

## Editorial Osseous Resection Revisited: A Conservative Approach for Periodontal Therapy?

As a person born in the final year of the Baby Boom, I find myself in the crosshairs between high technology, common sense, time-tested experience, and reality. Call me old-fashioned, but I still believe a gold crown is the best restoration. On the other hand, if I had to take a Kodachrome slide right now I would probably shoot myself. I am not averse to technology and progress. But when does it become detrimental? When does it adversely affect predictable outcomes for sound, proper oral health care that is conservative, long lasting, and functional? Using technology as a means to an end can be reverse engineering when it comes to evidenced-based therapy.

Whether something is conservative or radical is in the eye of the beholder. I feel that not doing periodontal surgery on a 35-year-old with moderate to severe periodontitis is radical. This belief leads me to the logical conclusion that periodontal disease should be treated early. For some reason, over the past 25 years of my career dentistry has delayed diagnosis and treatment of periodontitis. Even with the advent of soft tissue management in practices, I see improper diagnosis due to lack of proper probing, poor follow-up evaluation, poor maintenance, and often inadequate initial root planing and scaling. Local delivery of antibiotics and laser curettage have shown no long-term benefits over conventional treatment in controlled experiments. Nevertheless,

my recent experiences in predoctoral and graduate education have shown a positive shift in education and in collegiality between departments. My hope is that this is an ongoing trend.

Unfortunately, most disease I see has progressed well beyond the point of conservative osseous surgery. As described by Schluger,<sup>1</sup> Selipsky,<sup>2</sup> Friedman,<sup>3</sup> Oscheinbein,<sup>4</sup> and others, once the interproximal crater has formed (which must be diagnosed) a conservative palatal or lingual approach can be taken with little if any further loss of attachment or esthetics, especially in the posterior. Disease progression as described by Waerhaug<sup>5</sup> is usually 0.2 mm from the plaque front, which usually starts interproximally due to the difficulty of plaque control in that area. It makes sense that interproximal resection is an early treatment modality.

I am sure that many others in periodontics have patients who have been treated conventionally and have kept all their teeth for 20 or more years. Why doesn't Hirshfeld and Wasserman<sup>6</sup> seem to still be relevant?

I see the problem as fourfold:

1. Many dentists don't probe properly and miss bony defects that are not obvious on radiographs.
2. Practice promotion pushes untested, unpredictable, high-tech procedures to recruit new patients and maximize profits.

3. Implants have become a scapegoat for supervised neglect.
4. Good osseous resective surgery is technique sensitive, time consuming, and training intensive.

Dentistry is a difficult profession, and practitioners should be highly skilled in all procedures within their individual skill set. Attempts to short-change patients because of inadequate training, for financial gain, and following patient influence should be avoided. If we are astute clinicians and use all of our diagnostic and therapeutic approaches, it behooves us to treat conservatively and early—and yes, that includes osseous resection.

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