	lingual	██████	██████	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—
Pocket depth	labial	██████	██████	444	435	536	534	446	766	333	344	334	535	346	665
	lingual	██████	██████	645	544	664	534	546	666	564	534	544	554	434	656
Tooth number		18	17	16	15	14	13	12	11	21	22	23	24	25	26
		27	28												
Tooth number		48	47	46	45	44	43	42	41	31	32	33	34	35	36
Pocket depth	lingual	██████	445	545	435	435	533	334	343	455	444	333	336	234	365
	labial	██████	544	563	434	533	446	633	444	565	633	433	432	423	433
Bleeding on probing	lingual	██████	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—
	labial	██████	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-—	—-+
Plaque	lingual	██████	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+
	labial	██████	+—	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+	+—+
Mobility		1	1	1	1	1	1	1	1	0	1	1	1	2	

Figure 3. Periodontal examination before the treatment.

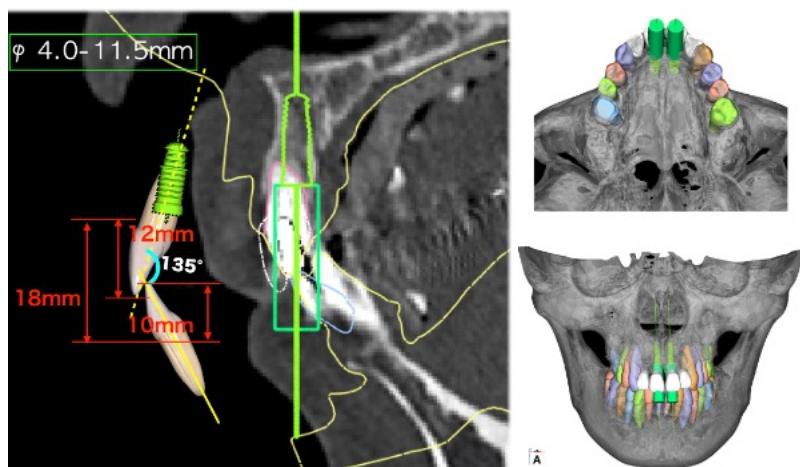


Figure 4. Digital setup of implant placement position.

8. The final positioning of the prosthesis.

The first periodontal therapy, root canal treatments (RCTs), caries treatments, and temporary prostheses were started in February 2016. After scaling and root planing, the patient had periodontal regeneration therapy for the maxillary molars. Computed Tomography (CT) and cephalometric (CE) images created an

exact implant placement plan. Using a surgical guide, autologous bone, and a bone-regenerating membrane, implants were inserted in December 2016. The left implant was placed near the neighboring tooth.

After the second round of implant exposure in March 2017, a connective tissue transplant was performed to increase soft tissue volume (Figure 5 a,b). OT started

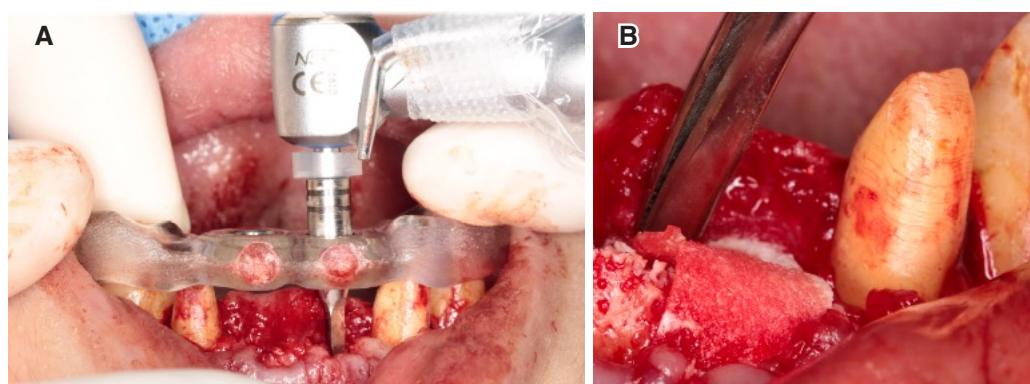


Figure 5. Implant placement (a) and guided bone regeneration(GBR) (b).

once temporary restorations were put in place. The orthodontic therapy was finished in February 2018. There were no clinical problems even though the implant was placed very close to the neighboring tooth. Because screw retention was difficult, final porcelain-fused-to-zirconia (PFZ) restorations were installed, and the implant was cemented in place. The patient's aesthetic look significantly improved after the prosthetic treatment (Figure 6 a,b). Every three months, maintenance appointments were planned. The periodontal condition remained steady at the five-year follow-up, the gingival tissue did not exhibit any notable changes, and the neighboring teeth continued to function (Figure 7 a,b,c,d).

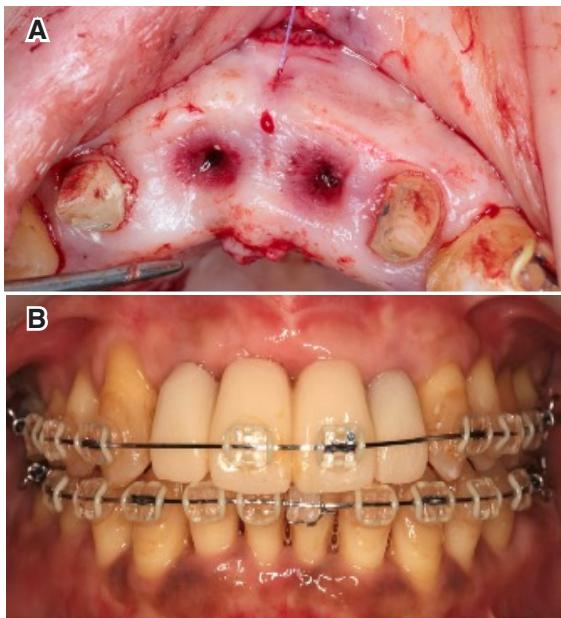


Figure 6. Connective tissue grafting (A) and orthodontic treatment (B)

Discussion

In the anterior region, where these connections are less frequently described, this example emphasizes the difficulties and factors to be considered when attaching dental implants to natural teeth (278–281). Extensive tissue regeneration procedures were unnecessary since the bond between implants and natural teeth stopped the hard and soft tissues surrounding the lateral incisors from resorbing (282–291). This made it possible to use a shorter and less invasive treatment plan (292–295).

However, some risks are associated with linking implants to regular teeth, including crestal bone resorption, natural tooth loss, implant failure, prosthesis loss, and intrusion of natural teeth (296–303). The biomechanical distinctions between implants and natural teeth cause these issues (304,305) (306,307).

Implants are inflexible and lack the flexibility of natural teeth, which are maintained by the periodontal ligament and can move slightly under pressure (308–310). Because implants can move more under strain, natural teeth may intrude when attached (311–314).

Several theories explain natural tooth incursion when attached to implants, including the stress wave theory, the differential energy dissipation hypothesis, and the reduced rebound memory theory (315–318). Although these hypotheses provide plausible answers, more investigation is required to completely comprehend the mechanics (319–321).

Because front teeth receive lower occlusal stresses than molars, load-related issues are less severe in the anterior region despite these hazards (322–324). However, long-term success is still significantly impacted by bacterially induced bone loss, especially when it comes to periodontal disease and peri-implantitis(325) (326–335). The bone around anterior teeth is more susceptible to resorption because of its thinner thickness,

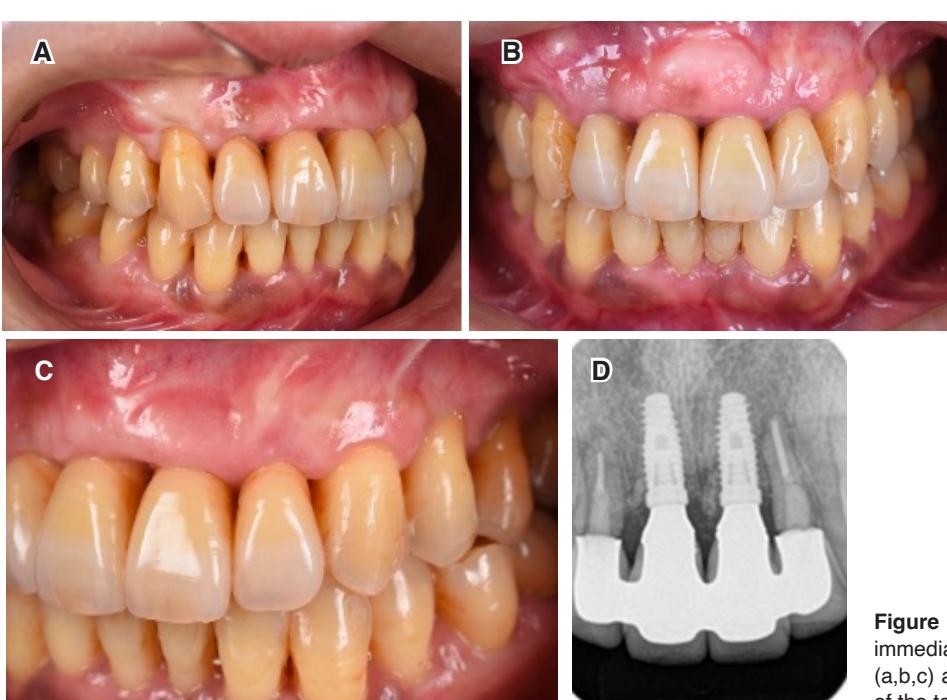


Figure 7 Intraoral photographs immediately after the treatment (a,b,c) and periapical radiography of the teeth 1.1,1.2,2.1,2.2 (d).

particularly on the buccal side (336,337). Maintaining the stability of the implants depends on preventing bone loss through routine dental care and monitoring (338,339).

In this instance, follow-up consultations were scheduled every three months to evaluate the patient's oral health (340,341) closely. These visits enabled assessments of plaque control and early identification of conditions like gingivitis or peri-implant mucositis (342,343).

Following treatment, the patient's plaque management considerably improved, which helped explain why there was no bone resorption at the 5-year follow-up (344–346). The patient's absence of risk factors, including diabetes or tobacco usage, most likely helped with this (347–349).

The patient expressed happiness with the aesthetic results, which were also successful (350,351). On the other hand, people with a history of diabetes or smoking can be more susceptible to peri-implantitis and periodontal disease, which could harm the implants and the tissues around them (352–355). In this instance, the favorable result was facilitated by the patient's absence of certain risk factors (356) (357).

Another crucial element in this case's success (358) was the use of implants as orthodontic anchors. Implant implantation before orthodontic treatment has been found to shorten treatment duration overall, particularly in the anterior esthetic zone (359) (360). Compared to the typical 14–16 months for orthodontic treatment without implants, the treatment period in this case was shortened by about 8 months (361). The reduction was made possible by careful preoperative planning, which included computer simulations and wax-ups (362,363). This allowed for precise implant placement and successful orthodontic treatment (364,365).

After five years, there are no discernible alterations in the gingival tissues or bone resorption, suggesting a

favorable long-term prognosis (366,367) (368): preoperative planning, implant implantation, and orthodontic treatment improved appearance and functionality (369,370). More research is necessary to completely comprehend the long-term consequences of joining natural teeth to implants in the anterior region (371,372). Despite its potential, this therapeutic approach necessitates close observation and documentation because of the paucity of available data (Fig. 8 a,b,c,d) (373,374). In conclusion, patients who have lost anterior teeth may find that attaching implants to their natural teeth is a successful therapeutic option (375,376). It has several advantages, such as maintaining periodontal structures, cutting treatment time, and producing beautiful results (377,378). However, hazards associated with the biomechanical distinctions between implants and natural teeth must be carefully considered (379) (380) (381). This method may be a good choice for anterior tooth replacement if planned, carried out, and continuously monitored (382,383). More study is required to maximize this therapy approach and reduce problems (384,385, 386, 387, 388, 389).

Conclusion

When several maxillary anterior teeth are lost, connecting implants to natural teeth may be a successful treatment option. This method provides patients with a quick, easy, and visually beautiful option while preserving the periodontal systems that surround natural teeth.

List of Abbreviation

Abbreviation	Meaning
CT	Computed Tomography
CE	Cephalometric
GBR	Guided Bone Regeneration
OT	Orthodontic therapy

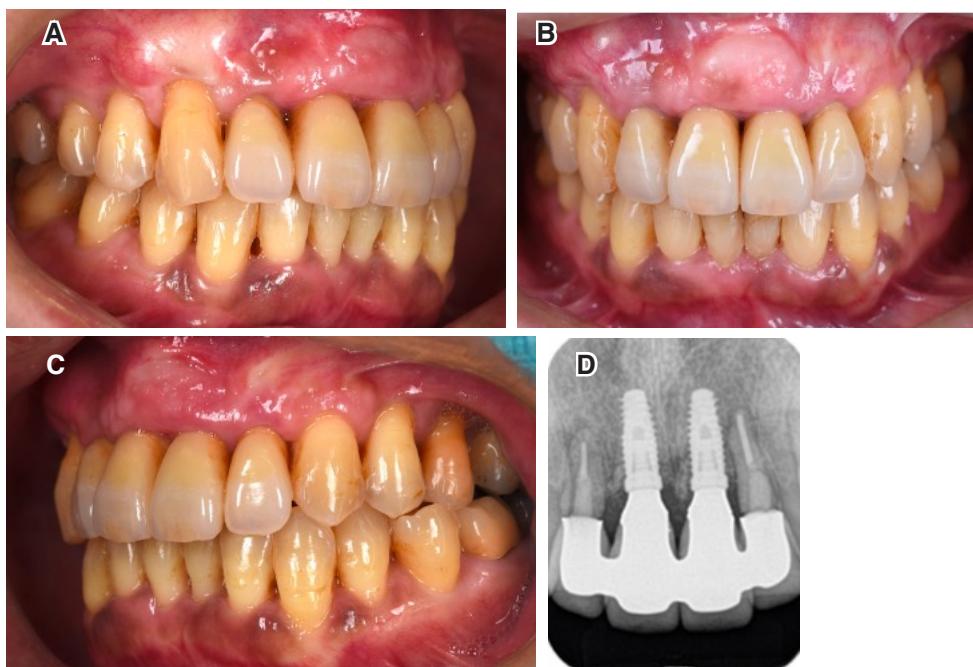


Figure 8. Intraoperative photographs 5 years after the treatment (a,b,c) and periapical radiography of the teeth 1.1,1.2,2.1,2.2 (d).

PFM	Porcelain-Fused-to-Metal
PFZ	Porcelain-Fused-to-Zirconia
RCT	Root Canal Treatment

Institutional review board statement

Not applicable.

Informed consent statement

Not applicable.

Data availability statement

Data are contained within the article.

Conflict of interest

The authors declare that they have no conflict of interest.

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