Guest Editorial Self-serving?

In our profession of periodontology, there has been a noted increase in the use of dental implant therapy coincident with a greater tendency to underestimate the long-term prognosis of treated teeth with a questionable or compromised periodontium. Has dental implant treatment by periodontists and our restorative colleagues replaced our practice of regenerating the periodontal tissues around teeth? And if so, who is being served by this?

Over the past 20 years, through ongoing well-documented research, the classic "gold standard" of regenerating new bone, periodontal ligaments, and connective tissue attachments has progressed from grafting with DFDBA, to using GTR, and now to the era of biological mediators. As periodontists, we need to step up to the plate and continue to save teeth with the best possible treatment modalities we can offer our patients and restorative colleagues. If we do not, our specialty surely will demise, and if our restorative colleagues cannot rely on us, whom are we serving?

All too often we hear that we can "win the battle but lose the war." The regenerative characteristics of periodontal tissues, both hard and soft tissues, can best be predicted with a complete understanding of the clinical parameters that we have developed, studied, tested, and retested. Prognosticating the periodontal disease activity level of a particular patient should not be undermined by an increased aggressiveness to extract and place dental implants, nor by "band-aiding" therapy, placing chemotherapeutic agents in the affected area, and ignoring the bony component of the lesion.

Teeth with a less than favorable prognosis often can be saved with regeneration of the periodontium, the best treatment available for many of our patients. Improving the prognosis of our patients' teeth still needs to be our primary consideration and the "front line" of defense in the treatment of our patients and in prognosticating treatment success for our restorative colleagues.

Although any colleague can place a "screw in the bone," the complete periodontal-prosthetic treatment plan and the patient's periodontal health need to be attained prior to the placement of any dental implant. I find that the main problem overlooked by clinicians is the establishment of a proper occlusal scheme. Once integration has occurred, occlusion is the predominant factor that may lead to a possible de-intregration (except for a bacteriologic issue). Paying attention to the overall plan for the betterment of our patient population remains key in their success.

Treating from established biologic principles still needs to be the cornerstone of the periodontal foundation. Let us not give up on the periodontium and the goal of reestablishing periodontal health. If we do, whom then are we serving? Is this simply a trend or are we self-serving our means to an end?

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