

# **Evaluation of PEEK versus Titanium Bar Attachments with Implant Assisted Mandibular Complete Overdenture fabricated by CAD/CAM Technology**

Protocol of Thesis Submitted in Partial Fulfillment of the  
Requirements for  
Doctor Degree

**In  
Prosthodontics**

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2024

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# Introduction

Edentulism is considered a poor health outcome and may compromise the quality of life. According to the (World Health Organization) WHO, complete edentulism is affected by several factors including access to care, attitude towards dental hygiene, dentist/population ratios, oral health knowledge, education level, socioeconomic status, and lifestyle. The prosthetic management of the edentulous patient has been a major challenge for dentistry.<sup>1</sup>

The classical treatment plan for the edentulous patient is the conventional complete denture, this treatment has several complications that occur frequently due to several factors as an atrophic alveolar ridge, thin mucosa covering it, reduced bony support, muscular factors, age of the patient, and its influence on adaptation.<sup>2</sup> Wearing mandibular complete dentures (CD) is usually more problematic than maxillary CD because of the inherent displacing movement of the tongue and muscular borders, and decreased surface area. These problems direct the researchers to focus more on the lower jaw. Therefore, the problem of stability and retention of a complete denture is partially solved with the use of an overdenture.<sup>3</sup>

Implant dentistry has given hope to edentulous patients in obtaining a prosthesis which is adequately retained, stable and comfortable as well. Insertion of implants creates a more favorable environment for restoration in such patients. Implant assisted prostheses options for edentulous arch include implant supported fixed prosthesis and implant supported removable prosthesis. While the first offers many advantages like being esthetically pleasing and feels like a natural dentition, they are very expensive and not indicated in many conditions. Due to the severe loss of mandibular alveolar

ridge, provision of fixed prosthesis would be inadequate to compensate for the loss of both soft and hard tissue, thus compromising the facial aesthetics.<sup>4,5</sup>

With time, mandibular implant assisted complete overdenture IACO treatment has gained considerable acceptance. It is an attractive treatment option because of its relative simplicity, minimal invasiveness, and affordability. The prosthesis is supported by both implant and mucosa and generally requires fewer implants when compared with the totally implant-supported prosthesis design. Fewer implants and a removable prosthesis offer a less complex and less expensive option for an edentulous patient and more hygienic.<sup>6</sup>

The most common protocol used in IACO treatment is the placement of two implants in the anterior area of the mandible. This can be carried out in 2 ways. It can be splinted implants by bar attachments or unsplinted implants by stud type attachments<sup>7</sup>. Many factors affect attachment selection, such as jaw morphology, inter arch distance, the desired retention, prosthesis type, inclination and number of implants, financial options, and the availability for maintenance visits<sup>3</sup>. Bar attachment increases overdenture retention and is used to splint implants with the lowest complications in the prosthetic superstructure and maximum patient satisfaction. It offers stress-breaking action and cross-arch involvement, which allows occlusal forces to be shared between the abutments.<sup>9</sup>

Three root form implants are placed in the A, C, and E positions for the second overdenture treatment option (OD-2). The advantages of splinting A, C, and E implants compared with implants in the B and D positions are many. The additional implant provides a sixfold reduction in superstructure flexure and limits the consequences previously discussed. In addition, screw

loosening occurs less frequently because three coping screws retain the superstructure rather than two. Implant reaction forces are reduced with a third implant compared with two implants.<sup>9</sup>

The introduction and evolution of computer-aided designing and computer-aided manufacturing (CAD\CAM) technology in dentistry have greatly revolutionized treatment concepts and prostheses fabrication. Full digitalization leads to favorable clinical outcomes, better retention, fewer patient visits, potentially enhanced material properties and biocompatibility, advances in standardization of both clinical results and research, simplified identification of anatomical landmarks on digitized casts reproducible and less time-consuming tooth arrangements, easy data storage, and production of duplicate dentures<sup>10-12</sup>.

In the prosthetic field, the digital revolution has a strong impact because the dentist can capture optical impressions with IOS these impressions are used by the dental technician for the planning and hence the production of a whole series of prosthetic restorations Patients favors optical impressions, which have eliminated the need for conventional analog impressions with trays and materials. The optical impressions also eliminate the discomfort linked to the conventional analog impressions; they are easy to capture for the clinician. They can be sent directly to the dental laboratory by e-mail, at no cost. The dental technician can view the impressions and immediately give feedback to the clinician, while the patient sits comfortably in the dental chair with no time wasting.<sup>13-15</sup>

During the manufacturing of a conventional cast-bar attachment, dimensional changes can occur, associated with the impression-making and fabrication of an accurate dental cast, as well as the lost-wax casting protocol.

These dimensional changes (if poorly controlled) risk causing distortion.<sup>16</sup> Using CAD/CAM technology in overdenture prosthesis provides a computerized virtual bar design and modification, eliminating the laboratory steps such as casting and modelling. A good passive fit, lower distortion ratio and long-term success are observed in bar-retained overdentures produced with this technique.<sup>17</sup>

Various metals and alloys are commonly used in the fabrication of bar attachments. In the past, gold alloys were preferred but, due to their expensiveness and flexibility, this material is no longer preferred. Alternative materials for the fabrication of metal bar frameworks are: cobalt-chromium (Co-Cr), silver-palladium (Ag-Pd) alloys and titanium (Ti) and non-metallic restorations are used with metal allergy patients., Polyetheretherketone (PEEK) can be used as an alternative for a non-metallic framework.<sup>17</sup>

PEEK was first developed in 1978 as a thermoplastic, polycyclic, semi-crystalline polymer obtained by binding ketone and ether functional groups with aryl rings. It has superior mechanical properties, resistance to hydrolysis, chemical wear, and high temperatures with its low-weight advantage. The modulus of elasticity is close to alveolar bone and additional advantages are shock-absorbing. It is a biologically inert material with no evidence of cytotoxicity or immunogenicity. It also offers corrosion resistance, low plaque affinity, and minimal creep. Several studies reported that using PEEK as a bar attachment material has better results.<sup>17-20.</sup>

Retention is the first factor responsible for patient satisfaction with the prosthesis, and it is defined as that quality inherent in the dental prosthesis acting to resist the forces of dislodgment along the path of placement. (33%) of prosthodontic complications are related to loss of retention. The rate of

attachment wear is related to its material of construction, which should be wear-resistant to maintain a stable retention force over-time. It was concluded that the least accepted retention force gained by different attachment systems in implant-retained overdenture was between 5 and 8 N in the long-term function.<sup>2,20,21.</sup>

Research on OD3 is very rare. So the first null hypothesis of this study is that there is no significant difference in retention, the second null hypothesis is there is no significant difference in bone loss around implant and the third null hypothesis there is no significant difference in bar deviation between Titanium and PEEK bars fabricated by CAD/ CAM technology used with implant assisted mandibular complete overdenture.

## **Aim of the work**

Evaluation of OD retention, bone level around implant and bar deviation of PEEK versus Titanium Bar Attachments with Implant Assisted Mandibular Complete Overdenture fabricated by CAD/CAM Technology.



# **Materials and Methods**

## **Study design**

This study will be conducted as a clinical trial.

## **Study setting**

This clinical study will be carried out at the Prosthodontic Department, Faculty of Dentistry, Tanta University and CAD-CAM laboratory.

## **Patient selection:**

The patients will be selected from those attending the outpatient clinic of the Prosthodontic Department , Faculty of Dentistry, Tanta University on the following criteria:

## **Inclusion criteria**

- Completely edentulous patients free from systemic diseases that may affect soft or hard tissue healing.
- Patient's age ranges from 40 to 60 years old.
- The bone quality and quantity of the mandibular alveolar ridge must fulfill the criteria for implant placement.
- They have normal class I maxilla-mandibular relationship and sufficient inter-arch space with at least 25mm for bar attachment.
- They have good oral hygiene.

## **Exclusion criteria**

- Systemic disorders that may influence soft or hard tissue healing as oral diseases.
- Patients with history of radiation therapy in the head and neck region.
- Patients with neurological or psychological problems that may impair good oral hygiene.

- Patients with parafunctional habits.
- Patients with heavy smoking, alcoholism, and drug abuse.

### **Ethical consideration**

The purpose of the present study will be explained to the patients and informed consents will be obtained according to the guidelines on human research adopted by the Research Ethics Committee, Faculty of Dentistry, Tanta University.

### **Patient number selection (power analysis)**

The total number of sample sizes for this study is 12 samples. The significance level was 0.05 and the power sample size was more than 80% for this study and the confidence interval 95 % and the actual power is 95.79%. The sample size is calculated based on a previous study <sup>21</sup>; the calculations are done using a computer program G power version 3.

The formula of sample size

$$sample\ size = \frac{(\sigma_1^2 + \sigma_2^2) (Z_\alpha + Z_\beta)^2}{(\Delta - \Delta_0)^2}$$

Where:

$Z$  = Z value (1.96 for 95% confidence level)

$\alpha$  = alpha level (The significance level was 0.05 )

$\beta$  = beta level.

$\Delta$  = difference under the null hypothesis

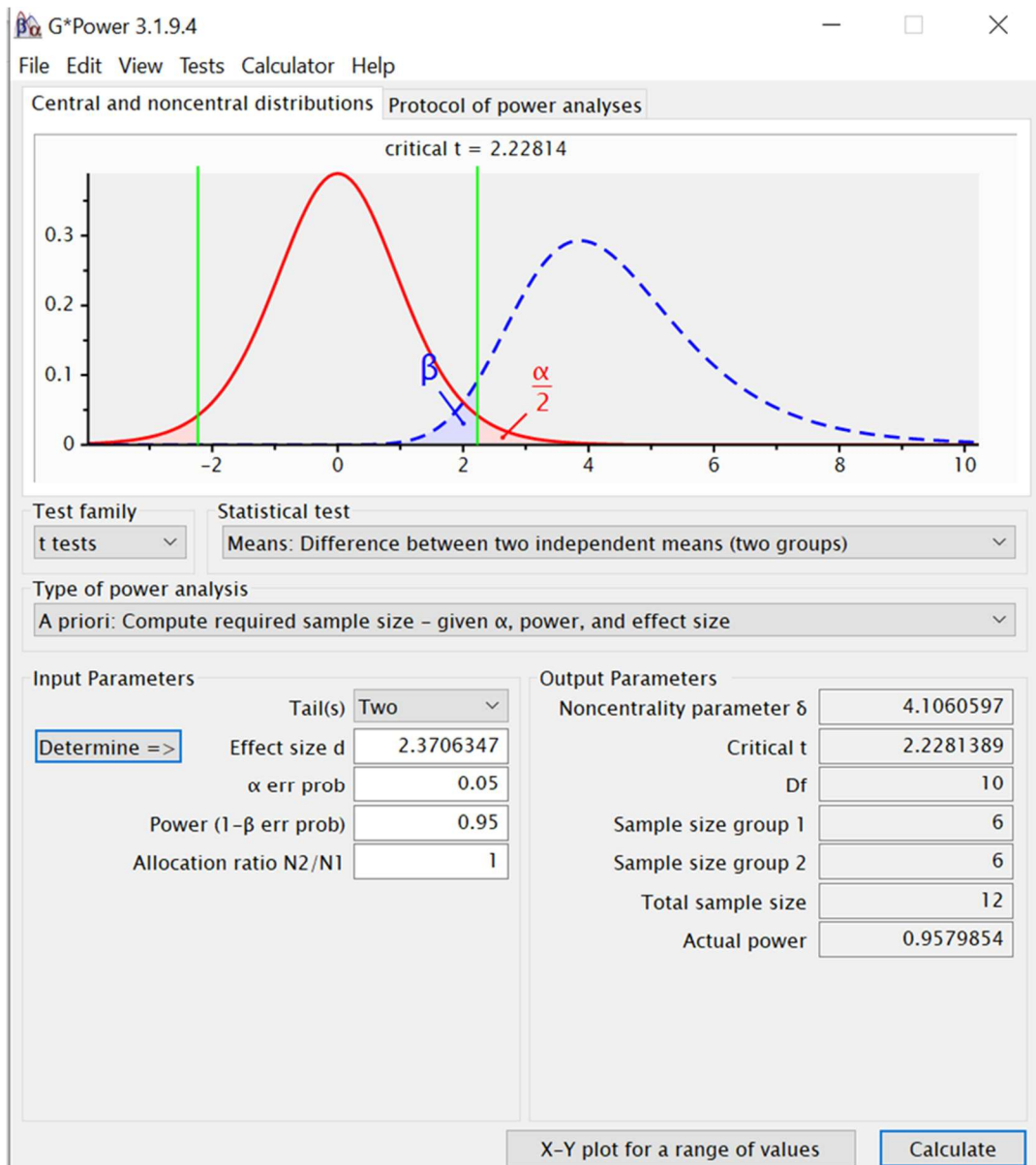


Fig1. Print screen of G power 3 software<sup>1</sup> showing samples size analysis

<sup>1</sup> G Power Analysis software, Heinrich Heine University Düsseldorf . Germany

## Prosthetic procedures

1. Accurate oral examination.
2. Conventional CD will be fabricated that will be needed for digital implant planning and surgical guide designing and fabrication.
3. Three relevant implants will be installed in ACE position in the mandible fig (2).

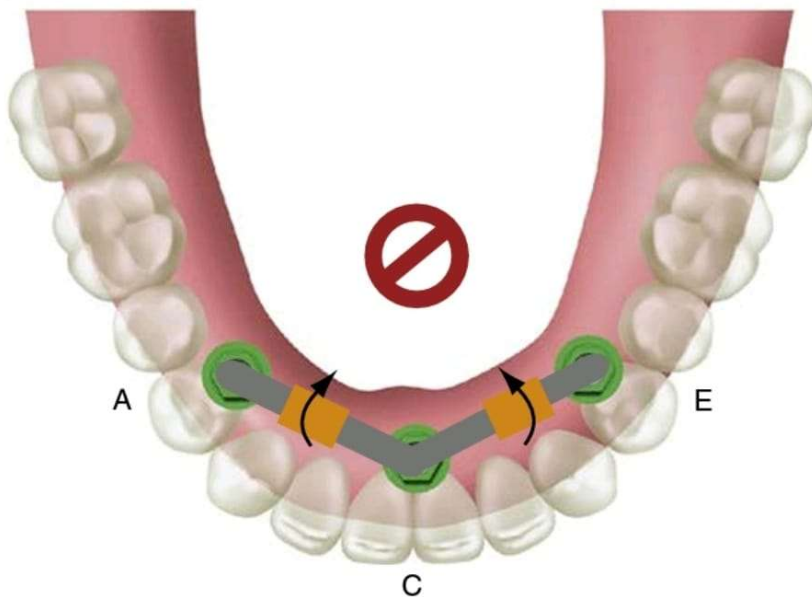


Fig (2) showing OD option 3 corresponds to implant in A, C,E positions are connected by bar.<sup>9</sup>

4. After 3 months healing and osseointegration. Intra oral scanning will be carried out using an intra oral scan body to transport the correct implant position to the designing software.
5. Hader bar will be designed.
6. 3d printed model will be fabricated and digital analogs will be cemented.
7. Verification jig will be fabricated and tried in the patient mouth.
8. After verification, the designed bar will be milled.

9. A complete overdenture will be designed on the virtual model with the virtual bar.
10. Conventional jaw relation will be performed and scanned by extra oral scan and the STL files will be stored in the software for virtual setting.
11. Digital try in will be printed and tried in the patient mouth.
12. The digitally designed complete overdenture will be completed digitally.
13. Finally, the milled bar will be tightened in the patient mouth and the female housing (clips) will be direct picked up.

### **Study groups.**

#### **Group I (control group):**

Six patients will receive digital mandibular implant overdenture assisted by CAD/CAM Titanium bar attachment.

#### **Group II (study group):**

Six patients will receive digital mandibular implant overdenture assisted by CAD/CAM PEEK bar attachment.

### **Methods of evaluation**

All patients will be evaluated radiographically, clinically, and digitally.

- **Radiographic evaluation**

Digital periapical X ray films will be carried out to measure marginal bone loss around implants at time of insertion of the prosthesis, after 6 months then after 1 year.<sup>22, 23</sup>

- **Clinical evaluation**

Retention of the complete overdenture will be evaluated clinically at insertion time, after 6 months and after one year of insertion. Retention force will be measure in Newton's using a digital retention testing device (Digital

force meter) \* which has wide range of force measurement (0-5000) gm, connect to a wire loop on the lower denture and pulled vertically.<sup>21</sup>

- Digital evaluation

The deviation of the bar attachments will be evaluated digitally by superimposition the STL files recorded by scanning the bar during follow up after six months then after 1 year over the reference data recorded at the time of insertion.<sup>24</sup>

### **Statistical analysis:**

Statistical analyses will be performed using Statistical Package for Social Sciences (SPSS version 26). Numerical variables will be expressed by descriptive statistics as mean, standard deviation, and range, nominal data will be represented by frequency, percent and median. P value <0.05(\*) was considered significant difference & P-value <0.001(\*\*) was considered highly significant difference.

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\*47544Lanetech Instrument, cooperation, Beijing

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# تقييم دعامة الببيك مقابل دعامة التيتانيوم مع الطقم السفلي الكامل المحمل على غرسات مساعدة المصنّع بتقنية الكمبيوتر

خطة بحث مقدمة استيفاء جزئيا للحصول على درجة الدكتوراة

في  
الاستعاضة الصناعية

مقدمة من الطبيب

**نورالهدى ابراهيم ابوالعزم**

بكالوريوس طب وجراحة الفم والاسنان عام 2014

ماجستير الاستعاضة الصناعية جامعة طنطا 2022

قسم الاستعاضة الصناعية

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# الملخص العربي

## مقدمة

يعاني مرضي فقدان الاسنان الكلي من كثير من المشاكل مثل صعوبة المضغ و الكلام و تغير الشكل لذلك يسعون لتعويض فقد هذه الاسنان.

قد اعطي غرس الاسنان املا جديدا لهذه الفئة من المرضى من ناحية تحسن المضغ و الكلام وثبات الطقم و الحفاظ علي عظم الفك لذلك تعتبر الأطقم الكاملة المحملة علي غرسات مساعدة ومتصلة بالدعامة خيار جيد لعلاج هذه الحالات.

أثناء تصنيع الدعامة الصلبة التقليدية، يمكن أن تحدث تغييرات في الأبعاد، ترتبط بأبعاد المقاسات، وتصنيع قالب أسنان دقيق، بالإضافة إلى بروتوكول صب الشمع وتغير أبعاده و كل ذلك يؤثر علي تطابق الدعامة ودقتها.

قد احدث استخدام الكمبيوتر والتقنيات الرقمية ثورة في عالم طب الأسنان وزيادة الدقة وإنجاز الوقت ورضاء كلا من طبيب الأسنان والمريض.

لذلك تهدف هذه الدراسة الي تقييم تصميم وتصنيع الدعامة الواصلة بين الغرسات بالطرق الرقمية الجديدة و ذلك باستخدام مادة التيتانيوم و البيك المعالج.

## الهدف من اجراء الدراسة

تقييم الدعامة المصنعة بمواد مختلفة في طقم الأسنان السفلي الكامل المدعوم بغرسات والمصنّع بتقنية الكمبيوتر.

## المواصفات المطلوب توافرها بالمريض

- فقد كلي للأسنان.
- أن تتراوح أعمار المرضى بين 40 و 60 سنة.
- أن تكون الحالات المختاره تتمتع بصحة جيدة وخالية من أي مرض يؤثر علي صحة العظم.
- يجب أن تكون كمية العظم الموجودة كافية لوضع الغرسات.
- أن يكون لديهم علاقة طبيعية بين الفك العلوي والسفلي ومساحة كافية بينهم

## مواد و طرق البحث

- سيتم تركيب ثلاث غرسات ذات صلة في الفك السفلي باستخدام الدليل الجرحي الرقمي.
- بعد ثلاثة أشهر من الشفاء والتكامل العظمي. سيتم إجراء المسح الضوئي داخل الفم لنقل موضع الغرسات الصحيح إلى برنامج التصميم الرقمي.
- سوف يتم تصميم دعامة تصل بين الثلاث غرسات .
- بعد ذلك سوف يتم خراط الدعامة باستخدام مادة التيتانيوم و البيك المعالج و ربطها في فم المريض.
- سوف يتم تصميم و اجراء طباعة رقمية ثلاثية الابعاد للاطقم المحملة علي الغرسات و الدعامة و تسليمها للمريض.

## مجموعات الدراسة.

### المجموعة الاولى (المجموعة الضابطة):

سيحصل ستة مرضى على طقم أسنان كامل للفك السفلي محمل علي غرسات متصلة بدعامة التيتانيوم المصنعة بتقنية CAD/CAM.

### المجموعة الثانية (مجموعة الدراسة):

سيحصل ستة مرضى على طقم أسنان كامل للفك السفلي محمل علي غرسات متصلة بدعامة البيك المصنعة بتقنية CAD/CAM.

## طرق التقييم

### • التقييم الإشعاعي

سيتم إجراء أفلام الأشعة السينية الرقمية لقياس فقدان مستوى العظم حول الغرسات في وقت استلام الطقم وبعد 6 أشهر ثم بعد عام واحد.

### • التقييم الاكلينيكي

سيتم تقييم بقاء الطقم إكلينيكيًا في وقت الاستلام وبعد ستة أشهر وبعد سنة واحدة. سيتم قياس قوة الاستبقاء بالنيوتن باستخدام جهاز اختبار الاحتفاظ الرقمي (مقياس القوة الرقمي).

### • التقييم الرقمي

سيتم تقييم انحراف الدعامات رقمياً عن طريق تركيب ملفات STL عن طريق المسح الضوئي للدعامة أثناء المتابعة وبعد ستة أشهر ثم بعد عام واحد على البيانات المرجعية المسجلة في وقت استلام الطقم.

### التحليل الإحصائي

سيتم جمع البيانات وجداولتها وتحليلها إحصائياً باستخدام نظام SPSS.