



Comparative Evaluation of Open Flap Debridement Therapy with Two Different Types of Platelet Concentrates, T-PRF and L-PRF as Adjuncts- A Systematic Review

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

Article Information

DOI: 10.9734/JPRI/2021/v33i54B33785

Editor(s):

(1) Dr. Ana Cláudia Coelho, University of Trás-os-Montes and Alto Douro, Portugal.

Reviewers:

(1) Saturnino Marco Lupi, University of Pavia, Italy.

(2) Bharat Joshi, HPU, India.

(3) Himani S Gupta, Bhabha Atomic Research Centre Mumbai, India.

Complete Peer review History, details of the editor(s), Reviewers and additional Reviewers are available here:

<https://www.sdiarticle5.com/review-history/78411>

Systematic Review

Received 02 October 2021

Accepted 07 December 2021

Published 13 December 2021

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ABSTRACT

Conventional Periodontal therapy such as scaling and root planing and open flap debridement aims to halt the inflammation process and promotes repair of disease-related defects. Current regenerative procedures offers a limited potential toward attaining a complete periodontal restoration and none is considered a gold standard in the treatment of intrabony defects. This study was done to compare the efficiency of Titanium-Platelet Rich Fibrin and Leukocyte-Platelet Rich Fibrin as adjuncts to Open Flap Debridement therapy to treat intra-bony periodontal defects. A search was conducted through PubMed and various other databases such as Cochrane, Google Scholar and EBSCO Host , under the key words, OFD , T-PRF,L-PRF, Clinical Outcomes, Comparison and Randomised Contolled Trials. Six relevant articles were selected for analysis. Compared to non-platelet concentrates, L-PRFproves to be the better adjunct to open flap debridement therapy. When compared to T-PRF, however, L-PRF has comparatively inferior properties of bone defect resolution and fill.We can conclude that T-PRF has better properties, greater bone defect fill and defect resolution as compared to L-PRF.

Keywords: Regeneration; open flap debridement; titanium-PRF; leukocyte-PRF; intrabony defect.

1. INTRODUCTION

Periodontitis is characterized by microbially-associated, host-mediated inflammation that results in loss of periodontal attachment [1]. Periodontal therapy aims to eliminate the inflammation process and promote bone and tissue healing. The purpose of said conventional therapeutic measures is to reduce pocket probing depth(PPD) and increase clinical attachment level(CAL).It unfortunately, cannot bring back the lost alveolar bone, which then leads to periodontal regenerative therapy to repair the intra-bony defect. Periodontal regeneration is a complex multifactorial process involving biological events such as cell adhesion, proliferation, and differentiation in a sequential manner [2]. Among the techniques used to manage residual pockets after cause related therapy OFD (Open Flap Debridement) has been considered as standard and one of the earliest modality [3].

Several regenerative materials have been looked at for the management of intrabony defects such as; bone grafts/ bone substitute materials,guided tissue regeneration (GTR), growth factors and enamel matrix derivatives. Consequently the quest on devising an autologous bioactive material that is most effective in its regenerative potential had been escalating. The Choukroun's Platelet-rich fibrin(PRF) is one such product that has proved its worth in terms of accelerated wound healing and regeneration [4,5].

Platelet rich fibrin (PRF), an autogenous biomaterial combines the fibrin sealant properties

along with growth factors and cytokines entrapped in a fibrin matrix thereby providing an ideal environment for wound healing and regeneration of tissues. In recent times it has been used in various disciplines in dentistry in a wide range of treatment modalities. It is prepared using the Choukroun's protocol. Choukroun's PRF protocol is a simple and free technique developed in France by Choukroun et al in the year 2001 [6]. It is considered to be a second-generation platelet concentrate because, natural concentrate is produced without anticoagulants. Blood is collected in dry glass tubes and centrifuged at low speed 2800 rpm for 12 min (Process protocol, Nice, France) [6]. In the absence of anticoagulants, platelet activation and fibrin polymerization are triggered immediately. The PRF clot forms a robust fibrin matrix with a three-dimensional architecture, in which most of the platelets and leukocytes from the collected blood are concentrated. When pressed between two gauzes,the PRF clot becomes a strong membrane [6].

Initially, Platelet Rich Plasma (PRP) was combined with various Bone Grafting materials which gave a satisfactory result. But due to risk of antigenicity by the presence of bovine thrombin, Leukocyte-PRF(L-PRF) was introduced by Choukroun in 2001 [7].In studies conducted by Sharma et al [8], and Pradeep et al [9]; it was repeatedly proven that autologous PRF had excellent healing abilities, due to the constant slow release of growth factors.

Titanium was brought into focus due to its osseointegration, heamatocompatibility and

superior properties of platelets on activation. Titanium PRF (T-PRF) is prepared using Tunali's Protocol [10]. A blood sample is collected from a willing volunteer. 10ml blood is transferred into a Grade IV titanium tube. The tube is immediately centrifuged with a specific table centrifuge at room temperature. It is centrifuged at 3500 rpm for 15 min clockwise [10]. Newer products like Titanium-PRF(T-PRF) should be tried as an adjunct to open flap debridement therapy, as titanium provides adjunctive properties to PRF. T-PRF is based on the principle that titanium tubes could be more effective in activating platelets than glass. It helps in enhancing the haematocompatibility of the material, which further facilitates the formation of a more polymerized fibrin network [10]. L-PRF on the other hand, is made without any added anti-coagulants. In this method, platelets and leukocytes are collected with high efficiency and leukocytes are intact throughout. Platelets are activated by silica from the glass tubes. L-PRF improves the preservation of the alveolar width resulting in less overall bone loss than in natural bone healing [11].

Very few studies have been conducted using T-PRF as an adjunct along with Open Flap Debridement to heal periodontal intrabony defects. This systematic review aims to collect all available and relevant data from standardized sources and compare the efficiency of T-PRF and L-PRF as adjuncts to open flap debridement therapy to treat intra-bony periodontal defects.

2. MATERIALS AND METHODS

All articles were searched using the PRISMA(Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines [12] (Fig. 1).

2.1 Eligibility Criteria

For the inclusion of articles in this study, the PICOS guidelines [13] (Chart 1) were followed which were as follows; comparative studies of either T-PRF and L-PRF as adjuncts with open flap debridement surgery, individual comparisons of T-PRF and L-PRF with other standard material as adjuncts, randomised control trials comparing either the two materials with each other or individually with other standard materials.

2.2 Exclusion Criteria

Any letters to the editor, abstracts and articles in other languages were excluded.

2.3 Outcome

The outcome of this systematic review is to collect all the full text data and compare the clinical efficiency of T-PRF and L-PRF as adjuncts to open flap debridement surgery to manage intra-bony defects.

2.4 Search Strategy

An electronic search was conducted in the PubMed/MEDLINE database, and other sources such as Cochrane Database, EBSCOHost and Google Scholar, with the following key words; Titanium enriched PRF, Leukocyte and Platelet Rich Fibrin, Open Flap Debridement, Periodontal Disease, Intrabony Defects, Comparative studies, Randomised Control Trials. A total of 6 full text records were selected for this study ;(Table 1).

2.5 Risk of Bias [14]

Cochrane Collaboration's Tool for Assessing Risk of Bias in Randomized Trials was used to evaluate the risk of bias. Critical assessments were made separately for different domains: random sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessment, incomplete outcome data, selective reporting, and other bias. For each domain, the risk of bias was graded as high, low, or unclear based on criteria described in the Cochrane Handbook for Systematic Reviews of Interventions.

3. OBSERVATIONS AND RESULTS

We selected six relevant studies for comparison as seen in Table 1. In both the studies conducted by Pradeep A et al, the first in 2009, and the next in 2012, L-PRF was compared to Peptide Enhanced Bone graft and PRP. It was seen in both studies that the L-PRF group showed better bone fill and resolution as well as healing compared to non platelet concentrate grafts. In the study conducted by Mathur et al in 2015, L-PRF was compared with Autologous Bone Graft (ABG) and it was proven that the L-PRF group showed greater bone defect resolution compared to ABG. From this comparison it becomes clear that compared to non-platelet concentrate, L-PRF proves to be the better adjunct to Open Flap Debridement therapy.

In the studies conducted by Chatterjee et al, 2017 and Ustaoglu et al, 2020 it was seen that T-PRF showed better defect fill, resolution and

healing compared to L-PRF. On the other hand when Mitra et al compared the same concentrates with the same therapy he found the two to have similar bone defect resolution, fill and healing properties. From the above comparison it is clear that titanium activated platelets have more potential for healing and regeneration than leukocyte activated platelets. They show a marked increase in CAL and reduction in the PPD. They also show greater bone defect fill and resolution. Therefore, T-PRF proves to be much superior in its properties than L-PRF.

4. DISCUSSION

In our study we compared the conventional L-PRF and the novel T-PRF as adjuncts to OFD to heal intrabony defects. We included in vitro and in vivo comparative studies, prospective and retrospective studies as well as randomised controlled trials for the same. After screening all available records, six relevant randomised controlled trials were selected for the analysis.

The main treatment modality chosen was open flap debridement. The aim of this procedure is to reduce the PPD and increase the CAL. This procedure includes well-defined incisions, flap reflection and an atraumatic procedure, whose primary goal is healing (long junctional epithelium) of the periodontal pocket with minimum tissue loss [15]. Because the alveolar process is only partly exposed, post-operative pain and swelling are rare. The main goals of the procedure include optimum mechanical subgingival root planing and "decontamination" with direct vision followed by healing (primary intention) [16].

According to a recent systematic review, the average CAL gain seen with OFD by itself was 1.65 mm, average PPD reduction was 2.80mm, gingival recession (REC) increase was 1.26 mm and bone gain at 12 months was clinically 1.04 mm and radiographically 0.95 mm [17].

The method of preparation of both products, T-PRF and L-PRF are almost the same, with the only difference is that T-PRF is produced in tubes coated with titanium. Therefore, titanium grants better properties to the platelets in the PRF produced. L-PRF is produced without any additional anti-coagulants and is only activated by the silica in the glass tubes. It has been proven to be a successful adjunct by various authors over the years. However, controversies regarding silica cross contamination were raised by O'Connell and Tunali et al; the focus shifted towards a new bio material [10,18].

In a study conducted by Pradeep AR et al; they concluded that autologous PRF (L-PRF) had better bone defect fill and resolution than the peptide enhanced bone graft [19]. In another study conducted by the same author in the year 2012, he concluded that autologous PRF (L-PRF) and the PRP groups proved to be better adjuncts to open flap debridement than just doing open flap debridement [9]. Amongst the two materials, L-PRF proved to be superior to PRP. In a study conducted by Mathur A et al [20]; it was proved that L-PRF had better healing and bony defect resolution properties after open flap debridement, than Autologous Bone Graft(ABG). These studies showed that autologous PRF has been a successful adjunct to OFD over the years. Ehrenfest et al; in his study showed that PRF induced a significant and continuous stimulation and proliferation of gingival fibroblasts, dermal pre-keratinocytes, pre-adipocytes, and maxillofacial osteoblasts (Dohan Ehrenfest DM et al., 2009). reference Platelet concentrates are better than any other biomaterial as there is a slow release of several factors such as; leukocytes, vitronectin, fibronectin, Bone morphogenetic proteins (BMPs), and cytokines that help in quicker healing and regeneration [11].

T-PRF on the other hand, is a relatively new product, and is also relatively expensive for research purpose as compared to L-PRF. Therefore, not many studies have been conducted for the same. Chatterjee A et al ,2017; it was seen that T-PRF proved to be a better adjunct to Open Flap Debridement, than autologous PRF [21]. There was a marked regaining in attachment as well as other clinical and radiographic parameters. Mitra DK(2019) showed that, T-PRF and L-PRF had similar clinical results but histologically, T-PRF produced a thicker fibril network [22]. Our study therefore, is in accordance with these studies where our end result was also that T-PRF had superior properties as compared to L-PRF, and therefore made a better adjunct to Open Flap Debridement to manage Intra-bony Defects.

5. CONCLUSION

L-PRF(Choukroun's PRF) has been a successful adjunct over time. Its resorption rate however, is very high. Conversely, T-PRF, has a lower resorption rate and higher haemato-compatibility and other superior properties compared to L-PRF due to titanium activated platelets. Further research needs to be conducted on the clinical outcomes of both

adjuncts individually and more split mouth trials need to be conducted comparing the two materials as adjuncts to have a more homogenous and standard data.

CONSENT

It is not applicable.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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Annexure-1

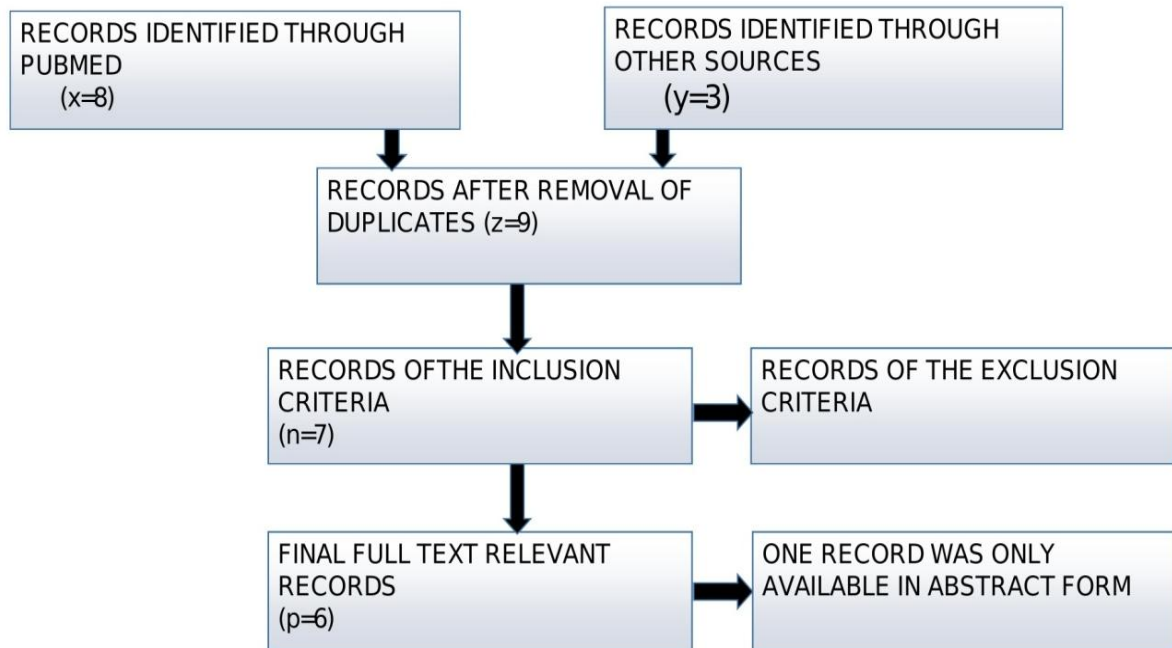


Fig. 1. PRISMA guidelines to perform the record search; Search Strategy

P (POPULATION)	PERIODONTAL DISEASE LEADING TO INTRABONY DEFECTS
I (INTERVENTION)	OPEN FLAP DEBRIDEMENT
C (COMPARISON)	T-PRF AND L-PRF AS ADJUNCTS TO OPEN FLAP DEBRIDEMENT SURGERY
O (OUTCOME)	BETTER DEFECT FILL AND RESOLUTION
S (STUDY DESIGN)	RANDOMISED CONTROL TRIALS, SPLIT MOUTH CLINICAL TRIALS, IN VIVO AND IN VITRO COMPAATIVE STUDIES, PROSPECTIVE AND RETROSPECTIVE STUDIES

Chart 1. PICOS guidelines for deciding the Inclusion Criteria

Annexure 2

Table 1. Characteristics of Included Studies

Name	Author/Year	Type of Study	Type of PRF Compared	Results
Clinical effectiveness of autologous platelet-rich plasma and peptide-enhanced bone graft in the treatment of intrabony defects.	Pradeep A et al 2009 ¹⁹	Randomized Controlled Trial	L-PRF compared to Peptide -enhanced bonegraft	CT revealed a greater defect fill for the L-PRF group
Comparative evaluation of autologous platelet-rich fibrin and platelet-rich plasma in the treatment of 3-wall intrabony defects in chronic periodontitis: A randomized controlled clinical trial.	Pradeep A et al; 2012 ⁹	Randomized Cotrolled Trial	L-PRF compared to PRP	Greater mean percentage of bone fill was found in the L-PRF group as compared to the PRP group
Evaluation of intrabony defects treated with platelet-rich fibrin or autogenous bone graft: A comparative analysis	Mathur A el al; 2015 ²⁰	Randomized Controlled Trial	L-PRF compared to Autologous Bone Graft	Greater defect fill and resolution was seen for the PRF with Open flap debridement group thanwith the ABG group
Treatment of periodontal intrabony defects using autologous platelet-rich fibrin and titanium platelet-rich fibrin: a randomized, clinical, comparative study.	Chatterjee A et al; 2017 ²¹	Randomized Controlled Trial	L-PRF compared to T-PRF	T-PRF showed better defect fill and defect resolution than L-PRF.
Comparative study using autologous platelet-rich fibrin and titanium prepared platelet-rich fibrin in the treatment of intrabony defects: An in vitro and in vivo study.	Mitra DK, et al; 2019 ²²	Randomized Controlled Trials	L-PRF compared to T-PRF	T-PRF and L-PRF showed similar healing and resolution of bone defects, but histologically T-PRF showed a thicker fibril network

Name	Author/Year	Type of Study	Type of PRF Compared	Results
Comparison of GTR, T-PRF and open-flap debridement in the treatment of intrabony defects with endo-perio lesions: a randomized controlled trial	Ustaoğlu G, et al; 2020 ²³	Randomized controlled study	T-PRF and open flap debridement, compared to Guided Tissue Regeneration, compared to only Open Flap Debridement	T-PRF group showed maximum healing and resolution of defect.

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Peer-review history:

*The peer review history for this paper can be accessed here:
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