

Cyanoacrylate Tissue Adhesive as a Membrane in Socket Preservation: In Vitro Cytotoxicity and Clinical Evaluation

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Abstract

Background: Cyanoacrylate-based adhesives provide immediate hemostasis when applied; this is attributed to their ability to form a mechanical barrier in the surgical site, favoring the coagulation process and allowing control of bleeding. The purpose of the present study was to demonstrate the *in vitro* effect of cyanoacrylate-based tissue adhesive and the clinical evaluation of wound healing of freshly extracted sockets with adhesives applied on an exposed collagen membrane, for preservation of the alveolar ridge.

Methods: Cytotoxicity was evaluated with sulphoradamine B assay with primary fibroblasts from gingival tissue. The *in vivo* analysis was carried out in 10 patients needing extraction of single-rooted teeth, who met the inclusion and exclusion criteria and signed the term of free and informed consent. Alveolar preservation was carried out with a mineralized cortical allograft bone substitute and a resorbable collagen membrane that was intentionally left exposed. On the exposed membrane, the Periacryl® 90 HV was applied as a barrier. The biocompatibility of the adhesive was assessed by the Early-Wound Healing Index (EHI) and Early Wound Healing Score (EHS), of perialveolar tissues at time intervals of 12, 30- and 60-days post-surgery.

Results: Reduced cell viability was observed for Periacryl® 90 HV when compared with cells without adhesive treatments. No postoperative complications were observed after the application of Periacryl® 90 HV on perialveolar tissues.

Conclusion: The use of the Periacryl® 90 HV cyanoacrylate-based tissue adhesive resulted in reduced fibroblast viability *in vitro*, and adequate results of wound closure in the clinical evaluation of EHI and EHS scores.

Introduction

Cyanoacrylates are acrylic resins that polymerize rapidly in the presence of a humid environment. Their adhesiveness, dependent on polymerization of the monomers in their composition, leads to bonding between structures [1]. Coover, in 1959, was the researcher who first recognized that the cyanoacrylates had adhesive properties; and since then these adhesives have commonly been used for daily applications [2]. In 1998, these adhesives were approved for use in surgical and traumatic wounds, after a series of improvements in their chemical composition [3,4]. The purpose of improvements was to reduce the cytotoxicity according to the number of alkyl groups and the number of chains in their composition, based on the conclusion that the larger the group and the longer the chain, the less toxic the adhesives would be, therefore, this would also reduce the risk of causing allergic reactions [5,6].

The use of tissue adhesives in both medicine and dentistry is well known, especially in the closure of incisions instead of using sutures, decreasing the sensitivity, edema, erythema and tissue inflammation [7,8]. Several studies have been developed to use tissue adhesives as a substitute for sutures or as a complement to wound closure [1,9]. Among the main properties of interest in these tissue adhesives, are

their bacteriostatic effects, which are explained by the strong electronegative charge of the polymer and the adhesive ability to form a mechanical barrier that prevents the entry of any debris or microorganisms into the wound [10]. In addition, reports have indicated that the adhesives exhibited antibacterial effects against gram-positive bacteria, inhibiting the *in vitro* spread of *Bacillus subtilis* growth [11]. Cyanoacrylate-based adhesives provide immediate hemostasis when applied, and this is attributed to the ability to form a mechanical barrier within the surgical site, favoring the coagulation process and allowing control of the bleeding [12].

At present, due to the improvements in the chemical composition of these adhesives, they are no longer limited to superficial use only, but may now also be used in deep wounds and bone regenerative procedures such as a biomaterial fixing agent [13,14]. In addition, they have shown favorable and post-surgical results in mucogingival surgeries [15-17], and in other types of surgical approaches, without major complications [18,19]. The PeriAcryl® 90 HV is a commercially available tissue adhesive composed of a blend of n-butyl cyanoacrylate and 2-octyl cyanoacrylate. These two cyanoacrylates have previously been studied, and by means of this combination, it is expected that the mechanical strength and cytotoxicity could be controlled, resulting in an adhesive that can effectively serve as a barrier without undesirable side effects [20-22]. Cytotoxicity is one of the three main biological responses studied in order to define whether a material has the ability to be biocompatible, and would obtain an adequate response when applied [23]. The other two biological responses are inflammation and wound healing that can be assessed in clinical evaluations [24]. In a previous clinical evaluation, the effect of cyanoacrylate-based adhesives was analyzed in the long-term, and showed adequate wound healing within a period of six months after tooth extraction [25]. Although this has contributed to understanding of the clinical performance of these adhesives, evaluation of the early stages of inflammation and wound healing have not previously been reported.

These parameters may be evaluated in a clinical scenario, based on the Early-Wound Healing Index (EHI) and Early Wound Healing Score (EHS), as accurate and reproducible methods to assess wound healing in periodontal soft tissues [26,20]. While the former describes the flap closure in 5 scores, considering the amount of fibrin and presence of necrosis, the latter, EHS, evaluates the early response of inflammation considering the clinical signs of reepithelization, hemostasis, and inflammation. Both the EHI and EHS have been used in the clinical evaluation of different periodontal and maxillofacial procedures and may be applied in the analysis of the socket healing process [27,28,21]. The purpose of the present study was to demonstrate the *in vitro* effect of cyanoacrylate-based tissue adhesive and the clinical evaluation of wound healing in freshly extracted sockets, with adhesives applied on an exposed collagen membrane, for preservation of the alveolar ridge.

Materials And Methods

In vitro cytotoxicity

Primary gingival fibroblasts were obtained from the gingival tissue of a healthy patient, after the study was approved by the Ethics Committee of Universidade Federal do Rio Grande do Sul. The primary cells were cultivated in Dubelco's minimum essential medium (DMEM) supplemented with 10% fetal bovine serum, and 100 IU/mL penicillin, 100 µg/mL streptomycin (Thermo Fischer Scientific, Waltham, Massachusetts, USA) at 37°C and 5% CO₂, until the cells could be used for culture. To test the effect of adhesives on cell viability, three independent samples were poured into 24-well plates and kept at 37°C for 72h to allow polymerization of adhesives. After this, DMEM at 37°C was added on top of adhesives for 24h. The media in contact with the adhesives were used to treat the cells during the test. To perform the test, gingival fibroblast cells were seeded in 96-well plates (5×10^3) and after 24h the subconfluent cell monolayer was treated with conditioned media for 72h. Cells were cultivated with pure DMEM as a positive control. All conditions were tested in triplicate for each independent sample. After treatment, cells were fixed with 50% trichloroacetic acid (Sigma Aldrich) and left at 4°C for one hour. Cells were stained with 0.4% SRB solution to identify the cells that had viable proteins after the treatment. The stained monolayer was suspended in 10% Trisma and the quantification was performed at 560nm in a Microplate Spectrophotometer (Multiskan GO, Thermo Fisher Scientific, USA). The absorbance values of cells treated with pure DMEM were used to normalize the viability of cells in contact with the conditioned medium, and thus, the percentage of viable cells was calculated.

Clinical Evaluation

A case series was performed by evaluating the post-operative healing patients, in a total of 10 post-extraction alveoli of single-rooted teeth. The study protocol was carried out according to the guidelines of the 1975 Declaration of Helsinki, (revised in 2013) and approved by the ethics committee of the Universidad Científica del Sur, by registration 064-2018-PRE8. The study included male and female patients aged 20-70 years, in need of single-tooth extraction with mobility degree III (Miller, 1938), who had been referred to the University Científica del Sur for clinic treatment. The patients were excluded in case of smoking, systematic diseases, use of medications and when acute infection in teeth was identified. The corresponding medical records of the patients who met the inclusion and exclusion criteria were compiled, in which their important medical history was detailed. All patients included in the study signed the term of free and informed consent and were notified about the possible complications of the treatments.

A trained operator performed all the tooth extraction and socket preservation procedures. Periapical radiographs and cone beam computed tomography (CBCT) scans were used to record the position, angulation, remaining bone plates and anatomical repairs of the teeth to be extracted, to avoid complications at the time of tooth extraction. Prior to the extraction, asepsis of the oral cavity was performed with a 0.12% chlorhexidine-based antiseptic (Perioaid®, treatment) for 30 seconds; and the patient's face was decontaminated with a 10% iodopovidone solution. The teeth were anesthetized by applying topical anesthesia with 20% benzocaine gel (Benzotop®), and then the infiltrative anesthesia was administered, using lidocaine 2%, with epinephrine 1:80 000 (New Stetic®). Sulcular incision and vertical liberating incisions were made with a 15C blade, and full-thickness flap elevation with the use of

a Molt curette, with the purpose of obtaining direct visualization of the vestibular bone plate. The teeth were excised with the use of a peristome, and once the tooth had been dislocated, an anterior forceps or elevator was used to perform avulsion, depending on the teeth to be extracted and the surrounding structures. On conclusion of the extraction, the walls of the alveolus were cleaned using a Lucas 48 curette, and washed with a 0.9% Sodium Chloride solution. After socket preparation, the alveolar flange preservation technique was performed, in which 0.5 grams of 300-500 µm mineralized cortical allograft (Puros®, Zimmer Biomet dental, Miami, USA) was applied, compacted into the alveolus and covered with a collagen membrane (OSSIX® PLUS). The vestibular flap was re-positioned without traction and an internal cross-type suture stitch and single stitches made with monofilament non-absorbable e-PTFE suture thread with a 16mm 3 / 8c cutting needle (GORE-TEX®) (Figure 1) were used on the proximal surfaces to close the wound, but intentionally leaving the membrane exposed.

After conclusion of the alveolar flange preservation technique, the cyanoacrylate-based tissue adhesive (PeriAcryl® 90 HV) was applied both on the perialveolar stitches and on the intentionally exposed membrane, creating a protective film, by using a plastic dosing pipette, in accordance with the manufacturer's instructions. The amount of adhesive to be used depended on the size of the exposed membrane to be covered in each case as shown in (Figure 1). The patients were provided with post-surgical recommendations with regard to restriction on brushing in the area, and were instructed to use 0.12% chlorhexidine-based mouthwashes every 12 hours for 2 weeks. All patients received postoperative antibiotic and anti-inflammatory therapy based on 500 mg Amoxicillin taken every 8 hours for 10 days, and 500 mg Paracetamol, depending on pain experienced.

Post-surgical controls were performed at time intervals of 12, 30 and 60 days after surgery, in which the presence of stitches (first control), and the presence of tissue adhesive was verified. Signs of inflammation such as edema, pain, erythema, suppuration and loss of the collagen membrane were evaluated, according to Early-Wound Healing Index (EHI) and Early Wound Healing Score (EHS) by a single calibrated operator. The calibration was performed by the Kappa index for the intra-operator correlation. The EHI of each patient was classified according to different scores considering closure of the flap:

1. Complete closure of the flap without fibrin line
2. Complete closure of the flap with fibrin line
3. Complete closure of the flap with fibrin clots present
4. Incomplete flap clot with partial tissue necrosis
5. Incomplete closure of the flap with total tissue necrosis, more than 50% of the flap.

The EHS was classified according to clinical evidence of epithelium formation (SCR); clinical evidence of hemostasis (SCH); and clinical evidence of inflammation (SCI):

SCR:

- 0 pts: distance between the margin of the incision,
- 3 pts: margins of the incision in contact,
- 6 pts: connected margins of the incision.

SCH:

- 0 pts: bleeding of the incision margins,
- 1 pt: fibrin in the margins of the incision,
- 2 pts: absence of fibrin in the margin of the incision.

SCI:

- 0 pts: redness in >50% of the length of the incision and/or pronounced inflammation,
- 1 pts: redness of the implies < 50% of the length of the incision,
- 2 pts; absence of the redness along the incision length.

Results

The viability of cells in contact with the conditioned medium was calculated based on the absorbance at 560nm found for the positive control. The percentage of viable cells was 39.66% ($\pm 6,31$). In the clinical evaluation, no postoperative complication was observed, and all patients attended to the three follow-up appointments. Analysis of the effect of the adhesive on EHI (Table 1). All the sockets showed a complete flap closure with the presence of fibrin clots at 12 days, four alveoli showed complete scarring with fibrin clots; four alveoli exhibited complete scarring with fibrin line; two alveoli showed complete scarring without fibrin lines at 30 days. At 60 days all the surgical sites showed complete closure of the flap without the presence of fibrin lines.

For EHS (Table 2 and Figure 2), at 12 days, four cases exhibited a visible distance between the margins of the incision; six cases had margins of contact incision; nine cases had presence of fibrin in the incision margins; and a single alveolus showed absence of fibrin in the incision margins. In this analysis, 50% of the sockets had erythema to an extent larger than 50% of the length of the incision extension.

At 30 days, 50% of the sockets exhibited fused margins of the incisions, absence of fibrin in the margins of the incision and seven alveoli had less than 50% of the length of the incision extension. After 60 days, 100% of the sockets exhibited fused surgical margins, absence of fibrine in the margins of the incision and absence of erythema and inflammation. This section could be divided into subheadings. It should provide a concise and precise description of the experimental results, their interpretation as well as the experimental conclusions that can be drawn.

Discussion

Numerous methods have been proposed over the years to evaluate wound healing in soft and perialveolar tissues [22]. In this study, cyanoacrylate-based adhesives were tested for their in vitro cytotoxicity and clinical performance in freshly extracted sockets. In these analyses, reduced cell viability was found, while a complete closure of wound was observed considering the EHI and EHS analysis, showing that the adhesive studied was safe with regard to tissue compatibility.

The in vitro cell viability was used to test the response of primary gingival fibroblasts in contact with the products of cyanoacrylate-based adhesives. Reduction in cell viability was observed in cells that were placed in contact with media containing Periacryl® 90 HV tissue adhesive. This behavior could be explained for two reasons in the anionic polymerization of cyanoacrylate materials. The first was the exothermic reaction of polymerization, which may lead to increase in temperature in surrounding tissues; the second was the release of degradation products from the reaction, in these cases, mainly cyanoacetate and formaldehyde [29]. It should be considered that a two-dimensional cell culture approach was used in this evaluation. Although this model is recommended by ISO 10993-12, it is known that this direct contact between cells and highly concentrated material extracts may result in an overestimation of the results [30]. Despite the limitations of this in vitro analysis, indirect cell cytotoxicity is a widely used method for assessing the potential of materials to promote cytotoxicity. Moreover, previous studies have shown conflicting results regarding the toxicity of cyanoacrylate adhesives [31,32]. These differences may be related to the chemical structure of their alkyl chains in the adhesives [31-33]. Short length chains (e.g. ethyl and methyl) are more prone to degradation, leading to increase in leached toxic products, whereas long chains are more resistant to degradation [31]. The tissue adhesive used in the present study is a blend of n-butyl cyanoacrylate and 2-octyl cyanoacrylate and studies that have attempted to evaluate the cytotoxicity of adhesives with similar composition, showed a level of cytotoxicity around 40% [34] 60% [31,35] which is higher than the values found for short length alkyl chains [31,34]. In the present study the cell viability was 39.66%, which was similar to findings of previous reports of similar adhesives, and lower when compared with the ISO 10993-12 specification that considers 70% to be the minimum requirement for toxicity in biomedical materials [34].

In addition to the local effect on cytocompatibility, further studies have addressed the systemic effect of these materials on animal models. The effect of cyanoacrylate-based materials may locally and systemically affect tissues, as observed in animal models, in which there were no effects on hepatic, renal and blood biochemical profiles, and in histologic analyses [36,37]. In the cases of the studies cited above, the release of potentially toxic products after the degradation of cyanoacrylate tissue adhesives was unable to affect animals at a systemic level. The accumulation of cyanoacetate and formaldehyde may cause inflammation in tissues in contact with these products both locally and systemically. The n butyl cyanoacrylate was tested in the cited studies and no toxic effect on animals was observed. Although these findings were observed in vitro, no effect on wound healing was observed in the clinical evaluation, at least, in the short period of time. No postoperative complication was observed for any patient during the 60-day follow-up. This is an important observation, as the collagen membrane in the procedures was left exposed after the flap repositioning. The exposure of membrane after guided bone regeneration membranes is known to increase the prevalence of postoperative bacterial infection in

surgical sites [38]. Furthermore, the cyanoacrylate-based adhesive (Periacryl® 90 HV) exhibited a hemostatic effect on the wound after 12 days, when the sockets already had fibrin formation, indicating a beginning of wound healing [39]. The formation of a film caused an interruption between the edges of the wound, generating redness and inflammation of the surgical area, however, these phenomena were only present in some alveoli, and complete healing was obtained at the end of the follow-up, with the highest scores being obtained in both the EHI and EHS scales of healing measurement. These results elucidated the ability of cyanoacrylate adhesives to adequately promote wound closure, facilitating healing after tooth extraction ¹ and avoiding the penetration of bacteria could promote postoperative complications. Furthermore, the inflammation that might have been promoted by degradation products of cyanoacrylate-based adhesives was not observed in the bonded tissues.

Cyanoacrylate-based adhesives may be an easy and conventional strategy for promoting the healing of soft tissue in different procedures [1,8,9]. Although some studies have attempted to analyze the cytocompatibility of these materials, few reports were found regarding the clinical determination of biocompatibility through healing and inflammation of the perialveolar tissues in regenerative treatment. Therefore, this case series is important to report the clinically perceivable changes that occurred in the tissues with the approached used, as an alternative to flap closure in alveolar ridge preservation treatments. However, long-term follow-up and studies with larger samples must be conducted to observe both soft and hard tissue behavior after the use of cyanoacrylate-based adhesive for wound closure.

Conclusions

Although the *in vitro* data showed a reduction in fibroblast viability, no effect on wound healing was found for the cyanoacrylate-based tissue adhesives. Based on the *in vitro* and *in vivo* findings it was possible to conclude that the cyanoacrylate-based tissue adhesive may be a suitable adjuvant material in wound closure in socket preservation treatments.

Declarations

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Availability of data and materials

The datasets used and analyzed during the current study are available from the corresponding

author on reasonable request.

Ethics approval and consent to participate

The study was approved by the ethics committee of the Universidad Científica del Sur, by registration 064-2018-PRE8. All participating patients gave informed written consent to participate in this study and for publications of the obtained data.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests

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Tables

Table 1. Scores for EHI analysis after post-operative time intervals of 12, 30 and 60 days

ALVEOLUS	12 days	30 days	60 days
#1	3	2	1
#2	3	3	1
#3	3	2	1
#4	3	3	1
#5	3	2	1
#6	3	1	1
#7	3	1	1
#8	3	3	1
#9	3	3	1
#10	3	2	1

Table 2. SCR, SCH and SCI scores as part of the EHS analysis of wound healing in perialveolar tissue.

	SCR			SCH			SCI		
Post-surgical controls	12d	30d	60d	12d	30d	60d	12d	30d	60d
#1	0	6	6	1	2	2	1	1	2
#2	3	3	6	1	2	2	1	1	2
#3	3	6	6	1	2	2	0	2	2
#4	3	3	6	1	1	2	1	1	2
#5	0	3	6	1	1	2	1	1	2
#6	3	6	6	1	2	2	0	1	2
#7	3	6	6	1	2	2	0	2	2
#8	0	3	6	2	2	2	1	2	2
#9	0	3	6	1	1	2	0	1	2
#10	3	3	6	1	1	2	0	1	2

Figures

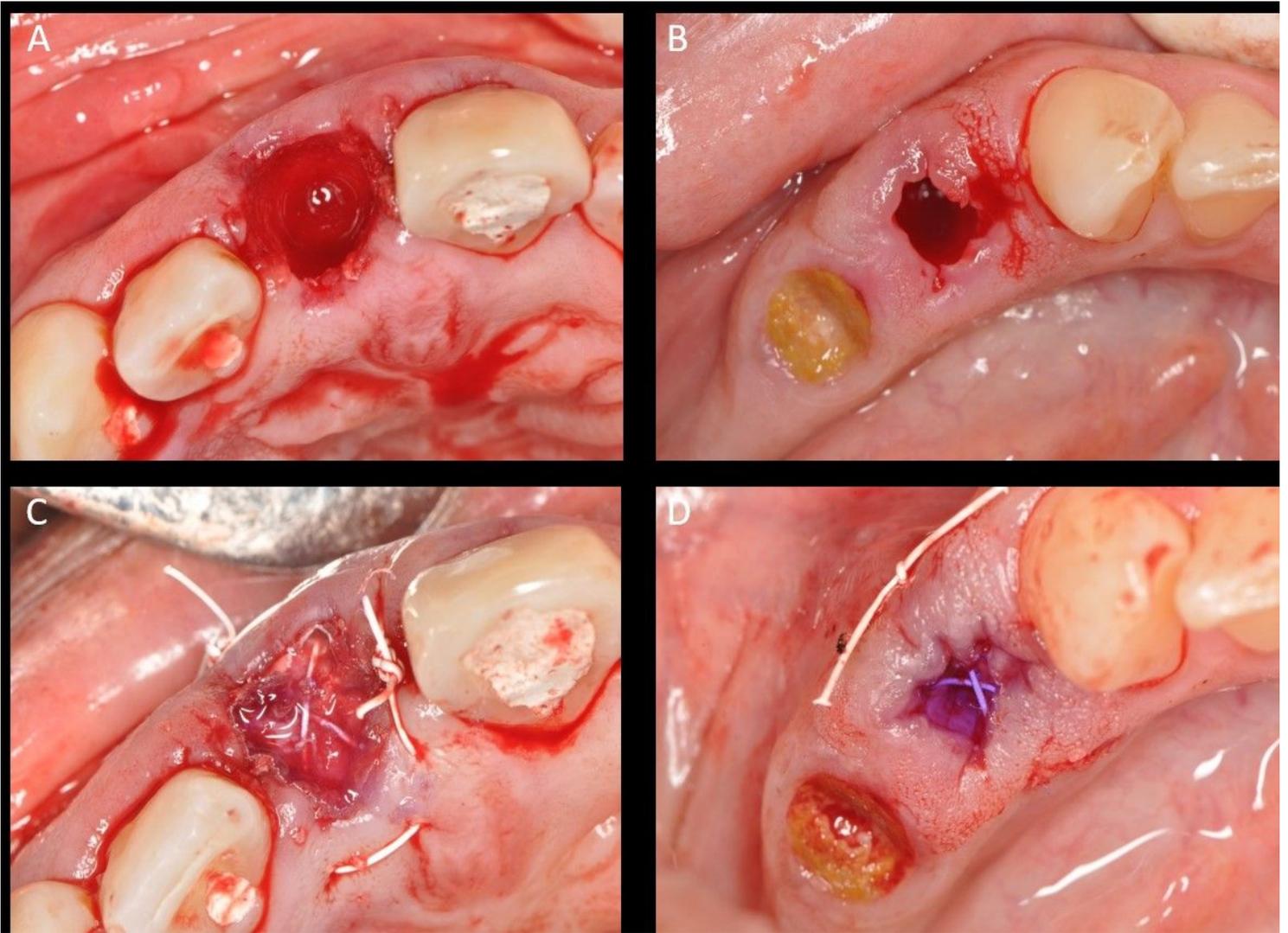


Figure 1

Surgical procedures for clinical evaluation of cyano-acrylate-based tissue adhesives: (A) tooth extraction; (B) the empty socket after tooth extraction; (C) socket preservation with socket filling and collagen membrane; (D) the cyanoacrylate-based tissue adhesive (PeriAcryl® 90 HV) applied to membrane.

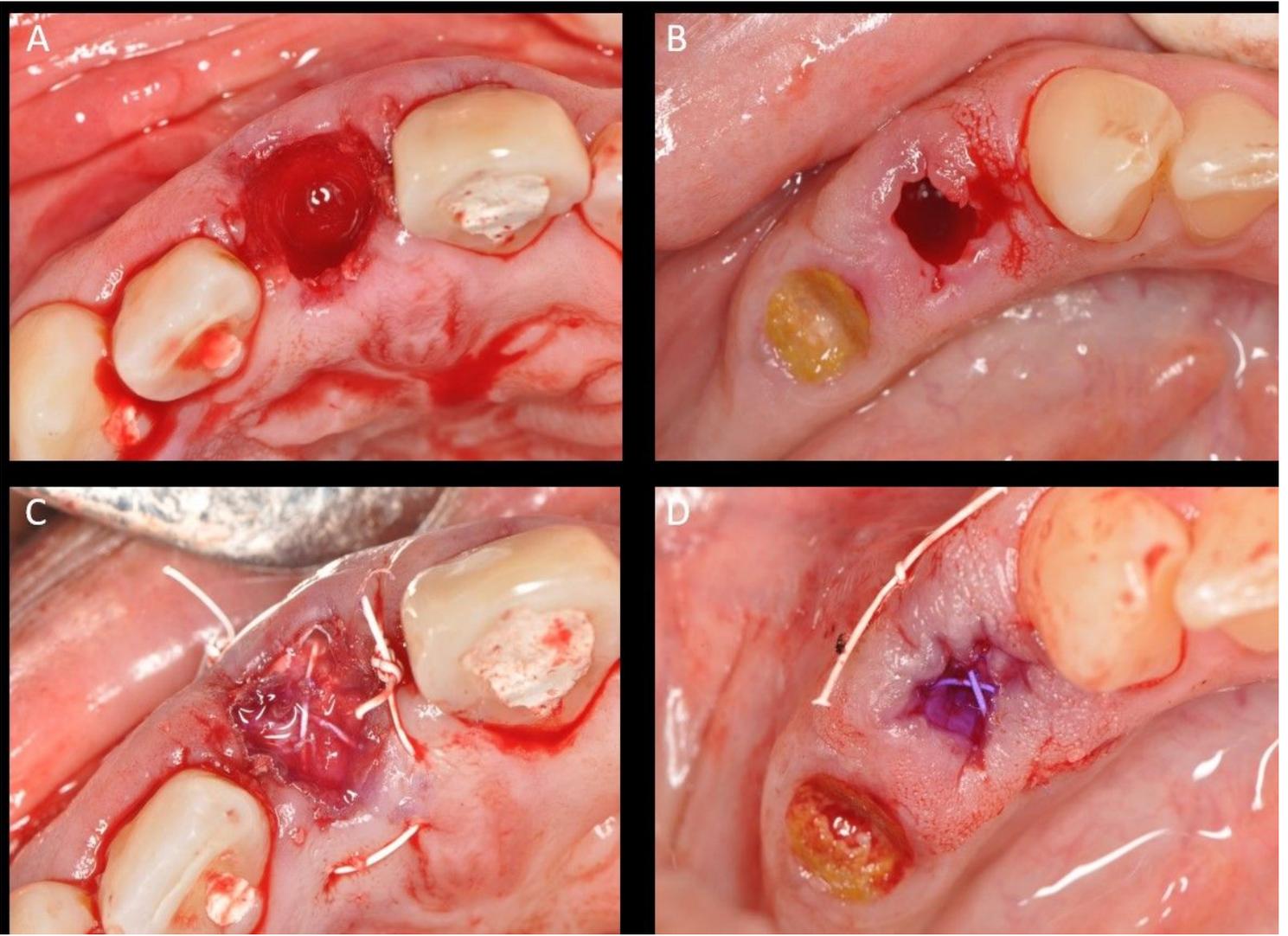


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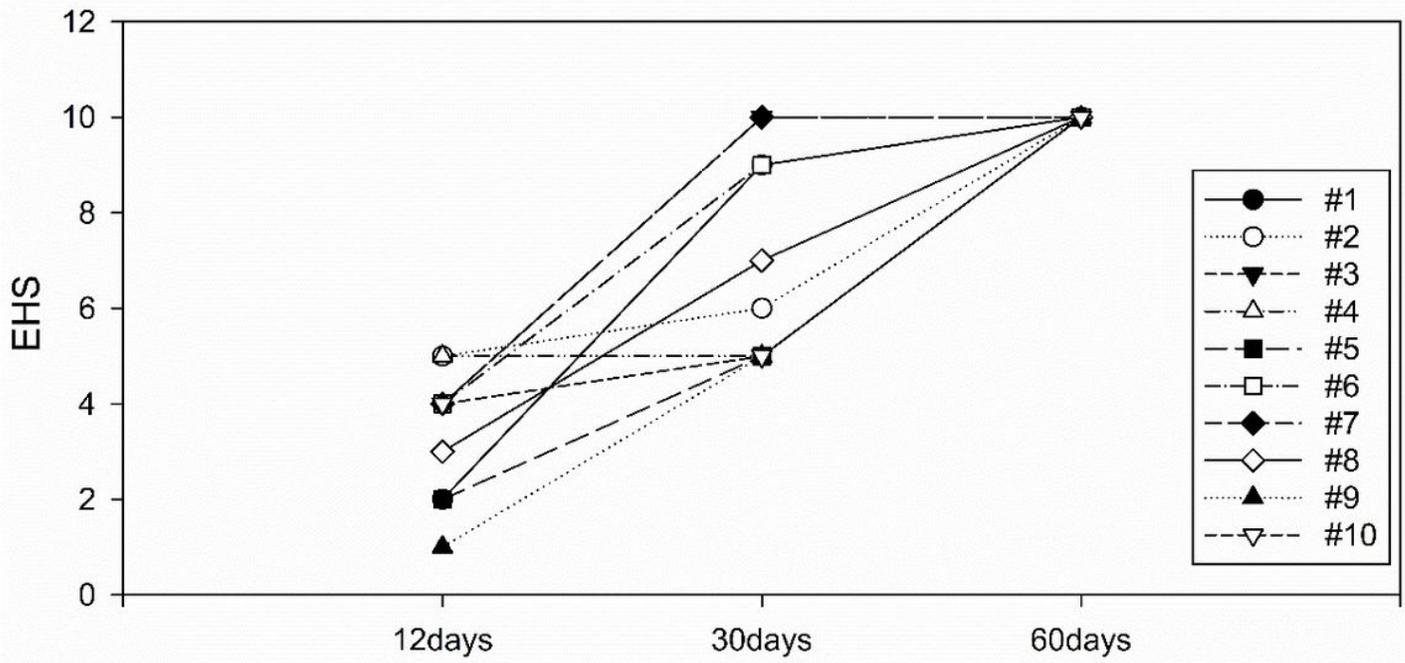


Figure 2

EHS values after time intervals of 12, 30 and 60 days after application of adhesives in perialveolar tissue.

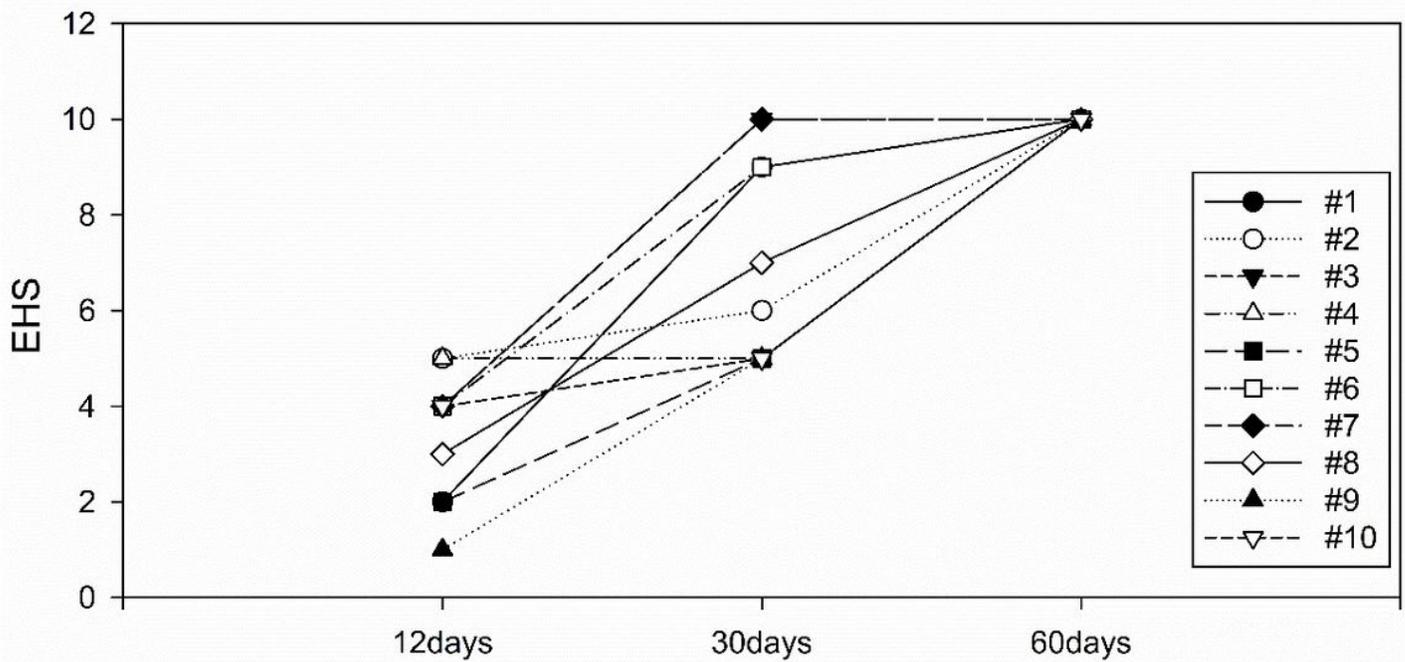


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