Initial implant stability is considered an important factor for achieving osseointegration, and it is regarded as a key success factor for immediate loading.\(^1,2\) Implant stability was defined by Sennerby and Meredith as the absence of clinical mobility.\(^2\) A similar definition was proposed by Ostman et al, considering it as the implant’s capacity to withstand load in the axial, lateral, and rotational directions.\(^2,3\)

These definitions indicate that initial stability is related to the stiffness of the bone-to-implant interface achieved at implant placement and is dependent on several factors, such as the mechanical properties of the bone, implant design and surface, and surgical technique.\(^2,5\)

Several studies have shown that low-density bone achieves lower initial stability and that cortical thickness has a significant influence on initial implant stability.\(^3,6,7\) Turkyilmaz found higher insertion torque values (ITVs) and implant stability quotient (ISQ) measurements in the anterior mandible.\(^6\) Also, Seong et al, using the same...
surgical technique to place identical implants in different bone locations, found higher initial stability in the implants placed in the mandible or in anterior areas, which are associated with higher bone densities, compared with those placed in the maxilla and in molar areas.  

The influence of the implant macrogeometry and microgeometry on the initial stability was also reported. Different studies in cadaveric maxillae in animal experiments with rabbits or with swine ribs found statistically significant differences in the implant stability when comparing different implant body designs, thread geometries, or surface roughness. Research from Misch et al, Miyamoto et al, and Zix et al reported that these geometry-related factors, together with the implant diameter, were found to have a greater impact on the bone-to-implant contact area and initial stability than the implant size. Östman et al found that shorter implants have higher stabilities. The implant design was also reported to be of more influence when type III or IV bone or nondiseased extraction sockets were considered. 

Regarding the influence of the surgical technique in this context, it was suggested that undersizing the implant bed when working on soft bone could be beneficial to obtaining higher stability. However, the adequacy of the surgical technique and the implant geometry may not be enough to compensate for the effect of the bone softness.

Several methods were proposed to evaluate the initial implant stability. Some involve major subjectiveness since they are based on the surgeon's clinical perception. Based on the correlation established by Friberg et al, the tactile perception of the bone resistance to drilling during the implant bed preparation and to the implant progression may give a clinical perception of the bone density. The percussion test, which involves tapping a mirror handle against the implant, may give the surgeon an indication of good or bad stability. However, these are poor methods providing only poor qualitative information.

Different tests may provide quantitative information. Some are not clinically eligible because they are invasive and result in implant removal. Tests such as the reverse torque test or the removable torque test should only be used for in vitro and animal experimentation. However, other quantitative tests may have clinical use. The Periotest, originally designed to establish a value for natural teeth mobility by measuring the damping characteristics of the periodontal ligament, was also recommended for use with dental implants. However, due to the absence of periodontal ligament, the range of values for implants was defined from –5 to 5, which represents a less sensitive method of providing information about the implant primary stability compared with natural tooth measurements. Among the tests of clinical use that provide quantitative information, ITV and ISQ appear to be of most use to determine the initial implant stability. ITV gives indirect information because it measures the frictional resistance that bone exerts to the progression of the implant and, consequently, the necessary torque to overcome it. Thus, as Aparicio et al stated, the Periotest assesses implant stability, while ITV only assesses the conditions of implant placement. An ITV of 32 to 35 Ncm would be the minimum necessary to allow immediate loading. The major drawback of this method is the impossibility of its use to assess implant stability over time. However, it is a method that does not need special instruments since it may be obtained by commonly used devices to prepare the implant bed and implant placement. ISQ consists of measuring the resonance frequency of the placed implants. A magnetic pulse is sent to a peg, which is temporarily screwed to the implant, inducing the implant vibration. The resonance frequency of the vibration is translated to an ISQ. The higher the ISQ, the higher the implant stability. This method, presented by Meredith et al, measures the implant stiffness in the surrounding bone, which is directly related to bone-to-implant contact. It has been proposed that an ISQ of 60 to 65 would allow immediate implant loading.

Although both methods are widely used, the correlation between them is not established beyond any reasonable doubt. Some studies found a statistically significant correlation between ISQ and ITV. Degidi et al found a statistically significant correlation between ISQ and ITV. Furthermore, Sarfaraz et al found a similar correlation when considering implants inserted in the posterior mandible. However, other researchers did not establish a statistically significant correlation between them. In a human cadaver study, Akkoaglu et al did not establish a statistically significant correlation between both methods, and identical conclusions were reported by dos Santos et al in an in vitro study, González-García et al considering the anterior mandible, and a cohort prospective study conducted by Norton. However, both methods significantly correlate with bone density.

This clinical research had three different aims. The first aim was to establish possible statistically significant differences when separately observing the evolution of ITV and ISQ, considering clinical variables such as gender, age, arch, location, implant geometry, diameter, length, and delayed or immediate implant placement. The null hypothesis for each variable was that there are no differences. The second objective of this research was to understand whether an overall positive correlation is possible to establish between ITV and ISQ (the null hypothesis was that no correlation exists between both entities). The third goal was to determine whether the presence or absence of a correlation between those methods is possible.
to establish for each of the clinical variables under scope (the null hypothesis was that no correlation exists).

**MATERIALS AND METHODS**

The patient selection for this research respected only one inclusion criterion: the indication for rehabilitation with osseointegrated implants; and only two exclusion criteria: the presence of health conditions or medication that may prevent oral surgery.

Two different implant geometries from the manufacturer Nobel Biocare were used: NobelParallel and NobelActive. Both implants have the same electrochemical anodization surface treatment. NobelParallel represents implants with a more traditional parallel-walled macrogeometry and a smaller pitch, which results in more threads. NobelActive represents implants with a pronounced tapered macrogeometry, with a reverse neck and a more aggressive and complex thread design, but with a larger pitch and a smaller number of threads (Fig 1).

All the implants were placed by the same surgeon (J.F.) following the manufacturer’s recommended drilling protocols regarding the implant geometry and bone density. These recommendations included bone bed undersizing for low bone densities and the use of a screw tap and/or countersinking for high bone densities. The bone density was subjectively evaluated by the surgeon, considering bone resistance to drilling. The bone bed preparation and implant placement were performed with the NSK surgical motor, Surgic Pro model, which ensures high-precision torque calibration. For each implant, the ITV was recorded from the indications on the motor’s display. The ISQ measurements were performed using the Penguin RFA (Integration Diagnostics). This is a wireless device that analyzes the resonance frequency and was considered as reliable as the Ostell (Ostell). The multipegs were manually placed in each implant, and the ISQ value was measured in the buccal-lingual and mesial-distal directions, twice for each direction. When the presence of adjacent teeth impaired the measurement in the mesial-distal direction, only the buccal-lingual data were collected. The highest overall value obtained was used in the present study.

The statistical analysis was intended to observe how clinically relevant conditions such as gender (male or female), age (≤ 60 years or > 60 years), arch (mandible or maxilla), implant location (incisors, premolars, or molars), implant geometry (NobelParallel or NobelActive), diameter (3.5, 3.75, 4.3, or 5 mm), length (< 10 mm or ≥ 10 mm), and delayed or immediate implant placement could influence the insertion torque or the ISQ measurements. Then, it was observed whether an overall correlation could be found between the insertion torque and the ISQ. The statistical analysis was also intended to observe whether the presence or absence of a correlation subsists for the clinical variables under consideration. Because the data did not meet the assumption of normality, nonparametric tests such as the Mann-Whitney-Wilcoxon and Kruskal-Wallis localization tests were used to compare two or more independent samples. To measure correlations between ITV and ISQ, the Spearman rank correlation (rho) was used. Rho values close to 1 indicate a strong correlation, and values approaching zero indicate an absence of correlation. The R statistical software (version 3.6.1) was used in all analyses. For a level of confidence of 95%, the null hypotheses were rejected for P values < .05.

![Fig 1 Two different implant geometries were used in this research. (a) NobelParallel represents a more traditional implant body design and threads. NobelActive represents the implants with a more conical macrogeometry, reverse neck, and complex self-tapered threads.](image)
A total of 51 consecutive patients (aged 36 to 79 years, average = 58.53, standard deviation [SD] = 10.38), 31 women and 20 men, received 137 implants; 75 implants were immediately loaded (12 implants, supporting provisional prostheses, were left without occlusal contacts with antagonist teeth; and the remaining 63 implants supported provisional prostheses with occlusal contacts). The rehabilitations included single-unit implant-supported prostheses (n = 32), partial fixed implant-supported prostheses (n = 50), and complete fixed implant-supported prostheses (n = 55).

Of the placed implants, 60 were NobelParallel (mandible, n = 52; maxilla, n = 8), and the remaining 77 were NobelActive (mandible, n = 22; maxilla, n = 55).

From the 137 placed implants, 49 were placed in nondiseased extraction sockets and 88 in healed bone. The implant distribution by geometry type and diameter is represented in Fig 2. The implant distribution by arch and location is depicted in Fig 3.

The overall median of the ITV recorded was 45 Ncm (interquartile range = 10 Ncm; interquartile interval = 35 to 45 Ncm). For ISQ, the median was 78 (interquartile range = 7; interquartile interval = 75 to 82).

The distribution of the results of each variable, considering the ITV and ISQ, and the respective P value are depicted in Tables 1 and 2.

Regarding the ITV distribution, the results suggest significant differences considering two variables for which it was possible to reject the null hypothesis. In the arch group, the maxilla showed lower ITV values than the mandible (P = .032; Fig 4a). In the length group, implants shorter than 10 mm showed higher ITV values than the longer implants (P = .03; Fig 4b).

The immediately placed implants recorded lower ITV values than the delayed implant placement (Fig 4c). Comparing the central tendency of both variables, the P value was .07, which is approaching significance, meaning that the obtained values should be carefully considered.

Observing the distribution of ISQ scores, it was possible to reject the null hypothesis for five variables, for which the results suggest statistically significant differences. In the arch group, the maxilla exhibited lower ISQ than the mandible (P = .0002; Fig 5a). In the age group, patients with an age ≤ 60 years showed higher ISQ values compared with older patients (P = .02; Fig 5b). In the implant geometry group, the NobelParallel implants showed a statistically significantly higher ISQ than the NobelActive implants (P = 7.32e–6; Fig 5c). Considering the diameter group, implants with diameters of 3.75 and 4.3 mm exhibited higher ISQ measurements than implants with diameters of 3.5 and 5 mm (P = .04; Fig 5d). Finally, immediate implant placement ISQ measurements were lower than implant placement in healed bone (P = 8.52e–07; Fig 5e).

Three particular cases associating more than one clinical variable were also observed. The first case consisted of studying the effect of the implant geometry...
when considering each arch separately. It was observed that for the maxilla, minor differences existed when comparing both geometries (P values of .89 for ITV and .84 for ISQ). Contrastingly, the same comparison reported for the mandible exhibited distinct results because the NobelActive implants showed higher ITV values (P = .04) but lower ISQ values (P = .0004; Table 3). The second case consisted of investigating whether the implant geometry influences the ITV when the implants are placed in healed bone or in nondiseased
extraction sockets (Table 4). Here, no significant measurement differences were found. Also, no ISQ differences were found for both implant geometries when immediately placed. Yet, comparing the ISQ values for delayed implant placement, the NobelParallel implants showed statistically significantly higher observations ($P = 5.29\times10^{-7}$) than the NobelActive implants. The third case consisted of comparing the ITV and the ISQ values obtained for implants placed in the maxillae of women $> 60$ years of age with the rest of the population under study (Table 5). In this case, relevant differences could be seen for the ISQ ($P = .005$).

Analyzing the correlation between ITV and ISQ, an overall statistical significance ($P = .0055$) was found, with a small positive value ($\rho = 0.237$). As seen in Fig 6, the two methods do not show a linear evolution over the entire range of observations. A nearly linear evolution is present for an ITV up to 40 Ncm and an ISQ up to 78. From this point, an increase in the ITV does not correspond to an increase in the ISQ, which remains at values close to 78. In fact, if a cut value of 40 Ncm is introduced, the subgroup with an ITV $\leq 40$ Ncm shows a huge probability value ($P = 8.023\times10^{-6}$) and the level of correlation rises to 0.541. Contrarily, in the subgroup with higher ITV, the correlation is no longer observed ($P = .70$).

Regarding a possible correlation between ITV and ISQ considering the different clinical parameters under scope (Fig 7), a positive correlation was found for the implants placed in one of the following subgroups: women ($\rho = 0.23; P = .02$); men ($\rho = 0.269; P = .068$); patients older than 60 years of age ($\rho = 0.3; P = .009$); maxilla ($\rho = 0.51; P = 1.3\times10^{-5}$); molar area ($\rho = 0.27; P = .04$);
NobelActive implants (rho = 0.3; P = .007); implants with a diameter of 4.3 mm (rho = 0.36; P = .02); implants with a diameter of 5 mm (rho = 0.36; P = .09); implants with ≥ 10 mm length (rho = 0.26; P = .003); and implants placed in healed bone (rho = 0.36; P = .006).

It was not possible to find a statistically significant correlation between ITV and ISQ when the implants were placed in one of the following conditions: in the mandible, in fresh extraction sockets, if the patients are < 60 years of age, in anterior or premolar areas.
when considering implants with a platform diameter of 3.5 mm or 3.75 mm, or for implants shorter than 10 mm.

After a mean follow-up period of 25 months, one single-unit implant, NobelParallel, had failed. It was placed in the posterior maxilla, in healed bone, without immediate loading. The patient was male, and the loss happened 1 month after placement. The failed implant had no impact on the statistical analyses.

**DISCUSSION**

This research aimed to analyze the isolated evolution of ITV and ISQ for different parameters under clinical conditions, verify the existence or absence of a correlation between those two methods for the initial implant stability measurements, and ascertain whether the determined correlation is maintained for different chosen clinical parameters.

Insertion torque is the measure of the frictional resistance encountered by the implant while moving apically through a rotatory movement on its axis, and ISQ relates to the percentage of bone-to-implant contact.\(^7,19\) The literature proposes values of 32 to 35 Ncm for the insertion torque and 60 to 65 for the ISQ as minimum values to allow immediate loading.\(^20,22\)

An overall correlation between ITV and ISQ was found with statistical significance (Fig 6). The stratification of the degree of association between both methods shows evidence for a low correlation. Similar results were obtained by Degidi et al and Sarfaraz et al.\(^23,24\) In a translation to the clinical scenario, the problem under analysis is to know whether the torque necessary to overcome the opposition that the bone offers to the implant progression, which indirectly permits inferring the implant stability, may have an association with the implant stability obtained by the bone-to-implant contact, measured by the ISQ. An association would mean that a high insertion torque corresponds to high bone-to-implant contact, and the increase in the insertion torque would be accompanied with an increase in the bone-to-implant contact. If such a correlation were obtained, it would have clinical relevance since the measurement of only one of those parameters may be enough to assess the initial implant stability and to support the decision of immediate or delayed loading.

In fact, this linear evolution was found in the first part of the scatter plot (Fig 6). When the ITV increases up to 40 Ncm, an increase in the ISQ is also expected to have a value up to approximately 78, and this correlation is, simultaneously, of greater value and of greater statistical significance than the overall correlation. Therefore, for this range of values, the single measurement of ISQ or ITV might give enough information about the initial implant stability. When the ITV rises over that level, the ISQ does not rise with it, but rather stabilizes. As a matter of fact, these late ISQ and ITV values have a negative impact on the overall level of correlation. However, this behavior should not prevent the clinical decision of immediate loading once the values of ITV and ISQ involved are in a range related to very high initial stability. Thus, it seems that the ITV or the ISQ alone may be enough to valorize the initial implant stability. The observation of how these measures behave and correlate under particular conditions may help the surgeon in the decision of immediate or delayed loading.

In detail, the assessment of the different clinical variables showed different evolutions of ITV and ISQ and distinct levels of correlation.

When considering patient gender, no statistically significant differences were found in ITV or in ISQ. Both methods exhibited a correlation for both genders. Thus, it is not expected that gender influences the initial stability of implants.

Regarding the evolution of ITV and ISQ for both arches, the two methods were significantly higher in
the mandible than in the maxilla. In fact, it was the only clinical variable that found, simultaneously, statistically significant differences for ITV and ISQ. This finding is consistent with several studies that have reported a link between increased implant stability and increased bone density in the mandible.\textsuperscript{7,30} Also, in line with the findings of Östman et al, the adequation of the drilling protocol with the bone density, even resulting in high implant stability, did not fully compensate for the soft bone effect associated with the maxilla once the implant stability in the maxilla and in the mandible was not equated.\textsuperscript{3} Interestingly, contrary to the studies of Sarfaraz et al but in concordance with González-García et al, a correlation between insertion torque and ISQ for the implants placed in the mandible was not found.\textsuperscript{24,26} However, the highest level of correlation accompanied by the highest probability value was found in the maxilla. Therefore, clinically, lower initial implant stability is expected in the maxilla but with a strong correlation between the ITV and ISQ values.

Despite the decrease in bone mineralization with age, especially in women after menopause, Turkyilmaz did not find differences in the ITV based on diverse ages, and the same result was observed in the present study.\textsuperscript{6} However, it was possible to see a relevantly higher ISQ for patients ≤ 60 years of age, and a correlation between ISQ and torque was seen for the group of older patients. Older women are substantially affected by osteoporosis and the maxilla has softer bone, so it was ascertained whether the results maintained the same pattern for this subgroup compared with the rest of the population. Again, the ITV did not show significant differences, probably due to the adaptation of the drilling protocol to low-density bone, and the ISQ was significantly lower (Table 5), which reflects the lower bone mineralization expected for this subgroup. A correlation was observed between ISQ and ITV (rho = 0.56; \( P = .002 \)). Clinically, higher ISQ is expected for younger patients. For older patients, ITV and ISQ are correlated. Implant placement in the maxilla of older women may present difficulties in achieving good initial implant stability.

The present study did not show differences in ITV or ISQ related to the area where the implants were placed. Nevertheless, the implants placed in molar areas showed a correlation between both methods. This effect may be attributed to the use of larger-diameter implants in this area, because, as it will be described later, an important correlation is observed for the wider diameters used in this research.

Different authors highlighted the role of implant macrogeometry and thread design in initial implant stability.\textsuperscript{12,31} The present study compared two different implants: a group with a more traditional parallel macrogeometry, a smaller pitch, and more threads; and another group with a pronounced tapered macrogeometry, a reverse neck, and a more aggressive and complex thread design, with a larger pitch and a smaller number of threads. This research did not find differences in ITV for both implant groups, potentially due to the adaptation of the drilling protocol to the implant type, which contradicts the in vitro studies with bovine and ovine bone from Falco et al, who expected higher ITV for implants with identical characteristics to the NobelActive implants.\textsuperscript{32} The same study indicated this type of implant for low-density bone, which was also contradicted by the present study, where the combination of the variables showed that there were no ITV and ISQ differences comparing both geometries when the implants were placed in the maxilla, which is accepted as having less dense bone than the mandible. When placed in the mandible, the parallel implant group showed a statistically significantly higher ISQ (Table 3), which may be explained, in accordance with Misch et al, by the increased implant surface as a result of a greater number of threads exhibited by this geometry and the denser bone in the mandible.\textsuperscript{12} The implants with more aggressive threads, represented in the present study by the NobelActive implants, showed a statistically significant correlation between ITV and ISQ, while traditional and less aggressive threads did not exhibit a correlation.

Farronato et al and Hong et al found a significant increase in ISQ with the implant length, as longer implants provide the possibility of greater bone-to-implant contact.\textsuperscript{33,34} The same authors found that ITV increased with implant length, but it was more significantly affected by the presence of large cortical bone width. Contrarily, Östman et al associated greater stability with short implants. The present study could not find differences in ISQ with the variation of the implant length but found higher ITV for shorter implants.\textsuperscript{3} These results may be explained by the combination of two different aspects. The first aspect is that the majority (67\%) of the short implants were placed in the mandible, where thicker cortical bone is expected, and therefore, higher torque values were needed. The second aspect is related to the findings reported by El Kholy et al, who concluded that longer drilling distances were associated with higher deviations, which may result in wider implant beds and, therefore, decrease the resistance to implant progression and bone-to-implant contact.\textsuperscript{35} It is not possible to see a simultaneous increase in ITV and ISQ when placing short implants, but that correlation is expected for implants ≥ 10 mm.

Farronato et al reported that implant diameter was not associated with either ITV or ISQ, but Bilhan et al and Sarfaraz et al reported that greater diameter was associated with higher ITV.\textsuperscript{24,33,36} The present research did not find differences for ITV, potentially due to the
adaptation of the drilling protocol to the implant diameter, but implants with diameters of 3.75 and 4.3 mm showed higher ISQ values compared with the implants with diameters of 3.5 and 5 mm. This difference may be explained by different aspects:

1. The diameters of 3.5 and 3.75 mm correspond to narrow-platform implants (NobelActive and NobelParallel, respectively), and the drilling protocol is identical for both. Therefore, the implant with the greater diameter will present the greater bone-to-implant contact percentage.

2. Out of 26 implants with 3.75 mm, 23 were placed in the mandible, where higher stability was found for the majority of the implants.

3. Almost half (48%) of all the 5-mm implants were placed in the maxilla, and almost 40% were placed in fresh extraction sockets. Both these conditions decrease the ISQ values. A statistical correlation between ITV and ISQ was found for the implants with 4.3 mm. For the 5-mm group, the probability value approaches statistical significance ($P = .09$).

A statistically significant difference was registered in the measures obtained for the ISQ, with higher values obtained for the delayed implants compared with the immediate implants. Considering the ITV, the $P$ value was .07, approaching statistical significance with a tendency toward a higher measure for the delayed implant placement. This seems to be a logical result when attending to the lower bone availability in the extraction sockets. Likewise, a correlation was observed between ITV and ISQ for the delayed implant placement. That correlation does not exist for immediate implant placement, probably due to the residual gap that negatively influences the percentage of bone-to-implant contact.\textsuperscript{37,38} Karl et al, in an in vitro study analyzing implant placement in fresh extraction sockets, found higher values with statistical significance when comparing ITV and ISQ achieved with NobelActive implants (36.52 Ncm and 53.9, respectively) with more conventional geometries.\textsuperscript{15} The same implant was scrutinized in the present research with an ITV average of 40.58 Ncm and an ISQ of 73.11, which are both higher than the results presented by Karl and Irastorza-Landa, but without statistical significance compared with the NobelParallel implants. Nevertheless, and contrarily to that study, the observation of the conventional-geometry implants revealed a statistical difference in ISQ (Table 2) with an advantage over the more aggressive geometry. Thus, due to the absence of correlation between ISQ and ITV, the present study also points to the choice of ITV as the best parameter to take into account in the decision-making of immediate loading.\textsuperscript{38} The choice between the implant geometry for this parameter does not seem to have importance.

One major difficulty in the results and discussion of a clinical study lies in the fact that it is not possible to separate the effect of each variable from the simultaneous effect of all the other variables. Each parameter under scope influences and is influenced by all the others. Another potential limitation of this study is the adaptation of the drilling protocol to the bone density and the implant geometry following the instructions of the implant manufacturer. A possible mitigation of this limitation is that it was the same surgeon who placed all the implants, with the goal of achieving good primary stability.

Although the number of implants in this research made the combination of different variables possible, resulting in a closer approximation to specific scenarios, it was not large enough to enable the same approach in a greater number of possible clinical situations.

**CONCLUSIONS**

Within the limitations of this study, it is possible to predict that when implants are placed in the mandible, when using short implants, or when implants are placed in healed bone, higher ITV will be found when compared with implants placed in the maxilla, with the use of longer implants, or with implants placed in nondiseased extraction sockets. For all other clinical conditions under study, no differences are anticipated.

Also, based on the results of this study, higher ISQ measurements are expected when implants are placed in the mandible compared with the maxilla, in patients with ages $\leq 60$ years compared with older patients, when implants have a traditional parallel-walled macrogeometry and a smaller pitch compared with implants with a pronounced tapered macrogeometry and a more aggressive and complex thread design, when the placed implants have a diameter of 3.75 or 4.3 mm compared with implants with diameters of 3.5 or 5 mm, and when the implants are placed in healed bone compared with implants placed in nondiseased extraction sockets.

Between these two methods for evaluating the initial implant stability, it was possible to obtain an overall high level of correlation with high statistical significance for an ITV $< 40$ Ncm. For an ITV $> 40$ Ncm, the ISQ values, although without exhibiting a correlation, are also in a range of values that would allow immediate loading. Therefore, this study indicates that the individual measurement of ISQ or ITV might give enough information about the initial implant stability to support the immediate loading decision.

Looking into the specific conditions under scope, ITV correlates well with ISQ, individually, in each of the following situations: the patient is older than 60 years of age; the edentation is in the molar area of healed maxillary bone; and the implant to be placed has aggressive
threads, ≥ 10 mm length, and a diameter of 4.3 or 5 mm. On the contrary, the results show a poor correlation between both methods when considering the other studied clinical conditions, advising that, when evaluating the implant stability in those cases, the differences found for the two assessment methods should be regarded individually.

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