

Letters to the editor

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Top tips

Unscientific statements

Sir, I read with interest the recent 'Top tips for managing implant complications in primary care' article (*Br Dent J* 2023; **235**: 299–301). This is an important topic which is why it was disappointing to find so many statements that are unscientific, not evidence-based or inaccurate. I have highlighted the most important below:

1. Alveolar ridge preservation (ARP) does not promote retention of alveolar bone or influence the bone remodelling process. Post-extraction remodelling is a natural process driven by haemostasis, inflammation, migration/proliferation of osteocompetent cells and remodelling. It is not promoted/influenced by ARP (or implant placement). What ARP provides, compared to natural healing alone, is a purely physical dimension advantage. The latest Cochrane systematic review identified the mean dimensional advantage as 1.18 mm horizontally and 1.35 mm vertically. Histomorphometry showed that most grafted sites demonstrated less new bone formation than non-grafted sites and many sites had high levels of residual graft and granulation tissue present¹
2. There is no evidence to support the concept of occlusal overload increasing the potential for marginal bone loss.² Various systematic reviews have failed to identify occlusal overload as a cause of marginal bone loss in subjects that maintain good oral hygiene.^{2,3,4}
3. Chronic sinusitis due to perforation of the Schneiderian membrane during implant placement is extremely rare. There are only a handful of case reports/case series from the global population of implantology. Most of these case reports, of chronic sinusitis are associated with

implants where sinus lift procedures have been undertaken in combination with implant placement rather than implant placement alone

4. The 2017 World Workshop on the classification of periodontal and peri-implant diseases characterised peri-implantitis as inflammation in the peri-implant mucosa and progressive loss of the supportive bone.⁵ Clinically, this means BOP and any further bone loss after remodelling following abutment/restoration connection. This is why a baseline radiograph, after abutment connection, is so important. It is only on subsequent follow-up (if no baseline radiograph is available) that the diagnostic criteria become a combination of bleeding and/or suppuration on gentle probing, probing depths ≥ 6 mm and bone loss ≥ 3 mm apical to the most coronal portion of the intra-osseous part of the implant⁵
5. The authors describe treatment of peri-implantitis as 'nonsurgical therapy', with surgical treatment described as 'pocket elimination, bone recontouring, implantoplasty and regenerative techniques'. Studies have shown that nonsurgical management of peri-implantitis is ineffective in the long-term.⁶ The purpose of a surgical approach in the management of peri-implantitis is to provide access to the implant to facilitate surface decontamination.⁷ There is low-level evidence to support surgical debridement over nonsurgical management.⁷ Systematic reviews have failed to show any benefit of chemical or physical adjunctive therapy (air-abrasion, laser or photodynamic therapy) or reconstruction of peri-implantitis defects over mechanical debridement alone.^{7,8,9}

R. Adams, Cardiff, UK

References

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See the response to this letter at <https://doi.org/10.1038/s41415-023-6618-7>.

<https://doi.org/10.1038/s41415-023-6609-8>

Missing the point

Editor-in-Chief's note: We asked the authors if they wished to respond to R. Adams's letter, 'Unscientific statements'. They do so below, pointing out that the context of their article was not a compendium of the evidence, but now including comprehensive references to back their case, which we publish in full in this particular circumstance.

Sir, thank you for the opportunity to respond to the feedback from R. Adams. Unfortunately, R. Adams has completely missed the point of this series of very