A Better View of Implants

Dr. Howard Farran and Dr. Ernest Orphanos discuss periodontics, implants and the importance of magnification at work

Ernest Orphanos: It’s inaccurate. There is a plethora of reasons why but, by virtue of understanding the literature, we know that the longitudinal studies of All-on-4—compared to All-on-6, immediate-load and delayed-loading—have the same 10-year success rate.

That’s No. 1. No. 2 is, if you do have a failed implant, you can replace the implant and weld to the titanium bar within the prosthesis. No. 3 is because you’re reducing the bone, and you’re reducing this alveolar ridge, you’re getting down into the better basal bone, so you have less remodeling. You have thicker soft tissue.

HF: I think that your specialty, periodontics, has changed more in the past 30 years than the other specialties combined. Do you agree?

EO: Not only has it changed, it has become more all-encompassing. When to extract the tooth is a very challenging question to address. The advent of LANAP surgery, which we use in my practice, brings in a whole other dynamic with respect to what we can do to save teeth. But we also have to be aware of the longitudinal studies. We can’t base the treatment we provide on our feelings or our opinions. It really should be based on the peer-reviewed literature.

HF: How can new dentists determine whether they should use old-school periodontal surgery or titanium?

EO: One has to defer to experts to really make the best clinical judgment for the patient, but a variety of factors come into play. Age of the patient is one. If I have a 25-, 30-year-old patient, I’m going to do what it takes to keep that tooth for as long as possible. I also consider root morphology, furcation involvement, the root trunk size, mobility and the opposing occlusion.

HF: Is All-on-4 moving toward All-on-3?

EO: It’s already coming out and has been through a rigorous five-year protocol. With All-on-3, a definitive prosthesis for the lower arch is
delivered the same day or the following day. It’s unlike All-on-4, where you’re in provisionals for several months, and it’s limited to the lower arch. It’s basically a treatment option for patients who can’t afford the luxury of All-on-4.

HF: You exclusively use Nobel implant products. Why is that?

EO: It’s a tried-and-true implant system with a lot of great features, including excellent primary stability and tolerance of prosthetic components. Dentists should use premium products that have research behind them. If you want to build a good reputation and a good practice, minimizing problems and maximizing results is the ultimate goal.

HF: Do you think magnification is directly related to better dentistry?

EO: There is a direct correlation between higher magnification and the quality of dentistry. The better the visibility, the better the quality of care that can be rendered.

I use OmniOptic loupes from Orascoptic. The optics on these particular loupes are fantastic because they’re magnetically held. They’re easily removed and you can replace them with varying magnifications, such as 2.5 to 3.5 to 4.5 to 5.5.

HF: When do you need to be at 2.5, 3.5, 4.5 and 5.5?

EO: The higher the magnification, the narrower the depth of field, and typically the narrower the width of field. Width of field is also related to proximity to the eyes, so the closer the lens is to your eye, the wider the width of field. I like to do my initial examinations with a 2.5. It gives me a good view of the entire arch. I’m not a “tooth-adontist”—I don’t look at single teeth; I assess mouths. For quadrant surgeries, I’d perhaps go with a 3.5. For a site-specific area, I would use a 4.5. In the event I break a root tip off and have to go and retrieve it, I pop in the 5.5. It just makes my life very easy. It allows me the luxury that my microscope doesn’t.

HF: How hard is it to switch from 2.5 to 3.5 to 4.5 to 5.5?

EO: Just pop off the magnetically held optics. To change lenses out probably takes a second—two seconds at most—per lens.

HF: I’ve always felt anyone working in the mouth should use magnification. What do you think about the dentists who use magnification but their assistant and their hygienist don’t?

EO: Loupes are cheap enough nowadays. For assistants, you can do the pop-up so it’s a one-size-fits-all, as opposed to through the lens. Pretty much everybody in my office, for the most part, wears loupes.
dentistry uncensored highlights

Why? Because they get the results they want. They get the soft-tissue response. They have the architecture. They have the prosthetics that allows for a beautiful result. I understand why some clinicians don’t refer—it’s an issue of, “Am I going to lose a patient?” It’s an issue of money, but I can tell you this: The finest clinicians in the world—many of whom I work with and many of whom I know—always refer out crown lengthening.

HF: What technologies are you passionate about?

EO: First, good loupes. If you can’t see your dentistry, you can’t do your dentistry. I’m also a big fan of 3-D technology. It improves our diagnostic capabilities. I would tell young clinicians to stay away from intraoral scanners for now. Soon they’ll be able to do full-arch scanning and capture soft tissue. CAD/CAM is very expensive, so put that on the back burner for now as well. The goal for young clinicians is diagnostics and carrying out good, basic dental care.

From a clinical standpoint, as a periodontist, loupes and cone beam are essential. I can’t tell you how many times I’ve diagnosed periodontic lesions that were never picked up and the prevalence of missed MB2 canals. I know these young clinicians want to treat maxillary first molars with endo because it’s a lucrative procedure, but if you don’t have loupes and you don’t have cone beam, you’re going to miss those MB2 canals, which are present about 90 percent of the time.

HF: It seems like 10 percent of dentists refer all crown-lengthening procedures to periodontists and the other 90 percent don’t refer at all. What does this say about crown lengthening?

EO: The most successful clinicians I work with refer for crown lengthening.

HF: Some dentists say if you place the crown and the margins on the bone, the human body automatically does a crown-lengthening procedure.

EO: Those dentists don’t understand what crown lengthening truly is. It’s not just vertically reducing the bone and the soft tissue. It’s also horizontally recontouring the tissue, such that you have a nice, scalloped contour. Think about crown margins today. How do you get a good crown margin if you can’t see it? How do you seal that crown margin if you don’t have a great impression? How do you remove the cement? That’s just such a weak argument, and from a biological standpoint it’s frighteningly wrong.

HF: What is your religion of the sinus?

EO: I’ve been a periodontist for 23 years. I’ve had three sinus postop complications during sinus surgery, and the fault was my own for not getting an ENT clearance to check the drainage of the ostiomeatal complex. If we do not have proper cone beam technology to understand what we’re looking at, we shouldn’t be messing with the sinus. If we’re messing with the sinus, we should get clearance from an ENT because just the trauma to a sinus is going to cause inflammation, and that inflammation can block the ostiomeatal complex. You need to make sure you have a patent ostiomeatal complex. If you do these things, your success rate for implants in the posterior will be through the roof.

Now, on the flip side of the coin, am I opposed to three-unit bridges? Let’s be more specific. Do any of those teeth have endodontics on them? Because if they do, your success rate drops precipitously.

If there’s endo on those teeth, on an abutment tooth, you might want to reconsider a three-unit bridge. There is a time and a place for an implant with a sinus procedure, and there’s a time and a place for a three-unit bridge.

HF: What knowledge could you impart on All-on-4 that you think dentists might not get?

EO: With my approach, All-on-4 is about facial analysis and restoring the face. If you go to my website, center4smiles.com, and visit the gallery in the All-on-4 section, you will see it’s not based on teeth; I diagnosis from the face on in, and not from the bone on out. I also have a training center where I train surgeons and dentists on the approach. All-on-4 is probably one of the most misunderstood concepts, and if you’re not adequately trained, you’re going to get yourself into trouble.