INTERVIEW
with — Dr. Goran Benic

In 2002, Goran Benic graduated with a DMD from the School of Dental Medicine, University of Zurich, Switzerland, and received his doctor medicinae dentium (Doctor of Dentistry) from the same university. In 2016, he obtained the venia legendi (permission to teach as a Privatdozent) for reconstructive dentistry and oral implantology from the University of Zurich. He is a member of the Swiss Society of Reconstructive Dentistry and the Swiss Dental Association.

Q: As a prosthodontic specialist, what is your main goal for a successful treatment?
A: The answer relates to my role as a prosthodontist and dentist and to the medical aspects as a doctor. Basically, for each case, the following aspects, according to importance, are always the same: a healthy oral health situation, function and finally esthetics. The most important thing is to have a happy patient. Generally, when I approach a case, to reach the goal of satisfying the patient's desires, it is very important to define individual needs, which differ from case to case and from patient to patient. The key is to take one's time, especially in the beginning. Interview and listen to the patient and involve the patient in the treatment plan, especially in cases with high esthetic demand, since esthetics is subjective and the perception of esthetics differs from person to person.

Q: What do you do to present the case and treatment options to your patients?
A: Photography is of course always used in the digital part, but in this part, I use the analog method, either by drawing and explanations on the computer or notes on a piece of paper or tablet. The digital key in terms of smile design is not as important. The most important item for me is the mock-ups. Generally, for the second appointment, I prepare mock-ups that are inserted into the patient’s mouth. This is the best possible diagnostic and the most important tool to show to the patient what can be done. This is also associated with a great deal of emotion, in this initial phase. Of course, there are new possibilities with digital smile design tools and so on, but personally I prefer to do something in the patient’s mouth so that he or she can touch it and see it in the mirror.

Q: What is your opinion on minimally invasive therapy?
A: In general, minimally invasive therapy in surgery has been around for many years in dentistry. It was made possible through the use of digital scans, guided surgery for flapless procedures and some others. These were important tools for 3-D diagnostics, which is very important today. We can no longer think about dentistry without 3-D diagnostics, but minimally invasive therapy in terms of flapless surgery was not as revolutionary, since the indications for such therapy are relatively restricted. For the esthetic regions, immediate implantation protocols are not completely predictable when it comes to esthetics. Overall, any type of procedure using invasive methods should not be used.

Q: Implant biomaterials can be essential for the long-term success of implants. What is your opinion, and which ones do you prefer?
A: In the past decades, things have changed. In the beginning, it was advocated that good biomaterials or good bone substitutes need to be completely replaced by new bone. In the meantime, things have changed since the observation that biomaterials that are completely resorbable and are replaced by bone are
associated with an overall loss of bone volume, which means that the rate of resorption is higher than the rate of growth of the new bone. In my opinion, the approach is different today. I chose to use biomaterials with a very low substitution rate, which means that they do not resorb or resorb very slowly in order to retain the volume. It is important to preserve the volume, particularly in the esthetic regions. Generally, this is done by proteinase scintigraphy or by synthetic materials. The best combination in my opinion is the combination of hydroxyapatite with tricalcium phosphate.

Q: What is your favorite instrument when it comes to minimally invasive therapy?
A: Generally speaking, when I think of minimally invasive surgery, of course it is 3-D planning, so cone beam computed tomography (CBCT)-guided surgery. At the moment, I see a lot more development and interest in the minimally invasive prosthetic approach, which I find very exciting. There are no-prep veneers that can be fabricated from different materials, such as feldspathic ceramic and glass-ceramic. It is impressive that we can achieve beautiful results with less anesthesia, less pain, less need for provisionals and less invasive therapy. I can only see advantages with minimally invasive therapy.

Q: What is the esthetic challenge in implant dentistry?
A: The greatest challenge is definitely the predictability of the pink esthetics. The challenge is the prediction of the interaction of the hard tissue and soft tissue. The key is the correct risk assessment in every single case, the correct treatment planning. We also have to keep in mind that the surgical way is not always the best and the most predictable way. For example, in a high-risk situation, one should rather consider a prosthetic option. Let’s use the example of a large tooth in an esthetic region. This is a high-risk situation and proper assessment needs to be considered. It might be more predictable to use a prosthetic solution that proposes the use of pink ceramics instead of a staged surgical approach. In summary, the challenge is the predictability of the pink esthetics and performing the correct risk assessment and the correct treatment planning.

Q: What makes hands-on courses such as the Tribune CME Clinical Masters Program so special when it comes to promoting expertise in esthetics in implant dentistry and the digital workflow?
A: What really makes a difference in medicine and dentistry are the small details, tips and tricks that can only be taught in practical courses.

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