Influence of scaling procedures on the integrity of titanium nitride coated CAD/CAM abutments

Peter Gehrke1*, Emmanouil Spanos2, Carsten Fischer3, Helmut Storck4, Florian Tebbel5, Dirk Duddeck6

1Private Practice, Ludwigshafen, Germany
2Private Practice, Sulzheim, Germany
3Dental Laboratory, Sirius Ceramics, Frankfurt am Main, Germany
4Dental Laboratory, LUSANUM, Ludwigshafen, Germany
5Mechanical Engineering, Mannheim, Germany
6Medical Materials Research Institute, Berlin, Germany

PURPOSE. To determine the extent of treatment traces, the roughness depth, and the quantity of titanium nitride (TiN) removed from the surface of CAD/CAM abutments after treatment with various instruments. MATERIALS AND METHODS. 12 TiN coated CAD/CAM abutments were investigated for an in vitro study. In the test group (9), each abutment surface was subjected twice (150 g vs. 200 g pressure) to standardized treatment in a simulated prophylaxis measure with the following instruments: acrylic scaler, titanium curette, and ultrasonic scaler with steel tip. Three abutments were used as control group. Average surface roughness (Sa) and developed interfacial area ratio (Sdr) of treated and untreated surfaces were measured with a profilometer. The extent of treatment traces were analyzed by scanning electron microscopy. RESULTS. Manipulation with ultrasonic scalers resulted in a significant increase of average surface roughness (Sa, \( P < .05 \)) and developed interfacial area ratio (Sdr, \( P < .018 \)). Variable contact pressure did not yield any statistically significant difference on Sa-values for all instruments (\( P = .8 \)). Ultrasonic treatment resulted in pronounced surface traces and partially detachment of the TiN coating. While titanium curettes caused predominantly moderate treatment traces, no traces or detectable substance removal has been determined after manipulation with acrylic curettes. CONCLUSION. Inappropriate instruments during regular plaque control may have an adverse effect on the integrity of the TiN coating of CAD/CAM abutments. To prevent defects and an increased surface roughness at the transmucosal zone of TiN abutments, only acrylic scaling instruments can be recommended for regular maintenance care. [J Adv Prosthodont]

KEYWORDS: Titanium nitride; Abutments; Scaling; Surface roughness; Scanning electron microscopy

INTRODUCTION

Achieving natural harmony between implant-prosthetic components and the surrounding soft tissues is challenging for the restorative team. The implant abutment design, its material and color seem to be of decisive importance for ensuring an esthetic mucogingival architecture.1,2 In the past, there have been two main types of abutments available for restoring implants: conventional titanium stock abutments, traditionally supplied by dental implant manufacturers to match their respective implant system, and custom cast abutments. Recently, novel computer-aided designed (CAD), computer-aided manufactured (CAM) abutments of various
materials have been introduced. CAD/CAM abutments can be custom designed to re-create the desired emergence profile and supporting crown orientation, facilitating the formation of anatomical mucosal topography and coronal contours for prosthetic replacement.\textsuperscript{14} Although very stable from a technical point of view, all abutments made of commercially pure titanium have been reported to cause a greyish discolouration of the surrounding soft tissues, compromising the esthetic outcome in the anterior region.\textsuperscript{5,6} This discolouration is most apparent in patients with a thin gingival biotype that is incapable of blocking reflective light from the metallic abutment surface.\textsuperscript{5} Due to their tooth-like colour and potential biologic advantages, ceramic abutments have been promoted to achieve better mucogingival esthetics.\textsuperscript{7-9} Nevertheless, the esthetic benefit of all-ceramic abutments needs to be carefully balanced against the reduced fracture resistance compared to titanium abutments.\textsuperscript{10} All-ceramic abutments cannot be machined to the same degree of precision as metal abutments. Recent studies have shown that zirconia abutments have a marginal misfit to the implant that might cause screw loosening, micromotion, wear of the implant-abutment interface, and increased size of the marginal gap subject to bacterial colonization.\textsuperscript{11-14} In addition to commercially pure titanium abutments, clinical studies have reported promising results with surface modifications of titanium, such as coatings of CAD/CAM abutments with titanium nitride (TiN).\textsuperscript{15,16}

The TiN-coating is created by a plasma coating process in which titanium and nitrogen ions are combined with TiN, and then molecularly bonded with the titanium substrate of the abutment. Reports have characterized TiN as having a high chemical inertness, low friction coefficient, and good biocompatibility.\textsuperscript{17,18} TiN has excellent infrared reflectivity properties, reflecting in a spectrum similar to elemental gold, achieving a warm esthetic tone under the mucosa because of its gold shaded hue.\textsuperscript{19} Less color difference of the peri-implant mucosa has been reported with gold-shaded and titanium nitride-coated CAD/CAM abutments.\textsuperscript{15,20,21} In addition, TiN coatings seem to have a beneficial effect on antibacterial activity inhibiting the formation of microbioplaque, minimizing the adverse effects of peri-implantitis on implant longevity. It reduces bacteria, diminishes its metabolic activity, adhesion and proliferation but simultaneously maintains the biological affinity of titanium surfaces towards bone cell precursors and promotes human gingival fibroblast adhesion.\textsuperscript{18,22-24} In light of this, antibacterial activity is a desirable property while, especially for an abutment, enhanced abrasion resistance against scaling treatments is wanted to maintain the surface finish of the abutment. The surface properties of implant components at a gingival level have a decisive impact on the long term success of dental implants. Surface roughness beyond a threshold of 0.2 µm was found to be unsupportive in the prevention of plaque accumulation.\textsuperscript{25,26} An ideal transmucosal implant surface should be smooth, in order to allow the formation of an epithelial seal that prevents plaque accumulation.\textsuperscript{25-27} However, inappropriate instruments during regular maintenance therapy and plaque control may have an adverse effect on the surface integrity and biocompatibility of TiN-coated implant abutments.\textsuperscript{28} Therefore, the aim of this \textit{in vitro} study was to investigate the extent of treatment traces, surface roughness (Sa, in µm) and developed interfacial area ratio (Sdr, %) of TiN CAD/CAM abutments after treatment with various implant prophylaxis instruments.

**MATERIALS AND METHODS**

A total of 12 titanium nitride coated (TiN) CAD/CAM implant abutments were virtually designed and centrally manufactured (ATLANTIS GoldHue, Dentsply Sirona Implants, Malmö, Sweden). The master cast of a clinical case in which the left maxillary first molar had been replaced by an implant restoration served as model of origin. The emergence profile of the peri-implant mucosa had been pre-conditioned by means of a temporary implant-supported single crown. The abutment and outer geometry were designed to allow placement of the crown margin slightly below the mucosa, following its scalloped anatomy. All specimens underwent a standardized ultrasonic cleaning procedure according to Gehrke \textit{et al.}\textsuperscript{29} (Fig. 1). The samples...
were cleansed three times in an ultrasonic bath at 60°C for 10 minutes each. A resin nano ceramic (RNC) crown (Lava Ultimate, 3M ESPE, Neuss, Germany) was CAD/CAM produced (Cerec 3D, Sirona Dental Systems GmbH, Bensheim, Germany) and fixed on each abutment with a low-viscous silicone (Fit Checker Advanced, GC Corporation, Tokyo, Japan) prior to testing. It was refrained from cementing the crown in order to avoid surface alterations of the abutment shoulder due to undetected cement remnants.

For the present in vitro study the abutment-crown assemblies (12) were randomly divided into four groups of three samples each (3 test groups/1 control group).

In the test groups, three assemblies each were instrumented for 20 strokes with 150 g contact pressure at the labial aspect and 200 g at the oral aspect at the submucosal TiN-abutment shoulder (two 5 × 5-mm test fields on each abutment) with the following instruments: group 1: acrylic scaler (Hu Friedy Mfg. Co., LLC, Frankfurt); group 2: titanium curette (Hu Friedy Mfg. Co., LLC, Frankfurt); and group 3: steel tip on ultrasonic scaler at 30 kHz (Cavitron Plus, Hager & Werken, Dentsply, Duisburg, Germany). Three other abutment samples were not treated and used as a control group. The in-vitro scaling of the abutments have been carried out in a custom-made device in order to allow for controlled, standardized conditions (Fig. 2).28 The abutment-crown assemblies were connected to the compatible implant analogs (XiVE D 4.5 mm, Dentsply Sirona Implants, Mannheim, Germany) and mounted into the test set-up. A rail mechanism allowed for horizontally defined sliding, simulating the movements of instruments during scaling with a defined pressure (150 g / 200 g).

The test and control abutments were examined for average surface roughness (Sa) and developed interfacial surface area ratio due to texture (Sdr) by means of profilometric focus-variation microscopy ( Infinite Focus Standard G4, Alicona Imaging GmbH, Graz, Austria). Treatment traces were analyzed by scanning electron microscopy (SEM) (Phenom ProX, PhenomWorld B.V., Eindhoven, Netherlands). The magnifications of the test and control fields were 1,000× and 5,000× times. The quality of the treatment traces on the abutment shoulder was classified by 3 independent investigators who, prior to study initiation, were calibrated for intra- and inter-examiner reproducibility using duplicate measurements of a minimum of 30 treated surfaces. These investigators classified the treatment traces using 3 grades: none, moderate, and pronounced. The untreated TiN-abutment surfaces served as controls.

For continuous variables, mean and standard deviation of the individual values were calculated. Frequency distributions were used to characterize categorical variables. Estimation of inter-rater agreement for the toolmark ratings of different raters were executed by calculating Cohens Kappa coefficient. Mann-Whitney-U-Test and Kruskal-Wallis H-Test were used to compare two (e.g. contact pressure 150 g vs. 200 g) or more than two (e.g. test and control groups) independent groups for continuous variables (e.g. Sa). In case of categorical comparisons (e.g. test and control groups vs. coating displacement), Pearson's chi-squared test was applied. Statistical analysis was carried out using the program packages STATISTICA (STATSOFT, Tulsa, OK, USA, version 9.1) and BiAS (Epsilon-Verlag, Frankfurt, version 11.02). Significance was set at $P < .05$.

**RESULTS**

Descriptive characteristic variables for the average surface roughness (Sa, in µm) and developed interfacial area ratio (Sdr, %) according to instrumentation is shown in Table 1 and Table 2. A pairwise comparison of treatment categories is presented in Table 3 for recorded Sa values. Profilometric images of the TiN-surfaces with various treatments showed differences depending upon the given treatment (Fig. 3). Manipulation with ultrasonic scalers resulted in a significant increase of average surface roughness (Sa, $P < .05$). Treatment group comparison proved likewise an increase of developed interfacial area ratio contributed by the texture of TiN-surfaces manipulated with ultrasonic instruments. (Table 2) Variable contact pressure did not yield any statistically significant difference on Sa-values for all instruments. (Table 3) The quantitative evaluation of treatment traces by SEM analysis revealed major disparities (Fig. 4). After instrumentation with ultrasonic scalers, all examiners classified the
Fig. 3. Profilometric microscopy images of the titanium nitride (TiN) surfaces displayed differences depending upon the given treatment. Samples treated with 150 g contact pressure: Untreated TiN surface/ control (A), TiN surface instrumented with acrylic tip (B), titanium tip (C), and ultrasonic scaler (D). The acrylic scaler did not appear to affect the TiN surface after treatment. The severity of surface traces increased from utilizing titanium curettes to ultrasonic scalers. Ultrasonic scaling led to a significant increase of mean surface roughness (Sa) and partially detachment of the TiN-coating.

Table 1. Descriptive characteristic variables for average surface roughness Sa (in µm) according to the used instrument and applied contact pressure (200 g/ 150 g; two 2 × 2-mm test fields on each abutment)

| Parameters                     | N  | Surface Roughness MV ± SD | Surface Roughness Min/Max |
|--------------------------------|----|---------------------------|---------------------------|
| Pressure = 200 g               | 12 | 1.76 ± 2.09               | 0.60 - 6.03               |
| Pressure = 150 g               | 12 | 1.23 ± 1.14               | 0.60 - 4.22               |
| Acrylic Scaler Instrumentation (AS) | 6  | 0.64 ± 0.04               | 0.60 - 0.69               |
| Titanium Curette Instrumentation (TC) | 6  | 0.65 ± 0.04               | 0.61 - 0.71               |
| Ultrasonic Scaler Instrumentation (US) | 6  | 4.00 ± 1.68*              | 2.28 - 6.03               |
| Control/ No Instrumentation (C) | 6  | 0.70 ± 0.05               | 0.63 - 0.78               |

Number of test variables (N), mean value (MV), standard deviation (SD), and minimum/maximum (Min/Max) are indicated. Instrumentation with ultrasonic scaler led to a significant increase of Sa-values.

Symbol * indicates statistical significance of \( P < .05 \).

Table 2. Descriptive characteristic variables for the developed interfacial area ratio (Sdr, %) according to the used instrument and applied contact pressure (200 g/ 150 g; two 2 × 2-mm test fields on each abutment)

| Parameters                     | N  | Surface Roughness MV ± SD | Surface Roughness Min/Max |
|--------------------------------|----|---------------------------|---------------------------|
| Pressure = 200 g               | 12 | 0.73 ± 0.24               | 0.33 - 1.07               |
| Pressure = 150 g               | 12 | 0.61 ± 0.18               | 0.28 - 0.85               |
| Acrylic Scaler Instrumentation (AS) | 6  | 0.79 ± 0.10*              | 0.62 - 0.92               |
| Titanium Curette Instrumentation (TC) | 6  | 0.46 ± 0.11*              | 0.28 - 0.60               |
| Ultrasonic Scaler Instrumentation (US) | 6  | 0.57 ± 0.23*              | 0.33 - 0.98               |
| Control/ No Instrumentation (C) | 6  | 0.85 ± 0.14*              | 0.64 - 1.07               |

Number of test variables (N), mean value (MV), standard deviation (SD), and minimum/maximum (Min/Max) are indicated. Treatment group comparison proved a statistically significant difference of Sdr-values for (AS) - (TC), (TC) - (C), and (US) - (C) (each: \( P < .05 \)).

Table 3. Difference of average surface roughness (Sa, µm) after instrumentation with 200 g vs. 150 g contact pressure

| Parameters | Pressure 200 g | Pressure 150 g | U | Valid N 200 g | Valid N 150 g | Exact p |
|------------|----------------|----------------|---|---------------|---------------|---------|
| Profile Sa (µm) | 155.0000 | 145.0000 | 67.00000 | 12 | 12 | 0.798745 |

The variable contact pressure did yield no statistically significant difference on Sa-values for all instruments (Mann-Whitney-U-Test: \( P = .8 \))
resulting treatment traces on the abutmen’s TiN-layer as pronounced. Ultrasonic treatment resulted in partial detachment of the TiN-coating in combination with a planning effect of the surface. Titanium curettes predominantly caused moderate treatment traces, while no traces or detectable substance removal have been determined after manipulation with acrylic curettes. However, the samples displayed organic material on the abutment surface due to wear of friction of the acrylic instrument (Fig. 4). The difference between the treatment groups were statistically significant ($P < .001$)(Table 5). An influence of variable contact pressure with 200 g vs. 150 g was negligible ($P = .843$)(Table 6).

---

**Fig. 4.** SEM images of untreated titanium nitride surfaces (A: control) and instrumented titanium nitride surfaces (test). B: acrylic scaler, C: titanium curette, D: ultrasonic scaler.
DISCUSSION

Since implant abutments are a part of the superstructure that is in direct contact with peri-implant tissues, their material and surface topography influence the soft-tissue reaction directly. A titanium nitride (TiN) coating of CAD/CAM implant abutments may clinically offer esthetic and biological advantages. Studies have shown a beneficial effect of TiN on antibacterial activity inhibiting the formation of microbial plaque and a prevention of compromising color differences of the peri-implant mucosa in patients with thin gingival biotypes. Although considered to be essential for the prevention of inflammatory peri-implant diseases, a periodic removal of debris from the implant abutment...
shoulder could damage the TiN layer and change or roughen the surface profile. Surface alterations occurring over time might jeopardize the biocompatibility of the material and consequently lead to increased plaque accumulation that could adversely affect the peri-implant region.\textsuperscript{31} Within the limitations of this in-vitro investigation, the results demonstrate that titanium curettes and ultrasonic scalers with steel tips leave gradually pronounced treatment traces on TiN-coated CAD/CAM abutments, independent of the contact pressure applied (200 g vs. 150 g). While titanium curettes caused predominantly moderate treatment traces, ultrasonic scaling led to a partially detachment of the TiN-coating. In addition, manipulation with ultrasonic scalers resulted in a significant increase of average surface roughness (Sa) and developed interfacial surface area ratio (Sdr). No treatment traces, no alterations of roughness depth, and no detectable substance removal could be observed after manipulation with acrylic curettes. A concern, however, is the organic material located on the abutment surface due to frictional wear of the acrylic tip of the instrument. The biological consequences of implant or abutment contamination with plastic residues are critically discussed. It has been suggested that the biocompatibility of the surface may be impaired by the debris.\textsuperscript{32} Yang \textit{et al.}\textsuperscript{33} demonstrated a surface coverage of plastic remnants of up to 15% on titanium discs after instrumentation with various plastic instruments and subsequent attempt of cleaning with water spray or a chlorhexidine-soaked cotton pellets. There is a relative abundance of literature on the effect of mechanical instruments on titanium implants;\textsuperscript{31,34,35} in contrast, the impact of scaling on the integrity of TiN coated abutments were not extensively studied so far. No \textit{in vitro} studies on this topic have yet been published. Mengel \textit{et al.}\textsuperscript{28} examined the treatment of uncoated and TiN coated abutments \textit{in vitro} with different instruments and summarized that a TiN coating may offer a way to prevent titanium abutments from sustaining damage during scaling. Moreover, the aforementioned trial concluded that, unlike the current study, TiN coated abutments can be treated with all instruments and equipment at low contact pressure without surface damage. Only high contact pressure on steel or titanium curettes and ultrasonic scalers with steel tips left pronounced treatment traces and caused a detachment of the surface coating.

While roughening of transmucosal prosthetic components should be avoided, it has not been adequately clarified to what extent various types of instrumentation alter the surface of the abutment shoulder and influence bacterial colonization. Similar to our results, Schmidt \textit{et al.}\textsuperscript{36} demonstrated an increase of average surface roughness using metal curettes at implant collars. However, no significant differences in surface roughness and biofilm formation based on one-time instrumentation have been observed with ultrasonic devices with steel or plastic coated tips. A single roughness parameter has only limited validity with regard to the surface texture. The Sa value as arithmetic mean possibly represents the most important parameter for assessment. To obtain a more detailed overview of the surface characteristics, however, inclusion of the area excess (Sdr) appears to be useful. Sdr further differentiates surfaces of similar amplitudes and average roughness. To simulate the clinical situation as close as possible, standardized conditions by means of a customized device have been applied for mechanical treatment with defined pressure of 20 strokes. A comparison of the results to previous investigations proved to be difficult since pressure applied for treatment, application time of instruments, and number of strokes varied greatly among these studies.\textsuperscript{31}

**CONCLUSION**

Within the limitations of this \textit{in vitro} study, the following conclusions can be drawn: inappropriate instrument selection during regular recall and plaque control measures may have an adverse effect on the integrity of the TiN coating of CAD/CAM abutments. The resulting roughness could increase plaque and bacteria retention. To prevent resolution defects and/or increased surface roughness at the transmucosal zone of TiN coated CAD/CAM abutments, only acrylic scaling instruments can be recommended for regular maintenance care.

**ORCID**

Peter Gehrke  https://orcid.org/0000-0002-0412-5615

**ACKNOWLEDGEMENTS**

The authors gratefully acknowledge Dr. Wolfgang Reimers for his contribution to data analysis.

The authors declare that they have no conflict of interest. Dentsply Sirona Implants (Möln达尔, Sweden) provided the CAD/CAM abutments for the experimental investigation. The design, documentation and analyses of this study were completed entirely independent of Dentsply Sirona Implants.

**REFERENCES**

1. Sala I, Bascones-Martínez A, Carrillo-de-Albornoz A. Impact of abutment material on peri-implant soft tissue color. An in vitro study. Clin Oral Investig 2017;21:2221-33.
2. Sicilia A, Quirynen M, Fontolliet A, Francisco H, Friedman A, Linkevicius T, Lutz R, Meijer HJ, Rompen E, Rotundo R, Schwarz F, Simion M, Teughels W, Wennerberg A, Zuur O. Long-term stability of peri-implant tissues after bone or soft tissue augmentation. Effect of zirconia or titanium abutments on peri-implant soft tissues. Summary and consensus statements. The 4th EAO Consensus Conference 2015. Clin Oral Implants Res 2015;26:148-52.
3. Sailer I, Zembic A, Jung RE, Hämmérle CH, Mattiola A. Single-tooth implant reconstructions: esthetic factors influencing the decision between titanium and zirconia abutments in anterior regions. Eur J Esthet Dent 2007;2:296-310.
4. Lops D, Bressan E, Parpaiola A, Sbricoli L, Cecchinato D, Romeo E. Soft tissues stability of cad-cam and stock abutments in anterior regions: 2-year prospective multicentric cohort study. Clin Oral Implants Res 2015;26:1436-42.

5. Park SE, Da Silva JD, Weber HP, Ishikawa-Nagai S. Optical phenomenon of peri-implant soft tissue. Part I. Spectrophotometric assessment of natural tooth gingiva and peri-implant mucosa. Clin Oral Implants Res 2007;18:569-74.

6. Ioannidis A, Cathomen E, Jung RE, Fehmer V, Hüsler J, Thoma DS. Discoloration of the mucosa caused by different restorative materials - a spectrophotometric in vitro study. Clin Oral Implants Res 2017;28:1133-8.

7. Bittencourt TC, Ribeiro CG, Devito KL, Ferreira CF, Cagna DR, Picorelli NM. Zirconia abutment supporting all ceramic crowns in the esthetic zone: Interim results of a prospective study. Eur J Prosthodont Restor Dent 2016;24:23-30.

8. Zembic A, Sailer I, Jung RE, Hämmerle CH. Randomized-controlled clinical trial of customized zirconia and titanium implant abutments for single-tooth implants in canine and posterior regions: 3-year results. Clin Oral Implants Res 2009; 20:802-8.

9. Degidi M, Artese L, Scarano A, Perrotti V, Gehrke P, Piattelli A. Inflammatory infiltrate, microvessel density, nitric oxide synthase expression, vascular endothelial growth factor expression, and proliferative activity in peri-implant soft tissues around titanium and zirconium oxide healing caps. J Periodontol 2006;77:73-80.

10. Nakamura K, Kanno T, Milleding P, Ortengren U. Zirconia as a dental implant abutment material: a systematic review. Int J Prosthodont 2010;23:299-309.

11. Brodbeck U. The ZiReal Post: A new ceramic implant abutment. J Esthet Restor Dent 2003;15:10-23.

12. Coray R, Zeltner M, Özcan M. Fracture strength of implant abutments after fatigue testing: A systematic review and a meta-analysis. J Mech Behav Biomed Mater 2016;62:333-46.

13. Gehrke P, Johansson D, Fischer C, Stawarczyk B, Beuer F. In vitro fatigue and fracture resistance of one- and two-piece CAD/CAM zirconia implant abutments. Int J Oral Maxillofac Implants 2015;30:546-54.

14. Garine WN, Funkenbusch PD, Ercoli C, Wodenscheck J, Murphy WC. Measurement of the rotational misfit and implant-abutment gap of all-ceramic abutments. Int J Oral Maxillofac Implants 2007;22:928-38.

15. Ferrari M, Carrabba M, Vichi A, Goracci C, Cagidiaco MC. Influence of abutment color and mucosal thickness on soft tissue color. Int J Oral Maxillofac Implants 2017;32:393-9.

16. Ferrari M, Tricarico MG, Cagidiaco MC, Vichi A, Gherlone EF, Zarone F, Sorrentino R. 3-year randomized controlled prospective clinical trial on different CAD-CAM implant abutments. Clin Implant Dent Relat Res 2016;18:1134-41.

17. Scarano A, Piattelli M, Vrespa G, Caputi S, Piattelli A. Bacterial adhesion on titanium nitride-coated and uncoated implants: an in vivo human study. J Oral Implantol 2003;29:80-5.

18. Annunziata M, Oliva A, Basile MA, Giordano M, Mazzola N, Rizzo A, Lanza A, Guida L. The effects of titanium nitride-coating on the topographic and biological features of TPS implant surfaces. J Dent 2011;39:720-8.

19. Vaz F, Cerqueira P, Rebouta L, Nascimento SMC, Alves E, Goudeau P, Rivière JP, Pischow K, de Rijk J. Structural, optical and mechanical properties of coloured TiN_xO_y thin films. Thin Solid Films [Internet]. Elsevier BV; 2004;447-8:449-54. Available from: http://dx.doi.org/10.1016/s0040-6090(03)01123-4

20. Lops D, Stellini E, Sbricoli L, Cea N, Romeo E, Bressan E. Influence of abutment material on peri-implant soft tissues in anterior areas with thin gingival biotype: a multicentric prospective study. Clin Oral Implants Res 2017;28:1263-8.

21. Ferrari M, Cagidiaco MC, Garcia-Godoy F, Goracci C, Cairo F. Effect of different prosthetic abutments on peri-implant soft tissue. A randomized controlled clinical trial. Am J Dent 2015;28:85-9.

22. Groessner-Schreiber B, Hannig M, Dück A, Grienpertrog M, Wenderoth DF. Do different implant surfaces exposed in the oral cavity of humans show different biofilm compositions and activities? Eur J Oral Sci 2004;112:516-22.

23. Kim YS, Shin SY, Moon SK, Yang SM. Surface properties correlated with the human gingival fibroblasts attachment on various materials for implant abutments: a multiple regression analysis. Acta Odontol Scand 2015;73:38-47.

24. Chien CC, Liu KT, Duh JG, Chang KW, Chung KH. Effect of nitride film coatings on cell compatibility. Dent Mater 2008;24:986-93.

25. Bollen CM, Papaioannou W, Van Eldere J, Schepers E, Quirynen M, van Steenberghe D. The influence of abutment surface roughness on plaque accumulation and peri-implant mucositis. Clin Oral Implants Res 1996;7:201-11.

26. Mehle C, Kern M, Schütte AM, Kadem LF, Selhuber-Unkel CS. Adhesion of living cells to abutment materials, dentin, and adhesive luting cement with different surface qualities. Dent Mater 2016;32:1524-35.

27. Grössner-Schreiber B, Grienpertrog M, Haustein I, Müller WD, Lange KP, Briedigkeit H, Göbel UB. Plaque formation on surface modified dental implants. An in vitro study. Clin Oral Implants Res 2001;12:543-51.

28. Mengel R, Meert C, Flores-de-Jacoby L. The treatment of uncoated and titanium nitride-coated abutments with different instruments. Int J Oral Maxillofac Implants. 2004;19:232-8.

29. Gehrke P, Tabellion A, Fischer C. Microscopical and chemical surface characterization of CAD/CAM zirconia abutments after different cleaning procedures. A qualitative analysis. J Adv Prosthodont 2013;7:151-9.

30. Rompen E, Domken O, Degidi M, Pontes AE, Piattelli A. The effect of material characteristics, of surface topography and of implant components and connections on soft tissue integration: a literature review. Clin Oral Implants Res 2006;17:55-67.

31. Louropoulou A, Slot DE, Van der Weijden F. The effects of mechanical instruments on contaminated titanium dental implant surfaces: a systematic review. Clin Oral Implants Res 2014;25:1149-60.

32. Schwarz F, Papanicolaou P, Rothamel D, Beck B, Herten M, Becker J. Influence of plaque biofilm removal on reestablishment of the biocompatibility of contaminated titanium sur-
faces. J Biomed Mater Res A 2006;77:437-44.

33. Yang SM, Park JB, Ko Y. Use of confocal microscopy for quantification of plastic remnants on rough titanium after instrumentation and evaluation of efficacy of removal. Int J Oral Maxillofac Implants 2015;30:519-25.

34. Schmage P, Kahili F, Nergiz I, Scorziello TM, Platzer U, Pfeiffer P. Cleaning effectiveness of implant prophylaxis instruments. Int J Oral Maxillofac Implants 2014;29:331-7.

35. Schmidt KE, Auschill TM, Heumann C, Frankenberger R, Eick S, Sculean A, Arweiler NB. Influence of different instrumentation modalities on the surface characteristics and biofilm formation on dental implant neck, in vitro. Clin Oral Implants Res 2017;28:483-90.