The effect of zirconia and titanium implant abutments on light reflection of the supporting soft tissues

Ralph van Brakel
Herke Jan Noordmans
Joost Frenken
Rowland de Roode
Gerard C. de Wit
Marco S. Cune

Key words: aesthetics, implant, spectrophotometry

Abstract

Objectives: To determine the difference in light reflection of oral mucosa covering titanium (Ti) or zirconia (ZrO2) abutments as it relates to the thickness of the covering mucosa.

Material and methods: Fifteen anterior implants (Astra Osseo speed™) in 11 patients were fitted with a Ti or a ZrO2 abutment (cross-over, within-subject comparison). Hyper-spectral images were taken with a camera fitted on a surgical microscope. High-resolution images with 70 nm interval between 440 and 720 nm were obtained within 30 s (1392 × 1024 pixels). Black- and white-point reference was used for spatial and spectral normalization as well as correction for motion during exposure. Reflection spectra were extracted from the image on a line mid-buccal of the implant, starting 1 mm above the soft tissue continuing up to 3 mm apically.

Results: Median soft tissue height is 2.3 mm (min: 1.2 mm and max: 3.1 mm). The buccal mucosa rapidly increases in the thickness, when moving apically. At 2.2 mm, thickness is 3 mm. No perceivable difference between the Ti and ZrO2 abutment can be observed when the thickness of the mucosa is 2 ± 0.1 mm (95% confidence interval) or more.

Conclusion: It is expected that the difference in light reflection of soft tissue covering Ti or ZrO2 abutments is no longer noticeable for the human eye when the mucosa thickness exceeds 2 mm. Haemoglobin peaks in the reflection spectrum can be observed and make hyper-spectral imaging a practical and useful tool for measuring soft tissue health.

The ultimate challenge of restorative and implant dentistry is to replace all lost hard and soft structures, restore function and aesthetics, thus mimicking the unrestored, healthy tooth and its bony and soft tissue surroundings. With respect to the latter, the architecture, contour, surface texture and colour of the perimplant tissue are important determinants of the appearance of the restoration. Not much research is available with respect to the colour of the gingiva or peri-implant mucosa and its influencing factors, but it is presumed to depend primarily upon the intensity of melanogenesis, the degree of epithelial cornification, the depth of epithelialization and the arrangement of gingival vascularization (Dummett 1960; Kleinheinz et al. 2003). However, the colour of underlying root surfaces or restorative materials such as implant abutments, crown margins or even MTA are also considered to be of influence on gingival colour (Takeda et al. 1996; Jung et al. 2007; Bortoluzzi et al. 2007; Watkin & Kerstein 2008).

In the past, titanium (Ti) abutments were the standard of care for implant restorations through-out the mouth. Unfortunately, blue-greyish shimmering of such abutments may hamper the aesthetic outcome in cases with thin overlying mucosal tissues and cause a noticeable colour difference with the gingival tissues of neighbouring teeth (Park et al. 2007). This is why initially alumina abutments were introduced, but the occasional fracture of abutments made from alumina was observed (Prestipino & Ingber 1993a, 1993b; Andersson et al. 2001, 2003). The use of partially stabilized zirconia (ZrO2) abutments has become more popular in recent years, especially in regions of high aesthetic demand (Watkin & Kerstein 2008). Such abutments combine high bending strength and toughness with good bio-compatibility and the limited amount of available data suggests that the clinical performance is comparable with that of Ti abutments [Manicone et al. 2007; Sailer et al. 2009a]. As with alumina abutments, the white colour of ZrO2 is considered aesthetically advantageous (Glauser et al. 2004; Tan & Dunne 2004; Canullo 2007; Ishikawa-Nagai et al. 2007; Park et al. 2007; Bae et al. 2008). Although it is considered by some to
be too white, and it is suggested that more tooth
coloured abutment materials are to be preferred
(Nakamura et al. 2010).

It was demonstrated in vitro that the thickness of
the overlying mucosa plays an import role on
discoloration and the aesthetic appearance of soft
tissues (Jung et al. 2007). Randomized controlled
clinical trials are needed to demonstrate the
optical effect of ZrO₂ and Ti materials when
placed subgingivally. On visual inspection and
graded on a four-item scale, less discoloration of
the buccal mucosa was seen at all ceramic
crowns on ZrO₂ abutments at 1–2 months after
crown cementation when compared with porce-
lain-fused-to-metal crowns on Ti abutments
(Hosseini & Gottfredsen 2010). Yet, when rated
more objectively by means of spectrophotometric
measurements at 1 mm below the gingival mar-
gin, no statistically significant differences in the
discernible amount of discoloration between cus-
d灵和 Ti abutments with either all-
ceramic or metal-ceramic crowns could be re-
vealed at all 3 years (Zembic et al. 2009;
Sailer et al. 2009b). The authors used a commer-
cially available device originally intended for the
determination of tooth shades. They stress the
need for more controlled clinical trials to study
the influence of the abutment material on the
colour of the soft tissues. Indeed, criteria need
to be defined to decide under what particular cir-
cumstances patients may benefit most from
ZrO₂ or Ti abutments. This is of interest, also,
considering the fact that the latter ones are
usually more affordable and have a longer track
record.

The present investigation focuses on the effect
of ZrO₂ and Ti implant abutments on light
reflection of the supporting soft tissues in man,
as it relates to the thickness of the peri-implant
tissues. A novel method for the assessment of the
colour of permucosal or gingival tissues is
presented.

Material and methods

A cross-over, within subject comparison study
was designed.

Patient population and implant placement

Eleven consecutive Caucasian subjects (six
males, five females; mean age 32.5 years; range
20.3–46 years) scheduled to receive a total of 15
implants in the anterior region of the maxilla
were included in the study after they had pro-
vided informed consent. Twelve out of 15 im-
plant sites had been augmented before implant
placement with autologous bone originating from
the retnomolar region. Soft tissue augmentations
were not performed.

Under local anaesthesia, a full-thickness flap
was raised with a crestal incision located approxi-
mately 2–3 mm toward the palatal aspect. Small
relieving incisions were placed into the gingival
sulcus of the adjacent teeth and extended to the
mesio-buccal site of these teeth.

The palatal and buccal mucoperiosteal flap was
elevated and the alveolar crest was inspected.
When a bone augmentation procedure had been
performed before implant placement, a small
vertical incision was made in the mucosa over-
lying the bone graft at the position of the fixation
screw. In this way, the screw could be removed
easily with little exploration and trauma, pre-
venting disturbance of the vascularization.

A surgical template was used to assure the
proper placement of the implant. The implants
(Osseospeed™, Astra Tech, Möln达尔, Sweden)
were 3.5 or 4 mm in diameter, placed at bone
level, mostly in a position 1 mm apical to the
cemento-enamel junction of the contralateral
tooth. In all situations, primary stability could
be achieved. When the implants were placed in a
submerged manner (seven implants), a cover
screw was utilized. In all other situations (eight
implants), a permucosal healing abutment of
appropriate dimensions was placed (non-sub-
merging healing). Wound closure was performed
with Gore-Tex® sutures (W.L. Gore & Associ-
ates, Newark, DE), which were removed after 2
weeks.

Assessment of soft tissue thickness and height

At least 3 months after implant placement, or
when applicable, at least 3 weeks after second-
stage implant surgery, the healing abutments
were disconnected. A standard open tray impres-
sion registering the implant position and the
surrounding soft tissues was made (Impregum,
3M Espe, Germany). Subsequently, an implant
analogue was connected to the impression post
and a plaster model was poured. The model was
ground in a mesial–distal direction, in a plane
parallel to the implant until the mid-buccal plane
of the implant was reached (Fig. 1). The specimen
were photographed using a Canon EOS 20D
(Japan) photo camera with a 100 mm macro
lens and a ring flash (8.2 mega pixels).

A line parallel to the implant was drawn.
Perpendicular to this line, a series of lines was
drawn with 0.2 mm intersections, starting at the
most coronal point of the peri-implant mucosa.
Along these lines, the facial soft tissue thickness
was measured in a commercially available com-
puter program that allows image analysis (Adobe
Photoshop CS3 extended). The images were
 calibrated, for which the known dimensions of
sections of the implant analogue or a ruler that
was photographed in the same plane were used.

van Brakel et al. Light reflection of peri-implant mucosa

ject, the reflection image was subsequently normalized by the reflection spectrum of ZrO₂, extracted 1 mm coronal of the mucosal margin. The validity of ZrO₂ being a good white reference was confirmed by spectral reflection measurements using a halogen light bulb and a calibrated Ocean Optics spectrometer QE65000 (Dunedin, FL, USA).

2. Movement during acquisition and matching of the images. As the capture sequence takes about 10–30 s, small movements occur during acquisition. Fast GPU-based image matching software was used to re-align the spectral slices based on rigid deformations and image correlation [Noordmans et al. 2007a]. This software was also used to match the hyper-spectral images of the ZrO₂ and Ti abutments.

Spectra were extracted starting 1 mm coronal until 3 mm apical of the soft tissue margin in 0.05 mm steps (Fig. 5). For each step, spectra were acquired in a small circular region to reduce noise and small highlights. The mean reflection spectrum along the ZrO₂ and Ti abutment was then calculated by averaging over the spectra of all patients.

Subsequently, they were processed as follows. First, calibration of the distance axis along the central line was performed by setting the distance from the marker and the edge of the abutment to its real physical value. Second, the distance axis along the central line was converted to a mucosa thickness axis. Values for mucosa thickness D as a function of the distance to the cervical margin of the mucosa were obtained from the measurements on the plaster model. Then, the resulting spectra were converted to XYZ-colour space and finally to L’ a’ b’ colour space using the following functions [Wyszecki & Stiles 2000]:

\[
\begin{align*}
R_{n,t}(x, y, \lambda) & = \frac{I_{n,t}(x, y, \lambda) - D(x, y, \lambda)}{W(x, y, \lambda)} \\
\end{align*}
\]

where \(I\) represents the captured image, \(D\) and \(W\) the dark and white reference and \(R\) the reflection image. To compensate for differences in distance between camera and subject, the reflection image was subsequently normalized by the reflection spectrum of ZrO₂, extracted 1 mm coronal of the mucosal margin. The validity of ZrO₂ being a good white reference was confirmed by spectral reflection measurements using a halogen light bulb and a calibrated Ocean Optics spectrometer QE65000 (Dunedin, FL, USA).

\[
\begin{align*}
l' & = \frac{I_1}{C_{17}} \\
\end{align*}
\]

\[
\begin{align*}
l'' & = \frac{I_2}{C_{13}} \\
\end{align*}
\]

\[
\begin{align*}
l''' & = \frac{I_3}{C_{16}} \\
\end{align*}
\]

where \(f_{P(D)_{n,t}}\) denote the colour matching functions and \(S(\lambda)\) the spectral power density of a D65 light source.

\[
\begin{align*}
\left( \begin{array}{c}
L' (D) \\
\a' (D) \\
\b' (D)
\end{array} \right)_{n,t} &= \left( \begin{array}{c}
116f_{D\lambda} - 16 \\
6\left(f_{D\lambda} - f_{\lambda,0}\right) \\
200f_{D\lambda} - 100f_{\lambda,0}
\end{array} \right) \\
\end{align*}
\]

where \(f_{D\lambda}, f_{\lambda,0}\) are the spectral functions of the light source.

\[
\begin{align*}
\begin{cases}
P(D)_{n,t} = \frac{P(D)_{n,t}}{1 + P(D)_{n,t}} & \text{if } P(D)_{n,t} > 0.009 \\
\text{if } P(D)_{n,t} \leq 0.009
\end{cases}
\end{align*}
\]

Results

Soft tissue thickness and height

The mean thickness of the buccal mucosa covering the abutment surface in the midline in relation to the distance from the cervical gingival margin is presented in Fig. 6. The median value for the height of the mucosa to the edge of the implant is 2.3 mm (mean 2.4 SD 0.5 mm, min: 1.2 mm and max: 3.1 mm).

Spectral analysis

As an example of the colour reconstructions, the processed images of patient 3 are presented following white balancing, vignetting, correction of movement and matching of the images of both abutment types [Fig. 7]. To enhance the difference in appearance of the mucosa, the images are
of the abutment can be perceived hinting that the
A small, dark region in the area of the emergence
divided by each other, resulting in a ratio image.
A small, dark region in the area of the emergence

Fig. 6. Mean facial soft-tissue thickness [and SD] in relation to the distance from the soft-tissue margin at 0.3 mm intervals, n = 15 implants in 11 patients.

Fig. 7. Difference in appearance of patient 3: (a) zirconia abutment, (b) titanium abutment, (c) ratio image.

discoloration of the mucosa. Only little information is available regarding the dimensions, which is height and
Kan and colleagues measured the mid-facial
height of the peri-implant mucosa in two-stage
anterior implants by means of bone probing with a
periodontal probe after anaesthesia. They found
an average height of 3.6 mm, with shallower
values for subjects that were categorized as hav-
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present study in which also two-stage implants
were used, the median facial soft tissue height
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height measurements on the plaster models
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Discussion

The appearance of the permucosal tissue is an
important determinant of the overall aesthetic
outcome of an implant–bone restoration. It has
proved difficult to mimic all aspects of the
gingival appearance of the neighbouring teeth
(Chang et al. 1999a; Belser et al. 2004, 2009;
Furhauser et al. 2005). When the mucosa is thin
and frail, it is prone for recession and underlying
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To observe the effect of this thickness thresh-
old on the distance at which differences may still
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the thickness/distance plots (Fig. 10). One can
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corresponds well with the measurements from the present study, although an explanation for the difference with the study of Jung and colleagues is not given. Ishikawa-Nagai denote that they measured gingival thickness around implants in a study on the shine-through effects of implants on the peri-implant mucosa, but do not report on the actual data [Ishikawa-Nagai et al. 2007]. In a recent study, the facial gingival thickness of anterior teeth at 2 mm below the cervical gingival margin was measured immediately after extraction by means of callipers. The average gingival thickness was approximately 1 mm [Kan et al. 2010]. From Fig. 6, it can be deducted that the corresponding thickness at implant sites in the present study averages at approximately 2.8 mm, and hence is considerably thicker.

In this study, the \( L^{a*b*} \) norm could also have been measured using commercially available calibrated RGB cameras, but using a hyper-spectral camera one obtains the full reflection spectrum for every point in the image. In combination with the Match software, subtle changes in the reflection spectrum can be tracked accurately over time. It has been demonstrated in the optical literature that such data can be used to quantify functional tissue properties like blood perfusion, tissue oxygenation and the longitudinal evaluation of healing response or disease progression of infections or tumour growth, also in the mouth, in a non-invasive, non-contact manner [Sorg et al. 2005; Subhash et al. 2006; Stamatas & Kollias 2007; Vogel et al. 2007; Noordmans et al. 2007a, 2007b; Mallia et al. 2008, 2010; Stamatas et al. 2008; Klaessens et al. 2009]. Such estimations are based on the principle that erythema of the skin (and also of the gingiva and oral mucosa) is associated with an increase in blood perfusion that is linked to the relative concentration of oxygenated haemoglobin. For example, blood perfusion can be perceived by determining the amount of haemoglobin present in the reflection spectrum and oxygenation by looking at the difference between the oxy- and deoxygenated haemoglobin spectra. Because our method not only yields the spectral information along the central line of the implant but also provides the full spectral information for the entire image, one could do tissue calculations for the entire image and assess the extent of tissue abnormalities. This opens an array of opportunities for a more objective evaluation of soft tissue health around oral implants \textit{in vivo}, as has been proposed for gingival tissues before [Zakian et al. 2008].

Although the study shows a satisfactory result, a number of improvements may be included in the measurement setup: (1) Perform a dark and white reference before each measurement. In this study, we made a dark and white reference only once, but it appeared that the camera set-up

Fig. 8. Mean reflection spectra of zirconia and titanium abutments, between 1 mm coronal of the cervical gingival margin and 3 mm apically. Note the particular shape of the reflection spectrum of oxygenated haemoglobin.

![Mean reflection spectrum as function of distance using zirconia abutment](image)

![Mean reflection spectrum as function of distance using titanium abutment](image)

Fig. 9. \( L^{a*b*} \) norms and difference as function of mucosa thickness to determine at which thickness no perceived difference is expected.

![L*a*b* norm for zirconia and titanium abutments as function of mucosa thickness](image)
varied too much over time that we finally had to make a white reference again using the zirconium abutment itself. [2] Include the ultra-violet range to study the fluorescence effects of abutments and crowns. [3] Use of a polarizer in the illumination path perpendicular to the polarizing axis of the tuneable filter to suppress specular highlights (Noordmans et al. 2007b). In this study, we choose not to use this cross-polarization approach as it removes 80% of the light resulting in longer exposure times or larger motion errors. In addition, we are studying the visual differences between Ti and ZrO₂ abutments and our eyes are not equipped with polarizers and thus see the reflected light. [4] Also, if one were able to measure the thickness of permucosal tissue of a sound tooth, one could compare the perceptible differences between permucosal tissue of sound teeth or that on implants. The method used to measure mucosa thickness on plaster models is not feasible for mucosa covering teeth.

Others have also focussed on the thickness of the mucosa as it relates to soft tissue aesthetics. Data from an in vitro experiment in sacrificed pig’s maxillae using spectrophotometry suggest that when the thickness of the mucosa exceeds 3 mm, both Ti and ZrO₂ do not cause a noticeable colour change of the mucosa (Jung et al. 2007). The authors used a L’ab*’ norms difference of 3.7, which is used in the literature as a threshold for perceivable colour differences (Johnston & Kao 1989). It would have to be determined how perceivable differences relate to clinical relevance or acceptability of a slight, but noticeable mismatch of mucosal appearance. From our in vivo data, it can be expected that a noticeable difference between Ti and ZrO₂ abutments occurs when the thickness of the facial mucosa is approximately 2 mm or less. There is considerable individual variance with respect to the depth at which this will be the case and therefore the choice of abutment material remains a decision that should be based on the clinical situation at hand. However, as a general rule of thumb, Ti implant abutments are best avoided in aesthetically critical areas when the desired location of the crown margin does not exceed 1 mm submucosally.

**Conclusion**

The labial mucosa covering an implant abutment rapidly increases in thickness when moving apically and is approximately 1 mm thick at 0.2 mm and 2 mm thick at 1 mm below the cervical margin on average. On theoretical grounds, it can be expected that the difference in light reflection between tissues covering ZrO₂ and Ti implant abutments is no longer noticeable for the human eye when the mucosa thickness exceeds 2 mm. Haemoglobin peaks are clearly visible in the reflection spectrum, which may render hyper-spectral imaging a practical and objective tool for monitoring soft tissue health. This could be the focus of further research.

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