

# Extraction force and its determinants for minimally invasive vertical tooth extraction

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1 **Extraction force and its determinants for minimally invasive vertical tooth extraction.**

2

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14 **Running title:** Extraction forces for vertical extraction

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2 **Abstract**

3

4 Background: Minimally invasive vertical extraction devices have been developed to  
5 minimise the need for flap surgery and trauma to alveolar bone during tooth extraction. The  
6 objective of this study was to measure the forces required for vertical tooth extraction and  
7 evaluate the determinants of these forces.

8 Methods: The investigators coupled a precision load cell with a Benex<sup>®</sup> extractor to record  
9 extraction forces for 59 consecutive routine extractions of tooth roots. Age, sex, tooth type,  
10 root surface attachment area (RSAA) and whether or not the tooth was in functional  
11 occlusion were evaluated as determinants of extraction forces using linear mixed models.

12 Results: Maximum extraction forces ( $F_{max}$ ) varied widely from 41N to 629N. On average,  
13 maximum extraction forces were 104N (95% CI: 38N, 169N) higher for teeth/roots in  
14 occlusion vs. teeth not in occlusion. An increase in RSSA by one standard deviation was  
15 associated with a marked increase in  $F_{max}$  by 64N (95% CI: 34N, 94N). Extraction forces were  
16 not associated with age, sex or tooth type (maxillary vs. mandibular).

17 Conclusions: Extraction forces using the Benex<sup>®</sup> vertical extraction system vary widely and  
18 can be less than 50N or exceed 600N. On average, higher extraction forces are required to  
19 extract teeth with longer and thicker roots, as well as for teeth that are in functional  
20 occlusion.

21

22 **Key words:** atraumatic extraction, risk factors, socket healing, tooth extraction, wound  
23 healing

24

## 1 **Background**

2

3 The desire to minimise bone loss following tooth extraction to facilitate subsequent implant  
4 restoration has led to the development of novel vertical extraction techniques. These  
5 techniques aim to extract a tooth by applying a pulling force to the tooth root that is  
6 directed strictly along its long axis, resulting in the severance of Sharpey's dento-alveolar  
7 fibres and tooth extraction. Importantly, in case of a conical root without significant root  
8 curvature or undercuts, this extraction technique will minimise any direct trauma to alveolar  
9 bone.

10 The clinical procedure of vertical extraction with the Benex® system has been previously  
11 described in detail [1]. The system allows the predictable extraction of non-molar teeth, i.e.,  
12 incisors, canines and premolars, as well as the extraction of some molar roots [2, 3].

13 Extractions are more likely to fail in multirrooted and/or root-filled teeth; however, the  
14 overall need for flap surgery for the extraction of non-molar teeth may be reduced with the  
15 use of the system [2]. Due to its high predictability and the minimisation of trauma to root  
16 surface and alveolar bone, the system is also suitable for use with surgical extrusion [4, 5].

17 Clinical experience suggests that forces required for tooth extraction and pull time can vary  
18 widely [3], although extraction forces have never been directly measured.

19 The aim of the present investigation was to measure extraction forces occurring during  
20 vertical tooth extraction with the Benex device. A further aim was to evaluate putative  
21 tooth and patient level determinants of the maximum extraction force required for vertical  
22 tooth extraction.

23

## 24 **Methods**

1

2 *Patient sample and clinical procedure*

3 The extractions described here were performed between December 2008 and October 2009  
4 as part of routine clinical care of patients referred for tooth extractions or attending  
5 emergency appointments at the Clinic of Oral Surgery, Department of Oral and Maxillofacial  
6 Surgery, University of Zurich. All patients required tooth or root extractions as part of their  
7 treatment plan and all provided informed consent to treatment. All procedures were  
8 performed under local anaesthesia.

9 The clinical procedures and success rates of Benex extractions have been described in detail  
10 previously [1-3]. Briefly, a specially designed self-tapping screw is anchored in the centre of  
11 the root to be extracted. A pull rope is attached to the screw head and a strictly vertical  
12 extraction force is then applied with the extractor device until the root yields. An optional  
13 support tray may be used to help stabilise the extractor and ensure optimal alignment of  
14 the pull rope as well as even distribution of extraction forces (Fig. 1).

15 All extractions were performed by a single surgeon (IS). If appropriate, multirooted teeth  
16 were sectioned and roots were extracted separately. Once the extractor was set up, the pull  
17 force was increased gradually by turning the extractor handle clockwise. When significant  
18 resistance was felt, pauses were made at the surgeon's discretion, before turning the  
19 handle further to increase the pull force. This procedure was followed until the root yielded.  
20 Roots that could not be extracted with the Benex® system [2, 3] were excluded from this  
21 study and extracted using a conventional approach with or without flap surgery.

22 *Measurement of extraction force*

23 In order to measure the forces on the pull rope/screw of the Benex® device, the device was  
24 coupled with a precision load-cell (Burster®-Sensor, Burster Präzisionsmesstechnik GmbH &

1 Co KG, Gernsbach, Germany), which recorded the applied force every 50 milliseconds. These  
2 measurements were then exported into Excel-Software (Microsoft Excel, Microsoft Corp,  
3 Seattle, USA) to allow graphical representation of the extraction force over time. The sensor  
4 was first calibrated using a universal testing machine (Zwick/Roell Z010®, Zwick GmbH & Co  
5 KG, Ulm, Deutschland) in a setup that simulated the clinical scenario. To this end, a plaster  
6 model in conjunction with the support tray and silicon putty material was fitted to an upper  
7 premolar and 5 measurements each were taken for forces of 100N, 200N, 300N, 400N and  
8 500N for calibration purposes. A calibration curve was fit using simple linear regression and  
9 the maximum extraction force was calibrated using the model estimates accordingly.

10

#### 11 *Other data*

12 In addition to patient age, patient sex and type of extracted tooth, we recorded whether or  
13 not the tooth was in occlusion at the time of consultation. Furthermore, we used digital  
14 radiographs to estimate the root surface area of the tooth root to be extracted. To this end,  
15 the length of the periodontal attachment  $i$  and diameter  $d$  of the root was measured using  
16 image analysis software (Digora, SOREDEX, Tuusula, Finland)(Fig 2). Based on the formula  
17 for the lateral surface area of a right circular cone, the root surface attachment area (RSAA)  
18 with periodontal attachment was estimated as  $RSAA \sim \frac{1}{2}\pi di$ .

19

#### 20 *Statistical analysis*

21 Summary statistics were calculated for all clinical variables as appropriate. A linear mixed  
22 model was fit to evaluate the association between maximum extraction force ( $F_{\max}$ ) as the  
23 dependant variable and root surface area, functional occlusion, jaw (mandible vs. maxilla),  
24 age and sex as independent variables, accounting for lack of independence between

1 multiple roots in the same patient. In order to enhance interpretability of estimates, root  
2 surface attachment area was standardised to have standard deviation equal to 1.  
3 Distributional assumptions for linear regression were checked using graphical methods and  
4 Shapiro-Wilk's test. Pearson's correlation coefficient was calculated to evaluate the  
5 correlation between maximum extraction force and pull time. All statistical tests were two-  
6 sided at  $\alpha=0.05$  and two-sided 95% confidence intervals were calculated using STATA 14.2  
7 (STATA Corp., College Station, TX, USA).

8  
9

## 10 **Results**

11

### 12 *Sample characteristics*

13 The sample included a total of 41 patients (28 Males and 13 Females) with a mean age of  
14  $45\pm 19$  years (range 16-89 years). A total of 59 distinct roots of 55 teeth were extracted with  
15 the Benex<sup>®</sup> system, including 3 molars and one premolar, which each had two roots  
16 extracted separately. An additional 5 multi-rooted teeth had only one of their roots  
17 extracted with the Benex<sup>®</sup> system, and only these roots were therefore included in this  
18 analysis (Table 1). The majority of teeth required extraction due to caries or a combination  
19 of caries and periodontitis, other indications included failed endodontic therapy, root  
20 fractures, supernumerary teeth or orthodontic treatment. 59% of roots were in occlusion at  
21 the time of extraction (Table 1).

22

### 23 *Qualitative analysis of extraction forces*

1 Three main patterns could be identified that describe the extraction process with the  
2 vertical extraction system. The first pattern is characterised by a gradual increase of force  
3 leading to rupture of periodontal ligament fibres and tooth root delivery, typically at  
4 relatively low forces (Fig. 3a). The second pattern typically occurred when higher extraction  
5 forces are required and the operator pauses once significant resistance is felt. The curve  
6 indicates that the tension then slightly decreases over time, until the operator continues to  
7 increase the force until eventual fibre rupture and tooth delivery (Fig. 3b). The third pattern  
8 is more irregular, and typically occurs when some force is required to deliver the root out of  
9 the socket after fibre rupture has occurred (Fig. 3c).

10

11

#### 12 *Quantitative analysis of extraction forces*

13 Maximum extraction forces ( $F_{\max}$ ) varied widely from just 41N for a mesial root of a lower  
14 first molar, to 629N for an upper first premolar tooth (Table 1). Pull time was highly  
15 correlated with  $F_{\max}$  (Pearson correlation coefficient  $\rho=0.71$ ).

16 In a multiple linear regression model, no differences between extractions forces were  
17 observed according to age, sex, or between maxillary vs. mandibular teeth. However, teeth  
18 with a larger estimated root surface attachment area and teeth that were in occlusion at the  
19 time of extraction required higher extraction forces (Table 2, Fig. 4). On average, maximum  
20 extraction forces were 296N (95% CI: 251N, 342N) and 193N (95% CI: 140N, 245N) for  
21 teeth/roots in occlusion and not in occlusion, respectively. An increase in the estimated root  
22 surface attachment area of one standard deviation was associated with a marked increase  
23 in  $F_{\max}$  by 64N (95% CI: 34N, 94N) (Fig. 4, Table 2). Mean maximum stress was 1.36 N/mm<sup>2</sup>  
24 (SD 0.71, range 0.80, 1.89).



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### **Discussion**

The present study determined the forces occurring during tooth extraction with a vertical extraction system. We found that the required maximum extraction force varied widely between teeth, ranging from less than 50N to over 600N. Extraction force also increased linearly with increasing root surface attachment area. The corresponding maximum stress ranged from 0.8 to 1.9 N/mm<sup>2</sup>. Larger forces were required for teeth that were in functional occlusion at the time of extraction, compared to teeth or roots not in occlusion. Age and sex did not affect maximum extraction forces.

It is important to note that technical difficulty and required extraction force are not synonymous. However, notwithstanding the strong negative association between perceived technical difficulty and operator experience and confidence, most clinicians will agree that technical difficulty and forces required for conventional exodontia are correlated and can vary widely. Although the literature on this topic is scarce, clinical experience and common sense can identify certain tooth and patient characteristics that predict extraction difficulty. Examples for tooth related factors are marked root curvature, root divergence and root bulbosity (e.g., due to hypercementosis). As conventional extraction technique relies on expansion of the bony socket, patient factors such as bone morphology (e.g., spongy vs. cortical bone) and bone mineral density, which is associated with sex, race/ethnicity and body mass [6, 7], are also important. However, vertical tooth extraction is fundamentally different to conventional forceps extraction in that it does not rely on socket expansion, and allows the application of a strictly vertical force vector, thereby minimising trauma to bone.

1 Ideally, i.e., in case of a conical tooth root with no undercuts, extraction will be the result of  
2 overcoming the tensile strength of the periodontal ligament with no compressive forces on  
3 alveolar bone. Our finding that the required extraction force is associated with the root  
4 surface attachment area is therefore not surprising [Fig 4]. For straight tapering roots,  
5 movement axial to the applied force occurs when periodontal ligament (PDL) fibres rupture,  
6 following breaks in covalent cross-links in collagen and slippages between the unit  
7 molecular chains [8]. Studies into the various factors influencing the mechanical properties  
8 of the PDL agree that the content, direction and organisation of the collagen fibre  
9 component is critical to the observed mechanical response [8]. The contribution to  
10 resistance of tooth movement of individual PDL fibres varies with location, due to differing  
11 alignment within the tensile stress field, and with time due to cumulative fibre rupture  
12 (beginning apically) [9] and the intrinsic viscoelastic behaviour of the PDL [8, 10]. The PDL  
13 exhibits time-dependent stress-release following force application, which is a property  
14 considered to be protective to reduce PDL injury. Multiple stress-relaxation mechanisms  
15 have been proposed and can be categorised into short, medium and long-term components  
16 and viscous and elastic components [8]. Mechanical characterisations have shown that the  
17 response is sensitive to the stressing-rate, with rapidly applied forces associated with  
18 relative increases in effective PDL stiffness and an increased stress required to cause  
19 rupture [8, 11]. In this study, in cases when the operator chose to wait following an increase  
20 in force applied, it was consistently observed that following application of an extrusive  
21 force, an initial rapid decrease in the measured force occurred, followed by a more gradual  
22 stress relaxation (Fig 3b, 5). This behaviour is consistent with previous observations which  
23 have elaborated further to show that the amount of stress relaxation that occurs is inversely  
24 related to the magnitude of the initially applied force [8, 12]. This non-linear behaviour

1 highlights the complex mechanisms underpinning the short and long-term relaxation  
2 components. Whilst factors such as water content [13] and PDL dimensions are certainly  
3 important to the observed behaviour, the response of collagen to the applied stress is  
4 central [8]. This is evidenced by studies exposing the PDL to collagenases prior to  
5 mechanical characterisation and showing significant increases in the magnitude of stress  
6 relaxation following loading [14]. The implications of this behaviour for tooth removal using  
7 controlled extrusion is that the PDL is adapted to accumulate damage sub-critically, prior to  
8 fibre rupture. This damage following masticatory loading cycles is likely reversible, with for  
9 example, re-crosslinking of collagen occurring. During tooth extraction the use of low  
10 stressing rates (applying force increases slowly) and maintained force application results in  
11 cumulative sub-critical damage resulting in a reduced force to cause fibre rupture. In this  
12 study when the operator chose not to continue to increase the force continuously, resulting  
13 in a static force application, stress relaxation was observed (Fig. 3b). Force-time plots show  
14 that as the loading increase paused, rapid stress relaxation occurred followed by a more  
15 gradual decay in measured force, which is consistent with animal-model (rabbit) data [12].  
16 Minimising extraction forces may be desirable to minimise the risk of root fracture and  
17 reduce the stress transferred to the dento-alveolar complex and may have biologically  
18 favourable results in terms of reduced trauma and improved healing, in particular in the  
19 case of surgical extrusion [5]. Further investigations are required to identify whether or not  
20 slower extraction, i.e., longer periods of sustained input of force would result in a reduction  
21 in the maximum extraction force and whether this is clinically significant in terms of  
22 biological sequelae.  
23

1 In the current study, reduced extrusion forces were associated with teeth that were not in  
2 functional occlusion. Numerous animal studies [15-17] and complementary observations in  
3 humans [18, 19] have demonstrated that decreased, or absence of, occlusal function leads  
4 to dimensional and structural changes in the both the PDL and alveolar process.  
5 Morphometric studies show that the PDL narrows with reduced function, and histology  
6 shows an associated reduction in the number [20] of collagen fibres, which are less  
7 organised [21-23] and are remodelled more slowly [24]. Experiments in rats have  
8 demonstrated a gradual decrease in required extraction forces within 8 days after loss of  
9 function [25]. Return to function is associated with increasing PDL thickness which is  
10 considered a protective adaptation to loading [26]. The reduced extrusion forces are likely  
11 to be a consequence of the changes to the collagen content of the PDL, although a  
12 contribution from changes in plasticity of the alveolar bone cannot be discounted.  
13 Explaining the observed behaviour solely on the mechanical response of the PDL is an over-  
14 simplification and tooth-related factors such as root curvature, root divergence or  
15 hypercementosis are also relevant for Benex® extractions. If these features are pronounced,  
16 vertical extraction may be impossible [2]. In case of minor undercuts or root divergence,  
17 sufficient force may be generated with the Benex® device to allow extraction via minimal  
18 socket expansion or even fracture (Fig. 5). The latter is an extremely rare complication and  
19 has been observed by the authors in only 2 cases in well over 500 extractions.  
20  
21 This is the first study to measure forces associated with tooth extraction in humans in vivo,  
22 facilitated by the use of an extraction device that allowed coupling to a load cell. However,  
23 our study has some limitations. Firstly, root surface attachment area was estimated based  
24 on 2 dimensional radiographs, which will have resulted in measurement error. Secondly, we

1 did not ascertain root features likely to affect extraction forces such as hypercementosis or  
2 root divergence. Finally, the sample size in this study is limited and we cannot rule out  
3 relatively smaller effects of other factors, such as age and gender.

4

## 5 **Conclusions**

6 Extraction forces required to extract teeth or tooth roots using the Benex vertical extraction  
7 system vary widely and can be less than 50N or exceed 600N. On average, higher extraction  
8 forces are required to extract teeth with longer and thicker roots, as well as for teeth that  
9 are in functional occlusion.

10

## 11 **List of Abbreviations**

12 RSAA root surface attachment area

13  $F_{\max}$  maximum extraction force

14 PDL periodontal ligament

15

16

## 17 *Availability of data and material*

18 Raw data have previously been published and are available through the university of Zurich  
19 (Schmid I, Kräftermessungen bei Zahnextraktionen mit dem Benex®-Extraktor,  
20 Zahnmedizinische Dissertation, University of Zurich, 2010).

21

## 22 *Competing interests*

23 None declared

24

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4

5

6 Authors' contributions

7 I.S. and M.L. conceived the idea and collected the data. T.D. performed statistical analysis  
8 and led the writing with O.A. All authors contributed to data interpretation and critically  
9 reviewed and approved the manuscript.

10

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14

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1 **Tables**

2

3 **Table 1: Characteristics of extracted teeth/roots**

Characteristic	Total N=59
Tooth, n (%)	
U1	0 (0%)
U2	2 (3%)
U3	5 (8%)
U4	9 (15%)
U5	6 (10%)
L1	1 (2%)
L2	1 (2%)
L3	4 (7%)
L4	6 (10%)
L5	12 (20%)
root <sup>a</sup>	13 (22%)
functional occlusion, n (%)	
No	24 (41%)
Yes	35 (59%)
indication for extraction, n (%)	
caries	25 (42%)
caries & periodontal	12 (20%)
endodontic failure	5 (8%)

root fracture	3 ( 5%)
supernumerary	8 (14%)
orthodontic	6 (10%)
maximum extraction force [N], mean (SD)	261 (152)
pull time [sec], mean (SD)	60 (44)
root surface attachment area [mm <sup>2</sup> ], mean (SD)	199 (75)
maximum stress [N/mm <sup>2</sup> ], mean (SD)	1.36 (0.71)

1

2 <sup>a</sup> single roots of multirooted teeth extracted following sectioning

3

4 **Table 2: Association of age, sex, jaw and root surface attachment area and functional**  
5 **occlusion with maximum extraction force (multiple linear regression, dependent variable:**  
6 **F<sub>max</sub>)**

7

Independent variable	$\beta$ - coefficient	(95% CI)	p-value
age (years) <sup>a</sup>	- 7 N	(-27N, 13N)	P=0.50
sex (Female vs. Male)	4.5N	(-75N, 84N)	P=0.91
jaw (mandible vs. maxilla)	-11 N	(-75N, 54N)	P=0.74
root surface attachment area (mm) <sup>b</sup>	64N	(34N, 94N)	P<0.001
functional occlusion (yes vs. no)	104N	(38N, 169N)	P=0.002

8 <sup>a</sup> estimates for increase in age by 10 years

9 <sup>b</sup> estimates for increase in RSAA by 1 SD

10

11

1 **Figure legends**

2

3 Fig. 1 Clinical procedure

4

5 (a) carious upper right lateral incisor

6 (b) use of Benex® diamond coated bur

7 (c) Benex self-tapping screw and support tray in place

8 (d) pull rope and Benex® extractor assembled (note that the extractor needs to be moved

9 slightly more towards the distal for perfect alignment of the pull rope)

10 (e) extraction of root.

11 (f) extraction socket after extraction

12

13 Fig. 2

14 Measurement of length of periodontal attachment (23.0 mm) and root diameter (5.2 mm)

15 on a lower right canine for estimation of root surface attachment area (RSAA)

16

17 Fig. 3

18 Representative examples of the three main qualitative patterns of force/time curves

19 observed during extractions

20

21 (a) constant increase in force leading to extraction

22 (b) increase in force followed by pauses during which a gradual linear drop in force can be

23 observed

24 (c) irregular pattern.

- 1 Fig. 4
- 2 Linear association between root surface attachment area and  $F_{\max}$
- 3 ( $F_{\max}$  adjusted for age, sex and jaw)
- 4
- 5 Fig. 5
- 6 Force/time curve for an upper first premolar with two slightly divergent roots and
- 7 undercuts. Benex extraction was ultimately achieved at high extraction forces. Note the
- 8 fragment of the buccal plate attached to the root surface.