

# Should Endodontists Place Implants?

by L. Stephen Buchanan, DDS, FICD, FACD

*Second opinions are common in health care, whether a doctor is sorting out a difficult case or a patient is not sure what to do next. In the context of our magazine, the first opinion will always belong to the reader. This feature will allow fellow dental professionals to share their opinions on various topics, providing you with a "second opinion." Perhaps some of these observations will change your mind, while others will solidify your position. In the end, our goal is to create discussion and debate to enrich our profession.*

– Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

In recent years, the question "Should endodontists place implants?" has crossed the minds of virtually every endodontist in the U.S., if not the world. Opinions range from yes to maybe someday to never. The objective of this article is to explain to general dentists the advantages of their local endodontists placing implants when a tooth with failing RCT is unfit to be saved, but also to answer the concerns of endodontists who answered "maybe someday." The endodontists who said never... well, I can't help them.

For general dentists, having an endodontist place implants is a positive. If your local endodontist does implant surgery and that is not who you want to place implants in your patients, just say "no" when he or she asks. You'll never get an argument, and if you say "no" a couple more times, your local endodontist who does implant surgery won't even ask, he will simply refer your patients with unsalvageable teeth to another surgeon of your choice. Even when referring dentists prefer another implant surgeon, endodontists who have trained up to place implants are more likely to be on the same page as the GP when it comes to treatment planning for a sketchy tooth. Endodontists

who place implants are the *least* biased of all specialists who place implants, simply because they are the only implant surgeons who can do either procedure.

Implants qualify as one of the greatest advancements in the history of dentistry. Implants have changed every specialty (except maybe pedodontics) and the whole of general practice forever, but I've seen it up close in the specialty of endodontics. Implant placement has radically morphed periodontal practice from a dreary specialty to a really cool, effective and profitable field. The aesthetic advancements that periodontists have brought

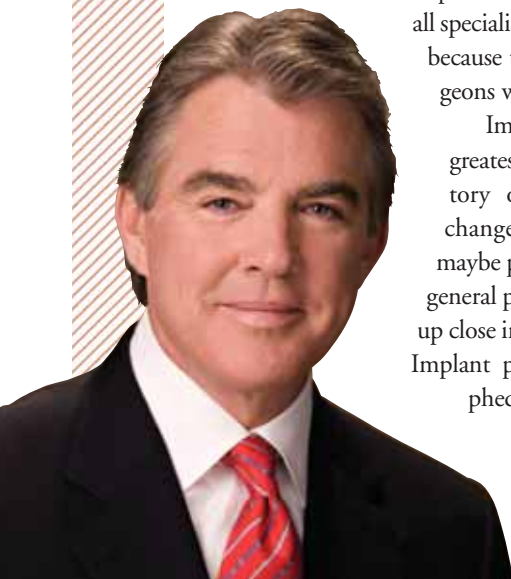
to the implant party are truly remarkable. The specialty of prosthodontics has changed nearly as much. Prosthodontists used to deal with slowly deconstructing full-mouth cases with few options besides removable prostheses after a certain point. Now, with the right implant placement, prosthodontists have become like Superman – they can put *anything* back together.

Just as the periodontists did 20 years ago, many endodontists have now trained up and implant surgery is a significant part of their practice. However they (we) are still a small minority of the specialty, so the majority of the changes to endo from implants have been less direct, but in significant ways that have irrevocably improved our treatment planning, and thus our success rates.

The best of those changes has been the fact that we are no longer asked to do heroic endo to save precarious teeth because they are the last distal abutment in an arch. Most of the teeth that were hemisected and root amped by periodontists back in the day were successfully treated by endodontists only to fail structurally when the same occluding forces were borne by fewer roots. Endo heroics aside, the greatest positive change the implant era has delivered to our specialty has been endodontists *placing* implants. When my colleagues ask how an endodontist, not trained in implant placement in grad school, can rationalize including implant surgery in their practice, I answer:

1. Everybody places implants, even orthodontists. The only dentists who think endos shouldn't place implants are insecure implant surgeons and endodontists who don't really feel comfortable doing endo surgery.
2. The majority of periodontists weren't trained to place implants in their graduate programs either, yet they have done magnificent work. Weren't periodontists rather uncomfortable when they began to cut bone near maxillary sinuses and mandibular alveolar nerve canals? Endodontists who do apical surgery on premolars and molars have been there their whole careers and are usually unconcerned by those situations.

*continued on page 28*



3. No patient wants to meet another specialist after the endodontist determines the prognosis is upside down.
4. Endodontists who can place implants offer the least biased specialty opinion about salvageability of teeth with failing RCT; whether to re-treat them or replace them with Ti. Including implant placement in my practice has been popular with my referring dentists from the start. New generations of endodontists will be trained to place implants in post-doctoral implant fellowships.

As an aside, endodontists, please stop badmouthing GPs' endodontic failures, it only teaches them to refer their next failing cases to a periodontist or oral surgeon who will "tisk tisk" that root canal treatment doesn't work very well,

conversely absolving the GP of responsibility while simultaneously building his implant practice. Also, please stop retreating loser teeth, it makes endo look like a space maintainer for an implant.

To the periodontists and oral surgeons, root canal therapy, when done correctly, works as often as implants do. The majority of RCT is done by GPs with a wide range of talent, and that's not to mention variance in the specialty pool. Implant surgeons who badmouth root canal therapy as a procedure sound just as dumb as endodontists who talk down implants. Please remember that dentists only refer failing RCT to you. Not one of them has ever sent a successful RCT to a periodontist or an oral surgeon and said, "Hey guys! Check it out! Nice endo outcome, huh?" Dentists only refer RCT failures to their favorite implant surgeon.

The best service for patients with failing RCT is always referral to an endodontic specialist with big talent, exceptional judgment and access to a cone beam CT machine. Ideally, when the prognosis may be upside-down, refer your patient to an endodontic specialist with talent, judgment, 3D imaging and an equal love of implant surgery.

Root canal therapy can be done through remarkably conservative access cavity preparations and it has never been easier to treat root canal systems to their full apical and lateral extents (Fig. 1). An experienced endodontist can, through conventional and surgical means, definitively resolve disease states inside teeth without destroying the structural integrity of the abutment (Figs. 2a-b).

## Conclusion

The time has come for endodontists to think of themselves as *understructure specialists*, rather than dentists with a specialty certificate who only do non-surgical re-treatment procedure that many GPs assume they can do themselves. If you want to be a specialist, be special (Figs. 3a-b). ■

## Author's Bio

**Dr. L. Stephen Buchanan** is a diplomate of the American Board of Endodontics and an assistant clinical professor at the post-graduate endodontic programs at USC and UCLA. He maintains a private practice limited to endodontics and implant surgery in Santa Barbara, California, and is the founder of Dental Education Laboratories, a hands-on training center serving general dentists and endodontists upgrading their skills in new endodontic and implant technology. Dr. Buchanan can be reached through his business, Dental Education Laboratories, [www.DEEndo.com](http://www.DEEndo.com), [info@endobuchanan.com](mailto:info@endobuchanan.com).

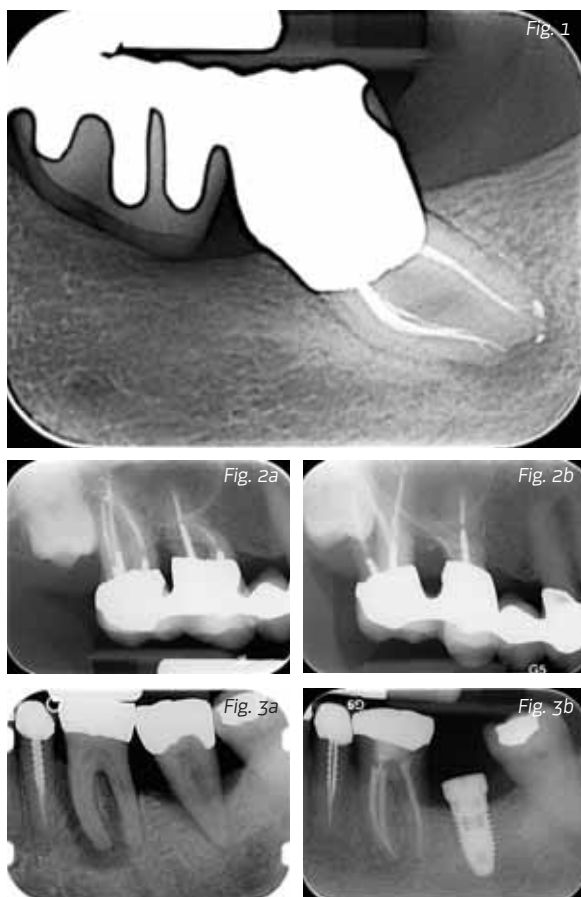


Fig. 1: Mandibular molar root canal therapy accomplished through a 3mm access cavity next to the MB cusp tip. CT imaging confirms how a tiny access cavity in this position allows nearly ideal file paths from MB, ML and distal canals.

Figs. 2a and 2b: Recent recall radiographs of maxillary teeth salvaged 25 years ago with non-surgical retreatment, surgical retro-fills and a root amputation.

Fig. 3a: Mandibular molars slated for replacement by implant surgeon. Consult by endo/implant specialist saves the first molar.

Fig. 3b: One year recall radiograph showing successful RCT of the first molar and replacement of the second molar with an implant.