Osseointegration is the biological process that leads to the direct structural connection between the vital bone and the surface of an implant under functional load. This process is attributed to a number of consecutive events in osteoblast activation, with subsequent production and mineralization of the peri-implant osteoid tissue.

However, in case of reduced stability, micromotion threshold passing (50-150 nm) or bone necrosis caused by overheating (47°C), the present literature recommends that the fibrous encapsulation should prevail on the osseointegration (1, 2).

Many authors have described some of the key factors for achievement of osseointegration around the implants, underlining the importance of the bone implant coupling during the surgical phase (3, 4). Thus the primary implant stability represents one of the fundamental prerequisites for the achievement of the osseointegration and it must be maintained for the entire healing period. The primary stability is a mechanical phenomenon influenced by several factors such as the implant (design, size, macro and micro surface), the patient (quality and quantity of the bone) and the operator (surgical technique).

Numerous studies have compare both in vivo and in vitro the improvement of the primary stability in conical versus cylindrical implants (5-
7). Also the implant surface treatment modalities increase the primary stability, since an increase in roughness may improve the contact between the bone and the implant. In addition, in vitro studies have shown that the sandblasted and etched implants promote the osteogenesis by improving the osteoblastic activity, as compared to the machined ones (8-10).

Regarding the quantity and the quality of the bone, there is a consistent literature showing that most of the failures in implantology are more linked to the quality than to the quantity of bone. Friberg et al. previously found a large number of failures in the resorbed maxillary with the soft bone (11). In a retrospective study, Jaffin and Bernam also reported implant failure in patients with poor bone density, besides other authors who documented that the major cause of implant failures was not linked to the healing, but rather to the indisputable influence of reduced bone density, with a failure rate ranging from 28 to 65% (12-14).

Several studies are present on factors related to the surgical technique in order to improve the implant stability. Indeed, some authors proposed the technique of dimensional under-preparation of the implant site in order to improve the bone-implant coupling and thus the implant stability (15-17). Other authors such as Summers, recommend the bone compaction through osteotomes to change the bone density and improve the stability (18).

With the technique of the expanders adopted by Sethi, it is possible to reach a 97% successful rate implant along with the implant stability improvement in the upper maxilla. Such improvement is confirmed by in vitro studies by Kraft, who compared the standard technique with that of the expanders where a considerable increase in stability and a high insertion torque were found (19-21).

The introduction of new tools for implant site preparation, such as piezo surgery, has generated an interest in the scientific community documented by various works. This technique favors a bone density improvement as compared to the conventional technique, with a rate of success of 100% (22). Stacchi-Vercellotti et al., by comparing the conventional technique with the piezo surgery, reach the conclusion that the two techniques are comparable as for the implant stability (23, 24).

The aim of this work was to evaluate the primary stability of 5 techniques of implant site preparation using the resonance frequency (Ostell mentor) in an animal model of type IV cancellous bone.

**Materials and methods**

In this study 50 Conical Active implants (Maco international) of conical shape, length 10 mm and diameter 3.9 mm mono coil were used. The surface treatment was performed by blasting with aluminum oxide particles (150-200 microns) followed by a double acid attack (Fig. 1).

Ten samples of fresh bone pig ribs (7 cm length) were prepared.

In order to obtain a type 4 bone, the proximal part of the ribs was used, where the cortical component was reduced. Additionally, the cortical component was completely eliminated, leaving exposed only the medullary part for implant placement (25). The bone was further treated with a 20% glacial acetic acid solution one hour

Figure 1
Conical Active implant (Maco International).
before performing the experiment, in order to increase the decalcification of the bone trabeculae (26). A reference template was also prepared in order to encode both the distance between the implants and the used technique.

For each rib, the sequence of the implant site preparation technique was randomly assigned by using a computer generated table, to increase the statistical rigor.

The surgical techniques used were the following ones:

1) conventional surgical technique (TC) with dedicated surgical cutters, as indicated by the manufacturer with a sequential cutter passage: 1.2 mm pilot cutter, 2.2 mm intermediate preparation cutter, 3.2 mm terminal cutter, to apply the implants in the soft bone.

2) The under-preparation technique (TS) with the preparation sequence, pilot cutter 1.2 mm, preparation cutter 2.2 mm and terminal cutter 3 mm. For the implant site with the conventional and under-preparation techniques, the Brånemark protocol was adopted, in which the speed rotation of the cutters does not exceed 800 rpm under continuous irrigation.

3) Technique of bone expanders (TE): following the manufacturer’s instructions, the protocol contemplated to perform the hole to the desired length with a 1.2 mm pilot cutter and to reach the established 3 mm diameter by using bone expanders of various sizes in a sequential manner.

4) Bone compaction technique (TO): the Summers protocol was followed, with this preparation sequence: pilot cutter and bone compactors n° 1, 2 and 3, to obtain the 3 mm diameter.

5) Technique with the piezo surgery (TP): the protocol contemplated the utilization of an handpiece with a pressure of 300g, the use of OP5 drill with coupled movement back and forth and 1/4 rotation, and then the passage in sequence of the other drills, IM2 (2 mm), OT4 (2mm), up to the final IM3 (3 mm) (Fig. 2).

All implants were screwed using a manual ratchet and then exposed to bi-dimensional evaluation of the implant stability with the Osstell Mentor instrument (Oststell instrument, Integration Diagnostics AB, Gothenburg, Sweden) (Figs. 3, 4) (27-29).
Statistical analysis

For each used technique, the statistical evaluation of central tendency (mean, median, mode) and variability (quartiles, variance, standard deviation, coefficient of variation, standard error) was performed (Tab. 1). For this type of analysis the “implant stability quotient” (ISQ) value was used as an independent variable, while the implantation technique was used as an explanatory qualitative variable at five levels. First, the distribution of the ISQ values was compared to the normal distribution using three tests (Kolmogorov-Smirnov, Lilliefors and Shapir-Wilk) (Fig. 5).

Subsequently, one-way analysis of variance (one-way ANOVA) was used to test the effect of the technique on the in vitro implant stability, that is, to check whether the ISQ values of the five techniques differed in statistically significant manner.

![Figure 5](image)

**Figure 5** Frequency distribution of ISQ values.

**Table 1 - Descriptive statistics of ISQ values.**

<table>
<thead>
<tr>
<th>Variable</th>
<th>ISQ TC</th>
<th>ISQ TS</th>
<th>ISQ TE</th>
<th>ISQ TO</th>
<th>ISQ TP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Mean</td>
<td>56.05</td>
<td>56.4</td>
<td>57.2</td>
<td>54.15</td>
<td>56.45</td>
</tr>
<tr>
<td>Median</td>
<td>55</td>
<td>57.75</td>
<td>55.5</td>
<td>53.5</td>
<td>57.25</td>
</tr>
<tr>
<td>Mode</td>
<td>55</td>
<td>61.5</td>
<td>52.0</td>
<td>Multiple</td>
<td>Multiple</td>
</tr>
<tr>
<td>Frequency of Mode</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Minimum</td>
<td>49.0</td>
<td>46.0</td>
<td>48.5</td>
<td>49.0</td>
<td>45.0</td>
</tr>
<tr>
<td>Maximum</td>
<td>64.0</td>
<td>63.0</td>
<td>67.0</td>
<td>61.0</td>
<td>68.0</td>
</tr>
<tr>
<td>Lower Quartile</td>
<td>52.0</td>
<td>52.0</td>
<td>52.0</td>
<td>51.0</td>
<td>49.0</td>
</tr>
<tr>
<td>Upper Quartile</td>
<td>61.0</td>
<td>61.5</td>
<td>64.0</td>
<td>58.0</td>
<td>62.0</td>
</tr>
<tr>
<td>Variance</td>
<td>27.469</td>
<td>35.266</td>
<td>42.344</td>
<td>19.113</td>
<td>63.469</td>
</tr>
<tr>
<td>Std. Dev.</td>
<td>5.241</td>
<td>5.938</td>
<td>6.507</td>
<td>4.371</td>
<td>7.966</td>
</tr>
<tr>
<td>Standard error</td>
<td>1.657</td>
<td>1.877</td>
<td>2.057</td>
<td>1.382</td>
<td>2.519</td>
</tr>
</tbody>
</table>

TO: osteotomes technique; TE: expanders technique; TC: conventional technique; TS: under-preparation technique; TP: piezo surgery technique; ISQ: Implant Stability Quotient; Std. Dev: standard deviation; Coef. Var.: coefficient of variation.
Results

According to all three tests used, the distribution of ISQ values was not significantly different from a normal distribution, legitimizing the use of parametric analysis method such as ANOVA. The constructed one-way ANOVA model was not statistically significant and no statistically significant differences among the ISQ values of the different techniques were found (Tab. 2). Thus, the performed analysis shows that the five implantation techniques do not significantly differ in implant stability as measured in vitro by the ISQ value.

As shown in the descriptive statistics, the average ISQ values corresponding to the different techniques are very comparable, with the possible exception of the TO technique that shows a slightly lower stability (Fig. 6).

Discussion and conclusion

The implant stability plays a key role in the osseointegration process and is conditioned by the quality of the bone (cortical cancellous bone ratio). Indeed, some researchers have shown that there is a strong correlation between cortical thickness and ISQ, playing a crucial role on the implant stability. As reported in literature, the shape of the implant and the surface treatment may also improve the stability, as well as the experience of the operator (30, 31).
This study was performed to evaluate the primary implant stability of 5 preparation techniques by using the resonance frequency in peeled and etched pig ribs. The length and implant shape parameters, the quality of the type IV bone and the operator experience were maintained constant, while the surgical technique comprising 5 different preparation systems was the only variant introduced. The results showed that the ISQ values obtained from 50 implants (10/technique) were comparable, and no statistical differences among these in vitro techniques in the type IV bone were found. The techniques appear to be comparable and the differences regarding the diameter of the preparation (3-mm for piezo, osteotomes, bone expanders and under-preparation techniques; 3.2 mm for the standard type IV bone technique) do not lead to increased stability. These findings are in line with other in vitro studies that compared two (piezo vs standard) or at most three techniques (24, 26, 32-34). The emerging data is that none of the techniques can change the bone marrow density when the trabeculae are of poor quality. In fact, as already described by Martinez (35), in case of bones with low density and insufficient stability, it is advisable to use the bicortical anchorage. Thus, it is essential to follow some simple rules to improve the stability of the implant: to use conical implants active also at the level of the collar to achieve the maximum anchorage, to under-prepare the implant site to save as much as possible the residual cortical, and search for bicorticalism where possible. Thus, in light of these results, in the clinical practice of the type IV bone one technique is replaceable with the other, as none of them improves implant stability. The choice should instead be directed to the technique that accelerates the healing process and the osseointegration.

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Conflict of interest

The authors report no conflicts of interest related to this study.

References


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