EDITORIAL

Prognosis Rules in a Depressed Economy

No one has to be told that society is facing the most severe recession of the last 80 years. Although I try to avoid generalizations, it is probably safe to say that these are trying times for dentistry throughout the world.

Accepting the notion that the economy is underperforming everywhere, it is likely that everyone involved in implant dentistry has seen some impact on their daily practices. Procedures that were considered as part of routine practice 2 years ago have become a little less prevalent. The ability to fill schedules with our favorite procedures has been diminished by the recession and we probably find ourselves working harder to gain patients' acceptance of our recommended treatments.

We have probably heard that adversity has a positive side, but finding it may take some effort. Perhaps the bright side of this recession is that patients and professionals will begin to place greater emphasis on prognosis when considering dental care, and this could be a positive factor for implant dentistry.

Emphasizing prognosis seems like an obvious approach, but we might be surprised to discover how rarely this happens in dentistry. The reason for this is that prognosis is not as easy to understand as we might think. An explanation of this statement demands an understanding of all the facets of the term "prognosis."

The traditional view of prognosis considers the outcome of a disease when no interventive therapy is provided. In this situation, prognosis reflects the natural course of a disease. Think about the number of diagnoses in dentistry for which intervention was considered before evaluating the results if only supportive care were provided. A good example is diagnosis of one of the categories of temporomandibular disorders. Since the prevalence of this disease is greatest in early- to middle-age population groups and since numbers decline as patients get older, it is apparent that most patients experience spontaneous remission—a fact that identifies most temperomandibular disorders as self-limiting.

Understanding the natural course of the disease provides direction to clinicians in its management. Regarding temporomandibular disorders, clinicians have witnessed an evolution from active therapeutic intervention in the form of occlusal treatment toward a management approach that is designed to provide symptomatic support until the disease transitions, along its natural path, to a quiescent form. Failure to understand prognosis in this case leads to therapy that might be more invasive than necessary to provide symptomatic relief for the patient.

Once an appreciation is gained for the natural course of a disease, therapeutic interventions may be considered. Appropriate therapy must provide more favorable outcomes than could be anticipated in the absence of intervention; however, prognosis does not end at this point, as the side effects of treatment must also be considered. Obviously, treatment that creates adverse outcomes more troublesome than the original disease state could not be considered as therapeutically superior.

So prognosis, to be considered favorable, must provide superior outcomes to those that occur naturally. Likewise, the condition of the patient should not be otherwise diminished through the method of intervention that addresses the disease. Lastly, prognosis must also factor in the intention to treat a disease, as there are times when a plan is developed, treatment is initiated, and for some reason treatment is not completed. In those situations, the failure to complete therapy represents a failure of the intention to treat and is therefore a negative prognostic event.

How does this appreciation for prognosis change treatment and why is this more critical in a time of economic crisis? The answer to the first question is that therapy should only be considered when prognosis is improved by provision of a specific therapy. The second question is answered by evaluation of socioeconomic issues that are related to patient acceptance of treatment while also considering initial cost, maintenance costs, anticipated complications, and time to re-treatment, as these factors, and others, determine long-term treatment effectiveness. In times of financial hardship, when any expenditure is carefully considered, long-term service with minimal ongoing intervention identifies "value" for specific interventions that may make that intervention preferable to other therapeutic approaches.

Sadly, implant treatment outcomes in the categories of function, esthetics, and psychosocial and socioeconomic satisfaction have yet to be agreed upon, making a true appreciation of prognosis difficult. Beyond the lack of accepted outcomes for comparison, one must also appreciate the fact that differences in residual anatomy, pathophysiology, and psychological outlook will influence the prognosis in each category. These factors are addressed by the Prosthodontic Diagnostic Index, created by the American College of Prosthodontists, as qualifiers of a specific diagnosis; however, prognosis of disease progression or for treatment provided for these diagnostic categories remains largely unaddressed.

This editorial began with the recognition that prognosis should dictate therapy. Since implants are primarily used in support and retention of dental prostheses, it is likely that implants should be compared with tooth- or mucosal-borne prostheses using similar outcomes for each of the treatments and for no treatment. When prognosis is identified for different therapies addressing the myriad of patient-specific factors, the profession will be ready to provide the most appropriate treatment for the patient, creating a situation where prognosis will dictate treatment under all economic conditions.

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