EDITORIAL

Roots

As I get older I find that my career is becoming increasingly dependent on the use of language. In my youth, language was a simple communication tool that was primarily used in conversation. Now I find myself thinking about the importance of words, and sometimes the use of words becomes an activity unto itself.

I recently started thinking about a word that is near and dear to all dentists. That word is "root." Even before we started our dental education we certainly recognized that teeth were supported by roots. Throughout our training we learned many methods to preserve, restore, amputate, or camouflage roots. Much research has been performed to cover roots, treat the canals within roots, or regenerate bone surrounding roots. And now we have the field of implant dentistry, which, in its simplest form, is committed to the development of analogs for missing roots.

At its root, osseointegration was used only to support and retain dental prostheses. Implant dentistry cut its teeth as a relatively utilitarian support mechanism for mandibular dentures. Restorations supported by implants were not necessarily beautiful, but they certainly were quite successful at restoring function that had disappeared with edentulism. Most remember, and many still use, the sanitary prosthesis design with contact between prosthesis and residual ridge. One might quip that those prostheses had their roots showing, a definite fashion faux pas. The thing to remember, however, is that these prostheses addressed one of the most difficult prosthetic situations, the edentulous mandible.

Indeed, with the use of implant support, the edentulous mandible is no longer a patient's greatest nightmare. Implants chart the route for a new phase in the management of edentulous patients. Whether the solution is the 5-implant-retained fixed prosthesis or the 2-implant-retained overdenture, the dilemma of poor retention and inadequate stability can now be eliminated. The solution, however, is not reached without costs in the areas of time and expense. Recent recognition that implants in the dense bone of the anterior mandible may be functionally loaded in an accelerated fashion has reduced concerns with the issue of time. Unfortunately the financial consequences remain, since even with an overdenture prosthesis the cost of care is many times the cost of traditional complete dentures.

At its root, osseointegration allowed average clinicians to perform procedures with a high likelihood of clinical success as long as they followed the prescribed route. The goal was to help debilitated patients achieve comfort and improve function, not to enhance beauty.

Today, in many cases a replacement tooth supported by a dental implant is expected to function as well as any natural tooth and to do so while being indistinguishable from the remaining teeth. The roots, natural or implant, are expected to be functionally identical. Considering that osseointegration has been recognized worldwide for a little over 2 decades, it seems that the profession has pretty high expectations for our relatively immature alloplastic friends.

As knowledge and skills have increased, and as new techniques and materials have been introduced, the demand for esthetic excellence has increased. Interestingly, the disciplines of esthetic dentistry and implant dentistry gained popularity at about the same time in dental history. Perhaps it is the parallel growth of these 2 fields that has forced implant dentistry to become another instrument in the esthetic armamentarium.

Today, if we attend an implant meeting and are able to identify the implant-supported crown on the 10-meter screen, we're disappointed. Of course this is a major departure from the roots of osseointegration, from the days when osseointegration was a technique that allowed the average clinician to gain acceptable results for the debilitated patient. Once the concept of esthetic parity with the natural dentition was promoted, the demand for clinical excellence eliminated the average clinician from the equation. No longer is simple osseointegration the goal, and as this goal has changed so has the route to achieve the revised goal of esthetic excellence. In addition, the ability for patients of average economic means to afford the more complex treatment needed to achieve these results may also have been compromised.

There comes a point when we need to question whether we have strayed too far from our roots. If dental implants single-handedly provide support, retention, and stability to dental restorations, should the profession be satisfied with this? Must we then demand cosmetic results that rival, or even transcend, what nature gives us? Is there a risk in being this demanding? I believe there is. Implant dentistry could become a boutique practice reserved for only the most affluent members of society provided only by the select clinicians with the incredible technical skills required to achieve these results.

I hope that the root of this discussion will not be lost. Implant dentistry is a very broad field. There's room for both clinicians who focus on one aspect of patient care, such as esthetics, and clinicians whose goals are more general. Indeed, there are patients who place so much emphasis on comfort and function that the cosmetic results of treatment may be virtually insignificant to them. Conversely, we have all treated patients who subordinate all concerns regarding longevity to their demand for enhancement of natural beauty. In the end, emphasis is determined by the desires of the patient. The task for the clinician is to match the appropriate treatment with those patient demands. Perhaps this rerouting of treatment to address demands will return implant dentistry to its roots as patient-centered therapy.

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