Fracture Resistance of Cement-retained, Screw-retained, and Combined Cement- and Screw-retained Metal-ceramic Implant-supported Molar Restorations

Violeta Malpartida-Carrillo¹, Pedro Luis Tinedo-López², Fernando Ortiz-Culca³, Maria E Guerrero⁴, Silvia P Amaya-Pajares⁵, Mutlu Özcan⁶

ABSTRACT

Aim: To compare fracture resistance between the cement-retained (CR), screw-retained (SR), and combined cement- and screw-retained (CCSR) metal-ceramic (MC) implant-supported molar restorations and the fracture mode after vertical loading simulation.

Materials and methods: Thirty MC molar restorations were fabricated on thirty tilted dental implants that were repositioned using prefabricated or universal castable long abutments (UCLA) with 15° of angulation divided into three groups of ten specimens each. Group C: CR, group S: SR, and group CS: cement- and screw-retained. The crowns in group CS were adhesively bonded extraorally, and composite resin was used to fill the screw access holes (SAHs) in groups S and CS. Subsequently, all the specimens were tested for fracture resistance. A scanning electron microscope (SEM) evaluation of the fracture mode was also performed. Mean values of fracture loads were calculated and compared in Newtons (N) using one-way ANOVA and Tukey post hoc test (p < 0.05) for each group.

Results: Mean fracture load values were 2718.00 ± 266.25 N for group C, 2125.10 ± 293.82 N for group S, and 2508.00 ± 153.59 N for group CS. Significant differences were found between group S and the other groups on fracture load values. However, no significant differences were found between groups C and CS (p = 0.154). The failures were at MC framework interfaces on mesiolingual cusps.

Conclusions: Cement and CCSR MC molar restorations showed comparable fracture resistance using abutments with 15° of angulation. However, SR design showed significantly the lowest values of resistance. Screw access hole did not significantly affect the fracture resistance of cemented MC molar restorations. All the specimens exhibited mixed adhesive fractures at the mesiolingual cusps.

Clinical significance: Combined cement- and screw-retained restorations (CCSRRs) incorporate the simplicity of the cement method and the retrievability of the screw method, offering good resistance, allowing the removal of the excess of cement before clinical placement of the restoration, and providing another alternative for dental implant rehabilitation.

Keywords: Dental casting techniques, Dental implants, Implant-supported dental prosthesis, Metal ceramic alloys.

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INTRODUCTION

Dental implants have been approved for their predictable success in complete dentures,¹ partial dentures,² and single-tooth restorations³ using metal-ceramic (MC) design due to their durability, aesthetics, strength, and less plaque adhesion.⁴ Classically, the retention of an implant crown can be accomplished by screw-retaining the crown on the implant or on a screw-onto implant abutment, or by cementing the crown on prefabricated or computer-aided design/computer-aided manufacturing (CAD/CAM) abutments.⁵

Screw-retained restorations (SRRs) offer the major advantage of retrievability for oral hygiene abutments and peri-implant probing, and present only one margin at the implant-abutment interface.⁶ They are more indicated when the interocclusal distance is limited and biological problems are not common.⁷ However, SRRs require complex lab procedures and the fracture or chipping of the layering porcelain is their principal mechanical complication owing to the presence of the SAH in the occlusal surface.⁸–¹⁰

Cement-retained restorations (CRRs) show better occlusion and esthetics, and they offer the possibility of more passive fit in multiple implants with splinted frameworks.¹¹ Also, severely divergent implants can be restored.¹² The evidence suggests that some residual cement may remain in the peri-implant sulcus and it is an important etiologic factor that can lead to implant failure.¹³,¹⁴

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In the current literature, there is no consensus on which type of restorations is better. However, in a systematic review, SRRs exhibited fewer technical and biological complications compared to CRRs.\textsuperscript{15}

A new technique for implant-retained restorations has been proposed incorporating the simplicity of CRRs and the retrievability of SRRs. This original technique is known as cement- and screw-retained implant prosthesis, cement- and screw-retained implant restoration, combination prosthesis, and screw-retrievable CR implant prosthesis.\textsuperscript{16–19} Combined cement- and screw-retained restorations allow to use a definitive cement and to remove the excess cement extraorally. Also, the abutment–crown interface can be polished preventing complications in the peri-implant sulcus. Some papers showed that CRRs had higher fracture resistance than CCSRRs because of the absence of SAH.\textsuperscript{20–22} However, recently some publications reported that the presence of the SAH in CCSRRs does not significantly compromised crown fracture resistance.\textsuperscript{23,24} Moreover, Honda et al.\textsuperscript{25} demonstrated that CCSRRs using MC design are comparable to porcelain-layered zirconia-based restorations and indirect composite-layered zirconia-based restorations. To our knowledge, although this new approach is a promising prosthetic implant solution, there is no data on fracture resistance of MC CCSRRs using abutments with 15° of angulation, which are used for tilted implants when the clinical conditions impede to use dental implants in a straight position. Besides, there are no studies that have compared the fracture resistance and fracture mode of single-unit MC molar CRRs, SRRs, and CCSRRs.

Hence, the objective of this in vitro study was to investigate the fracture resistance of CCSR MC molar restorations compared with CRRs and SRRs using abutments with 15° of angulation. Moreover, the fracture mode and the patterns of fracture origin were also determined.

### Materials and Methods

This in vitro study was performed at the Faculty of Health Sciences of the Universidad Cientifica del Sur, Lima, Peru. The specimens consisted of 30 single-unit MC implant-retained restorations (10 specimens per group) representing a mandibular right first molar according to previous similar studies.\textsuperscript{20–22,24}

The materials used in this in vitro study are shown in Table 1. One cylindrical morse taper implant with 4.5 mm diameter and 10 mm length (Super Line Implant, Dentium, Seoul, South Korea) was connected to a 15° prefabricated titanium hexagonal abutment acting collectively as implant-15° abutment. This unit was aligned vertically at 90° to the horizontal plane in an iron holder using a dental surveyor (model 1000 N, Bio-Art, São Carlos, Brazil). This unit was used to simulate a clinical condition with a divergent implant where a 15° angled abutment was necessary to reposition the future crown in an ideal axial position. Autopolymerizing transparent acrylic resin (Vitacron, New Stetic, Antioquia, Colombia) was poured in the iron holder to cover the implant body up to the first thread. Then, a hexagonal impression post was connected to the implant to make an open-tray impression. Subsequently, an implant was screwed to the impression post, the iron holder was placed in the silicone registration, and the autopolymerizing acrylic resin was poured until the iron holder was filled. This procedure was repeated to connect 30 implants securing the same position in all of them. Twenty 15° angled prefabricated titanium hexagonal abutments and ten UCLA plastic metallic ring abutments were connected to thirty implants. All the abutments were cut 3 mm in length using rotary cutting instruments for mandibular right first molar replacement with bucco-lingual, mesio-distal, and occluso-cervical dimensions of 10.5, 11, and 7.5 mm.\textsuperscript{26} Then, they were randomly divided into 3 groups ($n = 10$) according to the MC implant restoration design: CRR, SRR, and CCSRR.

### CR MC Implant Restorations (Group C)

The opening of a 15°-angled abutment was blocked using sticky wax. Then, the abutment received a laser scanning antiglare spray to create an opaque surface. Using an extraoral scanner (Model Smart, Open Technologies, Rezzato, Italy), the 15° abutment was scanned to create a virtual CAD/CAM model pattern. Then, the model was obtained in order to get a silicone index of the crown. The CAD/CAM model pattern was used to fabricate the waxed frameworks unified to a thickness of 0.5 mm for all axial walls, 0.8 mm for the abutment

### Table 1: Materials assessed in this study

<table>
<thead>
<tr>
<th>Material</th>
<th>Trade name</th>
<th>Components</th>
<th>Lot No</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>Super line</td>
<td>Ti 99% (grade IV)</td>
<td>F22D010216</td>
<td>Dentium</td>
</tr>
<tr>
<td>Cement abutment</td>
<td>Dual milling abutment</td>
<td>Ti 99% (grade IV)</td>
<td>201609210007</td>
<td>Dentium</td>
</tr>
<tr>
<td>Screw abutment</td>
<td>Metal casting abutment</td>
<td>Plastic Cr–Co ring</td>
<td>201609210043</td>
<td>Dentium</td>
</tr>
<tr>
<td>Abutment screw</td>
<td>Titanium square</td>
<td>Ti 99% (grade IV)</td>
<td>201609321000</td>
<td>Dentium</td>
</tr>
<tr>
<td>Impression post</td>
<td>Impression hexagonal post</td>
<td>Ti 99% (grade IV)</td>
<td>201609312000</td>
<td>Dentium</td>
</tr>
<tr>
<td>Autopolymerizing acrylic resin</td>
<td>Acrylic</td>
<td>Methyl methacrylate, benzoyl peroxide initiator 0.3%, hydroquinone 0.006%</td>
<td>208404</td>
<td>New stetic</td>
</tr>
<tr>
<td>Casting alloy</td>
<td>Wironia</td>
<td>Ni 64.5%, Cr 22%, Mo 10%</td>
<td>73724</td>
<td>Bego</td>
</tr>
<tr>
<td>Feldspatic porcelain</td>
<td>VITA VM13</td>
<td>SiO$_2$, Al$_2$O$_3$, Na$_2$O, K$_2$O, etc.</td>
<td>66660</td>
<td>VITA</td>
</tr>
<tr>
<td>Self-adhesive resin cement</td>
<td>RelyX U200</td>
<td>Base paste*, catalyst paste*</td>
<td>634614</td>
<td>3M ESPE</td>
</tr>
<tr>
<td>Bonding agent</td>
<td>Single-bond adhesive</td>
<td>Dimethacrylate resins, HEMA, vitrebond copolymer, ethanol, initiators, fillers</td>
<td>N764207</td>
<td>3M ESPE</td>
</tr>
<tr>
<td>Filling material</td>
<td>Filtek 2350 XT</td>
<td>Bis-GMA, UDMA, TEGDMA, Bis-EMA resins, fillers</td>
<td>7018A28</td>
<td>3M ESPE</td>
</tr>
</tbody>
</table>

*Base paste: methacrylate monomers, silanated fillers, initiator components, stabilizers, rheological additives

*Catalyst paste: methacrylate monomers, alkane fillers, silanated fillers, initiator components, stabilizers, pigments, additives

HEMA, 2-hydroxyethyl methacrylate; bis-GMA, bisphenylglycidyl dimethacrylate; UDMA, urethane dimethacrylate; TEGDMA, triethylene glycol dimethacrylate; bis-EMA: ethoxylated bisphenol-A dimethacrylate
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were tested under thickness, and the specimens were glazed. Finally, to ensure that the furnace (Vacumat 6000 M, VITA, Bad Säckingen, Germany). Then, a framework (VM® 13, Vident, Bad Säckingen, Germany) was applied to the metal frameworks. After that, the specimens were fired in a porcelain furnace (Vacumat 6000 M, VITA, Bad Säckingen, Germany). Then, a digital caliper (IP67, Mitutoyo, Illions, USA) was used to verify the thickness, and the specimens were glazed. Finally, to ensure that the veneering porcelain was crack-free, the finished restorations were tested under x40 magnification.

SR MC Implant Restorations (Group S)
Waxed frameworks reproducing the anatomy and the required dimensions were processed using the CAD/CAM method described above for group C. A perforation of 3 mm was done on the occlusal surfaces using an electric wax knife to access the UCLA cylinder, and after that, a silicone index was made. The waxed frameworks with 3 mm hole were seated on the UCLAs acting collectively as waxed UCLAs. Subsequently, waxed UCLAs were sprued, invested, and casted. Finally, the precision of the frameworks and the porcelain application were checked with the same methods previously mentioned.

Cement- and Screw-retained MC Implant Restorations (Group CS)
The same procedure for group C was followed, except for a perforation of 3 mm that was made in the occlusal surface wax with an electrical wax knife representing the diameter of the abutment screw. A screwdriver tip was connected to the abutment screw head to maintain the SAH after casting and porcelain veneering procedures. Then, a silicone index was made and the procedure was followed by the methods described earlier.

Cementation of Restorations to Implant Abutments
The abutment screws were torqued to 35 N in groups C and S using the torque wrench (SCB 10 IT, Dentium, Seoul, South Korea) as recommended by the manufacturer. The screws were retightened after 5 minutes to counteract the effect of screw-settling phenomenon preventing the screw-loosening under compressive load, and the channels were filled with cotton pellets. In group C, the crowns were bonded to the abutments with self-adhesive resin cement (RelyX U200, 3M ESPE, Neuss, Germany), and the excess cement was removed with a no. 12 blade after light-polymerizing.

In group CS, the abutments were fixed to an analog acting as a holder. After that, the crowns were cemented extraorally to the abutments using a self-adhesive resin cement, finger pressure, and light-polymerizing (Fig. 1). The excess cement was removed with the blade, and the interface abutment-crown was polished with a SEM (Model Inspect S50, FEI, Oregon, USA) under x100 magnification. The mode of fractures was classified as adhesive (failure at the MC framework interface) or cohesive (failure within the ceramic).

Statistical analysis of the data was performed using SPSS 22 (SPSS Inc., Chicago, Ill) software for windows. The Shapiro-Wilk test was analyzed to evaluate normality. Fracture resistance mean values were calculated for the 3 groups and were compared by using one-way ANOVA test followed by the Tukey post hoc test (p < 0.05).

Fracture Mode and Patterns at the Fracture Origin
After fracture resistance testing, the fracture interface of specimens was observed using a digital light microscope under x40 magnification. Representative specimens were sputter with osmium for 30 seconds and were observed with a SEM (Model Inspect S50, FEI, Oregon, USA) under x100 magnification. The mode of fractures was classified as adhesive (failure at the MC framework interface) or cohesive (failure within the ceramic).

The results of load and mode fracture testing are shown in Table 2. The highest mean fracture resistance value occurred in group C (2718.00 ± 266.25 N) followed by group CS (2508.00 ± 153.59 N) and group S (2125.10 ± 293.82 N). One-way ANOVA test showed a significant difference between the 3 groups (p = 0.000). The results of Tukey post hoc test revealed significant differences in load fracture values between the group S and the other groups. However, the difference between group C and group CS was not significant (p = 0.154). The results are shown in Table 2.

Regarding the fracture mode, all specimens exhibited mixed adhesive fractures at the mesiolingual cusps. The detachment of...
the ceramic was smaller in group C specimens compared to the other groups with slight parts of metal framework exposures. Moreover, group C showed a limited extent of microcracks with smooth edges around paramarginal areas. Contrarily, group S showed many microcracks generated at the level of the SAH with rough edges. Group CS showed mixed microcracks with smooth and rough edges (Fig. 4). Complete fracture of the restorations, screw bending, screw fracture, or implant neck distortion was not observed in any of the specimens examined.

**Discussion**

The present *in vitro* study compared the fracture resistance of CR, SR, and CCSR MC molar restorations using abutments with 15° of angulation. Similar methodology has been reported by Mokhtarpour et al. and Hussien et al. who evaluated the fracture resistance of CR and CCSR in all ceramic restorations. However, currently, MC restorations are still considered the gold standard in implant-supported prosthetic treatments and would be interesting to know the function of the combination prosthesis in this type of restoration. In this study, abutments with 15° of angulation which are required frequently for tilted implants when the clinical conditions impede placing implants in a straight position due to anatomic limitations and atrophic ridges were used. The use of tilted implants avoids common approaches as guided bone regeneration, block grafts, lateralization of the inferior alveolar nerve, and alveolar distraction osteogenesis techniques are often accompanied by unpleasant complications, morbidity, increased cost, and uncomfortable postsurgical period for the patients.28,29

In this study, the mean fracture loads of groups C, S, and CS (2718 N, 2125 N, 2508 N) exceeded the maximum physiological occlusion forces reported on several investigations, namely, Calderon et al. (424 N to 587), Palinkas et al. (234 N to 344 N), and de Abreu et al. (424 N to 630 N). However, these results are common in these types of *in vitro* studies. The results of this study revealed significant differences between the groups tested. However, no significant differences in fracture resistance between groups C and CS were observed. Hence, the presence of a SAH does not have a significant effect on the strength of MC cemented crowns where 15° tilted abutments were used. These results are not in agreement with the findings reported by Mokhtarpour et al. Nevertheless, these authors evaluated CCSR design in all ceramic central incisors that could have influenced the results.

Fracture resistance of CR and CCSR MC molar restorations were previously compared in studies reported by Al-Omari et al. and Shadid et al. who concluded that CCSR had significantly the lowest values. However, two reasons could justify the differences between the previous studies and this study. First, zinc phosphate cement for cementing the restorations over the abutments was used which is different to self-adhesive resin cement used in this study. Second, the SAH was not filled. In this study, a cotton pellet was used to cover the SAH under the composite resin because this combination is one of the most used on prosthodontic departments. Derafshi et al. support the findings of this study. They concluded that there were no significant differences in fracture resistance between CR and CCSR MC molar restorations using straight abutments. Moreover, da Rocha et al. reported that SAH had not compromised the retention of metal copings over

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**Table 2:** Fracture load results in N and fracture mode testing of metal-ceramic implant-supported molar restorations

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Mean*</th>
<th>SD</th>
<th>CI</th>
<th>Maximum</th>
<th>Minimum</th>
<th>AF</th>
<th>CF</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>10</td>
<td>2718.00a</td>
<td>266.25</td>
<td>2907.74–2528.25</td>
<td>3,043</td>
<td>2,284</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>S</td>
<td>10</td>
<td>2125.10b</td>
<td>293.82</td>
<td>2335.28–1914.91</td>
<td>2,576</td>
<td>1,699</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>CS</td>
<td>10</td>
<td>2508.00a</td>
<td>153.59</td>
<td>2618.17–2398.42</td>
<td>2,731</td>
<td>2,292</td>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

C, cement-retained MC implant-supported molar restorations; S, screw-retained MC implant-supported molar restorations; CS, combined cement- and screw-retained MC implant-supported molar restorations; AF, adhesive fracture; CF, cohesive fracture.

*Identical letters indicate no statistically significant differences (Tukey post hoc test, p < 0.05).
the implant abutments. In implantology, it is important to evaluate the marginal fit between CR and CCSR metal copings to have a better understanding of the cementation accuracy. The decrease on fracture strength found in SR MC restorations compared with CR restorations is in accordance with previous studies reported by Sailer et al.9 and Zarone et al. 36 However, it is impossible to make a direct comparison because of the use of different instruments and materials. SEM observations confirmed the mixed adhesive mesiolingual cusp fractures observed with digital light microscopy. The presence of microcracks around the SAH with rough edges was evident in S and CS groups. However, smaller fractures were observed around the microcracks in the last group. Group C showed limited extent of microcracks with smooth edges spread to the paramarginal areas, and these observations are in accordance with Zarone et al.36 who realized a SEM fractographic analysis between SR and CR MC crowns and more microcracks at the level of the SAH in SR compared with CR restorations were found. An interesting point was that adhesive fractures occurred at the mesiolingual cusps in all the specimens that could have been influenced by the abutment access following the implant direction offset from the center of the occlusal surface towards the lingual cusps.

In this study, prefabricated and UCLA abutments were used similar to a previous clinical study of 12-year follow-up reported by Nissan et al.37 These authors mentioned that SAH in CRRs improves the survival rates and lowers porcelain fracture and screw loosening. These results show that the retrievability of CRRs has an important impact on the cost of maintenance.38

In 2015, Heo and Lim39 proposed to use a specially designed abutment called SCRP for CR frameworks with SAHs on the occlusal surfaces. However, these new abutments lack long-term documentation.12 The results obtained give greater confidence in the use of this new design for MC retrievable crowns cemented to a titanium abutment as an extraoral or intraoral cementation approach before abutment screw tightening. This type of restoration offers advantages over traditional implant-retained restorations such as retrievability and the ability to use definitive cement, removing the excess cement before clinical placement. Also, these restorations add an interface more capable of dissipating the forces between the implant-abutment connections. Therefore, CCSRMs will be an interesting option for patients with periodontal disease and overload bite.

This study had some limitations. The restorations evaluated did not undergo accelerated aging, such as thermocycling and physiologic fatigue loading. However, Gale and Darvell40 stated that there is no consensus about the need of thermocycling use to evaluate in vitro specimens. Despite the meticulous protocol followed to achieve the standardization of the restorations, the control of the 3D slumping of porcelain was difficult during the firing process. Nonetheless, in an attempt to standardize the sample, the frameworks were obtained by CAD/CAM process and silicone indexes were used to compare the porcelain applications. Moreover, digital caliper and digital light microscopy were used to evaluate the adaptation between the framework and the porcelain over the abutment shoulder.

Although the results of this study are promising, additional in vitro and long-term clinical studies are necessary before developing detailed recommendations for the clinical use of CCSRMs. Also, SAH preparation techniques need innovations and more research as well as the evaluation with different esthetic materials.

**CONCLUSION**

No significant differences were found on the fracture resistance between cement and CCSR MC molar restorations using abutments with 15° of angulation, but SR design significantly showed the lowest values of resistance. Screw access hole did not significantly affect the fracture resistance of cemented MC molar restorations. All the specimens exhibited mixed adhesive fractures at the mesiolingual cusps.

**ACKNOWLEDGMENTS**

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**REFERENCES**


