Occlusive barriers in bone regeneration: review of the literature

Arianna Fiore[1]*
Liviana Balestriere[1]*
Filippo Cardarelli[1]
Nicola Sguera[1]
Lucia Memè[2]
Fabrizio Bambini[2]
Ioana Roxana Bordea[3]*
Micaela Del Vecchio[1]
Gustavo Vincentis Oliveira Frenandes[4]
Erda Qorri[5]
Lwai Almasri[7]
Marwa Alkassab[8]
Maher Almasri[8]
Andrea Palermo[5]**

[1] Department of Interdisciplinary Medicine, University of Bari "Aldo Moro" Bari, Italy.
[2] D.I.S.C.O. School of Dentistry, Polytechnic University of Marche, Ancona, Italy.
[3] Department of Oral Rehabilitation, Faculty of Dentistry, Iuliu Hațieganu University of Medicine and Pharmacy, Cluj-Napoca, Romania.
[4] Missouri School of Dentistry & Oral Health, A. T. Still University, St. Louis, MO, United States
[5] Department of Dentistry, Faculty of Medical Sciences, Albanian University, Tirana, Albania.
[7] King's College London, U.K.
[8] The The University of Buckingham, U.K.
[6] University of Salento, Lecce, Italy

Corresponding author: Ioana Roxana Bordea
e-mail: roxana.bordea@ymail.com

*These authors contributed equally as first authors.
**These authors contributed equally as the last authors

Abstract

Alveolar healing post-extraction is critical for implant success, especially in cases of severe bone resorption. Before implant therapy, alveolar healing was often overlooked. Today, bone augmentation techniques, including occlusive barriers, have improved bone regeneration outcomes. Customized titanium barriers, in particular, offer an innovative solution, overcoming the limitations of traditional membranes and enhancing the predictability and stability of long-term results in implant dentistry.

An online literature search was conducted using PubMed, Medline, and Google Scholar, focusing on studies from 1970 to 2023. The search included articles on bone regeneration, GBR (Guided Bone Regeneration), and occlusive titanium barriers. Inclusion criteria focused on recent studies and clinical cases, and information was gathered from the official websites of developers in the field.

Occlusive barriers in GBR have resolved many challenges of previous techniques, such as soft tissue perforation and the need for additional surgery. Recent studies show that titanium barriers, especially those customized with CAD/CAM technology, significantly enhance bone regeneration while reducing complications. These barriers prevent collapse at the regeneration site and allow the use of temporary prostheses during healing.

Occlusive titanium barriers have shown promising results for bone regeneration, overcoming the limitations of previous methods. This technique reduces the risk of perforations and complications and allows for temporary prostheses during healing. While further studies are needed, initial results indicate that occlusive

Authors

Arianna Fiore - Liviana Balestriere - Filippo Cardarelli - Nicola Sguera - Micaela Del Vecchio - Department of Interdisciplinary Medicine, University of Bari "Aldo Moro" Bari, Italy

Lucia Memè - Fabrizio Bambini - D.I.S.C.O. School of Dentistry, Polytechnic University of Marche, Ancona, Italy

Ioana Roxana Bordea - Department of Oral Rehabilitation, Faculty of Dentistry, Iuliu Hațieganu University of Medicine and Pharmacy, Cluj-Napoca, Romania

Gustavo Vincentis Oliveira Frenandes - Missouri School of Dentistry & Oral Health, A. T. Still University, St. Louis, MO, United States

Erda Qorri - Department of Dentistry, Faculty of Medical Sciences, Albanian University, Tirana, Albania

Lwai Almasri - King's College London, U.K.

Marwa Alkassab - Maher Almasri - The University of Buckingham, U.K.

Andrea Palermo - University of Salento, Lecce, Italy

How to Cite
A. Fiore, L. Balestriere, F. Cardarelli, N. Sguera, L. Memè, F. Bambini, I.R. Bordea, M. Del Vecchio, G.V.O. Fernandes, E. Qorri, L. Almasri, M. Alkassab, M. Almasri, A. Palermo. Occlusive barriers in bone regeneration: review of the literature.
Oral and Implantology
Vol. 16 No. 3 (S1) (2024), 322-336.
https://doi.org/10.11138/oi.v16i3 (S1).82

barriers are highly effective, especially for vertical ridge augmentation, improving long-term implant therapy success.

Keywords: Bone Augmentation, GBR, Guided Bone Regeneration, Resorbable Membranes; Titanium Barriers, Non-Resorbable Membranes, CAD/CAM Barriers

Introduction

The alveolar process is influenced by various factors that affect its function and integrity. Before implant therapy, alveolar healing post-extraction was often overlooked, but with implants, particularly in cases of severe bone resorption, it has become a key challenge (1–4). Clinicians now use protocols to minimize resorption or correct bone issues (5–10). Successful augmentation procedures focus on bone's biological and physical principles to enhance regeneration. Bone grafts, crucial for healing defects or augmenting atrophic ridges, are a gold standard in implant dentistry (11–18). Bone augmentation aims to ensure sufficient bone volume around implants for long-term stability and aesthetic outcomes (19–24, 294). The radiographic classification of bone quality and quantity by Lekholm and Zarb is commonly used for the preliminary evaluation of treatment options (25–31, 293, 294). Bone quality is typically classified into four types based on the radiographic assessment of cortical and trabecular bone (32–37):

- Type 1: Fully homogeneous compact bone (38–40).
- Type 2: Thick, compact bone surrounding a dense trabecular bone core (41–47).
- Type 3: Thin, compact bone surrounding a dense trabecular bone core (48–54).
- Type 4: Thin, compact bone surrounding low-density trabecular bone (55–60).

The classification of bone atrophy includes five categories:

- A: Nearly intact alveolar ridge (61–67).
- B: Limited resorption of the alveolar ridge (68–73).
- C: Advanced resorption of the alveolar ridge (74–77).
- D: Initial basal bone resorption (78–83).
- E: Extreme basal bone resorption (84–88).

Rehabilitating edentulous patients with osseointegrated implants has revolutionized dentistry, significantly improving their quality of life (89–91). Various therapeutic options are available for regenerating lost bone tissue, including particulate grafts, guided bone regeneration (GBR), onlay and inlay bone grafts, sinus lift techniques, ridge expansion, and osteogenic distraction (92–96, 292). The primary aim of these procedures is to restore lost bone, facilitate the placement of implants, and ensure that the implants integrate fully and remain stable during functional loading (97–104).

The use of grafts plays a critical role in achieving implant therapy's primary and secondary goals. The primary goal is undoubtedly the long-term maintenance of functionality and aesthetics. In contrast, secondary goals include completing the treatment with as few surgeries as possible, minimizing patient morbidity, and reducing healing times (105–109). However, the choice of technique depends on the amount and quality of bone required for the defect, the surgeon's experience, the patient's overall health, and their specific circumstances (e.g., patient type and motivation) (110–115).

GBR is one of the most widely used techniques for reconstructing alveolar bone structure and treating peri-implant bone deficiencies (116–122).

GBR: Concept and History

When osseointegrated implants were first introduced, most patients treated were fully edentulous (123–130). Over time, the indications for implants have expanded significantly to include single-tooth replacements (116,131–135). Bone regeneration techniques were developed to achieve favorable bone height (136–142). Bone regeneration involves a series of biological events, including bone induction and conduction, involving various cell types and intracellular and extracellular signaling pathways to optimize skeletal repair and restore function (143–150).

Pioneering studies on periodontal tissue healing after surgical therapy by Nyman and Karring in the early 1980s demonstrated that the type of tissue regenerated depended on the cells that migrated into the defined wound space (151–154). Since connective tissue cells proliferate faster than bone cells, membranes were developed to allow bone growth in the underlying space. The introduction of Expanded polytetrafluoroethylene (ePTFE) membranes, a bioinert material, facilitated GBR procedures and became a milestone in dental treatments (155–163). Despite initial complications such as membrane collapse and insufficient bone regeneration, new resorbable membranes, including polymeric and collagen membranes, were introduced to mitigate these issues and eliminate the need for a second surgery to remove non-resorbable membranes (164–166).

Materials for Guided Bone Regeneration

As previously mentioned, GBR is the most commonly used method for increasing bone volume in surgical procedures (167–171). Since bone is a relatively slow-growing tissue, fibroblasts and epithelial cells can spread more efficiently, forming connective tissue faster than osteoblasts can form bone. The biological mechanism underlying GBR relies on excluding unwanted cells from the wound site, allowing bone-forming cells to proliferate in the clot or grafted materials (172–175).

Selecting the appropriate graft and barrier membranes is crucial (176–180)for optimal clinical outcomes.

Bone Grafts

A bone graft is a tissue or material used to repair a defect or deficiency in bone contour and/or volume. Bone grafts and substitutes can be classified into four groups based on their origin: autografts (from the same individual), allografts (from a different individual of the same species), xenografts (from a different species), and alloplasts (synthetically produced). They can be used in particulate or block form (181,182).

Bone grafts for GBR must meet specific requirements: biocompatibility, adequate mechanical support for the membrane, biodegradability, and the ability to be replaced by the patient's bone (183–186). Autogenous bone, obtained from intraoral or extraoral areas, is considered the most predictable osteogenic material for bone regeneration, offering osteogenic, osteoinductive,

and osteoconductive properties (187–191). However, limitations such as morbidity, limited availability of donor sites, and unpredictable graft resorption necessitate the use of alternatives like allografts and xenografts (192–196).

Allografts obtained from the same species are advantageous because they are available in larger quantities and do not require a second surgical site (189,197–199). Xenografts derived from other species are biocompatible and osteoconductive. Lastly, biologically active elements like Platelet-Rich Plasma (PRP) and Platelet-Rich Fibrin (PRF) are gaining popularity for their growth factors that support bone regeneration and repair (200–204).

Membranes

For successful GBR, barrier membranes must fulfill several roles: exclusion of soft tissue cells, creation of space (tenting), provision of scaffolding for progenitor cells, stabilization of the clot, and support of the framework (205–207). The membranes can be either non-resorbable or resorbable (208,209).

- Non-Resorbable Membranes: e-PTFE membranes were the first widely used in GBR. These membranes are biocompatible and resistant to microbial colonization, but they require a second surgery for removal. Their main disadvantage is a higher complication rate related to soft tissue exposure (210–212).
- Resorbable Membranes: These membranes eliminate the need for a second surgery. Materials like collagen membranes (from bovine or porcine sources) and synthetic polymers are commonly used. While they offer lower patient morbidity, they may not maintain the barrier function as long as required (213–215).
- Titanium Mesh: Titanium mesh is a non-resorbable material with excellent mechanical properties. It prevents collapse and maintains volume under the membrane. Introduced in the 1960s, it is now used in customized forms to avoid complications related to soft tissue exposure and ensure more predictable bone regeneration (216–218).

Recently, “occlusive barriers” have been developed using advanced CAD/CAM technology. This allows for more effective and customized regeneration, especially in difficult-to-treat defects (219,220).

Materials and Methods

Search Analysis

An online literature search was conducted using PubMed, Medline, and Google Scholar with selected keywords. Relevant articles were also found through reference lists, success stories about occlusive barriers, and the official website of Osteophoenix, the group behind the bone augmentation technique using barriers.

Inclusion and Exclusion Criteria

Articles from 1970 to 2023 were analyzed, focusing on bone regeneration and the clinical foundations of Guided Bone Regeneration. The search included recent studies on resorbable, non-resorbable, and titanium membranes and clinical cases of titanium occlusive barriers. Due to the technique’s novelty, no published studies in high-impact journals exist.

Results

The review emphasizes significant developments in alveolar bone regeneration, with particular attention to applying occlusive barriers and guided bone regeneration (GBR). Barrier membranes are employed in the commonly used GBR procedure to keep soft tissue cells out and make room for bone growth. Titanium occlusive barriers, which offer a hermetically sealed environment that encourages significant bone volume and density growth, have shown excellent results in recent advances, especially for vertical ridge augmentation.

Unlike conventional membranes, titanium barriers do not require primary soft tissue closure, which lowers the risk of dehiscence and streamlines post-operative care. CAD/CAM technology improves precision by permitting bespoke barrier designs that guarantee the best fit and regeneration. Research indicates that by efficiently using the patient’s blood clot as an osteogenic media, these barriers do not require extra transplant materials.

Comparative analyses verify that occlusive barriers function better than porous membranes to attain dependable vertical bone regeneration. Significant bone development is regularly shown on radiographic evaluations, promoting long-term implant durability and functional results. Titanium occlusive barriers are a revolutionary development in alveolar bone regeneration techniques because of their streamlined process, less patient morbidity, and lack of transplant material requirements.

Discussion

Principle of Occlusive Barriers

The principle of occlusive barriers (ROG) involves creating a space with a barrier to allow bone growth. Initially, titanium meshes were considered porous to facilitate nutrient flow and vascularization. However, studies showed that fully sealed titanium chambers produced the same amount of bone as semi-permeable ones (221,222). The key issue remained the lack of space, which titanium-reinforced or Teflon membranes did not provide. Research demonstrated that larger, hermetically sealed titanium capsules produced more excellent bone regeneration than Teflon membranes (223–225). This led to the realization that barriers did not need to be permeable; a more significant “tent effect” produced better bone regeneration. Other studies showed bone growth was more efficient with resorbable biomaterials like blood clots. In contrast, similar bone formation was found in both blood clots and Bio-Oss, with Bio-Oss yielding denser tissue (226–229).

Titanium is ideal for making these barriers due to its biocompatibility, inertness, and ability to support osteoconduction, allowing bone to grow and adhere to it. Recent advancements in digital dentistry enable precise custom titanium barrier fabrication using CAD/CAM technology. This process involves scanning, designing, and 3D printing titanium barriers, followed by post-processing for optimal fit and surface texture to encourage bone regeneration (230–233).

Surgical Technique

In addition to occlusive barriers, manufacturers provide stereolithographic resin models to help clinicians plan the surgical technique for barrier placement. This preliminary

phase is critical for success, as each case is unique (234–237, 295).

The procedure, performed under antibiotic coverage with local anesthesia, begins with a crestal incision and full-thickness flap elevation. If a tooth extraction is needed, it is recommended on the same day to take advantage of the osteogenic potential, though regeneration can also be delayed (238–240, 291). In a typical case, the barrier is placed about 5 mm below the residual bone ridge, filled with the patient's blood clot. A stabilizer like beta-tricalcium phosphate may be added. The barrier is then gently adjusted for a perfect fit, and titanium screws are used to secure it to the bone (241–244).

A key aspect of vertical regeneration is flap suturing. The barrier creates a sealed environment for bone growth, and no primary closure of the soft tissues is needed, which is a significant advantage (232,245–248). The sutures are removed after 7-10 days, and the exposed barrier remains intact without compromising bone regeneration (249–255). Post-operative care involves external cleaning with chlorhexidine and internal irrigation using hydrogen peroxide (256–263). The barrier is removed four months later, and radiographic checks confirm successful bone and connective tissue regeneration, with mucosal tissue covering the area (264–273).

Comparison Between Barriers and Membranes

The CAD/CAM technique was introduced in bone regeneration with titanium meshes. Previous studies created custom perforated barriers based on CT scans, while other occlusive barrier techniques allow broader access to processing software and customized design (274–280). Unlike titanium meshes, which are perforated for nutrient flow, these barriers are fully occlusive, following the principles of impermeability for proper bone regeneration (281–283). The barrier can be left exposed, avoiding the need for primary tissue closure and preventing dehiscence or premature removal (284–286). This method promotes bone and connective tissue formation without requiring grafts, as the patient's blood clot suffices. Studies show significant bone gain and stability over time, confirming this technique's effectiveness, especially for vertical ridge augmentation (Table1) (287–290).

Conclusions

Occlusive barriers have shown promising results in bone regeneration. This practical and simple technique addresses the limitations of previous methods. While further investigation is still needed, this approach presents clear clinical advantages.

- No risk of soft tissue perforation: The occlusive barrier eliminates the risk of soft tissue compromise during regeneration.
- No collapse or grafting needed: The barrier prevents collapse at the regeneration site and eliminates the need for additional grafting.
- Allows for temporary prostheses: Temporary prostheses can be used during regeneration without compromising the technique's success.

Abbreviations

CAD/CAM - Computer-Aided Design/Computer-Aided Manufacturing
CT - Computed Tomography
ePTFE - Expanded Polytetrafluoroethylene
GBR - Guided Bone Regeneration
PRF - Platelet-Rich Fibrin
PRP - Platelet-Rich Plasma

Funding Statement

This research received no external funding.

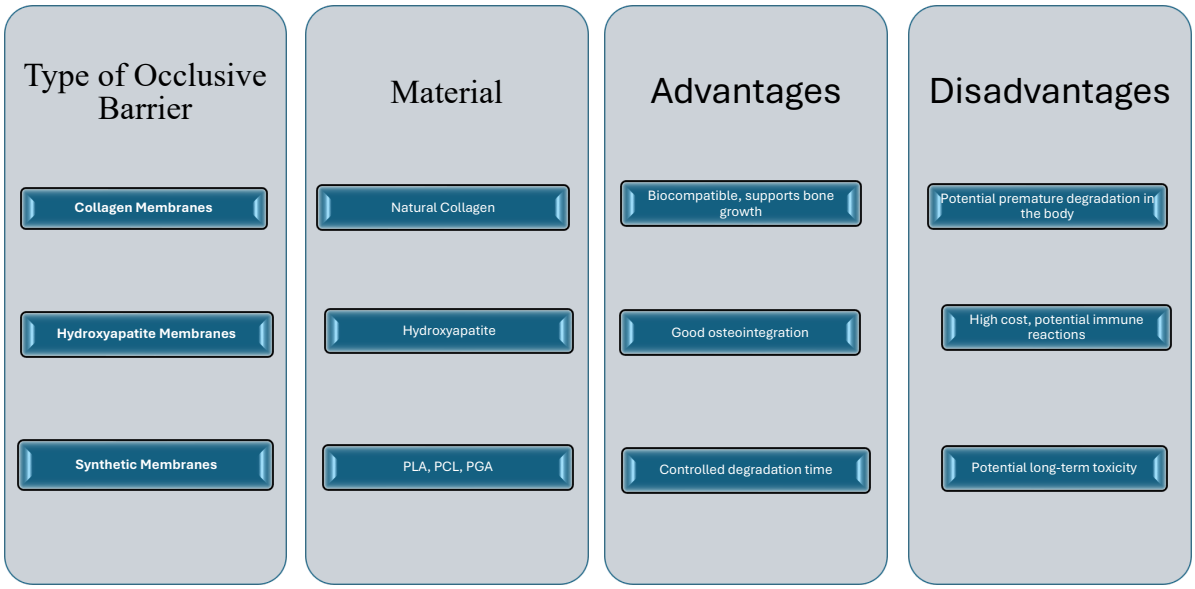
Data Availability Statement

Not applicable.

Conflicts of Interest

The authors declare no conflict of interest.

Table 1.



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