

## Roll Flap Technique to Enhance Buccal Gingival Thickness and Implant Emergence Profile: A Case File

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**Citation:** Chowdhury S, Karar CK, Singh DK, Dutta D, Singh G, et al. Roll Flap Technique to Enhance Buccal Gingival Thickness and Implant Emergence Profile: A Case File. J Oral Med and Dent Res. 4(2):1-8.

**Received:** December 15, 2023 | **Published:** December 29, 2023.

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### Abstract

Several techniques have been developed to enhance the buccal gingival breadth, gingival height and contour surrounding the implant. In this case file, a buccal rotational flap was used to improve the buccal emergence profile of implant site and increase gingival tissue thickness. This case involves the use of a rotational flap during second-stage implant surgery performed after 3 months of implant placement, with the use of a modified healing abutment to attain a thick gingival collar.

## Keywords

Rolling of flap; Emergence profile; Atraumatic extraction; Immediate implant

## Introduction

The placement of an implant requires comprehensive knowledge of anatomy. It requires evaluation of tissue breadth, tissue height and the healing process, along with good surgical skills [1]. The ideal need of tissue around the implant is thick attached keratinized gingiva [2]. An adequate gingival attachment level, the existence of interdental papillae, and the contour of the crown are mandatory for achieving a healthy periodontium around the implant [3-4]. Several techniques have been applied to improve the soft tissue profile around the implant, such as the AlloDerm roll technique, along with or without connective tissue grafts [5-7].

Connective tissue grafts serve a good for achieving adequate gingival thickness and increasing gingival level but do need a second surgical site. They fail to provide color match with the receptor site and sometimes result in tissue shrinkage and necrosis even though done with high professional skills [9-12].

The roll technique is used to enhance the gingival margin thickness when the defect is smaller than 3 mm. This technique has been found to be useful in second stage surgery to improve the buccal contour and tissue breadth around the implant [10-13]. The roll technique has many advantages and disadvantages. Advantages are the roll techniques helps in achieving a better emergence profile, with less scar tissue formation, more stable gingival margin, with no secondary site of surgery, maintains the blood supply to the rotated part, shorter healing period and faster tissue maturation, no need for advanced professional skills, cost effective and tissue harmony around the implant. While disadvantages are that it does not change the gingival biotype, tissue loss may occur at the implant site, not applicable for multiple implants, does not improve the interdental papillae level and it may leave a scar at the esthetic zone [14].

## Case File

A 35-years old patient came in OPD of Chandra Dental College and Hospital, Baranski (UP) with a non-restorable decayed root 46. Treatment steps was explained and discussed with patient which included removing the retained root and placing an implant to allow for soft and bony tissue healing. After an atraumatic extraction of the retained root, an immediate implant was placed; a full-thickness envelope was raised with the adjacent papillae. Bone recontouring was done as per selected size of implant, and an implant 12 mm in length and 4.5 mm in diameter was placed. The implant was placed with moderate stability (torque 40 Ncm). The cover screw was placed, the flap was approximated, and the implant was completely covered. The implant was left to heal for 3 months, after which soft tissue and hard tissue

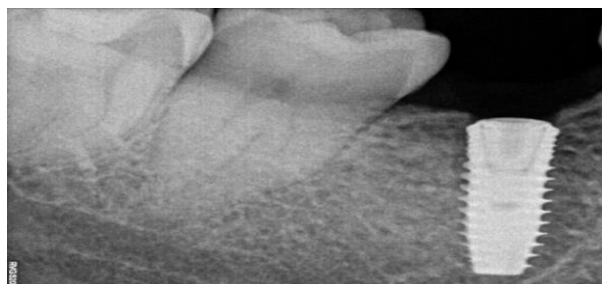
was evaluated clinically (Figure 1a) and radiographically (Figure 1b) for re-entry surgery. Second surgery was performed by raising a three-sided flap that excluded the adjacent papillae. A buccal crestal incision was made, the cover screw was removed, and a modified healing abutment with a gingival collar with of flowable composite was prepared. The modified healing abutment was small in shape (diameter and length) with open contact with adjacent teeth to allow soft tissue growth and thickening. The healing abutment was torqued into place.

One of the most important steps is the proper de-epithelialization. So, de-epithelization with done with B.P. blade no 11 and enabling the flap to berotated inward and was adapted with the keratinized mucosa facing the healing abutment (Figure 2) and simple interrupted suturing was performed to fix the rotated flap buccally against the abutment (Figure 3). The healing abutment was ensured to be kept out of occlusion during centric movement and excursion. Patient was recalled after 1 week and on examination healing was evaluated.

After one month, the treated site was evaluated with complete soft tissue maturation, to reveal an excellent emergence profile (Figure 4). The modified healing abutment was then removed (Figure 5), perfect thick gingival collar was attained and impression coping was screwed into the implant temporarily to make an impression. The permanent crown was placed, excess cement was removed, and occlusion was adjusted. The patient was seen again after 3 months, at which time the papillae were almost filling the interdental space and the scar was faded (Figure 6).



**Figure 1a:** Clinical image.



**Figure 1b:** Radiographic Image of healing after 3 months of extraction of retained root 46 and placement of an immediate plant.



**Figure 2:** Second stage surgery is performed 3 months after implant placement and buccal rotational flap performed simultaneously with a modified healing abutment with flowable composite. A three-sided flap with a more lingually placed crestal incision and the papillae reserved is created. After de-epithelization with scalpel, two vertical incisions are made to the vestibule so that the flap could be freely rotated.



**Figure 3:** Suturing was performed buccally to fix the rotated flap against the abutment.



**Figure 4a and 4b:** After 10 days, soft tissue healing is evaluated clinically and bone level is evaluated radiographically.



**Figure 5:** The healing abutment was then removed and perfect thick gingival collar was attained.



**Figure 6:** Final prosthesis is placed, and adequate gingival breadth is achieved.

## Discussion

Achieving an adequate gingival tissue collar is the key to success in implant dentistry. Reduced gingival breadth and gingival recession are common challenges after tooth extraction and implant placement [14-19]. In this case, an immediate implant placement regimen was followed, but it resulted in the occurrence of buccal bone reduction that required a roll flap during the second stage surgery to address the buccal defect. Since, a buccal gingival roll flap has many advantages when was used to increase the thickness of the gingiva and improve the crown appearance buccally. Harvesting the flap adjacent to the donor site gives additional advantage that it avoids second-site surgery and beneficial over the connective tissue graft, which is harvested from the palate [9-10]. The healing phase showed that, no shrinkage of the mucosa and no changes in color when the roll flap is placed at the gingival donor site [8, 9]. Risk of graft loss or necrosis was negligible as the rolled flap provides the blood supply to the grafted part of the gingiva. This technique requires less skills as it is not very technique sensitive and provides a shorter healing time compared with a connective tissue graft This technique provides thick gingival breadth that is needed to achieve better contour. It also increases the tissue breadth and height thereby, providing more tissue stability when compared with AlloDerm [8]. Some considerations must be followed to achieve better results while using the roll flap. Firstly, adequate amount of flap tissue thickness needs to be rotated to

improve the gingival contour. Secondly, sufficient amount of keratinized tissue should be present buccally at the donor site before the roll flap is started (presented case had more than 5mm buccal).

Thirdly, a papilla preserving flap should be raised buccally to prevent the interdental papillary loss [20]. However, there are numerous surgical, prosthetic, biological and anatomical factors, procedures and elements that contribute in successful rotational flap technique. Surgical factors are namely choosing a flap design with papilla preservation flap, avoiding a vertical cut on the keratinized mucosa and more palatal/lingual placement of the crestal incision. Prosthetic elements that need to be kept in mind are proper implant position (not ending with a ridge lab crown), concave provisional crown at the cervical area and smooth crown surface. Biologically, gingival tissue grafted changes according to the donor site of the implant, thus should be considered and evaluated consistently. Keeping in mind the anatomical aspect, oral mucosal tissue changes according to the type of surface facing the implant and there should be adequate thickness of the rotated flap (>1.5 mm). The surgical procedure cannot regenerate the papillae, but the surgery should be conservative and should not include the papillae from the first surgery [21]. This technique does not improve the interdental papillae level as the papillae depend on the crestal bone-contact point distance [22]. This Technique does not involve making a vertical incision in the keratinized mucosa, which avoids the formation of an unpleasant scar. Instead, the surgeon can use a pouch and tuck the rotated flap inside [10]. Using a temporary prosthesis will improve the gingival emergence profile to mimic a natural tooth profile [20]. The breadth of the rolled gingiva is crucial in this procedure to create more bulge and thickness on the buccal side of the implant [10].

## Conclusion

The use of the roll flap technique can improve and enhance horizontal concavity of the buccal bone and enhance the breadth and level of the gingival margin level around the final prosthesis of implant. Thus, increasing buccal gingival thickness and improved buccal contour.

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