

Diagnostic accuracy of imaging examinations for peri-implant bone defects around titanium and zirconium dioxide implants: A systematic review and meta-analysis

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ABSTRACT

Purpose: This systematic review and meta-analysis assessed the diagnostic accuracy of imaging examinations for the detection of peri-implant bone defects and compared the diagnostic accuracy between titanium (Ti) and zirconium dioxide (ZrO₂) implants.

Materials and Methods: Six online databases were searched, and studies were selected based on eligibility criteria. The studies included in the systematic review underwent bias and applicability assessment using the Quality Assessment of Diagnostic Accuracy Studies 2 (QUADAS-2) tool and a random-effect meta-analysis. Summary receiver operating characteristic (sROC) curves were constructed to compare the effect of methodological differences in relation to the variables of each group.

Results: The search strategy yielded 719 articles. Titles and abstracts were read and 61 studies were selected for full-text reading. Among them, 24 studies were included in this systematic review. Most included studies had a low risk of bias (QUADAS-2). Cone-beam computed tomography (CBCT) presented sufficient data for quantitative analysis in ZrO₂ and Ti implants. The meta-analysis revealed high levels of inconsistency in the latter group. Regarding sROC curves, the area under the curve (AUC) was larger for the overall Ti group (AUC=0.79) than for the overall ZrO₂ group (AUC=0.69), but without a statistically significant difference between them. In Ti implants, the AUCs for dehiscence defects (0.73) and fenestration defects (0.87) showed a statistically significant difference.

Conclusion: The diagnostic accuracy of CBCT imaging in the assessment of peri-implant bone defects was similar between Ti and ZrO₂ implants, and fenestration was more accurately diagnosed than dehiscence in Ti implants. (*Imaging Sci Dent 2021; 51: 363-72*)

KEY WORDS: Diagnostic Imaging; Cone-Beam Computed Tomography; Zirconium; Dental implants

Introduction

Dental implants are a clinical resource widely used in oral rehabilitation with a high success rate (97%) if the variables that influence their longevity are appropriately considered.¹ Despite clinical success, there is still a high prevalence of patients who experience diseases of the peri-

implant tissue. After 5 years of follow-up, approximately 8.6% to 9.7% of dental implants exhibit chronic inflammation of the soft and hard tissues around them. Peri-implantitis is characterised by increased probing depth, bleeding, and progressive alveolar bone loss and can result in bone defects such as dehiscence, fenestration and intrabony defects.²⁻⁴

The diagnosis of peri-implantitis and bone defects is based on clinical and imaging examinations. Early detection may lead to a more favourable prognosis. In contrast, an inaccurate diagnosis and unsatisfactory management can lead to gingival recession, aesthetic complications, and loss of implant osseointegration.⁴⁻⁶

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Periapical radiographs (PRs), panoramic radiography (PAN), magnetic resonance imaging (MRI), computed tomography (CT), and cone-beam computed tomography (CBCT) are imaging modalities used to detect peri-implant bone defects. Some authors have suggested the initial acquisition of PRs,^{7,8} which allow the visualization of mesial and distal aspects of the implant. However, 2-dimensional radiography can underestimate incipient lesions and intrabony defects.⁸

CBCT has become an important diagnostic tool to assess the peri-implant region. Although PR allows the visualization of mesial and distal bone areas around the implant, CBCT images prevent overlapping of anatomical structures,^{9,10} thus assisting in distinguishing buccal and lingual cortical bone plates in addition to mesial and distal bone tissue. The limitations of this modality include the metallic artifacts generated by the presence of high-atomic-number materials.

Metallic artifacts result from the beam-hardening phenomenon, which occurs due to the distinct absorption of low-energy X-ray photons by materials with high atomic numbers. This creates localised hypodensities or dark voids close to dense objects, such as titanium (Ti) and zirconium (Zr), and impairs assessment of the image.¹¹

Ti has been used for decades to manufacture dental implants due to its biocompatibility and osseointegration, but several other materials have also been used to manufacture dental implants in order to overcome the limitations of Ti. Zirconium dioxide (ZrO₂) implants are usually installed in maxillary or mandibular anterior rehabilitations for aesthetic reasons because they closely match the tooth colour, thereby avoiding darkened areas that are visible upon cervical exposure or through transparent gingival tissue.^{12,13} However, both types of implants produce metallic artifacts.^{11,14,15}

The demand for ZrO₂ implants in recent years has raised concerns about the presence of metallic artifacts in CBCT images. Several studies¹⁴⁻¹⁸ have reported a greater number of artifacts in images of ZrO₂ implants using some imaging modalities than in images of Ti implants. Based on these reports, it is fundamental to investigate the diagnostic accuracy of the imaging and the degree of artifact interference at the implant-bone interface for both Ti and ZrO₂ implants.

A systematic review is an important pre-specified tool that compiles available evidence to answer a defined question. Through meta-analysis it is possible to statistically analyse results from different individual studies. Both methods improve the synthesis of the best evidence, in order to guide clinicians in the decision-making process.¹⁹

Thus, this study aimed to perform a systematic review and meta-analysis to assess the diagnostic accuracy of imaging modalities in the detection of peri-implant bone defects and to compare the diagnostic accuracy between Ti and ZrO₂ implants.

Materials and Methods

This systematic review was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Diagnostic Test Accuracy (PRISMA-DTA).²⁰ Studies reporting the accuracy of imaging exams in the evaluation of peri-implant bone defects were extracted from the following databases: MEDLINE (PubMed), EMBASE, Web of Science, ScienceDirect, Scopus, and ProQuest. Keywords related to concepts addressed by the pre-defined question of this study were used to gather all relevant articles. The PubMed search strategy included a combination of Medical Subject Headings (MeSH) terms and text words described as follows: (“accuracy”) OR (“sensitivity”) OR (“specificity”) OR (“physical measurement”) AND (“peri-implantitis” [MeSH Terms]) OR (“periimplantitis”) OR (“bone”) OR (“bone defect”) OR (“bone loss”) OR (“bone-implant interface” [MeSH Terms]) OR (“bone-implant interface/diagnosis” [MeSH Terms]) OR (“bone-implant interface/diagnostic imaging” [MeSH Terms])) OR (“peri-implantitis/diagnostic imaging” [MeSH Terms]) OR (“peri-implantitis/chemically induced” [MeSH Terms]) OR (“peri-implantitis/diagnosis” [MeSH Terms]) OR (“peri-implantitis/classification” [MeSH Terms]) AND (“cone-beam computed tomography” [MeSH Terms]) OR (“spiral cone-beam computed tomography” [MeSH Terms]) OR (“diagnostic imaging” [MeSH Terms]) OR (“dental radiography”) OR (dental radiography [MeSH Terms])) OR (panoramic radiography [MeSH Terms])) OR (“periapical radiography”) OR (“ultrasound”) OR (“magnetic resonance”) OR (“tomography” [MeSH Terms]) OR (“radiography, dental, digital” [MeSH Terms]) OR (“radiography, dental” [MeSH Terms]) AND (“dental implants” [MeSH Terms]) OR (“dental implants, single-tooth” [MeSH Terms]).

For other databases, the search strategy was modified using appropriate Boolean strategies. A manual search was also conducted of reference lists in the included studies. The search was carried out in June 2020 and updated in December 2020.

The articles were evaluated by 2 independent and calibrated reviewers (kappa: 0.81). Through the Rayyan website (Qatar Computing Research Institute, URL: <http://rayyan.qcri.org>), duplicated files were excluded and titles and abs-

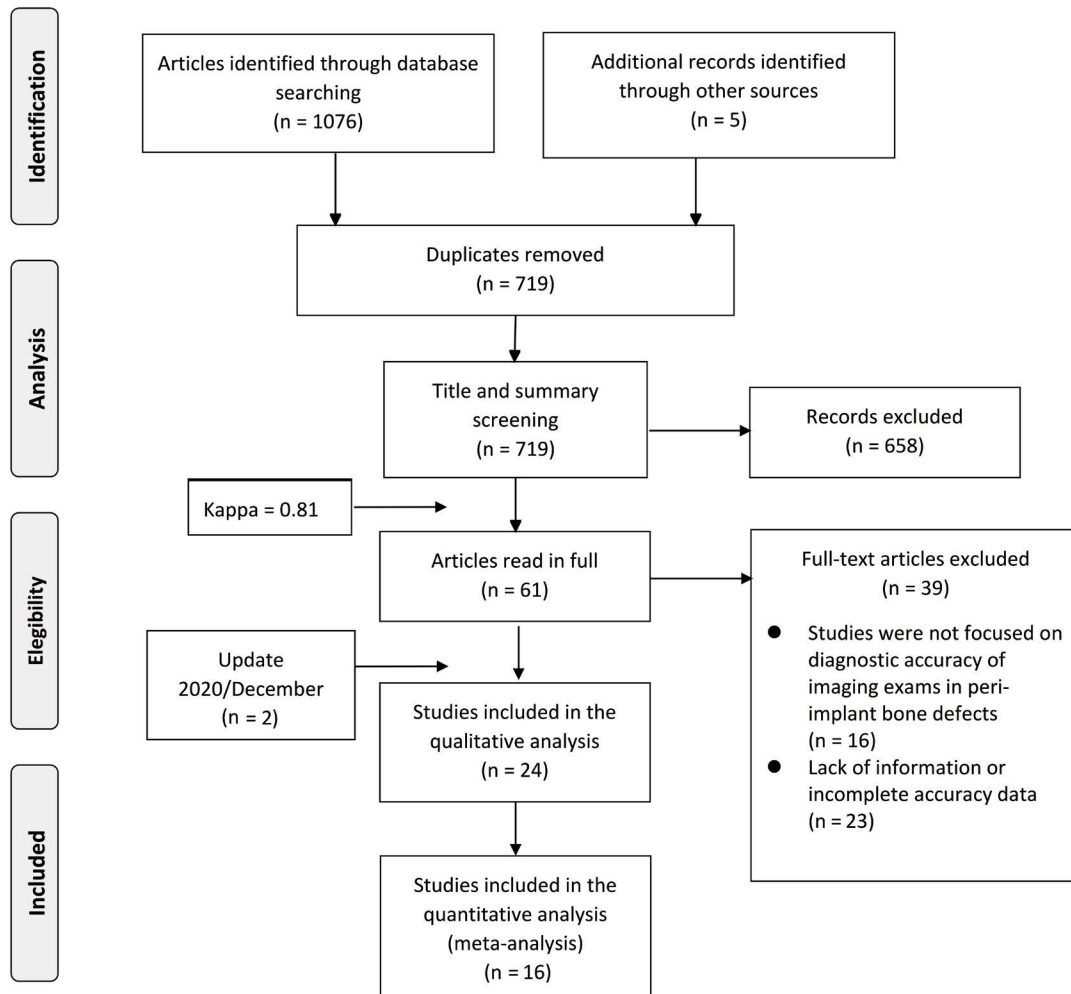


Fig. 1. Flow diagram of the systematic search.

tracts were screened according to the eligibility criteria. The initial screening included studies that evaluated the peri-implant region using any diagnostic imaging method. Studies that were not in English or Portuguese, systematic reviews, narrative reviews, letters, and case reports were excluded. The selected articles were then read in full and studies that evaluated the accuracy of diagnostic imaging methods in Ti or ZrO₂ peri-implant bone defects were included. These criteria were applied to full-text readings because titles and abstracts might not exhibit accurate or complete data. Reviewers discussed any disagreements between themselves to reach a consensus or a third reviewer was consulted. Studies that met the inclusion criteria and did not have any of the exclusion criteria were then accepted for data extraction and bias assessment.

The risk of bias and the applicability of the included studies were assessed independently by 2 reviewers using the Quality Assessment Tool for Diagnostic Accuracy

Studies 2 (QUADAS-2) and Review Manager version 5.4 (The Cochrane Collaboration, London, UK). Four domains were addressed: patient selection, index test, reference test, and flow and timing. Questions related to the study design could be answered with ‘yes’ if there was a low risk of bias, ‘uncertain’ when it was not possible to determine the risk, and ‘no’ for a high risk of bias.

Data extraction was performed by 2 independent reviewers. The meta-analysis included studies that presented precise numbers or any other data enabling the calculation of diagnostic performance. The extracted data included sensitivity, specificity, true/false and positive/negative results, and the disease prevalence in each sample. The Meta-Disc software (Ramón y Cajal Hospital, Madrid, Spain) was used to perform the random-effect meta-analysis and to identify sources of heterogeneity (the Cochran Q and I² tests).

Summary receiver operating characteristic (sROC) curves were constructed using RStudio software version

1.4.1106 (Integrated Development Inc., Boston, MA, USA) to compare the effect of methodological differences in relation to the variables of each group.

Results

Selection of studies

The search strategy yielded 1,076 studies. After removing duplicates, 719 articles were included for title and abstract assessment reading, and 61 articles were selected for full reading. After reading the studies in full, the reviewers excluded 39 articles. An updated search was carried out in December 2020 and 2 new articles were included, totalling 24 final articles for the systematic review. A summary of the results of the systematised search is illustrated in Figure 1.

Risk of bias and applicability assessment

The QUADAS-2 analysis of the 24 studies is summarised in Figure 2. Regarding applicability, patient selection in 17 studies was classified as high risk due to *in vitro* models that used animal samples (bovine rib, sheep and porcine jaws) or artificial material (plaster). Concerning the risk of bias, 2 studies^{21,22} were classified as high risk by the index test, since their results were interpreted with some knowledge of the reference standard. For the other studies classified as uncertain risk, that information could not be confirmed.²³⁻²⁵ For the item reference standard regarding applicability, only 1 study²⁶ was classified as uncertain risk because it used the “water volume displacement” technique as a standard. Except for the conditions mentioned, most studies had a low risk of bias in all categories. The QUADAS-2 assessment is illustrated in Figure 2.

Description of the included studies

All included studies had *in vitro* designs, experimentally simulating peri-implant bone defects in Ti and ZrO₂ implants. Artificial defects were created mechanically, chemically, or using both methods on the same sample. The defect morphology included 4-wall defects, dehiscence, fenestration, and any other shape created by chemical substances. Most studies applied CBCT to analyse diagnostic performance; i-CAT (Imaging Sciences International, Hatfield, PA, USA) and 3D Accuitomo (J Morita Mfg. Corp., Kyoto, Japan) were the most frequently selected devices. To assess diagnostic accuracy, all studies used a 5-point Likert scale.

The studies used PR, PAN, MRI, CT, and CBCT, in Ti^{12,13,22-42} and ZrO₂^{12,13,23,36,43} implants. The descriptive characteristics of the studies are shown in Table 1.

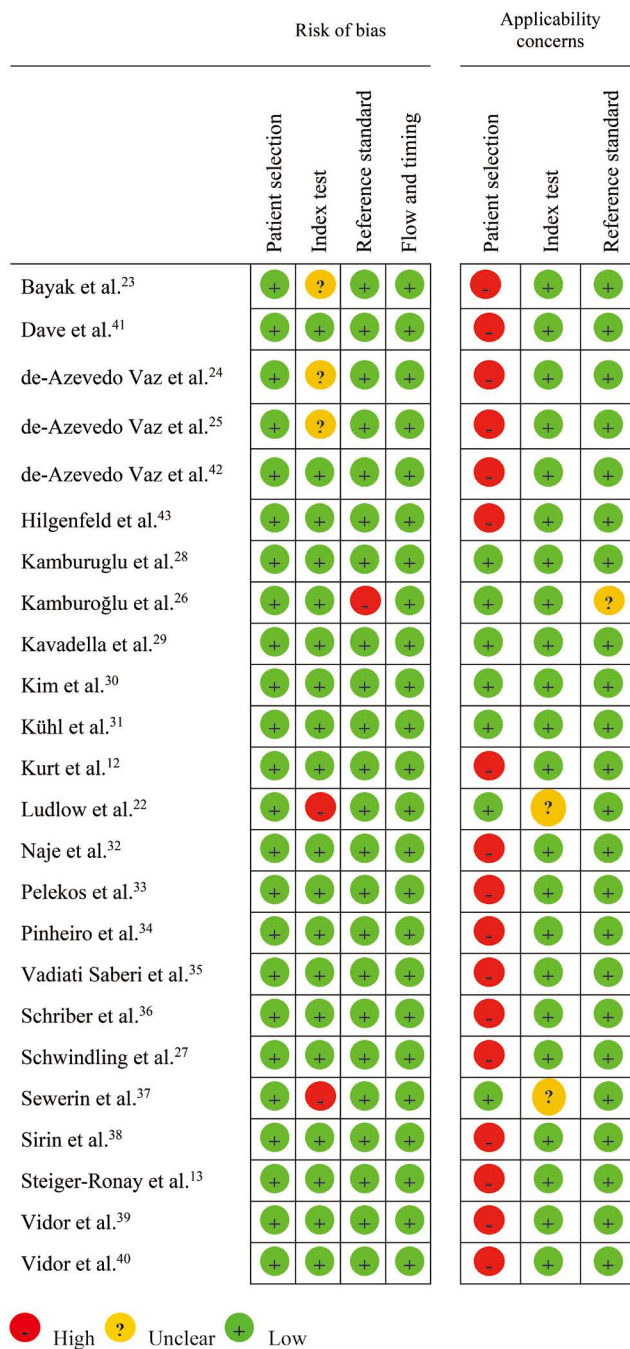


Fig. 2. Summary of Quality Assessment of Diagnostic Accuracy Studies-2 (QUADAS-2) of the included studies.

Statistical analysis

Only CBCT studies presented sufficient information for the quantitative analysis. All meta-analyses and source of heterogeneity analyses were conducted considering the Ti and ZrO₂ implant groups, including the following subgroups: fenestration defects, 4-wall defects, and dehiscence (the latter only for the Ti group). The sROC curves (Fig. 3) were performed considering the same subgroups.

Table 1. Descriptive characteristics of the included studies

Authors	Sample/Implant	Objectives	Findings and conclusions
Bayrak et al. ²³	Sheep jaw/Ti and ZrO ₂	Tested filter and MAR	Diagnostic efficacy was higher in Ti implants. MAR may improve performance.
Dave et al. ⁴¹	Bovine rib/Ti	Compared CBCT and PR	PR performed better than CBCT with a defect of 0.35 mm.
de-Azevedo-Vaz et al. ²⁴	Bovine rib/Ti	Tested voxel sizes in dehiscence and fenestration	Voxel size did not affect the evaluation of the 2 types of bone defects.
de-Azevedo-Vaz et al. ²⁵	Bovine rib/Ti	Tested filter in dehiscence	Some filters may improve diagnosis compared to original images.
de-Azevedo-Vaz et al. ⁴²	Bovine rib/Ti	Tested MAR and voxel sizes in dehiscence and fenestration	MAR did not improve the diagnosis in both defects and in the two voxel sizes.
Hilgenfeld et al. ⁴³	Bovine rib/ZrO ₂	Tested PR, MRI, and CBCT	CBCT and MRI were more accurate for identifying the morphology of major defects.
Kamburoglu et al. ²⁸	Human jaw/Ti	Tested MAR	No difference was found with and without MAR application.
Kamburoğlu et al. ²⁶	Human jaw/Ti	Tested acquisition protocol and FOVs	Different FOVs performed similarly in diagnostic accuracy.
Kavadella et al. ²⁹	Human jaw/Ti	Tested conventional and digital inverse images	Peri-implant defects might need to have a certain size to be detected.
Kim et al. ³⁰	Human jaw/Ti	Tested CBCT devices and acquisition protocols	Different devices and acquisition protocols did not affect the diagnostic performance.
Kühl et al. ³¹	Human jaw/Ti	Accuracy in CT, CBCT, PAN, and PR	PR showed better performance in all modalities. CBCT and PR showed similar sensitivity.
Kurt et al. ¹²	Sheep jaw/Ti and ZrO ₂	Tested acquisition protocol, voxel sizes in fenestration	Accuracy values were similar for all voxel sizes. Ti had higher AUC values than ZrO ₂ .
Ludlow et al. ²²	Human jaw/Ti	Accuracy of PR and CT in distinct defect sizes	CT provided better results than PR for all defect sizes.
Naje et al. ³²	Bovine rib/Ti	Accuracy of PAN and CBCT in distinct defect sizes	Accuracy, specificity, and predictive value were higher in CBCT.
Pelekos et al. ³³	Porcine rib/Ti	Accuracy of PR and CBCT in distinct defect sizes, thickness and morphology	CBCT performed better than PR. The examiner's experience affected the accuracy.
Pinherio et al. ³⁴	Bovine rib/Ti	Tested acquisition protocol and FOVs	Better performance for expert observers. No significant difference between the 2 FOVs.
Vadiati Saberi et al. ³⁵	Bovine rib/Ti	Accuracy of CBCT and PR in distinct angulations	High sensitivity of CBCT for all types of defects.
Schriber et al. ³⁶	Porcine jaw/Ti and ZrO ₂	CBCT accuracy in Ti and ZrO ₂ implants	ZrO ₂ implants showed lower accuracy (0.78) than Ti (0.91).
Schwindling et al. ²⁷	Bovine rib/Ti	Accuracy of low/high-dose CBCT	High-dose-CBCT accuracy was slightly higher but not statistically significant.
Sewerin et al. ³⁷	Human jaw/Ti	Tested PR accuracy in 2 angulations and defect sizes	PR was an unreliable method for identifying peri-implant gaps.
Sirin et al. ³⁸	Bovine rib/Ti	Accuracy of PR, PAN, CBCT, MSCT	PR and CBCT were accurate in detecting bone defects over 0.5 mm.
Steiger-Ronay et al. ¹³	Artificial model/Ti and ZrO ₂	Accuracy of PR and CBCT in Ti and ZrO ₂ implants	Higher accuracy in PR and in Ti implants than in ZrO ₂ implants.
Vidor et al. ³⁹	Bovine rib/Ti	PR, CBCT accuracy in different devices	Highest accuracy for PR. The size of the voxel did not change performance.
Vidor et al. ⁴⁰	Bovine rib/Ti	Accuracy of PR with filters	Filters may improve the diagnosis of the bone-implant interface.

Ti: titanium, ZrO₂: zirconium dioxide, MAR: metallic artifact reduction, CBCT: cone-beam computed tomography, PR: periapical radiography, MRI: magnetic resonance imaging, FOV: field of view, CT: computed tomography, PAN: panoramic radiography, AUC: area under curve, MSCT: multi-slice computed tomography

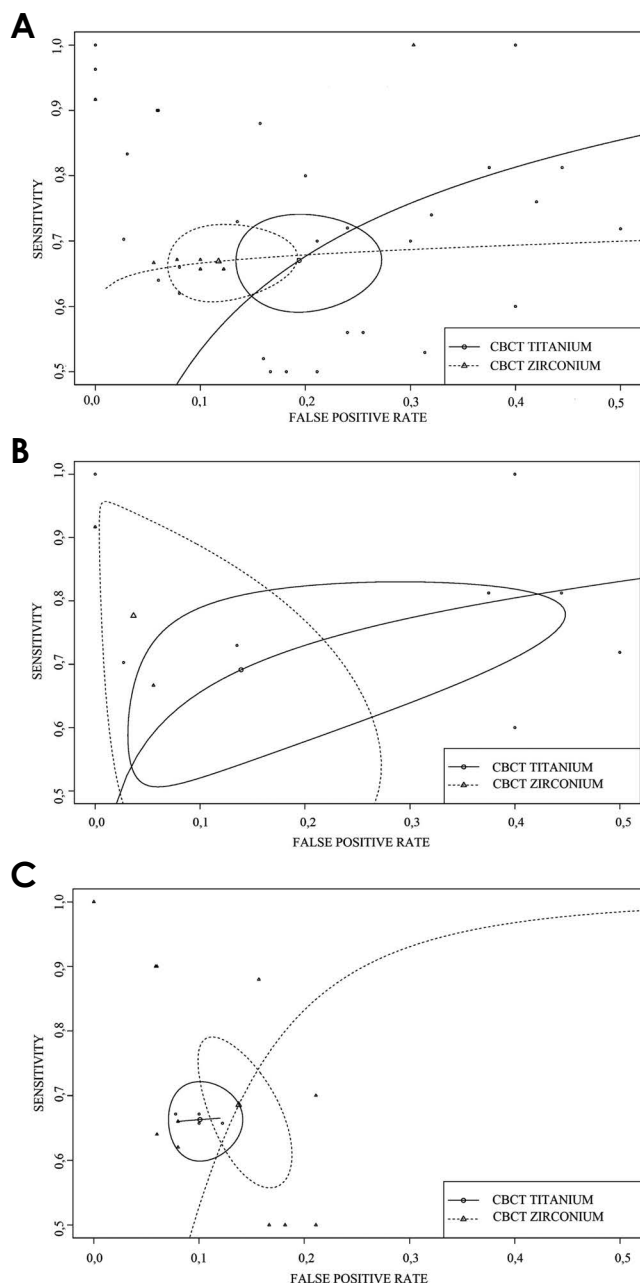


Fig. 3. A. Comparison of all subgroups (overall) for cone-beam computed tomographic (CBCT) imaging of titanium versus zirconium implants. B. Comparison of 4-wall defects using CBCT imaging for titanium implants versus CBCT imaging for zirconium implants overall. C. Comparison of fenestration defects using CBCT imaging for titanium implants versus CBCT imaging for zirconium implants. CBCT: cone-beam computed tomography.

The overall Ti implant analysis for sensitivity, specificity, and diagnostic odds ratio yielded lower values than the same parameters for ZrO₂ implants. The levels of inconsistency were higher in the first group.

The sensitivity values for Ti in the identification of 4-

wall defects, fenestration, and dehiscence were similar, with statistically significant results for the last 2 subgroups, which presented a high level of inconsistency (according to the criteria of Higgins et al.⁴⁴). The pooled values for the diagnostic odds ratio ranged from 4.21 (95% CI, 2.53-7.03) to 19.03 (95% CI, 6.55-55.33) for Ti, with the diagnostic odds ratio for dehiscence having the lowest value and the diagnostic odds ratio for 4-wall defects the highest.

The specificity values in the ZrO₂ group for the identification of 4-wall and fenestration defects were close (0.97 and 0.90, respectively) and higher than those of the Ti implant group, with no statistical significance. The pooled value diagnostic odds ratio was higher for 4-wall defects in ZrO₂ implants than in Ti implants (99.09; 95% CI, 6.77-1451.0), while the diagnostic odds ratio for fenestration was similar for both materials. These inconsistencies were considered moderate and minor, respectively, in relation to the Ti group.

The comparison between the sROC curves of Ti and ZrO₂ implants and their subgroups is demonstrated in Figure 3A-C. The area under the curve (AUC) was higher for the overall Ti group (AUC=0.79) than in the overall ZrO₂ group (AUC=0.69), and the 2 groups of implants showed similar AUCs for fenestration defects (Ti AUC=0.87 and ZrO₂ AUC=0.68), with no statistically significant difference. However, a significant difference was found between dehiscence and fenestration defects in Ti implants (Ti dehiscence AUC=0.73 and Ti fenestration AUC=0.87).

Discussion

The correct choice of an imaging examination is essential for the dental surgeon to identify, treat, and monitor bone defects and pathologies such as peri-implantitis.

The relevance of this study relates to the current popularity of ZrO₂ implants, primarily due to aesthetic demands. The tooth-like colour, reduced plaque accumulation (when compared to Ti implants), and promising osseointegration results^{45,46} have also contributed to the appeal of this material.

Recent studies have demonstrated that, in some imaging modalities, ZrO₂ implants generated more metallic artifacts than Ti implants.¹⁴⁻¹⁷ The presence of more metallic artifacts impacts image quality and the diagnosis of peri-implant bone defects.^{12,23,36,43}

The formation of greater numbers of artifacts in images may be associated with the higher atomic number (Z) of Zr (Z=40) than that of Ti (Z=22). A higher Z correlates with

a greater expression of artifacts, modifying the grey scale that affects image contrast, hence decreasing the visibility of anatomical structures.¹⁷

Sancho-Puchades et al.¹⁷ analyzed the increased formation of metallic artifacts close to ZrO₂ implants when compared to Ti and Ti-Zr in CBCT, which may explain the high number of false-positive diagnoses and lower accuracy.^{23,36} Steiger-Ronay et al.¹³ noticed similar results in terms of peri-implant bone defect measurements in CBCT images. Schriber et al.³⁶ observed measurement overestimations of 1.1 mm and underestimations of 1.28 mm. The imprecisions were attributed to the magnified negative influence of the ZrO₂ metallic artifacts. According to the studies, clinicians should be aware of these discrepancies when assessing ZrO₂ implants in CBCT images.

When assessing study samples, diagnostic studies can have a wide array of variables, resulting in potential heterogeneity. For this study, heterogeneity was assessed by the Q test (Higgins et al.⁴⁴). The levels of inconsistency were quantified through the I² statistic. The obtained values were considered high for the Ti group (92.5%) and low/moderate for the ZrO₂ group (76%). The meta-analysis outcomes presented significant inconsistency, reinforcing the importance of using this statistical method to consider this divergence among studies and produce more accurate results.

To assess heterogeneity, a meta-analysis of random effects was conducted. For both types of implants, defects were divided into 4-wall and fenestration defects. This subdivision of bone defect types was important for determining the accuracy in various clinical situations.

The sROC curves (Fig. 3) illustrate the data compiled from several studies. The grouping of data through simple pooled weighted averages can produce inaccurate interpretations as the data from individual studies may vary in terms of sample, methodology, and other characteristics. Two previous systematic reviews^{47,48} analysed the accuracy of imaging methods in detecting bone defects in Ti implants: Bohner et al.⁴⁷ used the aforementioned simple grouping of data, not exploring potential sources of heterogeneity, while Pelekos et al.⁴⁸ performed an analysis of random effects but studied only Ti implants.

In the present study, sensitivity and specificity values were higher for the detection of 4-wall defects than for the other subgroups of both implant types. The AUC values (ZrO₂: 0.95 and Ti: 0.80) were also high, although not statistically significant. Hilgenfeld et al.⁴³ evaluated the diagnostic performance of CBCT, PR, and MRI for bone defects at the implant-bone interface in ZrO₂ implants that underwent chemical induction of bone defects. As in our system-

atic review, CBCT and MRI showed better performance, mainly in large 4-wall defects.

Four-wall bone defects are among the most frequently observed defects in clinical situations.⁴ Although there is still no consensus in the literature that the morphology of the defect influences the prognosis, it has been demonstrated that some factors related to implant location and patient habits can be associated with morphological characteristics of bone defects, implying a potential relationship with disease severity. It is important to use the imaging modality that best identifies the morphology to better plan the treatment approach.^{4,7,49}

Several methodologies were found in the assessed diagnostic studies, either regarding the type of artificially induced bone defect or the different CBCT protocols applied. Schwindling et al.²⁷ analysed the accuracy of PR, low-dose CBCT, and high-dose CBCT for identification, classification, and measurement of peri-implant bone lesions in Ti implants. The accuracy of PR and CBCT were similar in the identification of defects, although low-dose CBCT images provided more accurate identification of defect morphology than PRs. High-dose CBCT slightly increased the diagnostic performance, albeit at the expense of a 14 times higher dose. This study was corroborated by Schriber et al.³⁶ who determined that low- or high-dose protocols did not significantly affect diagnostic accuracy.

Metallic artifact reduction (MAR) algorithms are designed to reduce the expression of metallic artifacts by increasing the imaging quality during reconstruction. Some researchers^{23,28,42} tested the effectiveness of MAR algorithms in detecting peri-implant bone defects, showing no improvement for either Ti or ZrO₂ implants. Comparisons among different acquisition protocols, with variation in terms of voxel size^{12,24,40,42} and field of view (FOV),^{26,34} resulted in similar diagnostic performance in both types of implants.

The use of filters is a post-processing image manipulation that has yielded positive results in improving diagnostic performance in both Ti and ZrO₂ implants.^{25,39} For ZrO₂, Bayrak et al.²³ found that the adaptive image noise optimiser filter with MAR improved interobserver agreement in the detection of bone defects. Another aspect that positively influenced diagnostic performance was the size of bone defects. In PR, Kühl et al.³¹ found that major defects (3 mm) demonstrated higher values of sensitivity and specificity. For CBCT, both a larger size of the bone defect and an increased number of affected bone walls resulted in improved diagnostic performance.^{34,41,43}

In addition to variability among the studies, another limitation was the *in vitro* design of all included studies. In exp-

perimental conditions, movement artifacts and gingival tissue attenuation are not reproducible.⁵⁰ Furthermore, fewer studies have investigated Zr implants since these implants were developed more recently than Ti implants. These factors hindered the formulation of a systematically analysed dataset with an acceptable level of evidence.

There were insufficient data to analyse quantitatively the performance of imaging methods (PR, PAN, MRI, and CT) for Ti and ZrO₂ implants. PR has already been extensively studied using Ti implants. However, with the recent advent of Zr in implant dentistry, only 1 study⁴³ used PR with Zr implants, and the accuracy results were lower than with CBCT and MRI.

Hilgenfeld et al.⁴³ emphasised the potential of MRI, which demonstrated a diagnostic accuracy similar to CBCT for ZrO₂ implants and even greater accuracy in small defects, as well as the advantage of non-ionising radiation. However, more studies evaluating the use of this imaging method are required.

No studies were found that evaluated diagnostic performance for PAN and CT in ZrO₂ implants. The radiographic detection of bone defects using both PAN and CT was inferior to other methods (PR and CBCT) in Ti implants.^{31,32,38} This implies that these imaging modalities (PAN and CT) are not appropriate for peri-implantitis assessment.

CBCT diagnostic accuracy in Ti and ZrO₂ implant defects was assessed by applying several methodologies; in most studies, CBCT was superior to PR, at the expense of a higher dose of radiation. According to the American Academy of Oral and Maxillofacial Radiology,⁵¹ before the decision to perform a CBCT examination is made, its use should always be weighted and clinically justified by the patient's clinical signs or symptoms.

In this analysis, high variability was found in imaging studies reporting the detection of bone defects in Ti and ZrO₂ implants. The use of CBCT imaging in the assessment of peri-implant bone defects in ZrO₂ implants seems to impair analysis and decrease accuracy, but statistical significance was observed. Furthermore, for Ti implants, fenestration was more accurately diagnosed than dehiscence. The use of different protocols with modification of the FOV, voxel size, MAR, and the application of filters did not significantly alter the diagnostic performance of the imaging methods for both types of implants.

In order to answer the guiding question of this systematic review with more certainty, further studies are needed using ZrO₂ implants to analyse diagnostic accuracy in different situations.

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Conflicts of Interest: None

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