EDITORIAL

On Widening the Stream

Health care innovation often results from separate streams of thought in experimental and clinical applications. These streams merge to catalyze new sources of creativity and professional purpose with an accompanying momentum for change and better treatment potential. This has certainly been the case with osseointegration.

We continue to believe that our three decades of experience with routine enrichment of our patients' oral health using implant protocols must not be compromised by our failure to take note of all adverse changes in clinical results. Therefore, it is necessary to take ongoing stock of the stream of accumulated knowledge in the area of implant therapy should reasonable doubt arise regarding the long-term effectiveness of our treatments—hence our emerging discomfiting sense with regard to recent literature's emphasis on so-called "peri-implantitis." Have we been so enthralled by the implant solutions we provided hundreds of prosthetically maladaptive patients that we overlooked the resultant incidence of significant inflammatory marginal bone loss around their implants? Or have well-intentioned colleagues in the field coalesced their own unique observations into a newly created diagnosis representing a disease entity with a catchy and logically sounding term? It is tempting to dismiss the assertions of a specific implant-related disease as rumor—in fact, one of us has purposely gone out on a limb and suggested expunging the term. On the other hand, there may be more than scientific calculus involved in dealing with this topic. It is clearly easier to accept the premise of a periodontitis-like pathogenesis for partial or complete bone loss around implants leading to the biologic loss of osseointegration than to seek to fully understand the diversity of events contributing to quantitative changes at the bone-implant interface. Indeed, the tasks for prudent clinicians in medicine and dentistry are to observe, investigate, and define. The order is critical for a specific diagnosis and implies a unique clinical condition rather than a renaming of an existing condition. The thought that the existence of one condition—periodontitis in this example—implies the same disease process in a completely different physiologic presentation represents a gross oversimplification.

Two independent groups of scholars have already taken the initiative to address this contentious issue; and both our journals are pleased to have the opportunity to include one of the group's conclusions (see page 736). The second group's contribution also comprised distinguished academics that formed a working group on treatment options for the maintenance of marginal bone around endosseous oral implants. Their discerning report was published in the European Journal of Oral Implantology earlier this year and also deserves serious scrutiny. Both these publications assist in the required distillation of current information, indeed clinical observational prudence. We also remind our readership of our determination to widen the knowledge stream that courses through both our patients' and our own professional lives.

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