Analysis of Bone Tissue Healing around Titanium Implant Surface Treated with Tio Sandblasted after Three and Six Weeks Used Different Histological Methods – a Study in Rabbits

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ABSTRACT

Objective: The aim of this study was to observe the in vivo cellular reaction and calcium deposition around dental implants after applying three histological techniques.

Methods: Six adult New Zealand rabbits, with an average weight of 3.5 kg, were included. Twenty-four cylindrical implants with an internal hex were used in the experiment. The implants were sandblasted with titanium micro-particles and then were conditioned with maleic acid. Calcein was injected subcutaneously at two different time points to assess calcium deposition on the bone at the first and second weeks in examination group 1 (exam 1); and at fourth and fifth weeks in examination group 2 (exam 2) - with three animals in each group. Each implant was cut into 3 slices, and each slice was used for a different histological technique: one for light microscopy, one for fluorescence, and one for scanning. The samples were analysed and compared with the reactions at the interface of the bone and implant after 3 and 6 weeks.

Results: The results demonstrated different reactions in bone tissue being observed at the time corresponding to the exam 1 group, mainly intense cellular proliferation and bone matrix production. The exam 2 group demonstrated organisation and the maturation of the newly form tissue. The clinical significance is that, under appropriate conditions, restorative procedures may begin after 6 weeks.

Conclusion: The implants showed large corticalised areas, and they featured lamellar bone after 6 weeks. Calcium deposition occurred with greater intensity between the 3rd and 6th weeks after implantation.

KEYWORDS: Osseointegration; dental implants; titanium oxide sandblasted; bone mineralization; histological methods.

INTRODUCTION

Proper shape and surface characteristics of an implant can provide great benefits in bony tissue healing, both accelerating and enhancing the tissue’s capacity (Aparício et al., 2011). Several studies have shown that the degree of surface roughness. This relationship can be attributed to factors such as physico-chemical properties, which enhance wettability and adhesion and promote cell proliferation. These factors can increase the contact area between the bone and implant, improving their biomechanical interaction (Chiesa et al., 2007; Hallgren et al., 2003; Le Guehennec et al., 2007; Simon et al., 2005). Cellular behaviours, such as adhesion, morphological changes, proliferation and differentiation, are determined mainly by surface characteristics. These characteristics include the chemical composition, surface roughness, hydrophilicity, texture and morphology present in titanium (Anselme et al., 2000a; b; Lincks et al., 1998; Nebe et al., 2010; Zhu et al., 2004). Recently, it has been shown that changes in the physicochemical properties of titanium can result in significant modulation of cell recruitment, adhesion, inflammation and bone remodelling activities, in addition to regulation of the bone formation response (Wennerberg and Albrektsson, 2009; Omar, 2010).

The micro-irregularities present in implants can induce different healing processes (Kaiser et al., 2006). In many ways, the ability of the cells to move depends on the surface to which they are exposed. The topography of metallic surfaces determines the type of implant healing response. Furthermore, implant surfaces with pores typically increase the quality of osseointegration. These porous interfaces increase the growth within ridges, forming a mechanical interlock (Giavarei et al., 2003). It has also been observed that cellular union, cell morphology and cell proliferation are influenced by surface treatment, with a significant increase in the activity of osteoblastic cells on surfaces with porous coatings (Simon et al., 2005).

The actual manufacture of clinically applied implants has undergone mechanical blasting coupled or not, with acid etching, bioactive coatings, anodised and, more recently, laser-modified surfaces (Cochran et al., 1998; Jansen et al., 1993; Palmquist et al., 2010). These implants have been extensively documented in vivo, including in long-term clinical studies and experimental histological and biomechanical evaluations using animal models. For more information on the clinical results with commercially available implants, the reader is referred to the cited literature (Esposito et al., 2005; Albrektsson and Wennerberg, 2004).

Also, differentiation of the cells surrounding implants should be the primary concern, as long as calcified bone around the implant is desired. However, in addition to the initial stages of the cellular phenomenon of ossification (proliferation, differentiation and cell multiplication), a factor of crucial importance for implants is bone matrix mineralisation around them. This process generally follows three stages: (1) incorporation by woven bone formation; (2) adaptation of bone mass to load (lamellar and parallel-fibered deposition); and (3) adaptation of bone structure to load (bone remodelling) (Schenk and Buser, 1998). An undisturbed healing period, along with adequate quality and quantity of bone available at the implant site, is essential for...
proper osseointegration (Wood and Vermilyea, 2004). However, mineralised-tissue deposition by osteogenic cells on titanium has not been examined thoroughly in vitro because reactive products of von Kossa or alizarin red staining, which are normally used to visualise mineralised tissue, are difficult to recognise on the surface of titanium (Groessner-Schreiber and Tuan, 1992). Fluorescence reagents, such as tetracycline (Rolle, 1965), calcein (Rasmussen, 1975), and alizarin red (Jensh and Brent, 1966), are used to label mineralised tissue, but this labelling can only be observed by fluorescent microscopy, which is not suited to the observation of wide areas.

The determination of the optimal time to wait before loading implants depends on bone healing which only occurs after bone matrix production and calcification. Thus, this study aimed to evaluate in vivo, using different histological methods, the bone remodelling and deposition of calcium on titanium surfaces at the 3rd and 6th weeks after implantation.

MATERIALS AND METHODS

Six adult New Zealand rabbits (Oryctolagus cuniculus), each weighing approximately 3.5 kg, were used for this study. The animals were kept in individual cages with controlled light and were given the ad libitum diet conventionally used in vivaria. This study had the approval of the ethics committee of the Federal University of Santa Maria (Brazil), under number 133/2011.

A total of 24 cylindrical implants, 4 mm in diameter and 8 mm in length, were manufactured by Implacil De Bortoli - Dental Products (São Paulo, Brazil). The implants were surface-treated by sandblasting with microparticles of titanium oxide (TiO), with an average particle size of 180 µm; then, the implants conditioned with maleic acid, packaged and readied for commercialisation. The implants were placed on both sides of the tibia. A milling installation was performed, following the proper procedure as indicated by the manufacturer, to a depth of 8 mm, where the implants were placed manually. Four implants were placed in each animal, two in each tibia.

Before surgery, the animals were administered general anaesthesia with an intramuscular injection of ketamine (35 mg/kg; Atener Pharmaceutica, Brazil). Then, the muscle relaxant Rompun (5 mg/kg, Bayer, Brazil) and the tranquiliser Aceptan (0.75 mg / kg, Univet, Brazil) were injected intramuscularly. Additionally, 1 ml of local aesthetic (3% felypressin prilocaine, Astra, Mexico) was injected intramuscularly at the surgical site to enhance analgesia and control bleeding. Postoperatively, we used a single dose of 600,000 IU of Benzetacil. After surgery, the animals were placed in individual cages with 12- hour cycles of light, a controlled temperature (21°C) and the ad libitum diet conventionally used in laboratories. Three animals were euthanised after 3 weeks, representing examination group 1 (exam1). Three additional animals were euthanised after another 6 weeks, representing examination group 2 (exam2). Euthanasia was performed with an intravenous overdose of ketamine (2 ml) and xylazine (1 ml), and then both tibiae were removed.

During the period of osseointegration, the bone marker calcein was injected subcutaneously at two different times: at the 1st and 2nd weeks after implantation in the exam1 group; and at the 4th and 5th weeks after implantation in the exam2 group. These injections of calcein were performed to analyse the deposition of calcium at different time points. After processing of the samples, the markers were identified by fluorescence microscopy.

For the histological evaluation, three different methods were used: light microscopy, fluorescence and SEM. The samples were processed first by initially setting them in a solution of formaldehyde (10%, 48 h), then by washing them in water (12 h) and finally by gradually dehydrating them by immersion in a sequence of alcohols (60%, 70%, 80%, 99%, 24-56 h). After drying, the samples were embedded in Technovit 7200 resin VLC (Kulzer & Co, Wehrhein, Germany). Then, they were sectioned with a cutter blade (Isomet 2000, Buehler, Germany), yielding three sections of each implant in the longitudinal direction, with one section from each implant being used for each type of evaluation. The slides were then ground to a thickness of 50 µm. All of the histological procedures were performed in the laboratories of Biotecnos in Santa Maria. The slides were then coated with gold, and micrographs were obtained using the back-scattered electron (BSE) detector of an XL30 Philips scanning electron microscope.

The images were analysed qualitatively by an investigator with extensive experience in bone histology. Additionally, the number of osteocytes present inside the coils of each implant was counted using Image Tool software, version 3.0 for Windows. This count was performed for each implant, and the results were then statistically compared between the groups using Student’s t-test ($P < 0.05$).

RESULTS

After 3 and 6 weeks, all of the implants had osseointegrated, and microscopic analyses of the implant surfaces verified good new bone formation. In sections analysed by light microscopy, we observed a fair amount of bone tissue growing on the surface of the implants after 4 weeks. However, the bone tissue was still organising itself. There were large numbers of fibres and cells present in those areas (Fig. 1).

SEM images showed that a large part of the implant was in contact with the forming bone, along with some corticalisation (Fig. 2).

In the samples evaluated by fluorescence microscopy, the deposition of calcium was visible by the presence of a small amount of green colour. This characterisation revealed a small amount of calcium deposition 3 weeks after implantation (Fig. 3).

After 6 weeks, the samples exhibited a structural remodelling of the bone that was more complete and uniform. The formation of a lamellar bone structure could be observed in all of the samples. Analysis of the cuts revealed osteons at the implemented interface, indicating the organisation of collagen fibres and nutritional support. Moreover, we observed several areas with cellular activity in the bone.
tissue near the surfaces of the implants, along with lamellar organisation with many canaliculi (Fig. 4).

The SEM analysis of the 6-week samples revealed a large amount of corticalised bone tissue in contact with the implants (Fig. 5). Furthermore, we observed with this histological technique that there were adequate contact and corticalised bone growth at the bone-implant interface, which was probably stimulated by the surface characteristics.

For fluorescence microscopy in the exam2 group, calcein (green) showed the deposition of calcium ions that corresponded to growth and bone formation, which appeared to be more intense than in samples from the exam1 group (Fig. 6). These results indicated that more extensive calcification of new bone occurred in large part after 3 weeks post-implantation. The colour appeared more intense around the centre of the lamellae, where the presence of blood vessels provides nutrition.

The number of osteocytes present in each implant was an average of 73.50 with an SD of 5.30 for the samples at 3 weeks and 69.60 with an SD of 4.72 for the samples at 6 weeks. There was no significant difference between the groups ($P = 0.087$), only better distribution (organisation) of cells in the studied areas.

**Figure 1:** Photomicrograph of implant (Imp) exam1 group after 3 weeks (stained with HE; x40).
The presence of intense cellular activity (Cel A) is indicated by yellow arrows.

**Figure 2:** SEM image of an implant exam1 group with an area of trabecular
Figure 3: Fluorescence photomicrographs obtained from implant exam1 group, showing a small deposit of calcium in the bone around the implant after application of calcein (stained green; x100).

Figure 4: Photomicrograph of implant (Imp) exam2 group after 6 weeks (stained HE; x100). We can observe the presence of major cellular activity (NB) and good organisation of the fibres, forming lamellae around the implants.

Figure 5: Analysis of the 6th weeks sample by SEM imaging, showing suitable bone growth over the surface of the implant, with a large amount of corticalised bone (x100).
DISCUSSION

In recent years, there have been major changes in the concepts and in our knowledge of the processes involved in the biology and physiology of tissues related to implantation. The evolution of drawings, the different types of materials used for the surfaces of biocompatible implants and new surgical techniques, which are considered responsible for the success rates and predictability of implant prostheses, have all helped to change the concepts of tissue biology and physiology in the context of implementation. However, there is an ongoing search for the optimisation of these techniques, with shorter procedures and greater success rates. This study analysed, using different histologic methods, the quality and quantity of osseointegration on surfaces that were blasted with microparticles of titanium oxide and conditioned with acid. The methods used to characterise the outcomes included light microscopy, fluorescence and SEM. With light microscopy, the quality of contact of the new bone and the cellular proliferation in the implanted area were analysed. With these images, the cellular organisation in forming new bone around the samples could be seen at two different time points, and lamellar conformation and adequate structural features appeared after 6 weeks.

Observations of the structural orientation of the implants have been described in some studies (Kaiser et al., 2006; Piattelli et al., 1998). One other important observation was the large number of osteons found in bone tissue after 6 weeks in the implanted area, which was also observed in other studies (Allegrini et al., 2006). The use of bone markers is very important for identifying the deposition of calcium during the growth of new bone tissue (Giavaresi et al., 2003). With fluorescence markers, the amount of bone deposition that occurs over time can be observed, and other information can be obtained from samples (Martin et al., 1996). In this study, only calcein was used as a marker for the identification of bone growth, which was indicated by the green colour on the photomicrographs. The excitation wavelength of fluorescent calcein reagents is relatively long, at 497 nm (Goto et al., 2003).

Furthermore, the decision to use only one marker was undertaken to facilitate its identification on the images, which would have been more difficult had multiple markers been used in the same group of animals. The intense presence of the fluorescence marker in all of the samples of the exam2 group indicated that there was an adequate response induced after stimulation by the placement of the implant in the bone and that there was adequate availability of minerals, especially calcium, in the bloodstream. This finding confirmed good maturation of the tissue at different times. However, tissue growth, organisation and bone calcification occurred with greater intensity between the 3th and 6th weeks. It was possible to observe and demonstrate, using different histological techniques, that the most intense cellular reaction occurred during the first 3 weeks, with little calcium deposition during that period. In the following weeks, there was a reduction in the numbers of cells in these areas, as well as increased calcium deposition.

These findings are in agreement with other studies, which showed that 4 months after implantation, the perimplant fibrous tissue almost disappeared, while new bone had begun functional remodelling. Six months after implantation, newly formed bone was so mature and functionally remodelled that the boundaries of the original bony defect were barely visible by microscopy (Giocan et al., 2011). A number of different types of studies have found that the phenomenon of osseointegration occurs with higher quality and better security when the implants have better primary stability (Donath and Breuner, 1982; Thomas and Cook, 1985). In the present study, all of the implants had good primary stability, which was probably one of the determining factors of the large amount of corticalised bone tissue in contact with the implant surfaces, indicating

Figure 6: Fluorescence photomicrograph obtained from implant exam2 group, showing intense deposition of calcium in the bone around the implant after the application of calcein (stained green). This experiment determined the period of deposition to be between the 4th and 6th weeks. The highest intensity of the marker can be observed around the blood vessels (x40).
adequate stimulus for the organisation of events related to osseointegration. The complex role of implant surface topography and its impact on the healing response affect the biological criteria that could guide the design and development of future tissue-implant surface interfaces (Stanford, 2010). Thus, within the limitations of this study, it was possible to observe that the events related to the bone healing process around of titanium surfaces occur in an organised manner over time. In situations where the implants are installed in healthy bodies, appropriate conditions and material presenting appropriate characteristics (eg. surface), restorative procedures may begin after 6 weeks.

CONCLUSION

Different histological techniques can be used to determine the osseointegration of implants, and the unification of the information presented provides greater understanding of the studied process. Thus, it was possible to conclude that practically all cell proliferation occurs during the first 3 weeks, and in the subsequent weeks, these cells organised in only one circular direction, forming the lamellae and resulting in the mineralisation of new tissue after 6 weeks.

REFERENCES


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