Endosseous dental implant fractures an analysis of 21 cases

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Received: 27/01/2007
Accepted: 6/12/2007

Summary
Implant fracture is an infrequent cause of implant failure. The present study evaluates 21 fractured implants, with an analysis of patient age and sex, the type, length and diameter of the implant, positioning in the dental arch, the type of prosthetic rehabilitation involved, the number of abutments and pontics, the presence or absence of distal extensions or cantilevers, and loading time to fracture.

Implant fracture was more common in males than in females (15:4), and the mean patient age was 56.9 years. Most cases (n = 19) corresponded to implant-supported fixed prostheses - 16 with cantilevers of different lengths – while only two fractured implants were supporting overdentures instead of fixed prostheses. The great majority of fractured implants (80.9%) were located in the molar and premolar regions, and most fractured within 3-4 years after loading.

It is important to know and apply the measures required to prevent implant fracture, and to seek the best individualized solution for each case - though complete implant removal is usually the treatment of choice.

Key words: Dental implants, osteointegration, fracture.

Introduction
The incidence of dental implant fracture is between 0.16-1.5% of cases (1-11). There are two main causes of implant fracture: (a) Mechanical overload leading to metal fatigue. When the resistance limit is exceeded, fracture results. Overload can also be a consequence of patient physiological alterations (e.g., parafunctional activity). In effect, both centric and eccentric bruxism can lead to implant overload and metal fatigue. Other overload-related factors are of prosthetic origin, including inadequate occlusion, the presence of distal extensions or cantilevers in implant-supported prostheses, and a lack of prosthetic passive fit over the implants (4,10,12-14); (b) Peri-implant vertical bone loss (4,10,12,15,16), attributable to both chronic peri-implant inflammation and occlusal trauma. When vertical bone loss coincides with the apical limit of the screw joining transepithelial abutment to implant, the risk of implant fracture increases considerably (10). The present study analyzes dental implant fracture on one hand to avoid such complications, and on the other to define the best management solution when fracture effectively occurs.
Material and Method

Twenty-one implant fractures were documented, corresponding to the period 1985-2003. Different parameters were recorded for each case, including patient age and sex, the type, length and diameter of the implant, positioning in the dental arch, the type of prosthetic rehabilitation involved, the number of abutments and pontics, the presence or absence of distal extensions or cantilevers, loading time to fracture, and the presence of parafunctional activity. Lastly, the therapeutic solution offered in each case was analyzed.

Results

In a series of 1500 implants documented during the study period, we recorded 21 fractured implants, representing an incidence of 1.4%. Of these 21 fractured implants, 16 were of the Branemark® type (Nobel Biocare®, Göteborg, Sweden), 3 of the Screw-vent® type (Dentsply®, Core-Vent Implant Division, Encino, CA) and 2 of the Dyna® type (Dyna Dental Engineering b.v. Robouw, The Netherlands). Fractured implant length ranged from 10-15 mm, while the diameter was 3.75 mm in almost all cases (n = 20), versus 4 mm in a single case.

Males predominated over females (15:4), and the mean age was 56.9 years (range 45-81). Most of the fractures (n = 19) corresponded to implant-supported fixed prostheses - 16 with cantilevers of different lengths – while only two fractured implants were supporting overdentures instead of fixed prostheses (Figure 1). The great majority of fractured implants (80.9%) were located in the molar and premolar regions: 8 in the molar zone, 9 in the premolar region, and 4 in the canine area. Most implants fractured within 3-4 years after loading (Figure 2). Most patients with implant fracture (83%) presented bruxism.

As to the management approach adopted, 17 fractured implants (81%) were removed entirely with the help of explantation trephines. In four of these cases no further implant placement proved necessary, while in 8 cases additional implants were placed in the same surgical
intervention (Figures 3-9). In the remaining 5 cases, re-
generative techniques were used to prepare the bone bed
for posterior implant placement.
Four fractured implants were subjected to removal of the
coronal portion, leaving the apical component integrated
in the maxillary bone (Figure 10). No case was managed
by removing the coronal portion of the fractured implant,
with posterior rectification of the apical fragment.

Discussion
The incidence of implant fracture in our series was 1.4%.
This percentage is in line with the figures reported in the
literature, since Pylant et al. (9) have reported an incidence
of 0.98%, while Goodacre et al. (10) reported 1.5%.
Although implant fractures are infrequent, it is important
to adopt measures to prevent them. In this context, a series
of factors should be taken into account, such as implant
location, diameter, the type of prosthesis, and the possible
existence of parafunctional activity.
Regarding implant location, Rangert et al. (4) reported
that 90% of fractured implants are located in the region
of the molars and premolars. While this percentage is
slightly greater than our own, it coincides in pointing to an increased prevalence of fractures in this region. Similar observations were made by Balshi (2), who found all implant fractures to occur in the area of the premolars and molars - no distinction being made between the upper and lower maxillas. In our series there were no variations in relation to either jaw.

Another important factor is implant diameter, since 20 of our 21 implants presented a diameter of 3.75 mm. In comparison, only one implant with a diameter of 4 mm suffered fracture, versus none of the larger-diameter implants. Both Eckert et al. (7,17) and Balshi (2) found all fractured implants to measure 3.75 mm in diameter. In this sense, it has been shown that an increase in diameter increases resistance to fracture (12).

Another factor to be taken into account is the type of prosthesis involved. It has been seen that many fractured implants supported fixed prostheses, and most moreover presented cantilevers of different lengths – in coincidence with the observations published by Eckert et al. (7). Possibly the stress and tension transmitted by fixed prostheses to the implants is greater than when removable prostheses are involved. In the same way, the presence of distal cantilevers can also increase the transmission of load and tension to the implants (2,4,10,12) – though fracture is also possible in the case of implants supporting fixed prostheses without cantilevers, as seen in our study, since 10% of the fractured implants supporting fixed prostheses presented no extension pontics.

The existence of occlusal parafunctional activity such as bruxism has been described as an etiological factor that generates mechanical overload directly related to implant fracture (2,4,12). This was supported by the findings in our own series of patients, since 83% of the fractured implants corresponded to patients diagnosed with bruxism. Balshi (2) recorded an even greater incidence of parafunction. In effect, a full 100% of the implant fractures reported by this author corresponded to patients with bruxism.

In the event of implant fracture, three possible solutions have been described (2,10,12):
(a) Complete fractured implant removal with explantation trephines. The different commercial sources offer explanation trephines specifically adapted to the dimensions of their respective implants. Once the fractured implant has been completely removed, a new implant can be placed in the same surgical bed, or elsewhere. If the aim is to place a new implant in the same location, the external diameter of the explanation trephine must be taken into account, in order to insert an implant with a larger diameter and thus ensure primary stability.
(b) Another solution is removal of the coronal component of the fractured implant, leaving the remnant apical fragment integrated in the bone. If no further implants need to be placed, the prosthesis can be modified to ensure adequate fitting in the absence of the fractured implant.

References