



Editorial

Clinical and Evidence-Based Decisions

I recently participated in a point-counterpoint debate at the American Academy of Esthetic Dentistry on where to place an implant relative to the alveolar bone crest. In our practice, we routinely encounter a bone surface that is not flat, and we need to be flexible in dealing with this common issue. Four decades into using osseointegration in the replacement of missing teeth, we continue to make clinical decisions without definitive evidence as to which of the three possible levels will provide the best result. The dental history of each patient in terms of susceptibility to inflammatory disease should be considered, as should the likelihood of future crestal bone loss adjacent to implants. The implant-abutment junction has been identified as a likely problem because of the microgap. Preclinical information demonstrates that the sub-bony level is the most challenging and the suprabone level the least. We must determine what bone level will provide an optimal result that, with patient compliance and professional oral hygiene care, can best resist soft tissue inflammation. We must make the decision now, as the alternative is to defer treatment until the results of lengthy, expensive, randomized controlled trials are available.

Perhaps the time has come to accept the reality that such studies are not available because there is no likely source to finance them, as regulatory groups do not ask for this information. We also depend on long-term observation and experience to achieve optimal results, but many of these reports that are manifest to clinicians are not represented in critical reviews of the literature.

It is interesting to contemplate the strategy to determine which bone surface—interproximal, lingual-palatal, or buccal—will provide the best result if we rely on radiographs to identify the disease process and when to initiate intervention. The periodicity of such information is relative to the circumstance for each patient, but early bone loss cannot be ignored. We can no longer anticipate 100% success for osseointegrated implants.

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