FIBER REINFORCED COMPOSITE VERSUS METALLIC FRAMEWORKS FOR IMPLANT SUPPORTED MANDIBULAR OVERDENTURES (STRESS ANALYSIS)

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Abstract This study was undertaken to analyze and compare the induced stresses at the osseointegrated implants, superstructures, prosthesis and the implant-bone interface area when utilizing two patterns of denture base reinforcement for implant supported mandibular overdenture; the glass fiber reinforced composite and the metallic frameworks. Two dimensional finite element method were implemented to build up the mesh model with element number = 7411 and total nodal number =22791.1 Newton load was exerted to the assembly in the axial direction to the long axes of the supporting implants and in the lateral (oblique) distomesially direction of 45 degree to the long axes of the supporting implants. It was found that the glass fiber reinforced denture base induced highest stresses at the implant –prosthesis complex, as well as at the implant-bone interface area with strain values near the borderline of the pathologic overload zone of the bone more than the metallic reinforced denture base. It was concluded that this may be attributed to the difference in the elastic moduli of the different patterns of denture base reinforcement and that the high rigid prostheses are recommended because the use of low rigid predicts the largest stresses at the implant-bone interface. The elastic moduli are 25.27 GPa for the glass fiber reinforced and 45.76 GPa for the metallic reinforced denture base.

Introduction

Implant overdentures are now accepted as a treatment alternative for many edentulous patients. Regardless of the technique used, the implants and attachments occupy space that would otherwise be filled with denture resin in the conventional denture. The result is either a denture that is thinner than normal, and therefore susceptible to fracture, or a bulky denture that may interfere with the tongue and speech.

To avoid either unfavorable situation, a metal framework is often made to provide rigidity and reinforcement to the acrylic resin overdenture, while allowing for natural contours of the denture resin. This metal framework is expensive, time-consuming to fabricate, unaesthetic and the metal alloys used pose potential toxicity problems during fabrication or after delivery.

Duncan et al, (2000)[1] described a method to fabricate a framework for an implant-supported overdenture using unidirectional glass fiber-reinforced composite (FRC) that replaces the standard Nickle chromium (Ni-Cr) or Cobalt chromium (Co-Cr) alloys frameworks. The authors stated that the advantages of a FRC framework make it a realistic option for replacement of a metal framework. A FRC framework has the potential to provide the same benefits as a metal framework in a more efficient manner.

Freilich et al, (2002)[2] stated that when FRC materials are compared to metal alloys, the toxicity and corrosion that plague metal and metal ions in the oral environment are not a concern with composite materials , and FRC substructures are less rigid than conventional metal substructures . Decreased rigidity may result in fewer fractures of an opposing complete denture and a difference in the strain placed on the dental implant-bone interface.

A key factor for the success or failure of a dental implant is the manner in which stresses are transferred to the surrounding bone. Finite element analysis method allows predicting stress distribution in the contact area of the implants with cortical bone and around the apices of the implants in the trabecular bone.

The aim of this study was finite element stress analysis of fiber reinforced composite versus metallic frameworks for implant supported mandibular overdenture. The stresses were analyzed under non-axial loads (lateral in distomesial direction at 45 degree to the long axes of the supporting implants) in the implant-bone interface.

Materials and Methods

Finite Element Analysis

The two dimensionally plane strain finite element method (2D-FEM) was selected to perform the stress analysis of this considered work. This method is particularly suitable for biological structure analysis as it allows great flexibility in dealing with geometric complex domains composed by multiple materials. In this study ANSYS software package was utilized.

Geometrical details:

The geometrical of the standard midlabiolingual section in the human interforaminal region of the mandible in the coronal plane with two osseointegrated root from implants, abutments, bar type superstructure with its clip and the implant supported overdenture PMMA denture base are illustrated as follows:

• Mandibular midlabiolingual section .

Length= 21 mm. With= 42 mm. The bony section represents cancellous bone.

• Implant fixture dimensions.

Length = 15 mm. Diameter= 3.4 mm. Number of threads=15.

Distance between the two implants=26 mm.

The implant on the left side of the model is referred to as implant 1, and the other one on the right side is referred to as implant2. Moreover implant-bone interface left to the implant 1 is assigned as area 1, Area 2 is denoting the interface between the right side of implant left 1 and the cancellous bone. The implant-bone interface left to implant 2 is area 3 and area 4 is the interface right to the implant 2.

• Implant abutments.

Length =3 mm. Diameter=3.4 mm.

• Abutment's screw.

Length =5 mm. Diameter=1.25 mm.

• Bar attachment (substructure).

Thickness= 2 mm. Inverted pear in cross section, the upper dimension = 2.5 mm and the lower =1.5 mm. width=45 mm.

• Bar connector and fixation screws.

Connector: Length= 3 mm. Diameter = 3.4 mm. Screw: Length= 5 mm. Diameter=1.25 mm.

• Metallic sleeve and rubber rider.
Width= 5 mm. Diameter= 3 mm.

• PMMA denture base.
Thickness= 2 mm. Width= 45 mm.

The denture base is postulated in a there separated different patterns of reinforcement which are:

1. Conventional (unreinforced) denture base utilized as control .
2. Reinforced with glass fiber reinforced composite (RB).
3. Reinforced with Cobalt chromium (Co-Cr) alloy framework (MB).

Finite element mesh:
The model was meshed using 2D plane stress element type, with quadrilateral shape, 0,2 mm size and 8 nodes for each element. The total element number is 7411, and the total nodal number is 22791.

Materials properties:
Finite element models, however, assume that materials are idealized as homogeneous and generally isotropic, linearly elastic and to be rigidly bounded together with continual interfaces between them. The elastic properties of the materials used to build up the model are as the follows:

1. Cancellous bone : Young's modulus : 1.37 sGPa, Poisson's ratio: 0.31 (Borchers and Reichart,1983)[3]
2. Cobalt chromium alloy : Young's modulus: 218 Gpa, poisson's ratio: 0.33(Craig, 1989)[4]
3. Titanium: Young's modulus: 115 GPa, Poisson's ratio: 0.35 (Meijer et al., 1993)[5]
4. Rubber rider; Young's modulus: 0.005 GPa, Poisson's ratio: 0.45 (Tillitson et al., 1971)[6]
5. PMMA denture base: Young's modulus: 2.7GPa, Poisson's ratio:0.35 (Craig, 1989)[4]
6. Glass FRC: Young's modulus: 72GPa, Poisson's ratio: 0.2 (Freilich et al., 2000)[7]

Vallittu (1996)[8] stated that the highest transverse strength with PMMA-based fiber composite was obtained by incorporating 58% weight (33% volume) glass fiber into PMMA resin. So, the Young's modulus and Poisson's ratio of the denture base reinforced with glass fiber reinforced composite (RB) are calculated by the equations:

1. Young's modulus:

$$E= (v_1 E_1) + (1-v_1) E_2$$

$= (0.33 \text{ X } 72) + [(0.67) \text{ x}2.7]$

$=25.57$ GPa

2. Poisson's ratio:

$V= (v_1 v_1) = (1-v_1)\, v_2$

$= (0.2 \text{ X } 0.33) + (0.8 \text{ X } 0.35) = 0.346$

Boundary conditions:

The boundary conditions in finite element models basically represent the loads imposed on the structures under study and their fixation counterparts, the restraints. In addition, they may involve interaction of groups of interconnected finite elements (constraints) or physically separated bodies (contact).

Constraints on nodal displacements were fed as input data to prevent movement of some nodal points along a specific direction according to the physical nature of the deformation taking place in the assembly with the different denture base patterns. The supporting alveolar bone was fixed along its boundaries as well. The finite element mesh model was loaded with 1 Newton (N) load in two directions; axial (vertical) direction along the long axis of the supporting implants and non-axial direction (oblique load of 45 degrees to the vertical axis of the supporting implants distomedially). The different patterns of denture base were interchanging for each load by applying the elastic properties for each one as input data.

Results

Regarding the dental implants; the stress contours with maximum von Mises stresses values of 0.680 MPa when conventional (unreinforced) denture base (PMMA) was utilized, 0.734 MPa with glass fiber reinforced denture base (RB) and 0.677 MPa for metallic reinforced denture base (MB). For the surrounding cancellous bone the maximum von Mises stresses were concentrated more around the necks (crestal bone) of the dental implants with the values of 0.252 MPa for PMMA, 0.244 MPa for RB and 0.227 MPa for MB.

Discussion

The use of implants to provide support for overdentures is an attractive treatment because it improves retention, stability, function and comfort of the prosthesis. Due to the relatively large space needed in the denture base to occupy the implants, abutments and attachment, the result is either a denture that is thinner than normal and therefore susceptible to fracture or an overbulked denture that may interfere with the tongue and speech; both are unfavorable situations for the patient. Therefore, reinforcement of the denture base with metallic or fiber reinforced composite frameworks may solve those problems without increasing the thickness of the denture base. However, the effect of this framework reinforcement on the stress distribution around the implants has not been clarified. This study aimed to investigate, analyze and compare the stresses around the implants supporting overdentures, when reinforced with metallic and glass reinforced frameworks. This study used two dimensional finite element methods (2D FEM) to investigate the stresses around implants supporting overdenture. The finite element method (FEM) is one of the most frequently used methods in stress analysis in dentistry. It is an accepted theoretical technique used in the solution of engineering problems. In implant dentistry, finite element analysis has become an increasingly useful tool for the prediction of the effect of the internal generated stresses and the distribution of these stresses in the contact areas of the implants with surrounding bone. FEM has other advantages, including accurate representation of complex geometries and easy model modification. FEM is a mathematical model of a real object and it is usually impossible to reproduce the entire details of natural behavior. Thus, an experimental or clinical study cannot be completely replaced by a numerical test. Several assumptions were made in the development of the model in the present study. The structures in the model were all assumed to be homogeneous and isotropic and to possess linear elasticity (Yokoyama et al., 2004)[9]. The properties of the material modeled, particularly the living tissues (cancellous bone), however are different. For instance, it is well documented that the bone is homogeneous and anisotropic. All interfaces between the materials were assumed to be bonded or completely osseointegrated, which is not 100% found naturally. In addition, the modeled section of the mandible was composed entirely of cancellous bone. Therefore, inherent limitations of FEM must be acknowledged.

When applying FE analysis to dental implants, it is important to consider, not only, axial loads and horizontal forces (moment-causing loads), but also a combined load (oblique occclusal forces) because the latter represents more realistic occlusal directions and, for a given force, will result in localized stress in the surrounding bone. Naturally, in-vivo, the occlusal forces exerted on the abutment (tooth or implant) vary in direction and magnitude; the largest forces occur along the axial direction, while the lateral component of the occlusal force is significantly smaller (Brunski, 1997)[10]. Oblique of 45 degree to the vertical axis of the supporting implant loads were considered. The results obtained from the analyses when IN load was exerted to the models are compared as follows:

The induced von Mises stresses in the MB and its rider component the highest, followed by RB and PMMA with their riders respectively. The opposite was for the sleeves: the highest induced stresses were accompanied with PMMA followed by RB and MB respectively.

For the superstructure bar, implant abutments and the surrounding cancellous bone, the induced von Mises stresses were the highest when postulated PMMA, and the lowest with MB. The situation was completely different with the fixation screws and the implant fixtures, the highest stresses were registered when the RB was postulated, and the lowest stresses occurred with MB.

Regarding the implant-bone interface areas (area1-area4), the induced von Mises stresses were the highest (in a similar aspect to the axial load) when loading the unreinforced denture base (PMMA) (the maximum values were 0.379 MPa (276.64 microstrain) along the bone side of the implant-bone interface area1 and 1.48 MPa along the implant side of the implant-bone interface area 2). Followed by by the glass fiber reinforced denture base (RB) (the maximum values were 0.366 MPa (267.15 microstrain) along the bone side of of the implant-bone interface area 2 the lowest stresses were generated in the implant-bone interface areas when using Co-Cr framework reinforced denture base (MB) the maximum values were 0.340

MPa (248.18 microstrain) along the bone side of the implant-bone interface area 1 and 0.877 MPa along the implant side of the implant-bone interface are 1. According to Frost, (1987)[11] who proposed that bone responds to a complex interaction of strain magnitude and time. As bone strains are typically very small, it is common to use the term μ strain (microstrain). Conceptually, the interfacial bone maturation, crestal bone loss and loading can be explained by the Frost mechanostat theory, which connects the two processes of modeling (new bone formation) and remodeling (continuous turnover of older bone without a net change in shape or size). In accordance with the theory, bone acts like a 'mechanostat', in that it brings about a biomechanical adaptation, corresponding to the external loading condition. Frost described four microstrain zones and related each zone to a mechanical adaptation. The four zones include the disuse atrophy, steady state, physiologic overload and pathologic overload zones. Both extreme zones (pathologic overload zone and disuse atrophy zone) are proposed to resolve in decrease in bone volume. When peak strain magnitude falls below 50-200 μ strain, disuse atrophy is proposed to occur, a phenomenon that is likely to explain ridge resorption after tooth loss. In the pathologic overload zone, peak strain magnitude of over 4000 strain may result in net bone resorption. The steady sate one comprises the range between disuse atrophy and physiologic overload zone, and is associated with organized, highly mineralized lamellar bone . The strain magnitude of 100-2000 μ strain is thought to elicit this favorable bone reaction. The physiologic bone overload zone covers the range between 2000 and 4000 μ strain, and is suggested to result in increase in bone mass. The new bone formed is woven bone (immature bone) that is less mineralized, less organized and consequently weaker than the lamellar bone. It is probable that bone mass will increase, until the bone interface accommodates this change, and the load strain values that falls back into the range of steady state zone.

Haraldson and Carlsson(1977)[12] measured 15.7 N for gentle biting, 50.1N for biting as when chewing, and 144.4N for maximal biting for 19 patients who had been treated with implants for 3.5 years. In another study, Carr and Laney, (1987)13 reported maximal bite forces between 4.5 and 25.3 N before and 10.2-57.5 N after 3 months of treatment with implant-supported prosthesis, and emphasized that the amount of increase was dependent on the duration of being edentulous.

If an average of 30 N force is applied axially, the maximum strain magnitudes in the peri-implant bone are 4270 μ strain with PMMA, which is located within the pathologic overload zone, 3941μ strain (proximate to the borderline of the pathologic overload zone) for RB and 3285 μ strain for MB which is located within the physiologic overload zone. Above the magnitude of 36 N in the axial direction, the peri-implant supporting bone of the various patterns of denture base reinforcement is located within the pathologic overload zone. While, if an oblique (non-axial) force of 20N or more is exerted, the peri-implant supporting bone of the various pattern of denture base reinforcement is located within the pathologic overload zone.

Occlusal loads, in general are classified as axial and non-axial forces. Axial forces act perpendicular to the occlusal plane and are suggested to be more favorable as they distribute stress more evenly throughout an implant, while non-axial forces

act in a non-perpendicular direction to the occlusal plane thought to disrupt the bone-implant interface (*Isidor, 1996*).
Depending on the magnitude and the direction of the force, force appeared to induce higher stresses at the implant-bone interface areas when PMMA is utilized; i.e. stress transmission is greatest, for MB it is found that the transferring of stresses were the lowest to implant-bone interface. Moreover, RB gained the intermediate state of transmission of the stresses to implant-bone interfaces. This may be attributed to the difference in the elastic moduli of the different patterns of denture base reinforcement. PMMA with the lower elastic modulus which is 2.7 GPa induced highest stresses and concentrate them at the implant-bone interface areas on the loading side than the RB and Mb which have elastic moduli equal to 25.57 and 45.76 GPa respectively.

Benzing et al., (1995)[15] recommended to use high-rigidity prostheses, because the use of low elastic moduli alloys for the superstructure predicts larger stresses at the bone-implant interface on the loading side, than he use of a rigid alloy for a superstructure with the same geometry. Stegariou et al., (1998)[16] used 3-dimensional FEA to assess stress distribution in bone, implant and abutment when gold alloy, porcelain or resin (acrylic or composite) were used for a 3-unit prosthesis. In almost all situations, stress in the bone-implant interface with the resin prosthesis was similar to or higher than that in the models with the other 2 prosthetic materials. Sertgoz, (1997)[17] used three-dimensional finite element analysis to investigate the effect of three different occlusal surface materials (resin, resin composite, and porcelain) and four different framework materials (gold, silver-palladium, cobalt-chromium, titanium alloys) on the stress distribution in a six-implant-supported mandibular fixed prosthesis and surrounding bone. One of the main results of his study was demonstrated that using prosthesis superstructure material with a lower elastic modulus did not lead to substantial differences in stress patterns nor in values at the cortical and spongy bones surrounding the implants.
Despite significant differences between the previous studies and the current one (implant-supported mandibular overdenture), the concept of prosthesis materials, their elastc moduli and the mode of stress transferring to the implant supporting bone are approximately common.

Conclusions

A two dimensional finite element model was constructed to compare the stresses transferring to the implant-bone interface by two different patterns of implant supported denture base reinforcement; glass fiber reinforced denture base and Co-Cr framework reinforced denture base as well as unreinforced denture base was utilized. Within the limitations of this study, the following conclusions were drawn:
1- Oblique loads induced higher stresses, while vertical loads resulted in better distributed stress.
2- The conventional denture base (unreinforced denture base) and the glass fiber reinforced denture base induced the highest stresses at the implant-bone interfaces.

3- Denture base reinforced with Co-Cr framework induced the lowest stresses with better distribution.

4- High rigid prostheses are recommended because the use of low rigid predicts largest stresses at the implant-bone interface.

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