



KEYNOTES AND RESOURCES

Episode 141 – AO and AAP Consensus on Prevention and Management of Peri-Implant Diseases and Conditions: Part One **September 26, 2025**

Introduction

The Academy of Osseointegration (AO) and American Academy of Periodontology (AAP) released a consensus report offering evidence-based strategies to prevent and manage peri-implant diseases and conditions. The report was developed by more than 40 experts, including periodontists, prosthodontists, general dentists, and oral surgeons involved in dental implant therapy. The collaborative workshop focused on both prevention and surgical management of peri-implant diseases.¹

Detailed flow diagrams were created to guide clinicians through treatment pathways. Risk assessment and prosthetic considerations were emphasized, noting how implant positioning, soft tissue phenotype, and prosthetic design affect long-term outcomes. [1]

Background

The global use of dental implants has risen significantly over recent decades. This widespread use has also increased the prevalence of peri-implant complications. Peri-implant diseases are primarily biofilm-mediated inflammatory conditions that compromise the soft and hard peri-implant tissues. There are two distinct peri-implant diseases: peri-implant mucositis and peri-implantitis.² Peri-implant mucositis affects approximately 43-47% of individuals with dental implants, with peri-implantitis affecting 20-22%. [2]

Peri-implant mucositis is characterized by inflammation of the soft tissues around the dental implant, without progressive bone loss beyond the normal physiological bone remodelling. Clinical signs of peri-implant mucositis include bleeding on gentle probing, erythema, swelling, and/or suppuration. If not treated effectively, peri-implant mucositis may progress to peri-implantitis. [2] [3]

Peri-implantitis is characterized by persistent inflammation of the peri-implant mucosa and progressive loss of supporting bone that can compromise the longevity of the dental implant. Compared to periodontitis, bone loss associated with peri-implantitis tends to progress more rapidly, following a nonlinear, accelerating pattern. [2]

¹ Refer to Episode 46 for discussion on the AAP classification of peri-implant diseases and conditions.

² Refer to Episode 84 for additional information on peri-implant disease.

Peri-implant biofilms are considered the primary etiological factor in the onset and progression of peri-implant diseases. Risk factors for peri-implant diseases include:

- Previous history of periodontitis
- Diabetes³
- Obesity⁴
- Smoking⁵
- Heavy alcohol consumption⁶
- Lack of preventive maintenance programs
- Surgical variables (e.g., dental implant malposition)
- Prosthetic parameters (e.g., abutment height or restorative emergence angle and profile, which are linked to an increased risk of peri-implant marginal bone loss) [2]

Understanding these risk factors is crucial for proper case selection and treatment planning to minimize the risk of peri-implant diseases, including conditions such as peri-implant soft tissue dehiscence. Prevention is essential to dental implant success due to the lower predictability of successfully treating peri-implant disease compared to treating periodontitis.⁷ [2]

Peri-implant disease treatment

Peri-implant disease treatment can be divided into nonsurgical and surgical therapies. Nonsurgical therapy primarily involves debridement using various devices, with possible adjuncts, such as antiseptics or antibiotics. Nonsurgical debridement remains the primary approach to treat peri-implant mucositis. Addressing risk factors, such as smoking, improper prosthetic design, deficient oral self-care,⁸ is also necessary. Although evidence suggests that adjunctive therapies can help reduce biofilms, they may not provide significant benefits over debridement alone in achieving long-term success. [2]

Surgical treatment can be divided into non-reconstructive and reconstructive therapies, with the common goals of decontaminating the dental implant surface and reducing peri-implant pocket depth. Non-reconstructive surgeries aim to provide access to remove biofilm, decontaminate the dental implant surface, and reduce pocket depth, though disease resolution remains a challenge in some cases. [2]

Reconstructive surgeries aim to gain bone and restore the architecture of peri-implant bone, either alone or in combination with soft tissue augmentation. These techniques have shown potential in achieving greater pocket depth reduction and peri-implant bone gain. However, their effectiveness in decreasing mucosal inflammation and preventing disease recurrence has been limited. Adjunctive pharmacotherapy, such as the use of antiseptics or antibiotics, has also been proposed in conjunction with surgical therapy. However, there is limited evidence to support their added value. [2]

³ Refer to Episodes 91, 93, and 94 for detailed discussion on diabetes and oral health.

⁴ Refer to Episodes 120, 121, and 122 for discussion on obesity and oral health.

⁵ Refer to Episode 101 for additional information on tobacco use and cessation.

⁶ Refer to Episodes 104 and 105 for discussion on substance use and oral health.

⁷ Refer to Episodes 128 and 129 for additional information on periodontal therapy.

⁸ Refer to Episode 89 for additional information on oral self-care.

The main challenge in peri-implant disease treatment is effectively decontaminating the dental implant surface due to the complex design and microscopic features of most dental implants. Various approaches have been investigated to develop optimal decontamination protocols that eliminate biofilms without damaging the dental implant surface or hindering re-osseointegration. Many studies have compared the effectiveness of different decontamination methods, including the use of curettes, ultrasonic devices, pharmacotherapeutics, (e.g., chlorhexidine⁹ and citric acid), air polishing systems,¹⁰ implantoplasty, antimicrobial photodynamic therapy, and lasers, either individually or in combination. While all these methods have shown varying degrees of success in completely removing biofilms, no gold standard method has yet been established. [2]

Methods

The goal of the AO and AAP consensus meeting was to evaluate and synthesize the most relevant evidence on the epidemiology, risk factors, and management of peri-implant diseases and conditions. The evidence, combined with expert opinion, aimed to develop an evidence-based framework to identify risk factors at the client and dental implant site levels and to propose comprehensive treatment recommendations and decision-making tools to manage peri-implant diseases and their sequelae. [2]

The event was held in Oak Brook (Illinois, USA) from August 14-16, 2024 and brought together a panel of international experts with extensive clinical and research experience in peri-implant disease risk assessment and management. Participants were divided into two groups. Group one focused on defining client- and site-level risk profiles associated with the onset and progression of peri-implant diseases and peri-implant associated defects. Group two focused on developing risk-stratified treatment protocols based on current scientific evidence and clinical best practices. [2]

Results

Each group was assigned four focused research questions, which were addressed through systematic reviews, with meta-analyses performed where possible. The findings of each systematic review were presented and the available evidence was categorized as high, moderate, or low/unknown quality. Panel members appraised the presented evidence and contrasted it with their experiential knowledge.

Participants voted on their agreement with the presented statements. The degree of consensus was classified according to the following grading system:

- Unanimous (100% agreement),
- Strong consensus (greater than 95% of participants),
- Consensus (75%-95%),
- Simple majority (50%-74%), or
- No consensus (less than 50%).

⁹ Refer to Episode 103 for additional information on the role of mouthrinses in oral care.

¹⁰ Refer to Episode 35 for discussion on air polishing.

This grading system was used to construct evidence-based flow diagrams to guide clinical decision-making. The final consensus papers were published across multiple journals.¹¹ [2]

Client-related risk factors and indicators for peri-implant diseases

Research has shown various systemic factors, including smoking, diabetes, metabolic syndrome, cardiovascular diseases,¹² obesity, and alcohol consumption, significantly influence bone physiology and wound healing. As a result, these conditions may be important risk indicators or factors¹³ for the prevalence and incidence of peri-implant diseases. [4]

The systematic review and meta-analysis by [Galarraga-Vinueza et al. 2025](#) assessed the incidence, prevalence, systemic, behavioural, and client-related risk indicators and factors for peri-implant diseases in adults with dental implants. [4]

Their meta-analysis found nearly half of people with dental implants had peri-implant mucositis, and about one in five had peri-implantitis. Over a period of 20 years, the incidence rates for developing these conditions were approximately 53% for mucositis and 22% for peri-implantitis. [4]

The authors identified several health and lifestyle factors that may increase the risk of peri-implant diseases. Smoking and periodontitis were recognized as risk indicators for developing both peri-implant mucositis and peri-implantitis. Obesity was identified as a potential risk indicator for peri-implant mucositis. Diabetes and alcohol consumption were identified as possible risk indicators for peri-implantitis. However, the evidence linking alcohol consumption and peri-implantitis is limited. There is weak evidence suggesting hypertension¹⁴ and other cardiovascular conditions can influence the prevalence of peri-implant diseases, indicating the need for further research to clarify this association. [4]

Surgical- and implant-related factors

Peri-implant diseases and periodontal diseases share similar causes and risk factors. However, they differ significantly in their development and progression. Experimental peri-implant mucositis can be partially reversible, but its resolution may take twice as long as that of experimental gingivitis. If left untreated, peri-implant mucositis may lead to peri-implantitis. Peri-implantitis lesions are more than twice as large as those seen with periodontitis. Evidence suggests peri-implantitis might be more destructive and progress at a faster rate than periodontitis. [3]

Studies show peri-implantitis is a complex infection caused by various periodontopathic organisms, including *Tannerella forsythia*, *Prevotella intermedia*, *Fusobacterium*

¹¹ Refer to the additional resources below for hyperlinks to the consensus papers.

¹² Refer to Episodes 78, 79, and 80 for discussion on cardiovascular diseases and oral health.

¹³ Note: Risk indicators may determine associations and are identified in observational studies. In contrast, risk factors are characteristics that increase the likelihood of developing a disease and are confirmed through longitudinal interventional studies. [4] [8]

¹⁴ Refer to Episodes 135 and 136 for additional information on hypertension and oral health.

nucleatum, *Porphyromonas gingivalis*, as well as uncultivable anaerobic gram-positive and gram-negative rods, enteric rods, and *Staphylococcus aureus*. Additionally, the microbiome around dental implants is more diverse and varied than that around natural teeth. Research indicates less than 50% of the species found in the biofilms around teeth and dental implants overlap, with 85% of the abundant species being shared in less than 8% of cases. Therefore, while the infectious nature of peri-implant diseases is evident, the microbiomes associated with periodontal tissues and dental implants are distinct ecosystems. [3] [5]

Peri-implantitis is site specific, which means in susceptible individuals, certain sites may be more prone to developing peri-implantitis compared to others in clients with multiple dental implants. This emphasizes the importance of local factors that may predispose or precipitate plaque accumulation and affect the immune response¹⁵ in the prevention and management of peri-implant diseases. For example, data from a clinician survey indicated that factors such as dental implants placed too buccally, thin soft tissue thickness, and a deficient buccal band of keratinized mucosa contribute to peri-implantitis. Some researchers have speculated that peri-implantitis may represent an inflammatory disease initiated by bacterial challenge that is essentially a “human-made” disease triggered by local factors that lead to a foreign body reaction to the dental implant. Thus, site-specific conditions appear to favour peri-implant disease development. [3] [6] [7]

The systematic review by Monje et al. (2025) examined the impact of surgical and implant-related factors on the onset and progression of peri-implant diseases. The review found improper dental implant positioning plays a critical role in the peri-implantitis development and progression. Dental implants placed in regenerated bone also contribute to peri-implantitis to a lesser extent. Additionally, a short distance between the prosthetic margin and the crestal bone during dental implant placement may be a predisposing factor for peri-implantitis. [3]

Prosthetic design and peri-implant bone loss

Crestal bone remodelling is a natural process that occurs after dental implant placement. Various local and systemic factors influence this process. However, it is essential to differentiate between initial physiological bone remodelling and progressive crestal peri-implant bone loss, as the latter indicates an ongoing pathological process. Alveolar bone remodelling during the first year in function may depend on the type and position of the dental implant, but loss of alveolar bone starting after the dental implant was placed in function should not exceed 2 mm. Changes of 2 mm or more at any time during or after the first year should be considered pathologic. [8] [9]

Once the bone remodelling is complete, a supracrestal soft tissue attachment interface develops around the dental implant, with fibre bundles oriented parallel to the dental implant surface. [10]

¹⁵ Refer to Episodes 44 and 45 for additional information on the immune system.

The cause of peri-implant marginal bone loss is multifactorial. These factors can be associated with plaque biofilm, surgical practises, and prosthetic designs. Growing evidence shows strong associations between dental implant prosthetic design, biofilm accumulation, and peri-implant health. [10]

Various prosthetic factors play a significant role in influencing peri-implant marginal bone levels, including:

- Screw-retained versus cement-retained implant prostheses
- Nonsplinted versus splinted dental implants
- Platform-switched abutments
- External versus internal abutment connections
- Crown-to-implant ratio
- Abutment heights
- Frequency of abutment disconnections
- Emergence angle and profile [10]

Without careful consideration of prosthetic designs, the risk of peri-implant bone loss escalates, potentially leading to peri-implant disease and unfavourable outcomes. [10]

Previous systematic reviews have explored how different prosthetic factors impact peri-implant bone levels. However, there is still a need for a comprehensive assessment of emerging concepts. A systematic review and meta-analysis by [Lin et al. \(2025\)](#) examined various principles of prosthetic design and their associated risks of peri-implantitis and marginal bone loss. [10]

The authors found certain factors were associated with reduced marginal bone loss, such as:

- Nonsplinted dental implants
- Platform-switched abutments
- Abutment heights of 2 mm or more
- One abutment-one time protocol
- Emergence angles less than 30°
- Concave or straight emergence profile

Additionally, no definitive benefit was found between screw-retained and cement-retained prostheses or varying crown-to-implant ratios.

Nonsplinted dental implants

Nonsplinted dental implants showed reduced marginal bone loss compared to splinted implants. This highlights the need for clinicians to be cautious with splinted dental implants due to the potential risk of peri-implantitis. However, evidence also suggests a higher incidence of biomechanical and prosthetic complications, such as screw loosening, when dental implants are not splinted. Therefore, in certain situations, such as when there is a large interarch distance, heavy occlusal forces, or increased clinical crown height, splinted restorations may be better to reduce the risk of these complications. [10]

Platform-switched abutments

A statistically significant reduction in marginal bone loss when using platform-switched abutments compared to platform-matched abutments. However, there was no difference in the dental implant survival rate. These findings highlight the benefits of using a narrower abutment. This design promotes a horizontal inward shift of the microgap at the dental implant-abutment interface, especially in cases with internal implant connections. Additionally, platform-switched implants provide extra space for soft tissue growth, resulting in thicker soft tissue. This enhancement improves dental implant aesthetics and stability of the surrounding soft and hard tissues, especially in the anterior region. [10]

One abutment-one time protocol

One abutment-one time approach, which involves attaching the definitive abutment during the implant placement surgery, significantly reduced marginal bone loss. However, it is important to recognize that following this protocol may present challenges, such as adjusting the emergence angle and profile, as well as limiting flexibility for final restorative margin adjustment. Therefore, clinicians should weigh the risks and benefits before choosing the one abutment-one time protocol. [10]

Emergence angle

An emergence angle of less than 30° and a concave or straight emergence profile are associated with a lower risk of peri-implantitis. This is because an over-contoured profile can hinder proper oral hygiene, potentially leading to tissue inflammation and soft tissue recession. [10]

Screw-retained vs. cement-retained prostheses

No definitive advantage between screw-retained and cement-retained prostheses was found in the review. However, residual cement has been identified as a potential factor contributing to peri-implant tissue inflammation and bone loss. To address concerns about residual cement, several techniques have been developed to minimize this issue. Some studies have used water-soluble zinc oxide cement or glass ionomer cement to reduce residual cement. Others have introduced radiopaque resin cement for easier cement removal. Techniques such as magnification or refining the finish line to enhance biological compatibility have been used for more effective cement removal. Additionally, most of the studies included in this review were conducted in academic settings, where cemented crowns were placed by experienced specialists. These factors may have influenced the findings, suggesting that there is no clear association between the type of prosthesis retention and marginal bone loss. With proper selection and removal of cement, cement-retained prostheses exhibit marginal bone levels comparable to those that are screw retained. [10]

Client-specific homecare

These findings demonstrate careful dental implant design can enhance long-term oral health, minimize complications, and ensure stability around dental implants. Regardless of prosthetic design, it is essential to provide clients with customized homecare instructions based on factors such as their dexterity and the accessibility of the prosthetics for cleaning. Neglecting to do so may increase the risk of peri-implantitis.

For hard-to-reach areas, using a smaller-diameter interdental brush is recommended. When implant-supported restorations limit access for oral hygiene, a stiffened-end dental floss threader may effectively facilitate proper homecare. Long-term peri-implant health requires not only well-designed prosthetics but also a structured maintenance protocol and thorough homecare instructions for clients. [10]

Soft tissue dehiscence at implant sites

Thousands of dental implants are placed every day to facilitate oral rehabilitation. Dental implants have a significant positive impact for many people. However, implant-related complications can occur, such as soft tissue dehiscence, which have become a concern due to clients' aesthetic expectations. [11]

Soft tissue dehiscence (recession) at dental implant sites has been compared to gingival recession in natural teeth, with some authors suggesting these conditions may share similar causes. Unlike shallow gingival recession in natural dentition, which may not always raise aesthetic concerns, even a minor soft tissue dehiscence that exposes the titanium surface of an implant or abutment can compromise aesthetics and increase the risk for the onset and a more rapid progression of peri-implant diseases. [11]

Tavelli and Barootchi (2025) conducted a systematic review and meta-regression analysis to evaluate the prevalence and incidence of soft tissue dehiscence at implant sites in absence of disease, together with the related risk and protective factors.

The following definitions were used:

- Peri-implant soft tissue dehiscence is the apical position of the peri-implant soft tissue margin in relation to the cemento-enamel junction (CEJ) of the tooth in the same position on the opposite side of the mouth.
- Mucosal recession is the presence of a mucosal cleft that exposes the implant shoulder, prosthetic abutment, or implant surface.
- Apical shift of the mucosal level is the progressive apical shift of the soft tissue margin over time compared to the position of the mucosal level at crown delivery. [2]

Soft tissue dehiscence is commonly observed at implant sites. The estimated prevalence of peri-implant soft tissue dehiscence was 46.2%, while its incidence within the first 5 years from loading was up to 38.3%. [11]

The authors' identified several risk and protective factors associated with peri-implant soft tissue dehiscence, mucosal level apical shift, and mucosal recession. For example:

- Risk factors for peri-implant soft tissue dehiscence include reduced mucosal thickness, immediate implant placement, and lack of soft tissue augmentation.
- Risk factors for mucosal level apical shift include reduced mucosal thickness, inadequate keratinized mucosa width, and immediate implant therapy
- Protective factors for mucosal level stability include digital guided implant surgery, bone grafting at implant placement, soft tissue augmentation, and adequate keratinized mucosa width and mucosal thickness.
- Risk factors for mucosal recession include insufficient keratinized mucosa width and interproximal marginal bone loss.

- Several risk indicators and risk factors of peri-implant soft tissue dehiscence, mucosal level apical shift, and mucosal recession include implant malpositioning, surgical factors, soft tissue-related parameters, bone-related parameters, and prosthetic factors.
- Connective tissue graft-based soft tissue augmentation procedures were the most common and effective therapies for managing peri-implant soft tissue dehiscence and mucosal recessions. [11]

Preventive strategies targeting these contributing factors are vital to mitigate soft tissue defects and enhance client-reported outcomes. [2]

Evidence-based clinical considerations for peri-implant soft tissue dehiscence include:

- Dental implants should be placed in a favourable three-dimensional position.
- Computer-assisted guided implant placement is recommended.
- Identify and address thin buccal bone and dehiscence before or at the same time as implant placement.
- Delaying implant placement may minimize the effect of some risk factors.
- Soft tissue augmentation during implant placement or before final restoration can significantly reduce the risk of aesthetic complications.
- Consider using a flapless surgical approach.
- For long-term mucosal stability, attempt to maintain interproximal bone level. [2]

Take home messages

- The use of dental implants has significantly increased over the past few decades, offering both functional and aesthetic benefits to many clients. However, this widespread adoption has also led to a rise in peri-implant complications. As a result, oral health professionals need to be well-informed about the prevention and treatment of peri-implant diseases and conditions.
- Educating clients on the importance of managing systemic conditions, periodontitis, and harmful habits, such as smoking and alcohol consumption, that may affect peri-implant disease progression, is vital.
- Surgical and implant-related parameters, including prosthesis design, critically influence the onset and progression of peri-implant diseases, particularly improper implant positioning. Thus, careful case selection and implant treatment planning are essential to minimize the risk of peri-implant diseases.
- Customized homecare regimes are crucial for dental implant health, emphasizing daily oral hygiene practices to prevent plaque accumulation. Client education should also highlight the importance of attending regular maintenance visits to monitor dental implant health.

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Client Resources

Dental Implants, ODHA factsheet

<https://odha.on.ca/wp-content/uploads/2016/08/ODHA-Facts-Dental-Implants.VFS23.3.pdf>

Smoking and Smokeless Tobacco, ODHA factsheet

<https://odha.on.ca/wp-content/uploads/2016/08/ODHA-Facts-Smoking.VFS19.1-copyright.pdf>

Additional Resources

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<https://www.quintessence-publishing.com/usa/en/article/6246721/the-international-journal-of-oral-maxillofacial-implants/2025/supplement/efficacy-of-decontamination-methods-for-biofilm-removal-from-dental-implant-surfaces-and-reosseointegration-an-aapao-systematic-review-on-peri-implant-diseases-and-conditions>

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