

Angulated Implants: An Alternative to Bone Augmentation and Sinus Lift Procedure: Systematic Review

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ABSTRACT

Rehabilitation of completely edentulous patients with implant becomes challenging due to reduced amount of bone available and pneumatization of maxillary sinus or both. To successfully treat such patients, prior to implant placement, patient has to undergo invasive procedures like sinus lift and/or bone augmentation which is not possible many time due to many reasons. This article focuses on an alternative treatment procedure in which two posterior implants are placed at an angle and two anterior implants are placed axially thereby eliminating the need for sinus lift or bone augmentation procedures. This article broadly discusses this "All on Four" concept in all aspects, its effects on bone, prosthesis survival, forces acting etc along with various related studies.

Keywords: "All on Four", "Angulated implant", "Axial implant", "Sinus lift", "Tilted implant"

INTRODUCTION

Edentulous patients in one or another sense are living a life with too much of physical, emotional and psychological burden. Various causes of this include decreased chewing efficiency, decreased esthetic look resulting in poor health, decreased self confidence of the patient. Edentulism can be a result of poor oral hygiene, negligence towards dental health or heavily restored failing dentition. Increasing number of population possesses a terminal dentition and ability to re-treat is restricted due to poor bone support and reduced bone volume [1].

Prosthetic rehabilitation of completely edentulous patients with implants is a well established and reliable mode of treatment. Availability of good quality and quantity of bone for implant placement is very important aspect. Patients with severe resorption of alveolar bone require prior surgical intervention in the form of bone augmentation and sinus lift procedures for its successful outcome.

Traditionally, it is well established that the masticatory forces must be directed along the long axis of the tooth or implant which increases the longevity and reduces the amount of bone resorption. Due to lesser amount of bone available in severely resorbed alveolar ridges, researchers have been trying to find a suitable alternative to bone augmentation and sinus lift procedures so that additional surgical procedures could be avoided.

Dr. Paulo Malo in 1993 advocated angulated placement of implants in such cases and named this concept as "All on four" in which two vertical implants are placed in anterior region and two implants in posterior region are placed at an angulation of 35-40 degrees [2]. Since then, several clinicians and researchers have reported use of angulated implants with varying degrees of success over a period of time but there is no consensus about the routine use of angulated implants for rehabilitation of patients with severely resorbed alveolar ridges.

The aim of this review article was to evaluate the success rate of implants placed according to this concept and prosthesis fabricated on angulated implants over a period of 1-10 y. Literature review was performed in Pub Med Central, EBSCOHOST, scholarly articles using terms 'Angulated implant', 'offset implant' and 'tilted implant'.

MATERIALS AND METHODS

a) Search Criteria

Inclusion Criteria

- The search was limited to studies involving human subjects.
- Restrictions were not placed regarding the study design and the language usage.
- A minimum follow-up duration of one year was selected.
- All original research articles, review articles, case reports, case series and pilot studies were included.
- Immediate as well as delayed implant placement cases were included.

Exclusion Criteria

- Studies conducted in animals.

b) Search strategy

A literature review was performed in Pubmed Central, scholarly articles, EBSCO host, google etc. Keywords such as "dental implant," "tilted implant," "angled implant," "angulated implant," "offset implant," "upright implant," "axial implant," "edentulous patient," "edentulous mandible," "edentulous maxilla," and "all on four" were used alone or in combination.

ADVANTAGES OF TILTING IMPLANTS

1. Stability even in minimum bone volume: Longer implants can be used in minimum bone volume with advantage of increasing bone-to-implant contact and reducing the need for vertical bone augmentation.
2. Good clinical results.
3. Eliminates the need for bone grafting which is invasive with unpredictable outcome [3].
4. Can usually be performed in patients with various systemic conditions which are often contraindications for bone grafting [3].
5. The angulations allow placement that avoids anatomical structures [1].
6. There is a biomechanical advantage in using tilted distal implants rather than distal cantilever units [4].
7. Reduce the length of cantilevers without performing bone grafting or sinus lifting [5].
8. Effective and safe alternative to maxillary sinus floor augmentation procedures [6] and to pneumatized maxillary sinus [7].
9. Distally tilted implants induced better loading transmission than vertical implants [8].

10. Excellent prognosis in short-medium term [9] as well as in long term [10].

DISADVANTAGES

1. Procedure is highly technique sensitive.
2. Surgeon need to be very skilful.
3. Computer guided surgical stent required for implant to be placed in desired angulation.
4. Even slight change in angulation may pose problem to patient and operator.
5. Long term studies are not available.

DISTANCE BETWEEN TWO IMPLANTS

A trigonometry ratio was developed to estimate a two-dimensional safe distance between a tilted implant and an adjacent vertical implant. The distance or length between the fixtures can be determined by multiplying the known length of each implant by a constant derived from the sin of the insertion angle [11]. In edentulous maxillae if inter-implant distance is increased, load distribution will be better [12].

RECOMMENDATIONS [13]

- The use of angulated implants should remain confined to situations of favourable bone quality (preferably greater than D3).
- Angulated implants should only be placed after suitable three-dimensional-planning, leading to three-dimensional treatment guidance.
- Greater inclinations of the implants (>30°) lead to increased force levels at the implant-bone and implant-abutment-interfaces. Therefore extreme angulations should be avoided.
- Inter-implant angulations should be confined to a single three-dimensional plane to simplify prosthetic restoration.
- Single tooth restorations and cantilever bridges on angulated implants should be avoided, and the aim should be to splint the implants.

BACKGROUND

Before we proceed for discussion about angulated implants, we must take a brief insight regarding axial implant. Axial implants are those which are placed perpendicular to the bone or occlusal surface or parallel to the long axis of an adjacent tooth.

Success of an implant treatment is viewed via various aspects like osseointegration, marginal bone loss around implant, effect of implant angulation and prosthesis survival.

After implant is placed into bone, it gets osseointegrated with the bone which is related to the bone quality, host response, asepsis maintenance, general health of patient, site of implant placement etc.

a) Success Rate:

Various studies are available regarding success rate of angulated implant placement at various time intervals.

- Malo et al., [13] clinically retrospectively All on Four immediate function concept in 44 patients in which 176 implants were loaded. Cumulative survival rates of 96.7% and 98.2% for development and routine groups respectively were noted with 100% prosthesis survival rate and low marginal bone resorption over period of 6 months.
- Calandriello and Tomatis [14] conducted one year prospective clinical study in 18 patients to treat atrophic posterior maxilla with 60 tilted implants with cumulative survival rate of 96.7%.
- Penarrocha et al., [15] concluded after one year follow up study of tilted implants in buccolingual direction in restoration

of posterior mandible with horizontal atrophy provided good results.

- Graves et al., [16] reported good performances of this technique, in terms of implant survival rate and function in a large cohort of 276 patients, evaluated after 16 months from prosthesis placement.
- Malo et al., [17] conducted an open cohort study with mean follow up of two years for immediate rehabilitation of completely edentulous arches with four implant prosthesis concept in 142 patients who received 227 implants and concluded that this procedure in difficult conditions is a viable concept in short term.
- Babbush et al., [18] retrospectively studied 708 implants placed at an angle in 165 patients and reported cumulative survival rate of 99.6% (99.3% in maxilla & 100% in mandible) for up to 29 months of loading. Definite prosthesis survival rate was 100%.
- Agliardi et al., [19] evaluated prognosis of immediately loaded fixed full prostheses for treatment of edentulous patients with extreme bone loss in posterior mandibular region over mean period of 30.1 months and found excellent outcome.
- Butura et al., [20] studied mandibular all on four technique using 857 angled implants in 219 jaws over three years and stated that procedure can be carried out with high confidence.
- Crespi R et al., [21] reported 98.96% of implant survival rate after three years from loading for 24 maxillary rehabilitations without any prosthetic complete failure.
- Krekmanov et al., [22] studied tilting of posterior implants for improved prosthesis support in 47 patients and found that there were no implant failures in mandible while cumulative success rates in the maxilla at five years were 98% for tilted implants and 93% for non-tilted implants.
- Rosen and Gynther [10] evaluated retrospectively the surgical outcome of tilted implants in severely resorbed edentulous maxilla as an alternative to bone grafting. They demonstrated that such patients can be treated successfully with success rate of 97% in 103 implants of 19 patients over long term follow up of 10 y (mean).
- Ata-Ali et al., [23] performed meta-analysis on oral rehabilitation with tilted implants and deduced that tilted implants exhibit same evaluative behaviour as axial implant. There was no evidence of differences in success rate between tilted and axial implants in either the prospective or retrospective studies subjected to review. The marginal bone loss observed with the tilted and axial implants likewise proved very similar.

b) Implant bone Interface

- Cehreli et al., [24] demonstrated in their in-vitro study that angulated implants were associated with higher forces acting on the implant-bone interface during axial loading of maxillary or mandibular superstructures that were supported by four implants.
- Particularly high loads acting on the implant-bone interface must be expected in single tooth restorations, and these loads will become more severe with increasing length of the load arm involved (off-axis loading) [25].
- Kvanc and Haldun [26] performed spiral CT study to evaluate effect of residual bone angulation on implant supported fixed prosthesis in 30 patients and found minimum angulation values at second premolar, first and second molar region were 0°, 3°, 9° respectively. Average values being 4°, 10°, 15° and maximum values 11°, 18°, 22° respectively.
- Bone loss around an implant placed at an angle is same or less as compared to that around axial implant [10,14,19].

- No correlation exists between implant angulation and bone loss [27,28].
- c) Implant Angulation:**
- Angled implants have smaller quantity of fringes and stresses which were located mostly around apical region of lateral implants [29].
- Gulizio et al., [30] studied an effect of implant angulation on retention of overdenture attachment and concluded that angle had an effect upon retention of gold matrices, but not for titanium matrices.
- Pellizzer et al., [31] studied influence of implant angulation with different crowns on stress distribution and found that screwed prosthesis exhibited highest stress concentration. Higher the implant angulation, higher is the stress value, independent of crown type.
- Increasing the tilt of distal implant does not increase the stress significantly. Architecture of mandible plays a major role during treatment planning of complete edentulous patients [32].

DISCUSSION

The present review discusses an alternative mode of treatment in cases where there is too much of bone resorption which limits implant treatment. To avoid various invasive procedures like bone augmentation and sinus lift, this modality is gaining popularity amongst patients and surgeons. Various short term studies are supporting this procedure strongly in terms of success rate.

Axial implant placement has been accepted worldwide as a successful treatment modality for prosthodontic rehabilitation. When various criteria for success of implant prosthesis like osseointegration, crestal bone loss around implant neck, longevity or survival of the restoration etc. are considered along with complications associated with implants; most of the studies have demonstrated excellent success rate over a period of time (1-10 y) with an average of more than 95%. Commonly accepted criteria for assessment of implant success were proposed by Albrektsson et al., [33] Misch et al., [34] at the International Congress of Oral Implantologists (ICOI) pisa consensus conference.

Based on above criteria, number of studies has been reported claiming success rate of the order of 78-100% with more than 15 y of observation time [35-37].

In case of atrophic maxilla, implant placement isn't possible without undergoing invasive procedures like bone augmentation or sinus lift procedure or both. Several types of complications may occur during and after the sinus elevation procedure like Schneiderian membrane perforation, nose bleeding, post operative pain and swelling even though it was not described an important negative effect on implant success rates [38]. But patient may be under psychological stress and addition of burden of an extra surgery and increased cost if enough bone isn't available to carry out sinus lift and implant placement at same appointment [39].

Bone grafting, though practicable now a days is dependent on many factors like type of bone graft used (autogenous, alloplastic or xenograft), host response, age of patient, various complications associated with grafting procedure, infection and most importantly time spent while graft material matures and is taken up by bone. One review revealed that there are not many studies providing data on success rate of dental implants placed in onlay graft augmented ridges and demonstrated, on average, a poor methodological quality [40].

Considering all these things, placement of an angulated implant avoiding both invasive procedures like sinus lift and bone augmentation procedure is a viable treatment option [41].

Bone tolerates the forces more favourable when those are directed vertically. Forces on axial implants are directed vertically along long

axis of an implant and suggested to be more favourably as they distribute stress more evenly throughout implant [42]. This explains high survival or success rate of axially placed implants with a minimum crestal bone loss of 0-0.2mm/year [43-45]. But scenario is different in case of angulated implants. The angulated implants direct the forces at an angle and thus are associated with higher forces acting on implant bone interface during axial loading [24] which should logically induce bone resorption by disrupting bone implant interface which is supported by in vitro experiments that show that non axial loads cause stress concentration in the marginal area of bone [38-41] but this hasn't been demonstrated in vivo or in other words crestal bone around neck of an implant but this doesn't happen because all prostheses fabricated on implants placed using this technique are removable type and produces intermittent type of force on implants in contrary to fixed prosthesis. But, one study has showed excellent outcome with immediately loaded fixed full prosthesis [19]. Also, it has been proved that tilting of posterior implants improves prosthesis support [22].

Various studies carried out regarding success rate of angulated implants have shown same or less amount of crestal bone loss in comparison to axial implants [10,14,19]. Some studies have advocated that we should not place single angulated implant to replace single missing tooth since prosthesis fabricated over it will be of fixed type creating more amount and duration of load and increased off axis loading [25]. In one meta analysis, author found no difference in success rate between tilted and axial implant [23]. This opens our thought process that tilted implants can be placed at high success rate as that of axial implant.

In various studies surgeons used four implants to replace complete maxillary or mandibular denture of which two were placed at an angle and two axially. None of the researchers have used or advocated the use of all four angulated implants since load distribution will not be favourable in such case. It seems that in their opinion, placement of two axial implants is essential when two angulated implants are used in order to distribute load more favourably. In addition, most of the studies are short term ranging from 1-3 y. Though short term studies show no difference in amount of bone loss around axial and angulated implant, data available is not sufficient to predict long term success.

Vertical forces applied during mastication and deglutition is supposed to cause more bone destruction than horizontal forces acting around an angulated implant. Also, stress values are directly proportional to implant angulation. Deflection and stress concentration generally increases with increase in either magnitude or angle of loading. When vertical loads are applied to vertical and angled implants, there is only apical migration in vertical implants but there is significant deflection coupled with some apical migration in angled implants [46]. Duration of force applied is more influential in bone resorption and deformation than is the amount of force [47].

Therefore, long term clinical and histopathological studies are necessary and recommended to utilise this modality in routine practise. However, this procedure is a viable concept in short and medium term [13-15,17].

CONCLUSION

This technique is extremely technique sensitive, useful in patients with resorbed ridges but long term studies are required to evaluate its success rate in terms of load distribution, marginal bone loss around implant and prosthesis survival but currently many practitioners are treating patients with this modality with a great success.

REFERENCES

- [1] Christopher CK. Implant rehabilitation in the edentulous jaw: the "All-on-4" immediate function concept. *Australasian Dental Practice*. 2012;138-148.
- [2] Ashley D. The man behind the success of all on four dental implants. *u Publish*. info 2011;1.

- [3] Bilhan H. An alternative method to treat a case with severe maxillary atrophy by the use of angled implants instead of complicated augmentation procedures: a case report. *Journal of Oral Implantology*. 2008;34(1):47-51.
- [4] Zampelis A, Rangert B, Heijl L. Tilting of splinted implants for improved prosthodontic support: A two dimensional finite element analysis. *J Prosthet Dent*. 2007;97(6):S35-43.
- [5] Iglesia MA. Anteriorly Tilted Implants in Maxillary Tuberosity: Avoiding the Maxillary Sinus. *CPOI*. 2012;3(1):6-16.
- [6] Aparicio C, Perales P, Rangert B. Tilted implants as an alternative to maxillary sinus grafting: A clinical, radiologic, and periosteal study. *Clinical Implant Dentistry and Related Research*. 2001;3(1):39-49.
- [7] Lim TJ, Csillag A, Irinakis T, Nokiani A, Wiebe CB. Intentional Angulation of an Implant to Avoid a Pneumatized Maxillary Sinus: A Case Report. *J Can Dent Assoc*. 2004; 70(3): 164-68.
- [8] Baggi L, Pastore S, Di Girolamo M, Vairo G. Implant-bone load transfer mechanisms in complete-arch prostheses supported by four implants: A three-dimensional finite element approach. *J Prosthet Dent*. 2013;109(1):9-21.
- [9] Fabbro MD, Bellini CM, Romeo D, Francetti L. Tilted Implants for the Rehabilitation of Edentulous Jaws: A Systematic Review. *Clinical Implant Dentistry and Related Research*. 2012;14(4):612-21.
- [10] Rosen A, Gynther G. Implant Treatment Without Bone Grafting in Edentulous Severely Resorbed Maxillas: A Long-Term Follow-Up Study. *Journal of Oral and Maxillofacial Surgery*. 2007;65(5):1010-16.
- [11] Geramipana H, Sadighpour L. Estimation of the safe distance between the implant and an adjacent tilted implant using trigonometry. *Journal of Oral Implantology*. 2012;38(3):289-90.
- [12] Wentaschek S, Lehmann K, Behneke N, Scheller H. Changes of the polygonal area of prosthesis support by tilted implants. Poster presented at: Aesthetic Regeneration versus Functional Rehabilitation – Is there a Contradiction?. SKY Meeting; 2012 April 26-28; Munich, Germany.
- [13] Malo P, Rangert B, MechEng, Nobre M. "All-on-Four" Immediate-Function Concept with Brånemark System® Implants for Completely Edentulous Mandibles: A Retrospective Clinical Study. *Clinical Implant Dentistry and Related Research*. 2003;5(1):2-9.
- [14] Calandriello R, Tomatis M. Simplified treatment of the atrophic posterior maxilla via immediate/early function and tilted implants: A prospective 1-year clinical study. *Clinical Implant Dentistry and Related Research*. 2005;7(1):S1-12.
- [15] Penarrocha DM, Maestre FL, Penarrocha OD, Canullo L, Calvo GJL. Tilted implants for the restoration of posterior mandibles with horizontal atrophy: An alternative treatment. *Journal of Oral and Maxillofacial Surgery*. 2013;71(5):856-64.
- [16] Graves S, Mahler BA, Javid B, Armellini D, Jensen OT. Maxillary all-on-four therapy using angled implants: a 16-month clinical study of 1110 implants in 276 jaws. *Dental Clinics of North America*. 2011;55(4):779-94.
- [17] Malo P, Nobre MA, Lopes A. Immediate Rehabilitation of Completely Edentulous Arches with a Four-Implant Prosthesis Concept in Difficult Conditions: An Open Cohort Study with a Mean Follow-up of 2 Years. *The International Journal of Oral & Maxillofacial Implants*. 2012;27(5):1177-90.
- [18] Babbush CA, Kutsko GT, Brokloff J. The All-on-Four Immediate Function Treatment Concept With NobelActive Implants: A Retrospective Study. *Journal of Oral Implantology*. 2011;37(4):431-45.
- [19] Agliardi E, Clerico M, Ciancio P, Massironi D. Immediate loading of full-arch fixed prostheses supported by axial and tilted implants for the treatment of edentulous atrophic mandibles. *Quintessence International*. 2010;41(4):285-93.
- [20] Butura CC, Galindo DF, Jensen OT. Mandibular all-on-four therapy using angled implants: a three year clinical study of 857 implants in 219 jaws. *Dent Clin North Am*. 2011;55(4):795-811.
- [21] Crespi R, Vinci R, Cappari P, Romanos GE, Gherlone E. A clinical study of edentulous patients rehabilitated according to the "all on four" immediate function protocol. *The International Journal of Oral & Maxillofacial Implants*. 2012;27(2):428-34.
- [22] Krekmanov L, Kahn M, Rangert B, Lindstorm H. Tilting of Posterior Mandibular and Maxillary Implants for Improved Prosthesis Support. *International Journal of Oral and Maxillofacial Implants*. 2000;15(3):405-14.
- [23] Ata-Ali J, Penarrocha-Oltra D, Candel-Marti E, Penarrocha-Diago M. Oral rehabilitation with tilted dental implants: A metaanalysis. *Med Oral Patol Oral Cir Bucal*. 2012;17(4):582-87.
- [24] Cehreli MC, Iplikcioglu H, Bilir OG. The influence of the location of load transfer on strains around implants supporting four unit cement-retained fixed prostheses: in vitro evaluation of axial versus off-set loading. *J Oral Rehabil*. 2002;29(4):394-400.
- [25] O'Mahony A, Bowles Q, Woolsey G, Robinson SJ, Spencer P. Stress distribution in the single-unit osseointegrated dental implant: finite element analyses of axial and off-axial loading. *Implant Dent*. 2000;9(3):207-18.
- [26] Kvanc A, Haldun I. Evaluation of the Effect of the Residual Bone Angulation on Implant-Supported Fixed Prostheses in Mandibular Posterior Edentulism. Part I: Spiral Computed Tomography Study. *Implant Dentistry*. 2001;10(3):216-22.
- [27] Tabrizi R, Pourdanesh F, Zare S, Daneste H, Zeini N. Do angulated implants increase the amount of bone loss around implants in the anterior maxilla? *J Oral Maxillofac Surg*. 2013; 71(2):272-77.
- [28] Francetti L, Romeo D, Corbella S, Taschieri S, Del Fabbro M. Bone Level Changes Around Axial and Tilted Implants in Full-Arch Fixed Immediate Restorations. Interim Results of a Prospective Study. *Clinical Implant Dentistry and Related Research*. 2012; 14(5):646-54.
- [29] Ueda C, Markarian RA, Sendyk CL, Lagana DC. Photoelastic analysis of stress distribution on parallel and angled implants after installation of fixed prostheses. *Braz Oral Res*. 2004;18(1):45-52.
- [30] Guizio MP, Agar JR, Kelly JR, Taylor TD. Effect of Implant Angulation upon Retention of Overdenture Attachments. *Journal of Prosthodontics*. 2005;14(1):3-11.
- [31] Pellizzer EP, Falcon-Antenucci RM, De Carvalho PSP, Sanchez DMIK, Rinaldi GAT, De Aguirre CC, et al. Influence of implant angulation with different crowns on stress distribution. *Journal of Craniofacial Surgery*. 2011;22(2):434-37.
- [32] Malhotra AO, Padmanabhan TV, Mohamed K, Natarajan S, Elavia U. Load transfer in tilted implants with varying cantilever lengths in an all-on-four situation. *Australian Dental Journal*. 2012;57(4):440-45.
- [33] Albrektsson T, Zarb G, Worthington P, Eriksson AR. The long-term efficacy of currently used dental implants: a review and proposed criteria of success. *The International Journal of Oral & Maxillofacial Implants*. 1986;1(1):11-25.
- [34] Misch CE, et al. Implant success, survival, and failure: the International Congress of Oral Implantologists (ICOI) pisa consensus conference. *Implant Dentistry*. 2008;17(1):5-15.
- [35] Albrektsson T, et al. Osseointegrated oral implants. A Swedish multicenter study of 8139 consecutively inserted Nobelpharma implants. *J Periodontol*. 1988;59:287-96.
- [36] Engquist B, Bergendal T, Kallus T, Linden U. A retrospective multicenter evaluation of osseointegrated implants supporting overdentures. *Intern J Oral Maxillofac Implants*. 1998;3: 129-34.
- [37] Jemt T, Lekholm U, Adell R. Osseointegrated implants in the treatment of partially edentulous patients: A preliminary study on 876 consecutively placed fixtures. *Int J Oral Maxillofac Implants*. 1989;4:211-17.
- [38] Taschieri S, Fabbro MD, Tsesis I, Corbella S. Maxillary Sinus in relation to Modern Oral and Maxillofacial Surgery. *International Journal of Dentistry*. 2012:1-2.
- [39] Bortoluzzi MC, Manfro R, Fabris V, Cecconello R, Derech ED. Comparative study of immediately inserted dental implants in sinus lift: 24 months of follow-up. *Ann Maxillofac Surg*. 2014;4(1):30-33.
- [40] Clementini M, Morlupi A, Agrestini C, Ottria L. Success rate of dental implants inserted in autologous bone graft regenerated areas: a systematic review. *Oral Implants (Rome)*. 2011;4(3-4):3-10.
- [41] Lim TJ, Anna C, Tassos I, Adi N, Colin WB. Intentional Angulation of an Implant to Avoid a Pneumatized Maxillary Sinus: A Case Report. *Journal of the Canadian Dental Association*. 2004;70(3):164.
- [42] Rangert B, Jemt T, Jorneus L. Forces and moments on Branemark implants. *Int J Oral Maxillofac Implants*. 1989;4(3):241-47.
- [43] Kline R, et al. A prospective multicenter clinical investigation of a bone quality-based dental implant system. *Implant Dent*. 2002;11:224-34.
- [44] Cox JF, Zarb GA. The longitudinal clinical efficacy of osseointegrated implants: A 3-year report. *Int J Oral Maxillofac Implants*. 1987;2:91-100.
- [45] Lekholm U, Adell R, Lindhe J, et al. Marginal tissue reactions at osseointegrated titanium fixtures. II. A cross-section retrospective study. *Int J Oral Maxillofac Surg*. 1986;15:53-61.
- [46] Canay S, Hersek N, Akpınar I, Asik Z. Comparison of stress distribution around vertical and angled implants with finite-element analysis. *Quintessence Int*. 1996;27:591-98.
- [47] Brosh T, Pilo R, Sudai D. The influence of abutment angulation on strains and stresses along the implant/bone interface: Comparison between two experimental techniques. *J Prosthet Dent*. 1998;79:328-34.

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FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Sep 22, 2014**
Date of Peer Review: **Jan 07, 2015**
Date of Acceptance: **Jan 22, 2015**
Date of Publishing: **Mar 01, 2015**