Dear Reader,

I am happy to report that Dental Tribune has received many provocative responses (some of which appear below) to the opinion piece by Louis Malcmacher, DDS, MAGD, “Where did all the periodontists go?” in the Vol. 5, No. 12 edition.

Personally, I am still here and I didn’t know that the rest of us had gone anywhere, but I guess that too, can be a topic of provocative discussion.

First off, let me acknowledge that the piece was supposed to be labeled as our new Opinion section, but due to a production error, the article retained the Practice Matters section label. However, even without the correct section label, the piece achieved our goals for it: it got people writing us with their responses.

The goal of the new Opinion section is to give dentists a forum in which to agree, disagree, discuss and inform, and given the response to the first article, it has certainly achieved this goal.

Thankfully, we live in a country where our Constitution guarantees us the right to free speech. You should feel privileged to exercise that right and send in a response to future Opinion section articles should you be moved to do so.

That being said, Malcmacher’s article is especially provocative because he discusses an approach that allows patients to determine the dental treatment that they will receive based on the patients’ own habits, rather than depending on evidence-based facts, proven knowledge and objective clinical results.

The goal is to encourage health with proven minimally invasive treatments, and this can only be done with evidence-based facts, proven knowledge and objective clinical results. Malcmacher clearly stated that he bases his opinion on no authoritative evidence except discussions with dentists he has had during his travels.

Malcmacher makes an analogy of being a quarterback, so allow me to build on that analogy and leave you with this to think on: a quarterback who doesn’t play with an effective, cohesive team gets sacked every time.

Best Regards,
David L. Hoexter
Editor in Chief

Dear Dr. Hoexter,

We are writing this letter in response to Dr. Louis Malcmacher’s article, which appeared in the May issue of Dental Tribune, titled “Where did all the periodontists go?”

First of all, let us assure you that, as a specialty, periodontology is alive and well, and the increasing number of research studies supporting the perio-systemic link demonstrates that the role of the periodontist is more relevant than ever. While we agree with Dr. Malcmacher that general dentists are the “quarterbacks” of the dental team, we also view the periodontist as the specialty team member who is uniquely qualified in providing an accurate prognosis of all viable treatment options, whether it is non-invasive periodontal therapy, periodontal surgery or extraction followed by replacement with dental implants.

Dr. Malcmacher mentions that he has spoken to many periodontists but this, in our view, is anecdotal and does not accurately represent the entire periodontal profession. We believe that the majority of periodontal specialists make ethical decisions every day regarding retention of the dentition versus extraction and placement.

TempSpan™ Dual-Cure Temporary C&B Material

...Save time without sacrificing esthetics.

TempSpan Dual Cure Temporary Crown & Bridge Material is specifically formulated to produce highly esthetic and durable provisional restorations in the shortest time possible. The unique dual cure ability of TempSpan C&B Material provides clinicians with the choice to light cure in 60 seconds or bench cure in 2 minutes.

> Dual cure formulation for intra-oral or extra-oral polymerization reduces chair time.
> Outstanding physical properties ensure durable provisional restorations.
> 7 shades provide an extensive palette to match your patient’s dentition.
> Ideal working and setting times whether you light cure or self-cure.
> 1:1 mixing ratio for convenient dispensing with standard 50ml gun.
> Composite formulation is easily repaired or touched up with flowable composite.

Don’t compromise between esthetics and speed. Now you can have it all with TempSpan Temporary Crown & Bridge Material.

Promo Code: DT10510

Order Today!
From: Dr. Eric Hamrick  
Sent: Tuesday, May 11, 2010  
To: Louis Malcmacher  
Subject: Where have all the periodontist gone

Good afternoon, Dr.Yowza. I wanted to briefly comment on your article. I am a practicing, board-certified periodontist who has been in private practice for 26 years. I teach one day a month with the residents at the Medical University of South Carolina School of Dentistry, and also lecture on the topics of periodontics and implant therapy to study clubs both locally and nationally.

I enjoyed your article, as I thought the title was very appropriate for our current time in dentistry. What I stress to periodontists, especially the younger ones, is the need for practice diversification. In my practice, here are some of the procedures I provide for my referring doctor’s patients:
- Basic periodontal therapy, including the LANAP procedure, where it is appropriate.
- Mucogingival surgery, including a number of different procedures on both teeth and implants.
- Implant therapy for both edentulous and partially edentulous patients. This includes multiple types of bone grafting procedures, except for extra-oral grating (from hip or tibia).
- PAOO, OR Wilckodontic surgery.
- Uncovery of impacted teeth as part of orthodontic therapy.

Where I think our profession has failed our patients the most in regard to providing good, comprehensive care, especially periodontal care, is that dentists for the most part have lowered the standard in regard to how they define periodontal health. Just because someone has been through scaling and root planning doesn’t mean they are automatically stable. My experience is that very few dentists do a good re-evaluation to determine what has happened, and they just assume the patient is OK.

As you mentioned in your article, some patients are better served by having the guarded teeth extracted and replaced with implants to reach the goal of periodontal health and stability; however, economics often dictates treating some questionable teeth in an effort to keep the dentition intact, which often requires surgery of some form, including the LANAP procedure.

I think there will always be the need for periodontists, as I don’t think too many general dentists are going to tackle the entire list above. Although there is some overlap with us and oral surgeons, I simply say let the general dentist in any given area use the specialist he or she thinks is best for patients and their needs.

Thank you for taking the time to read my comments.

Sincerely,
Eric Hamrick  
Periodontics of Greenville  
One Charis Drive  
Greenville, SC 29615  
(864) 271-4330  
info@periogreenville.com

Either way, my mission is to get a discussion going and this article certainly did that. All the best! Thanks and have a great day!

Louis Malcmacher DDS, MAGD  
27239 Wolf Road  
Bay Village, Ohio 44140  
(440) 892-1810  
www.commonsensedentistry.com
Subject: Re: Where did all the periodontists go? [Online Posting]

From: Dr. Stuart J. Froum
Sent: Monday, May 10, 2010
To: dryowza@mail.com
Cc: r.goodman@dental-tribune.com

Dear Dr. Malcmacher,

I am writing in response to your commentary in the Dental Tribune posted [online] on May 7, 2010, titled “Where did all the periodontists go?” In answer to this question, I would say “We’re still here.” Your observation that there have been changes in all specialties (you cite orthodontics, endodontics and periodontics in your article) is of course accurate. Any specialty that has not undergone change in light of all of the new emerging information, technologies and materials would certainly be failing our patients and profession.

One of the most significant changes in the periodontal specialty has been that clinical diagnoses, treatment planning and treatment procedures are now decided, wherever possible, on evidenced-based data and controlled clinical studies as reported in peer-reviewed scientific literature. As such, your reporting that you are being told by many periodontists whom you “spoke to over the last couple of years” that “they would rather remove teeth and place implants than actually treat patients through traditional periodontal surgery and try having them maintain their dentition” is quite disconcerting.

As a periodontist who treats patients in private practice, and as a clinical professor in the department of periodontology and implant dentistry at New York University Dental Center who teaches periodontics and implant dentistry to periodontal residents in training, I feel that the periodontists you are quoting are, at the very least, misguided and should be made aware of a number of facts that may change their opinions.

First, by and large, most of the periodontists I meet in my lectures and travels around the country realize the value of attempting to save a tooth or teeth that can be retained in a healthy functional and an esthetic state. In fact, traditional periodontal treatment including both non-surgical and surgical techniques, have very high success rates in accomplishing this goal as shown in longitudinal studies (see Hirschfeld and Wasserman, J Perio 1978; Oliver J, West Society Perio 1969; Goldman MJ et al., J Perio 1986, etc.) over 20–50 years. It has been known for over three decades that periodontal surgery, when not followed by good professional and personal care, will in many cases fail (Nyman et al. J Clin Perio 1977).

That is why successful surgical treatment designed to save teeth requires meticulous and regular professional maintenance. Becker et al. (J Perio 1984) and others have shown that when this maintenance is provided, a surgical approach to treatment of moderate and advanced periodontitis is highly successful. Patient compliance, even when not optimal, must be reinforced by frequent maintenance and recall. This requires a team effort by the referring dentists, hygienist and periodontist, which must be undertaken.

To extract teeth and place implants is not the panacea that you and those periodontists that you spoke to believe it is. First, the 94 percent implant success rates you quote should be qualified. You mean a 94 percent implant survival rate because success implies implants that lose no more then 0.2 mm of bone per year following final restoration and remain esthetically pleasing to the patient.

By the way, these long-term survival rates that are often quoted are based on use of implants with surfaces that are no longer available (i.e., machined surface implants) and no longer being placed. Therefore, to compare long-term success of implants versus treated teeth is not possible because long-term data on currently used implants is lacking.

However, as I stated above, there are many long-term studies show-
ing natural teeth, when treated with traditional periodontal surgery, have excellent long-term prognoses (Lindhe and Nyman, J Clin Perio 1984). The fact that implant surfaces and designs are changing so rapidly makes it difficult to find any comparable long-term statistics for implants currently being placed.

Moreover, currently used implants, like natural teeth, can and do develop bone loss (peri-implantitis), which has been documented to be more prevalent than formerly believed.

In fact, in a recent consensus report and literature review authored by Lindhe and Meyle and published in the Journal of Clinical Periodontology 2008, they cite two cross-sectional studies documenting that peri-implant mucositis occurred in 80 percent of the subjects and in 50 percent of the implant sites. Peri-implantitis was identified in 28 percent and greater than 56 percent of subjects and in 12 percent and 45 percent of implant sites, respectively.

This was corroborated by a more recent study (Koldstand, J Perio 2010) that documented a prevalence of peri-implantitis of 11.5 to 47.1 percent. This, combined with the results of two long-term studies (Pjetursson, 2004), who reported that 38.7 percent of patients had complications in the first five years after implantation; and Lang (2004), who reported that biological and technical complications with implant-supported restorations occurred in about 50 percent of the cases after 10 years in function — should dispel any beliefs that implants are a trouble-free panacea when compared to retention of teeth that require periodontal treatment.

As for your contention that new procedures, i.e., wavelength optimization techniques and Nd:YAG (neodymium: yttrium aluminium garnet) laser present minimal invasive alternatives for patients who want to keep their teeth without “heavy invasive periodontal surgery,” I again refer to the dental profession’s reliance on evidence-based data before recommending new treatment modalities. I ask you: Where’s the proof that these modalities are as or more effective than what has been proven through evidence?

Before using a new modality, any dentist should have histological, clinical and long-term proof that these procedures are effective. Many therapies are “minimally invasive” but useless for effective periodontal treatment.

Dr. Malcmacher, I’ve been performing and teaching periodontal therapy for over 35 years and have seen trendy, minimally invasive and “easy” therapies fall by the wayside when clinically tested in randomized controlled studies. The Keyes technique, many time released local antibiotics (i.e., chlorhexidine in a gelatin chip, tetracycline fibers, doxycycline hyclate in a polymer carrier or minocycline microspheres) and even lasers were tested scientifically and found to yield little, if any, improvement over traditional scaling and root planing (without surgical therapy).

Utilizing ineffective therapies to avoid traditionally effective ones oftentimes results in progression of the disease around teeth that, when finally referred to a periodontist, are truly hopeless and have no other option but extraction.

However, the proper use of surgical regenerative procedures, with a variety of grafts and membrane barriers, have shown that bone and soft tissue that had been lost due to periodontal disease can be regenerated and questionable teeth saved. This has been well documented over the last 50 years.

New products, i.e., tissue healing modulators, growth factors (BMP-2) and even stem cells, are promising additions to currently proven materials and techniques but require evidence-based research, which in many cases is currently being performed before being recommended as replacement materials.

I feel that general practitioners and periodontists should be co-therapists in patient treatment. The decision to extract or attempt to save a tooth should be made by the dental team, not by one quarterback. I feel the periodontal specialist is in the best position to advise the referring dentist of the risks, options and treatment required to save a tooth or teeth. I don’t see many patients who come to my office or the New York University Dental Center clinic who would rather have an implant than a healthy functioning tooth. That’s why I advocate saving teeth, and periodontists are trained to save teeth.

There certainly are circumstances where extraction and implant placement is indicated and, here too, periodontists should be part of the team involved in these decisions and procedures. Periodontists have always been involved with soft- and hard-tissue esthetics around teeth and implants, and certainly have the experience and expertise in both areas. It would be best for the patient and treating team to be on the same page when it comes to knowing the options, risks, benefits, anticipated results and potential complications before any implant treatment option is considered.

You concluded with the statement: “You are the dental clinician, so it is for you, the periodontist and the patient to decide.” I couldn’t agree more, but the decision should be based on sound evidence-based data that is currently available rather than promises or hype from any company with minimal scientific long-term data to back up their claims.

So again, to answer your question, “Where did all the periodontists go?” “We’re here and available for a team approach to predictable dentistry.”

I urge you and your readers to attend the Joint Periodontal-Restorative Dentist Conference that will be held in Chicago in April 2011 so you can see first hand how this collaboration can work. I would direct you to a book I edited, “Dental Implant Complications — Etiology, Prevention and Treatment,” that will be published by Wiley-Blackwell within the next two months (www.wiley.com/WileyCDA/WileyTitle/productCd-0470884130.html).

The latter is a comprehensive textbook discussing potential implant complications and how to avoid them. This should be of interest to all dental practitioners be they general dentists or specialists. The book emphasizes the team approach to avoiding unwanted complications and results. If you have any questions or comments, please do not hesitate to contact me.

Best Regards,
Stuart J. Froum, DDS, PC
• Diplomate of the American Board of Periodontology
• Diplomate of the International Congress of Oral Implantology
• Periodontics and Implant Dentistry
• Clinical Professor and Director of Clinical Research Dept. of Periodontology and Implant Dentistry at New York University College of Dentistry
New York, N.Y. 10019-5404
Tel. (212) 316-4209
www.dstuartfroum.com

Based on your excellent response and the many others I received from dentists and periodontists on both sides of the “implant vs. teeth” controversy, I feel that the article has succeeded in bringing the discussion to the forefront. Thanks and have a great day!

Louis Malcmacher DDS, MAGD