In my lecture at this year’s EAO meeting, attendees received an overview of over 50 years of working with implants and why we did it in certain ways back then and why we do it differently today. When I started placing implants, they were only for specialists in oral surgery and prosthetics. Periodontists were not even allowed to listen to our lectures. One also had to be thoroughly trained if one wanted to purchase implants. Companies kept records of the clinician’s success rates and if he or she had a higher than normal failure rate, they showed him or her the door to figure out alone what had gone wrong.

In some instances, the warranty did not even apply if the dentist was not very good. I wish we had a similar system today to save patients from less skilled peers. Later, everyone was allowed to take a course and to place implants. Often, these were just weekend courses after which the dentist was supposed to be a fully qualified surgeon and prosthodontist and knew everything, including single-tooth restoration, full-arch rehabilitation of severely resorbed jaws with bone grafts and immediate loading concepts. It was totally absurd. To place implants, one needs to be well trained—learn to walk before one starts to run.

To my delight, I see that more and more implant companies are abandoning weekend courses and instead offering high-quality courses over a longer period. Attendees have to treat patients under supervision and companies even offer mentor support, which means clinicians are receiving guidance in conducting their treatments. The best courses are of a

Teeth within an hour:
A ticking time bomb

Author: Dr Göran Urde, Sweden
general nature, where the sole purpose is to train dentists to place implants and do this well and not how to do it with a specific implant system.

One thing that worries me a great deal is all the copy-cat versions of implants that are being marketed to less experienced dentists who cannot determine what a good product is. I always tell my audience to never treat patients differently to how they would treat their own family. The unfortunate thing is that I often see members of the audience looking down because they feel admonished. They do not understand that they get what they pay for and that failures are very costly and can hurt both their reputation and patients.

Another topic that gets me going is the marketing of new teeth in an hour. Patients that for decades have not taken care of their natural dentition are now being treated in accordance with concepts like immediate loading. Within an hour, any remaining decayed teeth are removed and replaced with implant-supported crowns and bridges in the belief that the patients will start taking care of their new teeth. Unfortunately, this is not realistic.

In my opinion, this is a ticking time bomb. It is just a matter of time before patients will come back with problems like peri-implantitis and failing implants. Who is going to sort that out? In the good old days, patients had to cooperate first and then we placed the implants. Maybe this was a bit harsh, but success rates were higher then and fewer patients ended up with problems. One does not have to be a rocket scientist to understand that, with a mouth full of pathogens, the success rates will go down.

I have been heavily involved in developing concepts like "Tooth Now", according to which a tooth is extracted and immediately replaced with an implant and loaded with the final abutment and a temporary crown, with extremely high success rates when it comes to both implant survival and even more so the aesthetic outcome. Therefore, I am not against immediate loading at all, but case selection is very important. That is why good training courses conducted over longer periods are so important.

Guided surgery is both, good and bad. The saying of "garbage in, garbage out" is apt in this regard: if one has the wrong information or interprets the digital information incorrectly, one might get into trouble if a fully guided surgical template is based on that. I do not agree with fully guided surgery as it is today, as I believe our brain needs to be connected instead of just computers. Do not get me wrong, I love to work with digital planning tools like NobelClinician (Nobel Biocare) to optimise my treatments, but instead of fully guided I prefer to use simpler surgical and/or pilot bur guides that do not force me to drill in a certain way...

Editorial note: At EAO 2017, Dr Göran Urde presented a paper titled “Evolution of surgical protocols in implant dentistry” as part of the scientific programme.

Dr Göran Urde is the director of the Futurum Clinic at the Malmö University’s Faculty of Odontology in Sweden.