

# Saving the Teeth

What is that new paradigm? In a few words, saving teeth may not be the best thing for our patients.

**I** felt it necessary to comment on Dr. Cho's article in the December 2004 *Journal of the California Dental Association*.

In his review, "Evidence-Based Approach for Treatment Planning Options for the Extensively Damaged Dentition," Dr. Cho discusses current modalities for saving and or replacing diseased natural teeth. He spends most of his time reviewing fixed partial dentures, endodontic treatment, root resections/hemisections, and other ways of saving teeth. At the end of the article, he makes a case for the implant alternative. While I applaud the general thrust of the article, I feel he understates his prime point: Implants are changing the way we save teeth in dentistry.

The reality is that implant therapy is introducing a new paradigm that is going to have some major impacts on at least two major specialties in dentistry: endodontics and periodontics. What is that new paradigm? In a few words, saving teeth may not be the best thing for our patients.

This represents a major philosophical change that is hard, even for implant dentists, to embrace. Dr. Cho inadvertently illustrates this with a radiograph (Figure 4, Page 985. Here, the picture shows the lower left quadrant of a patient who originally had a four-unit bridge from Nos. 18 to 21. The bridge evidently failed for some reason, but the abutments were salvageable as individual crowns (Nos. 21 and 18), and implant/crown combos were placed at the Nos. 19 and 20 sites. All well and good. But the picture shows the No. 21 was now failing (previous endo/post, and now vertical root fracture). This is the classic error in "save the teeth" mentality. Had the treating dentist been aggressive enough with the new paradigm, he or she would have removed No. 21 at the time of the initial bridge failure, placed implants in the Nos. 21 and 19 sites only, and placed a three-unit, implant-

supported bridge, saving the patient the cost of the No. 20 fixture. (Certainly, the placement of No. 20 implant gives the patient the ultimate in 1:1 tooth replacement, eliminating the need to thread floss under the bridge, but with a price.) This is the part of the new paradigm that's hard for us die-hard "save the teeth" dentists to swallow. I know, I struggle with this everyday.

Perhaps the first, real penetration of the new paradigm will be experienced with bicuspid teeth, especially those with small, slender roots.

A patient presents with an MO, DO, MOD, or maybe even an occlusal amalgam on tooth No. 5. The amalgam is 15 years old, the tooth is sensitive to percussion and biting pressure. You make the diagnosis of an incomplete crown fracture, and discuss the need for endodontic treatment, maybe a post, and certainly a crown. In the new paradigm, you discuss extracting the tooth, placing an implant at the same appointment, and placing a crown in two months or so, depending on the surface of the implant. The cost is several hundred dollars more than the "traditional" treatment (about \$600 in our office), but the long-term success is vastly different. With the traditional treatment, everything is "successful" for awhile. My observation shows an average life of the above of maybe seven years. Then a post lets go. Or a root splits. Or the patient gets some recurrent decay. And the \$1,500-\$2,000 the patient spent on the tooth is down the drain. With the implant, we have a 95 percent success during the first six months, and a bit higher than that if the implant makes it past the first six months. No chance ever of recurrent decay, and the implant is mostly impervious to periodontal disease.

This new paradigm has some consequences for the endodontist. He or she's out of the equation completely. If you apply the

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new paradigm to moderately periodontally involved teeth, you extract teeth that would otherwise need regenerative periodontal surgery, stopping bone loss with the placement of the implant. And the periodontist gets cut out of that equation (unless he or she is placing implants).

Will we cease to use endodontics? No, but we will use the modality less. Will we cease using the traditional services of the periodontist? No, but we will use them less. Heroic regeneration/membrane procedures will be limited to critical abutment teeth of multi-unit FPDs, where the cost of saving the tooth significantly outweighs the cost of replacing the FPD. How many of those situations do you run into in a year? Not many.

This new way of thinking is radical and it's hard to accept. But implants are vastly more reliable than most of what we've done in the past. Dr. Cho gives us an introduction to the change, but the total impact of the new paradigm is actually tsunami-like in nature.

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## Licensure Process Needs Live Patients

We read with great interest your editorial in the January *CDA Journal*. We digested all the information on licensure from the House of Delegates, read numerous licensure-based literature, and discussed the subject matter with a great many dentists in practice and academia. What this all boils down to is a simple question: Can minimum clinical competence be determined without using live patients? We don't think so. Knowing what to do and being able to do it are two entirely different things. How is the elim-

ination of live patient exams going to objectively prove the graduates possess minimum clinical skills? We feel there must be objective third-party oversight of dental education. How can licensure by graduation or any examination model that does not test minimum clinical skills by an objective third party be valid and reliable? Even researchers who oppose a one-shot State Board Examination are not opposed to live patient examination if such examinations can be designed to be valid and reliable.

We agree that anyone completing a one-year approved internship, as is required in medicine or completing a residency in an approved postgraduate program, should not have to take our board exam. We do not agree, based on our experience and conversations with our medical colleagues, that dental students are any more qualified to treat patients after graduation than medical students.

Regarding dental students: Is it the dental students or the deans pushing for all these changes?

Maybe the current exam is not valid and reliable. Maybe we need a dental internship or some other means of evaluation, objective third-party evaluation of the clinical skills of the graduates. But we firmly believe that evaluation, however it is structured, should include live patients.

You write "the quality of our schools, and our graduates in general, mandate that alternative means of licensing can be considered." Does this mean the recent decline in passing percent on the State Board Examination is related to the quality of the graduates being graduated? Does this mean that because of this decline, the board examination must be made even less challenging by eliminating clinical

testing? Does this mean that CDA is not willing to work with the State Board of Dental Examiners to make the exam more valid and reliable? What do you mean?

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## Revamp the Licensure Process

Your editorial in the January 2005 *CDA Journal* was right on target. Our profession has lagged behind our medical colleagues for too long in licensure. I originally came to California via the Navy and had to jump through all the hoops to get my dental license even though I had completed a general practice residency and was licensed in another state. This was 10 years ago, and our system is still antiquated even though we have allowed reciprocity and credentialing. I feel that the State of New York has thrown down a challenge to all the other states with their licensure protocol. California, who trains a great many more dentists every year than any other state, should be the next state to revamp the old licensure process.

Let us be a leader in this trend toward national licensure and not continue to be considered stuck in the old way of thinking by other states. I am proud to be a member of the California Dental Association and hope that the rest of the country will look to us to continue the push to bring dental licensure in the 21st century the way medicine has already done.

I want to thank you for bringing this topic to the forefront as I believe most of the dentists in our state feel the same way about licensure.

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