

Facts, Not Opinions: What Is Old Is New Again

As I write this editorial, I'm attending a genetics meeting in the UK listening to brilliant minds discuss the substantial medical conditions affecting these ipatients. One key aspect is the need for complex oral habilitation; because those patients often don't form teeth, it's not truly rehabilitation. As I listen and reflect on the life journeys of these patients, I'm struck by how much we do to improve their lives. Yet, by necessity, they remain deeply dependent on their healthcare teams for significant life decisions. Small choices on our part can affect them for decades. It's a privilege to be part of their journey, but it also carries a profound responsibility.

Most patients present with advanced dysplastic bone formation, requiring either major grafting or graftless approaches such as zygomatic implants or, more recently, the (re)introduction of printed subperiosteal implants. Each method comes with its own learning curve and advantages. A month ago, I had an in-depth discussion with a patient about printed implant systems. We proceeded with a medical preauthorization request to their insurer. I was certain it would be denied. To my surprise, the insurer approved full coverage immediately, and I was confronted with a hard truth. I needed a gut check.

I had to admit that this is a relatively new approach in North America and my experience with it was limited—mostly in cancer patients. I was honest with the patient and said I had no long-term outcomes for a middle-aged, otherwise healthy individual and I wasn't prepared to apply an untested system in this genetic population. I could feel the tension in my gut as I faced a dilemma of my own making. Despite having the financial "green light," I knew I wouldn't sleep well knowing I had initiated a significant surgical intervention with uncertain longevity. The calculus is much different for a patient with an end-stage disease than a healthy individual with potentially 50 years ahead of them.

Thus, I stepped back. I wasn't ready to proceed with this approach—at least not yet. Yes, my surgical team was disappointed, but I couldn't look the patient in the eye and say, "Now is the time." I needed data—more than case studies and online testimonials. I wanted facts, not opinions.

One of the joys of my role as editor is reviewing, supporting, and guiding authors who are doing remarkable work that has the potential to transform clinical

practice. I also strive to maintain a healthy amount of skepticism, ensuring the journal publishes information that is both trustworthy and relevant. At the same time, I want to provide a strong platform for emerging ideas backed by solid data. The challenge is that researchers and manufacturers are evolving their systems so rapidly that the field feels like the Wild West again.

Why does this matter? I thought about this recently when I re-restored a mandibular arch with Brånemark implants that were placed in 1982. I had to design a new biomechanical solution to end a 43-year history of broken bridge and abutment screws, and so far it's stable. The implants had functioned remarkably well in the mandible for decades. However, the patient (now 47) was in an early clinical trial and likely has another 30 years ahead. The decision made in 1982 tied him to that system for life. Fortunately, it was well designed and well documented for its time.

This long-term perspective reinforces the importance of caution, trust in research, and verification of outcomes. I don't want to deploy a solution that closes doors or makes choices that will affect someone long after I'm gone. Respecting the trust placed in us is essential. There's a saying worth remembering: "We are but guests in our patients' lives," here for a short time but leaving impacts lasting a lifetime. It's truly humbling.

Thank you,



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