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Editorial

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Implantology have Forever Changed Dentistry

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Implantology have forever changed dentistry as we know it and its rapid leaps and bounds are trying to keep up with many of the patient's wants and needs as well as with all the clinician's skill sets. It used to be implants had to be long, engaging the zygomatic bone in places where bone was low on the maxilla, and dentistry evolved to move and lift the sinus. We used to have to move nerves on the mandible, but now we have mini implants for patients who would not be great candidates for such major surgical procedures. We used to have no options when a tooth would fracture and had to bring the depressing diagnoses to our patients with a sad look and offer last ditch efforts in things like root hemisections to help retrieve some semblance of occlusal function for people that desperately wanted to avoid dentures. Dentures are still the basis on which I scare my younger patients to brush and floss and to avoid the lifestyle of their grandparents, but implants have even become a life saver for those patients in dentures as well who used to suffer through their meal, eating more fixodent then food. Speaking about the good old days of enjoying a simple meal.

Implants have brought a lot of confidence to dentists in many other dental procedures, like root canals, knowing that if a tooth breaks or a root canal fails, all we have to do is open up a small sterile container and take out a titanium masterpiece of a tooth that comes in many sizes, which we can use to build a whole new foundation for the patients future bite. And these days, implants allow for amazing immediate placement, which with bone grafting has been shown to allow for easier and faster healing of extraction sites with less bone loss then if the implant was to be placed after the healing of the socket has taken place. It seems like the implant is the perfect tool for any general practitioner and can truly be a rescuer of hopeless teeth, impossible dental procedures and the patient's bite.

Other things we have noticed in the 4 years we've been placing implants and in the 5 years our office has been open, when an oral surgeon used to place our implants for us, is the staggering ability of patients to gain comfort and confidence in areas where they had severe pain, periodontal destruction around teeth, infections from endodontic failures, and general oral discomfort in all the areas where we would expect someone to be hurting. All that was to keep the hopeless teeth in place for a better picture, or for the lack of desire to have a gap in the mouth.

Interestingly enough, it was the other areas that the patients never complained about that began to become noticed and sore by the patients. Areas that we as providers had mentioned to them years before and got the same response of "*It doesn't hurt though Doc*." By eliminating the areas that the patients are desperately clinging on to, and treating those areas first, we were able to reduce the general discomfort the patients have been living with for years, and after the major problems were gone, patients started to feel the minor ones as uncomfortable, helping us as clinicians to deliver the full array of dentistry and help prevent the full destruction of the rest of the mouth. It was as if the patients have been experiencing so much pain that they had what I call "*referred comfort*." Referred comfort is the camouflaging of pain in minor areas by pain and discomfort from major ones. This was most notably seen in old failed root canal procedures with sinus tracts that the patients wanted to hold on to in order to chew, but always avoided

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when eating. This would lead to the overuse of the opposite side. This would lead to further poisoning of the periodontal ecosystem and eventually bone loss, and possible endodontic needs on the surrounding teeth from combined periodontal and endodontic lesions and J-lesions. Many people had said they never knew that teeth were not supposed to hurt after age 50. They believed this was the normal progression of aging.

Another issue I've seen increase drastically is dental hygiene compliance to flossing on a regular bases. We have all had patients that told us that they were afraid to floss because they were "*gonna pop out their old filling or crown*," and that was a good enough reason for the patient to fully neglect flossing in their own minds.

As irrational as it sounds, there are patients like this that I encounter every week. And this condition will not change until the patient will have a stable oral cavity. However with the types of forces that the mouth experiences, and especially in today's grind happy and stressed out society, floss is hardly the culprit in the destruction of teeth.

Once the implants are placed and the loose teeth were eliminated, we had noticed that patients increase the flossing of the entire oral cavity. The stability of their teeth allows them to focus on the rest of the big picture and to maintain the remainder of their teeth with gusto and vigor. This of course could be from the sticker shock of the still very expensive dental implant as well, and the desire to maintain something new and beautiful that the patient hasn't had. Especially when we are talking about the anterior region of the mouth. But whatever it is that elevates the compliance, it's there, and we hope it's there to stay. This allows us to retain a healthy periodontia which will be important not just for dental reasons but for medical ones as well, as Diabetes and Heart disease have been linked to periodontitis for many years now, as have some cancers. The British Journal of Medicine as well as the American Diabetes Association, since 1993 and 2008 accordingly had listed that periodontal disease increases the correlation to risk factors of heart disease by 72 percent, diabetes by 50%, and certain cancers by 30-50%. But these facts alone were not always able to motivate the patient that was concerned about flossing damaging their mobile tooth. Pus from the teeth in the mouth was not enough to have flossing compliance. However, the delivery of the final fix in a form of the implant was indeed something that we have seen change our patients behavior. This allows me to confidently say that even a single implant has a huge impact on oral hygiene compliance of the entire oral cavity. This is of course not a full-fledged correlation, but something that had been noticed in the majority.

It is also widely known that people without any teeth don't suffer from periodontal disease. Let's not go ahead and rush all of our patients for full mouth extractions though as a ploy to prevent cancer. But keeping a destructive tooth in a healthy mouth or in an unhealthy mouth is never a good idea. However, helping people treat their dental problems and reducing their general oral inflammation and pain is certainly something to practice on a regular bases. By eliminating the hot spots, patients have started to notice other areas, such as old root canals that have stood for decades, as something that was now bothersome. Those areas may not warrant treatment immediately but become something we watch on a regular bases. Sometimes a CT scan of the patient will be a peak into what you may not see on a 2-Dimentional Periapical Radiograph. Using the Planmeca Head and Neck CT we have found more asymptomatic abscesses then I'd like to count. Everyone from family members to implant patients treating neighbouring voids has fallen into this category. It appears to me, their old root canals have found a balance in the infection and the body's ability to respond and tame the discomfort, but the abscess is still there like a time bomb waiting to break the confines of the immune system and erupt with pain or a sinus tract. There would be a time when we could only hope that the endodontists could retreat these failed old root canals, or in a worst case scenario perform an apicoectomy to further close the leaking, abscessed tooth, as if it was an agitated soda can of infection. And as long as it remained closed, the infection was left in the tooth and the decay would slowly continue.

I used to advocate the saving of the natural tooth by any means possible, but today with the magic of our tooth in a jar, aka Implant, I am able to provide the type of service to my patients that I myself would want. And an apico is not a procedure I'd be very excited about, especially knowing the epidemiology of the inside of the apicoectomied tooth. My personal philosophy has changed in my office, and it is entirely due to implants. Implants have even changed endodontic practices at their fundamental core both in my office and in that of my fellow endodontists. I have become quite proficient at root canal retreats in my career, but I simply do not do them myself anymore. I always give my patient the available option of seeing my fellow endodontists, who are true magicians at their craft. But with the costs of a retreat being what they are, and the drop in the price of implants, I find it hard for myself to fight for preserving the tooth as much as I used too. And especially when I think of how humbling it is to remove a tooth that had undergone an apicoectomy and has been "Saved" in the mouth for 30 plus years. The bone we have to lose to retreat the entire tooth's root tips and shards and the old amalgam filler is truly sad. This is all bone that could be supporting a bigger, longer implant and aid in avoiding peri-implantitis.

We still do dozens of root canals a month at my office, and the root canals are still outnumbering implants 5 to 1, but I do not see many retreats these days, nor do I have many patients opting to see the endodontists. There are a few exceptions, such as patients

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on Bisphosphonate cancer therapy, and people who mentally can't handle the idea of an implant. But those are fewer in number now than ever before. I used to try to retreat front teeth and still may to save the natural anterior tooth due to their enamel rich structure and esthetic importance, but with the revolutionary break through after break through with tissue grafting and zirconium abutments, these are becoming less common as well.

Peri-implantitis is still the major problem with implants and one that has to be communicated to patients. Nothing will last forever in this world, but a well maintained implant has the best chance of all. It has been a break through saver of edentulous patients with locator supported over-dentures and those broken teeth in accidents that would have needed a flipper or a prepping of 2 healthy adjacent teeth for a fixed partial bridge. The future is looking bright for us dentists and I feel more and more confident each and every time I sit chairside with my patient knowing that in the drawer beside me is an amazing piece of engineering, science and art called a dental implant which I can place and allow my patient to have a great solution for years to come, and one we could both be happy and proud of. Here is to the implant revolution and evolution.