Dear reader,

If the recent International Dental Show in Cologne has shown us one thing that the dental industry is doing surprisingly well and that dentists, at least in Europe, are still willing to invest largely into new equipment.

What it also demonstrated was that digitalisation in dentistry has developed further and found its way into other fields beyond dental CAD/CAM. While this, let’s call it evolution, promises much easier diagnosis and treatment, it will also require dentists to constantly gain more education and to acquire new skills.

Unfortunately, it also holds the danger of dentists becoming too dependent on technology and part of their expertise into corporate hands. There is an increasing number of high-end systems being launched onto the market that clinicians probably never be able to use and understand thoroughly. Who is to blame when a diagnosis fails?

Technology is a good thing but its benefits should not hide the fact that the profession still requires skill and critical thinking. These cannot be replaced by a push of a button.

Yours sincerely,
Daniel Zimmermann
Group Editor
Dental Tribune International

“Let’s take a look at your gums”

Crisis in endodontics

There has been an alarming increase in the number of retreatments of endodontically treated cases recently – I have even heard that an endodontist proudly proclaiming that he performs many retreatments for failed root-canal cases. Having practised endodontics for more than three decades, I know that if the basic principles of endodontic treatment are adhered to, the majority of root-canal-treated cases can remain asymptomatic for many years.

There are two aspects to the crisis we are facing. First, working width has become a totally forgotten dimension. In the past, we only had stainless-steel hand instruments with which to work and attempts were made to enlarge the canals to at least a size 55 or 40. The current trend is to stop instrumentation at a size 20 or 25 tip with tapered rotary NiTi instruments and perform a single-cone situation. A science-based treatment protocol is replaced by corporate-dictated norms that go against all the principles of surgical treatment, which prescribes the removal of all infected dentine from the root-canal walls, particularly in the apical third. It is non-ethical not to address the biologic width because there are now instruments that can help us do it. I was shocked to hear a University of Pennsylvania staff member recently advocating size 55 for all canals.

The second aspect is that the number of years for which an endodontically treated tooth remains functional in the oral cavity is seriously decreasing. This is due to the stripping of critical healthy cervical dentine owing to the use of instruments with larger tapers. An increasing number of patients are therefore returning to their dentist with horizontal fracture of the root-canal treated and crowned teeth at the cervical area.

For how long can we remain complacent about this deteriorating situation? It is time that the profession sets things right and lead less-experienced dentists back to the correct path.

To the Editor

Re: “Study suggests dentists cause implant failure” (Dental Tribune Asia Pacific, Vol. 10, No. 11, page 7)

The implant failure rate for two surgeons involved in the study (with > 5 years of surgical experience) was 2.4 per cent (two of 85 implants), whereas the remaining 18 surgeons (those with < 5 years of surgical experience) incurred an implant failure rate of 12.2 per cent. This particular observation can be explained by the fact that the 18 less experienced surgeons were graduate students with minimal implant surgical experience.

Dentists generally do not cause implant failure. But implants placed in immediate loading protocols for completely edentulous patients by inexperienced dentists experience higher failure rates.

Prof. Jaime Lazado,
11 November 2012

Contact Info

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