Antibiotics in the treatment of periodontal and peri-implant infections

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This article will discuss the updated rationale for the supplementary use of systemic antibiotics (antibiotics administered per os) in periodontal and peri-implant infections in the light of the recent global antibiotic resistance threat. As a consequence, different aspects of clinical and microbiological considerations including relevant groups of antibiotics and their antimicrobial resistance, will be discussed. Aggressive and chronic periodontitis which comprise heterogeneous constellations of destructive periodontal disease, are included in the periodontitis section (1). The reader should be aware of the recently modified classification of periodontal diseases (2) where the two principal forms above have been put into the diagnosis “Periodontitis” (reclassified based on stages and grading). With the diverse clinical picture of periodontitis, the clinician will with either classification have to carefully evaluate each patient and decide an individual treatment plan. The general rule for adjunctive antibiotics must be restrictive, and the knowledge about the antibiotic resistance profile from microbiological testing is an important tool for a good treatment decision.
The basic approach for treatment of plaque-induced periodontitis has been established as anti-infective therapy; without the use of antibiotics (3-5). Long-term clinical studies have documented that infection control by mechanical periodontal treatment can be maintained with regular supportive care for most patients. The cornerstones in the maintenance are to monitor the quality of the patient’s oral hygiene, the clinical symptoms (bleeding on probing (BOP) and pocket probing depths (PPD)) and X-ray information on a regular basis (6-8). Furthermore, periodontal therapy is dependent on skilled clinicians (dentists and dental hygienists) who are able to diagnose and treat according to accepted guidelines (9).

Systemically administered antibiotics in this field were introduced in 1976 or even earlier when metronidazole was used for targeting anaerobic bacteria in dental infections (10). Tetacyclines were also tested experimentally (11-13) and used in cases of “juvenile periodontitis,” (14) before amoxicillin or the combination of amoxicillin and metronidazole were shown to improve the treatment results (15,16). Later, studies by Loesche and coworkers showed a clinical benefit of metronidazole, used in addition to scaling and root planing (SRP), which seemed to reduce the need for periodontal surgery (17,18).

At the same time, Slots and coworkers reported on advanced cases of periodontitis where the treatment did not halt the periodontal breakdown. Such cases assigned as “refractory” or “therapy-resistant” may have originated from periodontal disease originally diagnosed as “chronic periodontitis”. According to Armitage (9) “refractory periodontitis” could be a heterogeneous group including multiple forms of nonresponsive periodontitis (19,20).

The observations of the periodontal microbiota “superinfection” with non-oral Gram negative facultative rods (Escherichia coli, Klebsiella pneumoniae, Serratia spp., Pseudomonas spp.), yeasts, and even Staphylococcus aureus, often corresponded with these non-responsive cases. In vitro antibiotic resistance profiles to several antibiotics could also be detected as typical characteristics reflecting that the periodontal microbiota could be a reservoir of bacterial resistance. More than 20 years later, data from microbiological samples of untreated periodontitis patients show a high prevalence of antibiotic resistance in the microbiota, supporting its role as a reservoir of antibiotic resistance genes (21,22).

**PERIODONTITIS**

**Aggressive periodontitis and chronic periodontitis**

In the classification from 1999 “juvenile periodontitis” was placed in the aggressive periodontitis group (1) due to characteristics with early onset and rapid attachment loss. Treatment of these cases have for many years been accepted as a challenge for the clinician. If treatment is to succeed tooth loss should be limited as much as possible and be intensive and careful with the clinician’s knowledge of etiology, pathogenesis, microbiology and clinical features. Patients included in these categories are those who may benefit from the use of systemic antibiotics as a supplement to conventional periodontal treatment (16,23). However, antibiotics should only be prescribed to patients with severe periodontal breakdown in order to treat the patients individually and reduce antibiotic use to the minimum.

Localized and generalized aggressive periodontitis have several common clinical characteristics, including a 3-4 fold higher speed of progression/destruction rate compared to chronic periodontitis (1,24). Periods of progression are followed by periods of regression (25). The treatment should always include an initial periodontal therapy phase, a second phase that may include the use of antibiotics together with SRP or SRP plus periodontal surgery, with a carefully planned supportive therapy (maintenance) in all cases. Since the biofilm is 100-1000 times more resistant to antibiotics than planktonic bacterial cells (26,27), the biofilm must be broken mechanically to make the antibiotics sufficiently effective in reaching the target.

The rationale for the use of antibiotics is that pathogens after mechanical debridement persist in the periodontal tissue, in furcation involvements, root concavities or dentin tubules and may recolonize as the basis for recurrent disease. The presence of *Aggregatibacter actinomycetemcomitans* and *Porphyromonas gingivalis* in the microbiota in patients with aggressive periodontitis may have increased indication for the use of supplementary antibiotics due to their ability to invade host tissue cells (epithelial and connective tissue cells) (28,29). If antibiotics are to be prescribed, it should be administered during a short period of disease activity/progression, and considered only for patients with sufficient oral hygiene (plaque index not exceeding 15%) after initial treatment. These criteria for antibiotics should be met: Presence of several probable pockets of ≥6mm (at least 2 sites in patients with localized aggressive periodontitis), persistent inflammation registered as BOP and/or suppuration, documented increased loss of clinical attachment level (CAL), verified progression of bone loss on radiographs and an unfavorable subgingival microbiota (30). Thus, the adjunctive use of antibiotics in patients with aggressive periodontitis has become part of the national antibiotic guidelines in several countries due to the reported effect of systemic antibiotic therapy with a mean difference in PPD and CAL of 1.05 mm and 1.08 mm 6-month post-treatment, respectively (31,32).

If antibiotics are considered in the treatment of chronic periodontitis, it should always be administered as a supplement to conventional therapy (27,33).

Many studies with variable observation periods and results have during the last twenty years been performed to evaluate the effect of adjunctive systemic antibiotics as part of the initial treatment of chronic periodontitis. Several treatment schemes have been used followed by discussions and arguments of pro et contra of how to implement these drugs with the best effect, and several types of antibiotics have also been tested. Most prevalent is the combination of amoxicillin and metronidazole (34).

According to a meta-analysis from 2003 analyzing 29 studies, the authors (33) concluded that systemic antibiotics had a statistically significant positive effect on clinical attachment loss with the greatest effect in patients with aggressive periodontitis.
Periodontitis versus peri-implantitis – similar or different?
Periodontitis and peri-implantitis are both infections linked to the formation of biofilms located at the gingival margin where the subgingival/submucosal sites of an affected tooth/implant have similar major risk factors, as poor oral hygiene, smoking, and diabetes (43, 48, 49). Periodontitis per se forms an increased risk for peri-implantitis (48-50). One drastic difference is a non-linear, accelerating pattern of bone destruction and its fast progression in peri-implantitis (51, 52). In addition, the type of implant surface seems to have an impact on the susceptibility to develop peri-implantitis and on the resolution of infection (53, 54).

The periodontal pathogens have been considered causative agents also in peri-implantitis due to the potential transmission of pathogenic species from periodontal pockets to peri-implant sites (55, 56). Factors that determine the composition of the periodontal microbiota are defined by the microbial ecological niche (57). Essential for subgingival bacterial growth is the anaerobic condition, the supply of nutrients from the gingival crevicular fluid, temperature and other factors which favor the composition of the microbiota in that niche.

The microbiota of chronic periodontitis has been characterized by different bacterial complexes that cooperate in the pathogenesis (58). The red complex consists of P. gingivalis, Tannerella forsythia and Treponema denticola and with the members of the orange complex (a number of other anaerobic, Gram negative species) have been proposed to be responsible for disease progression (Fig. 1). The established subgingival biofilm in periodontitis is dominated by facultative and strict anaerobic species included by Prevotella spp., Fusobacterium spp., Porphyromonas spp., Treponema spp. and others. Recent studies indicate that P. gingivalis represents a "keystone pathogen" which is able to modulate the subgingival biofilm into dysbiosis, thus exerting the whole bacterial community into disfavor of the host (59, 60). A. actinomyceseiccomitans associated with local aggressive periodontitis ("juvenile periodontitis") may also be detected in other forms of periodontal disease. Thus, the virulence factors of these species represent a potential arsenal for local tissue destruction.

The red complex bacteria (P. gingivalis, T. denticola, and T. forsythia) are abundant in peri-implantitis as well. Microbial interacting networks are dissimilar between periodontitis and peri-implantitis (61). In a study by Kumar and coworkers (62), significant compositional differences were detected between four groups with healthy teeth, teeth with periodontitis, healthy implants or implants with peri-implantitis. The bacterial communities varied considerably between teeth and implants in health and between periodontitis and peri-implantitis sam-

Bacterial complexes

Fig. 1. Bacterial complexes in chronic periodontitis. The red and orange complexes are associated with the cultivable species in the microbiota important in the pathogenesis of chronic periodontitis. From Socransky et al., 1998.

Fig. 1. Bakterielle komplekser i kronisk parodontitis. Det røde og det orange kompleks er forbundet med dyrkbare arter i mikrobiotaen og vigtige i patogenezens af kronisk parodontitis. Fra Socransky et al. 1998.
ple. Interestingly, peri-implant communities proved to be less diverse, and several species, including previously unsuspected and unknown organisms, were unique to the peri-implant niche (62). These results also correspond with results from earlier studies indicating a similarity with cases of “refractory” or “therapy-resistant periodontitis” (non-oral Gram negative rods, pseudomonads and S. aureus and with detectable in vitro resistance to several antibiotics).

The bacterial profiles in peri-implant health and disease have been summarized in recent systematic reviews (63,64).

Results from new advancements in gene sequencing methods have also revealed the microbiota diversity in peri-implant sites. In different studies, peri-implant biofilms are reported to contain known periodontitis-associated species and opportunistic pathogens (53,65), to be connected to periodontal pathogens and staphylococci (62,66,67). In addition, certain clusters of spirochetes (Treponema) and Synergistetes, which are mainly uncultivable, have been observed in increased prevalence and numbers in peri-implantitis lesions (68). Some reports also indicate that viruses (Epstein-Barr virus-1 and human cytomegalovirus-2) may contribute to the pathogenesis (69), as has been proposed for periodontitis (70).

To date, there is increasing evidence on the effect of smoking on the composition of subgingival biofilms. It seems that smoking shapes the peri-implant microbiome even during clinical health by depleting commensals and enriching for pathogens (71). In both smokers and non-smokers, peri-implant mucositis is a sentinel event indicating the environment is primed for future disease.

There is evidence that diabetes is linked to changes in the periodontal/peri-implant microbiota. Demmer and co-workers investigated abnormal glucose metabolism and periodontal microbiota prior to diabetes development and overt hyperglycemia; higher levels of many subgingival bacteria associated with a two- to three-fold higher prevalence of prediabetes among diabetes-free adults (72). A study by Ganesan and co-workers (2017) revealed that environmental stress, caused by smoking and diabetes, affects the structure and membership of the subgingival microbial communities. The combined effect of smoking and hyperglycemia proved to be greater than the sum of the parts (73). It was shown that a hyperglycemic microenvironment favors organisms that thrive under glucose-rich, pro-oxidant, protein-rich, and anaerobic conditions. No such data exist on dental implant-related submucosal biofilms so far. However, in a recent systematic review, it was demonstrated that hyperglycemic individuals have an increased risk for peri-implantitis but not for peri-implant mucositis (74).

**ANTIMICROBIAL RESISTANCE (AMR)**

Most of the studies in periodontal literature investigating the effect of adjunctive use of antibiotics are primarily focusing on the clinical effect of the treatment and do not take into account the negative side-effects of these drugs: 1) the questionable and unethical use of broad spectrum antibiotics with no actual information about the microbiota (composition and resistance profile (see later), 2) the negative effects on the normal microbiota (unfavorable dysbiosis in the gut and other niches), and 3) the upgrowth of resistant bacterial clones. Investigations demonstrating these side effects have been available for many years, but may have been forgotten in the context of the goal of a successful periodontal treatment. Now, it is time to closer elucidate and weigh the pro et contras for adjunctive antibiotics in periodontology (21,23,75). These are summarized in Fig. 2.

AMR is the ability of bacteria to survive and grow in the presence of antimicrobial drugs. It is a natural phenomenon that existed long before the introduction of antibiotics in medicine and can be an intrinsic property of a species, which means that all members of the species are resistant to a certain compound. It is however important to realize that AMR is an emerging problem worldwide and according to the WHO, one of the most important threats to global health (76,77). This is associated with the potential of susceptible microorganisms to acquire resistance to drugs or spread of AMR in previously susceptible species directly which is connected with the overuse and misuse in human and veterinary medicine and food production (78). Bacteria can acquire AMR by either mutation of existing genetic material that changes or enhances the activity of a gene product or horizontal gene transfer (HGT) of extrinsic DNA creating novel genetic material. Horizontal gene transfer occurs via three general mechanisms: 1) phage transduction, 2) transformation and 3) conjugation. Phage transduction is the transfer of genetic material via infection by a bacterial virus – a bacteriophage (79). Transformation is the acquisition of extracellular genetic material from the environment whereas conjugation is direct cell-to-cell transfer of genetic material via conjugative pili.

Antimicrobial drugs generally target one of the essential structures or processes of bacteria including the cell membrane or enzymes involved in: i) maintenance of the cell wall, ii) replication, iii) transcription, iv) translation or v) metabolism. The mechanisms utilized by bacteria to withstand the effect of antimicrobial drugs are generally divided into three major strategies: 1) prevention of the drug from reaching...
its target, 2) alteration of the target or 3) inactivation of the drug (80).

Antimicrobial drugs can be prevented from reaching the intended target by passive mechanisms such as the natural barriers that exist in certain types of bacteria such as the outer membrane of Gram negative bacteria. Both Gram positive and Gram negative bacteria also possess membrane spanning proteins (efflux pumps) that actively extrude drugs from the cytoplasm thereby reducing the intracellular concentration. There are both specific and multi-drug transporters, with affinity for one or different types of drugs, respectively. Protection of the target site can also often be achieved by expression of specific proteins that interact with the drug target and prevent access of the drug to the target site. A common strategy of bacteria to resist antimicrobial activity is to alter the target which may reduce the interaction between the drug and target. These modifications can consist of point mutations in the genes encoding the target, enzymatic alteration of the drug binding site or replacement or bypass of the original target. Inactivation of the antimicrobial drugs occurs via enzyme mediated chemical modifications, such as acetylation, phosphorylation, adenylation or hydrolysis of essential components of the drugs. This leads to reduced binding to the target or destruction of the drug (80). Importantly, resistance mechanisms against several antibiotics often localize on the same transferrable genetic element, which means that the use of one class of antibiotics may promote persistence and spread of resistance mechanisms to other classes of antibiotics, hence increasing the dissemination of multidrug resistant bacteria (81).

**MICROBIAL DIAGNOSTICS IN PERIODONTITIS AND PERI-IMPLANTITIS**

Bacterial sampling from periodontitis and peri-implant sites can be performed either with sterile paper points, a sterile periodontal probe or a curette. Since it is easy to induce bleeding from initially inflamed deep pockets, paper points are usually preferred to minimize the risk of blood contamination. Samples are usually taken for analysis with DNA probes (checkerboard) or with PCR (qPCR/or real time PCR) (82) and transported dry, in a buffer solution or in an anaerobic transport medium to the laboratory. The choice of transport medium for transfer of viable anaerobic bacterial samples is of outmost importance for the culture analysis because *in vitro* susceptibility testing can only be performed when the bacterial samples contain viable bacteria (83).

As a general molecular screening of periodontitis or peri-implant microbiota, the DNA checkerboard analysis has been used for many years and represents a panel of predefined DNA probes (bacterial markers) where many samples can be tested at the same time (84). Analysis with qPCR has a greater sensitivity but is limited by the fact that fewer bacterial species (red complex) can be routinely quantified. In addition to identification by molecular methods, cultivation and susceptibility testing ought to be included in the total microbial analysis due to the increasing antibiotic resistance that has emerged (see below).
For cultivation, both anaerobic and aerobic conditions should be included as well as detection of superinfecting organisms such as enteric rods and *Candida* spp. by using selective agar media for these organisms. The susceptibility testing should include antibiotics and antifungal medicaments that are used in dental infections.

**Need for antibiotic susceptibility testing**

Since there is a direct correlation between antibiotic consumption and the global development of resistance (85-86), every effort has to be taken to reduce antibiotic misuse/overuse. A serious problem with the development of oral bacterial resistance is that the commensal bacteria also may transfer resistance genes to other pathogens such as *Streptococcus pyogenes* (87), supporting that the oral microbiota can be reservoir of AMR. Rams and co-workers (88) found that 71.7% of 120 peri-implantitis subjects exhibited submucosal bacterial pathogens resistant in *vitro* to one or more of the tested antibiotics (doxycycline, clindamycin, amoxicillin, and metronidazole) (see earlier (21)).

For targeted selection of adjunctive antibiotic treatment, it would be of outmost importance to test the antibiotic susceptibility pattern in periodontitis and peri-implant infections. Susceptibility testing of relevant microorganisms is performed at most microbiological laboratories. However, unless these laboratories have special knowledge and interest in the "niche" of oral microbiology, important details in the analysis may easily be overlooked. Antibacterial susceptibility testing against antibiotics used in dental care should be preferred, but there is no consensus on how the oral microbial analysis should be designed. Under any circumstance, *in vitro* antibiotic susceptibility testing should always be included in the microbial analysis to be of any value in the clinic (89). Even in the Scandinavian countries, a coordination of these matters should be focused on.

For peri-implantitis, it seems that the benefits of the adjunctive use of antibiotics in the treatment remain questionable. Whenever prescribing antibiotics, it is important that clinicians carefully consider expected benefits and risks, including side effects due to disturbance of the commensal flora in the gut, and in particular, the risk of the development of resistant clones. Peri-implant superinfections form a potential risk in patients treated empirically with broad-spectrum antibiotics (90). Gastrointestinal discomfort and mild diarrhea seem to occur in approximately 10% of the cases treated with a single antibiotic (54,91), whereas side effects are more common when the combination of amoxicillin and metronidazole is used (92).

**ANTIBIOTIC RESISTANCE MECHANISMS**

**Beta-lactam resistance**

Phenoxyxmethylpenicillin and amoxicillin are β-lactam antibiotics commonly used in dentistry. This class of bactericidal drugs function by inhibiting the transpeptidase reaction catalyzed by penicillin binding proteins (PBP) during synthesis of the peptidoglycan layer of the bacterial cell wall. The result is a weak cell wall and cells that easily burst due to osmotic lysis (93). Because of physiological differences between Gram positive and Gram negative bacteria and differences in number, activity and functionality of PBP of different species, bacterial species are differently susceptible to various β-lactam antibiotics (94-96).

The most important mechanism of resistance to β-lactam antibiotics is the enzyme mediated hydrolysis of the β-lactam ring, resulting in inactivation of the drug. These enzymes are called β-lactamases and are strategically located together with the PBP; extracellularly in Gram positive bacteria and in the periplasmic space of Gram negative bacteria (93). In this way they protect the integrity of the peptidoglycan layer by inactivating the antibiotic before it can inhibit the transpeptidase activity of the PBP and weaken the cell wall. They are naturally occurring and chromosomally encoded in many species, but can also occur in mobile genetic elements including integrons and plasmids, which facilitate their dissemination.

Bacteria can be intrinsically resistant to some β-lactam antibiotics due to differences in the structure of PBP. Resistance also occurs due to mutations in genes encoding PBP that result in structural changes and altered affinity for the antibiotic. This has been described for methicillin resistant *Staphylococci* (MRSA) (97) as well as penicillin resistant *Streptococci* and *Neisseria* species (98,99).

Because of the occurrence of penicillin resistance, novel β-lactam antibiotics were developed to circumvent the problem. However in parallel, novel β-lactamases with wider spectrum of activity emerged and/or spread in bacterial communities counteracting the development of new generations of drugs. *This explains the complex and intriguing problem of AMR where the bacteria always find a new way to survive by genetic modification and exchange.*

The extended spectrum β-lactamases (ESBL) are enzymes that can inactivate 3rd generation cephalosporins as well as earlier generation drugs (100). Dissemination of plasmid encoded extended spectrum β-lactamases is an emerging problem because they are resistant to most β-lactam antibiotics, and in addition, these plasmids often contain resistance mechanisms against other antibiotics leaving very few treatment options available (101). The treatment of choice for serious infections caused by ESBL producing organisms is carbapenem, but plasmid mediated carbapenem-resistance has recently been described (102). Carbapenem resistant organisms are classified as priority 1: critical in need of development of novel antibiotics by the world health organization (103).

**Clindamycine resistance**

Clindamycin is a semisynthetic antibiotic of the lincosamide family, with primarily bacteriostatic effect. It is mainly active against Gram positive bacteria, and anaerobic bacteria (104), and thus could be excellent for the treatment of odontogenic infections, including periodontal and peri-implant infections. It binds to the 50S ribosomal subunit and inhibits bacterial protein synthesis by interfering with the transpeptidation reaction and peptide-chain elongation (105). The drug shows little effect against most aerobic Gram negative bacteria due to their intrinsic resistance and poor permeability of the cellular outer porins (104).

However, there are several mechanisms of resistance to clindamycin, including modification of the target, inactivation...
of the drug and drug efflux (104,105). Resistance occurs by both plasmid mediated and chromosomally mediated mechanisms and include chromosomal mutations of ribosomal subunits, plasmid encoded efflux pumps and drug-adenylation or ribosome-methylating enzymes altering the drug-ribosome interaction. Thus, the drugs ability to counteract antibiotics and cause AMR by several different mechanisms should be taken as a warning by clinicians intending to use it, and it constitutes an example of the importance of susceptibility testing in the microbial analysis.

**Metronidazole resistance**
For some clinically important anaerobic species a slight increase in resistance to metronidazole has been reported, but fragment ed information is available (106,107). Metronidazole belongs to the nitroimidazole group and is mainly active against obligate anaerobic bacteria (and to a small extent microaerophilic or facultative anaerobes), while Actinomyces and Propionebacterium spp. are resistant (108). This indicates that the metabolic state of the organism is important and in line with the fact that the drug must be reduced to be active (109). The ability of metronidazole to compete as an electron acceptor is important for function and changes in metabolism of organisms have been shown to impact the susceptibility to metronidazole. The mechanisms of resistance are complex and include reduced uptake, increased efflux, reduced rate of drug activation, drug inactivation and increased DNA repair mechanisms (21,109), with only scarce information available.

**Quinolone resistance**
Ciprofloxacin is one of the drugs in the group of fluoroquinolones. The drug targets are the type II topoisomerases gyrase and topoisomerase IV (110). These drugs are ineffective in anaerobic infections, while effective to non-oral Gram negative rods (E. coli, Klebsiella spp., Pseudomonas spp. etc.) frequently detected in therapy-resistant periodontal and peri-implant infections. Acquired quinolone resistance is associated with three types of mechanisms: i) chromosomal mutations altering the drug binding affinity, ii) chromosomal mutations resulting in decreased influx or increased efflux of the drug and iii) acquisition of plasmid mediated genes coding for target protection proteins, drug modifying enzymes or drug efflux pumps (111). *The quinolones are extreme drivers of antibacterial resistance, and for the use of quinolones in this respect, susceptibility testing and careful consideration about all aspects of the patient is of utmost importance (112).*

Quinolone resistance can occur as a result of decreased influx, increased efflux or both. Exposure of bacteria to quinolones can select for mutants that overexpress efflux pumps, usually as a result of mutations in regulatory proteins and less often as a result of mutations in the structural genes associated with quinolone resistance. In general mutations affecting quinolone uptake and efflux cause only low-level resistance and do not usually represent a major clinical problem in the absence of additional resistance mechanisms (110-112). However, efflux systems have been shown to be of critical importance for the development of high level quinolone resistance and reduced intracellular concentration of quinolones may favour the emergence and dissemination of other types of resistance. Efflux pumps involved in quinolone resistance have been identified in both Gram positive and Gram negative species.

**Tetracycline resistance**
Tetracyclin is a broad spectrum antibiotic that interacts with the 16S rRNA of the 30S ribosomal subunit, thereby inhibiting protein synthesis by blocking attachment of charged aminoacyl-tRNA to the A site of the ribosome (113,114). Tetracycline enters Gram negative cells via diffusion through the outer membrane porins. Resistance to tetracyclines often occur as a result of acquisition of mobile genetic elements carrying tetracycline resistance determinants, mutations within the ribosomal genes or mutations leading to decreased cytoplasmic accumulation of the drug (115).

**Macrolides**
Macrolide antibiotics are natural or semisynthetic compounds that function by binding to the ribosome and stalling protein synthesis (116). Macrolide resistance is increasing and can occur via several different mechanisms. The use of macrolides has been shown to induce mutations in the chromosomally encoded 23S ribosomal RNA (rRNA) as well as in genes encoding protein subunits of the ribosome (117). The RNA methyl transferases constitute an important and widespread resistance mechanism that function by methylating a residue in the 23S rRNA and thereby prevent interaction between the ribosome (target) and the macrolide drug (118,119). Mutations and/or methylation of rRNA or ribosomal protein subunits separately lead to reduced macrolide susceptibility and can in combination result in high level of macrolide resistance (120,121). Importantly, the binding site of macrolides, lincosamides and streptogramins overlap, and it has been shown that mutations or methylation of the rRNA can confer cross-resistance to drugs of these three antibiotic classes and expression of the MLSB-phenotypes (varying levels of Macrolide, Lincosamide, Streptogramin B resistance) (122) (Poehlsgaard and Douthwaite, 2005). Furthermore, macrolide can be inactivated by macrolide esterases and/or phosphotransferases that hydrolyze macrolides or transfer a phosphate moi ety onto the drug (123,124). There are both specific macrolide efflux pumps and unspecific multidrug resistance pumps that can lower the intracellular concentration of macrolides in both Gram positive and Gram negative bacteria (117).

**TREATMENT**
**Treatment of aggressive and refractory periodontitis with adjunctive antibiotics**
The most commonly used systemic antibiotics are metronidazole, amoxicillin and tetracycline /doxycycline. Amoxicillin has a broad antimicrobial spectrum and is bactericidal on Gram positive coccius and rods, Gram negative coccus and some Gram negative rods. Metronidazole primarily inhibits strict anaerobe microorganisms, and in combination with amoxicillin has a synergistic effect on the facultative part of the microbiota, in-
including *A. actinomycetemcomitans* (A.a) (125). Due to the relatively high occurrence of A.a. in patients with localized aggressive periodontitis, the combination of these two drugs is the primary choice. In cases of β-lactamase producing organisms amoxicillin plus clavulanic acid (β-lactamase inhibitor) will be a preference if it is available for prescription in the primary care.

Tetracycline/doxycycline, a broad spectrum antibiotic from the TET-group, is less effective against periodontal infections with A.a. However, due to a high degree of bacterial resistance, the use of these drugs should be minimized as much as possible (126). Doxycycline can be administered if its anti-collagenase effect is considered important (127).

Microbiological testing of the subgingival microbiota including identification and susceptibility testing to appropriate antibiotics should always be performed for the use of broad spectrum antibiotics proposed in the treatment of periodontal infections due to the fact that the clinical picture cannot display species identification or susceptibility pattern of the microbiota of interest.

The final decision on the use of antibiotics must be based on anamnestic information on health status and previous periodontal treatment, clinical parameters, radiographic analysis of bone loss and infrabony defect formation.

**Treatment of peri-implantitis with adjunctive antibiotics**

In the treatment of advanced peri-implantitis, mechanical anti-infective therapy is necessary but seldom results in the resolution of the infection, and therefore, access surgery is considered an essential part of the treatment (128). Systemic antibiotics have been used both in the mechanical anti-infective treatment phase and in connection to regenerative surgical procedures. However, no standardized guidelines are available regarding the use of systemic antibiotics in peri-implantitis. Adjunctive antimicrobials have been advised as a potential treatment regi-men in severe cases, like in those having deepened pockets of > 5 mm, notable cratering of more than 2 mm, and bleeding on probing, as stated in the cumulative interceptive supportive therapy (CIST) flowchart (129).

There are studies where systemic antimicrobials and antiseptics are routinely included in the surgical treatment protocol of peri-implantitis. In a two year prospective study, all 31 patients started a prophylactic one week course of cindamycin the day before surgery (130). A delay of re-growth of submucosal bacteria at the 6-month examination did not sustain, where only 50% of the patients were without signs of peri-implant disease after two years. A study from Switzerland and Western Australia including 24 patients treated with a combination of amoxicillin and metronidazole (seven days), starting immediately after surgery, showed that the majority of peri-implantitis patients can be treated successfully, with a strict anti-infective protocol (5). In a five year follow-up of these patients with regularly supportive peri-implant therapy, 63% had a successful treatment outcome (53% at implant level) (131). An anti-infective surgical peri-implantitis treatment protocol with adjunctive antimicrobials and regular maintenance visits were considered moderately effective. Thus, it is not possible to solve the role of antibiotics as a separate issue in the treatment outcome, since randomized controlled clinical trials are needed to show the effect of selected adjunctive systemic antimicrobials.

One randomized controlled clinical trial, where 100 patients with 179 dental implants affected by severe peri-implantitis were recruited to investigate the adjunctive effect of systemic antibiotics (amoxicillin) and local antimicrobial decontamination agents (chlorhexidine) (54). The patients were randomly assigned to four groups, of those two groups with or without antimicrobial decontamination, and they had a 10 day course of amoxicillin, commenced three days prior to resective surgery. One fourth of the implants had a non-modified surface, while the rest presented different types of modified surfaces. The microbiological and clinical treatment outcome was evaluated at six- and 12-month intervals; while bone gain was reported in patients treated with adjunctive amoxicillin and further bone loss was observed in those without amoxicillin. Interestingly, only a minor positive effect was found around implants with non-modified surface, whereas the potential benefit of systemic amoxicillin was limited to implants with modified surfaces (54). In a subsequent 3-year follow-up, the analysis included 83 patients and 148 implants, confirming the positive outcome of surgical therapy for the majority of these peri-implantitis patients (132). Whether surface characteristics influence long-term treatment outcomes and the susceptibility to recurrent disease could be speculated, because the pocket depth reduction was more pronounced at implants with non-modified surface. Instead, the moderate benefit of systemic amoxicillin that was gained at implants with modified surfaces at the time of first intervention (54) did not sustain over the follow-up period of three years (132).

Azithromycin belongs to newer macrolides, and it is increasingly used in periodontics. It has been shown to be able to suppress periodontal pathogens, to possess anti-inflammatory properties, and to persist in host cells like gingival fibroblasts and macrophages (133). However, the reported short-term effect of azithromycin at clinical and microbiological level does not support its use in the treatment of peri-implantitis (91,134) (see also section Antibiotic resistance mechanisms).

**CONCLUSIONS**

The scientific evidence for the benefits of adjunctive systemic antibiotics in the treatment of periodontitis and peri-implantitis are generally not acceptable due to the unfavorable health risks to patients, society and the world’s ecosystems. However, in cases of aggressive and unresponsive cases of advanced chronic periodontitis antibiotics could be considered after microbiological analysis based on molecular methods, culture analysis (anaerobic and aerobic growth) and susceptibility testing.

Reliable scientific evidence on the use of systemic antimicrobials as an adjunctive treatment for peri-implantitis is scarce with no proven effective treatment protocol to keep all peri-implantitis patients free of inflammation on a long-term basis, underlining the significance of preventive approach for individuals with dental implants.
ANTIBIOTIKA I BEHANDLINGEN AF PARODONTALE OG PERI-IMPLANTÆRE INFEKTIONER

Terapeutisk anvendelse af systemisk antibiotikum i forbindelse med behandlingen af parodontitis og peri-implantitis har i mange år haft forskningsmæssig interesse grundet sygdommenes individuelle kliniske manifestation og respons på behandling. På verdensplan er antibiotikaresistens et alvorligt problem og en af de vigtigste trusler mod den globale sundhed som følge af misbrug/overforbrug af antibiotika. I betragtning af mikrobiotaens mangfoldighed i mundhulen og dets potentielle som reservoir for antibiotikaresistens kan misbrug af antibiotika medføre bivirkninger for både individet og dets omgivelser. Da de positive langsigtede virkninger af antibiotika i behandlingen af de fleste parodontale infektioner er tvivlsomme, bør anvendelsen af terapeutisk antibiotika begrænset og som regel kun overvejes efter mikrobiologisk diagnostic, der omfatter artsidentifikation og følsomhedstest. For peri-implantitis savnes dokumentation for effekten af systemisk antibiotika, og der findes ingen protokol for en behandlingsplan, der på lang sigt giver gode resultater.

REFERENCES


ABSTRACT (DANSK)

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