Editorial

Prosthetically Driven or Periodontally Maintainable? We Need Both.

We were educated in the age of periodontal prostheses, when periodontics and prosthetics were integrated and dependent upon each other. The authors of this editorial would often travel to hear the masters, including Abrams, Amsterdam, Cohen, Kramer, Nevins, Skurow, Weisgold, and others. We were taught restorations had to be hygienic. Rules about contour, emergence profile, embrasures, attached gingiva, tooth positioning, adequate support, and balanced occlusion, to name a few, were emphasized and mandated. In the era of periodontal prostheses, we were nervous about long teeth, small gingival overhangs on restorations, and inadequate embrasures.

In the 1980s, we embraced implants, but Brånemark again emphasized "high water" cases that allowed access for oral hygiene, debridement, and maintenance. Years later, as a reaction to the concept of placing implants "where the bone is," we embraced the concept of prosthetically driven implant placement. Adopting this concept has not solved all of our problems, and improvements in guided bone regeneration (GBR) and prosthetic abutments are not always the complete solution.

Presently, many treatment plans are based on the prosthesis that is currently preferred or can be marketed profitably. It is not uncommon to see periodontally maintainable teeth extracted, or 5 to 8 mm of vertical bone removed, to make room for prosthetic materials. That removed bone could prove to be critical if, in time, peri-implantitis strikes the patient. We often see prostheses inserted with inadequate access for patients or clinicians to debride the area, or hybrid prostheses with significant buccal/facial cantilevers that are not maintainable. Due to patient esthetic demands, we often place a fixed appliance when it should be removeable.

Staging cases with natural teeth and/or transitional implants may add additional time and cost to the case, but there are benefits: Very often, bone can be preserved, hygiene assessed, GBR sites kept from loading forces, soft tissue managed, vertical dimension maintained or adjusted, and better implant positioning achieved.

Years ago, when an implant-supported hybrid prosthesis was placed, it was common to remove it during maintenance visits to access the implants for debridement, and we often saw significant amounts of plaque and calculus on the intaglio surfaces. The implants were debrided, the prosthesis was cleaned, and many times the screws were removed and changed.

Why have peri-implantitis rates skyrocketed? The literature lists multiple possible explanations, including plaque-retentive surfaces, active periodontal disease on remaining teeth, occlusion, inadequate zones of attached keratinized gingiva, and poorly positioned implants, among others. At what point do we embrace restorations, which are both prosthetically driven and periodontally maintainable? Restorations should be esthetic but must be cleansable by both the patient and the clinician. We need to remember the masters, and an appliance placed in a sound periodontal environment needs to be our primary goal.

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