

MTG August 10

Research from Dental Implantology Masters students at Sheffield has shed some light on some fascinating problems. In particular, amongst the comparisons of types of study, accuracy of impression copings and surveys of clinicians' protocols has come a study considering the rationale of clinicians in proposing a particular treatment plan. Intriguing outcomes from this latter study, which would be inappropriate for me to reveal further, suggest that dentists are highly likely to follow a particular treatment strategy, with less emphasis on the presenting clinical situation. This disconcerting finding brings with it a conundrum for the replacement of missing teeth, and this problem becomes magnified when the planning becomes more complex – for instance in the difficult decision of when to extract a tooth, or perhaps some/all the remaining teeth. Certainly this is a difficult subject, and there will be many reasonable treatment suggestions. As the old adage goes 'give me six dentists and *'I'll show you half a dozen treatment plans'*. Sifting through all the different strategies takes some thought and consideration, and can only happen when a dentist has realised, through experience and training, what options there are. That is not easy in itself. It is therefore no surprise for us to find a great deal of difficulty in *getting a patient to comprehend the options*. In fact I spend as much time, sometimes more, discussing and consenting a case than actually undertaking the treatment and I know I am not alone in this. It is therefore reasonably common to find a patient returning after a number of months, sometimes years to continue the discussions. This week I have seen three such cases. One of these patients appeared with a treatment proposal from a geographically distant colleague, which was a dispiriting read. In fact there was no treatment plan, just a computer generated list of the fees with no explanation of any treatment. Bear in mind that this was for a maxillary full arch fixed implant retained restoration. As responsible clinicians we need to take this matter seriously, and perhaps this is a good opportunity to encourage clinicians to embrace the ideas of reconstructive plastic surgeon Kayvan Shokrollahi (1), in his approach to verifying the consent process.

I have just read Trevor Burke's comment in Dental Update June 2010, where he reports leaving the auditorium at an aesthetic dentistry meeting. His concern was with the

presenters' lack of respect for biology, the wanton destruction of sound dentine for 'minimal aesthetic gain'. I share his concerns and suspect he too was appalled by a recent article where healthy incisor teeth were extracted and sound canines heavily prepared to enable a six unit maxillary bridge. I am normally presented with patients who have already lost teeth, usually as a result of enthusiastic restorative dentistry. As a restorative dentist, I wish to embrace minimally destructive restorative techniques. The least biologically invasive technique to replace teeth would avoid damage to tissues that cannot repair themselves. Clearly there is some way to go before we have the ability to repair enamel and dentine without a synthetic material; however we do have a tissue with a remarkable property. Bone. With correct management bone has the ability to repair without scarring, a unique property. If it were my daughter with missing teeth I would factor this property high in my wish list when it comes to their replacement. Osseointegration has a significant role to play in minimal intervention, though I just wish modern dentistry could resolve the need for losing teeth as a result of treatment aimed at generating fees rather than improving a patient's long term dental health.

1. *"Request for treatment: The evolution of consent"*. **Shokrollahi, Kayvan**. March 2010 Ann R Coll Surg Engl., pp. 92(2):93-100.