



Osseointegrated implants were introduced for patient care as an alternative to traditional dental therapies. The early evidence, by Per-Ingvar Brånemark and his team, provided implant-supported prostheses for edentulous patients, and the contemporary scope of treatment has expanded to include the partially dentate patient, opening the door to innovation. The dental community at large has explored the possibilities for expansion, including implants placed in extraction wounds, localized enhancement of the atrophic alveolar ridge, construction of bone in the maxillary sinus, and immediate loading of the prosthesis. Of special interest has been the conceivability of satisfying the patient's esthetic demands using prostheses engaging the periodontium and, perhaps, introducing peri-implantitis.

Consideration of the problem allows one to consider three possibilities. The first is to identify the manufacturer relative to the surface of the implant or the connection of the abutment to the implant. This is in conflict with the many practitioners who seldom experience this issue. The second possible problem is with the surgical and restorative diagnosis and treatment. The third is lack of patient compliance, together with a significant shortage of dental hygienists to provide competent maintenance.

In recent symposia, precious time is devoted to the management of peri-implantitis complications. There is a collision of ideologic thought as to whether the etiology is mechanical force of the prostheses or inflammation related to bacterial infection; nevertheless, it poses a major inconvenience. It is particularly interesting how many publications demonstrate the resolution of the problem by decontamination of the surface of the implant in trouble and a myriad of regenerative techniques with no change in the prostheses or in the occlusal table of the prostheses.

The implant population should be considered in two different strata. First are patients with congenitally missing teeth, root resorption, extensive caries, or root fracture, with no history of periodontal disease. The second category should be confined to patients who have identified susceptibility to inflammatory oral disease and periodontitis and make decisions that will reduce the likelihood of an inflammatory insult. Osseointegration has been an important therapeutic development. Significant advances have been made in bone enhancement, and treatment periods have shortened. The profession must carefully consider the total patient complex before establishing a personalized treatment plan. It is impossible to forecast all of the potential issues in an editorial, but we do not want to lose the public's confidence in a therapy whose percentage of success exceeds many others in the healing arts.

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