What’s the worst that can happen?
Michael Sultan discusses treatment planning

When I was young, my mother – bless ‘er – always used to say to me, “Michael, you should always ask a girl to dance – after all, what’s the worst that can happen? She can only say no!”

Oh how wrong she was… Children can be very cruel sometimes, and as a shy young man growing up into the world I learnt, as I suspect many of us have over the years, that my mother was wrong, and her philosophy of always asking a girl to dance would on occasion lead to my complete and utter humiliation.

Advice
But now, many years later, in my work as a dentist I do still find myself thinking about my mother’s advice, and that age-old phrase, “what’s the worst that can happen?” Though obviously used in a completely different context, I do find it an interesting phrase, and one that particularly applies to the process of treatment planning.

As dentists, sometimes we are involved in doing a treatment that if it fails could have a worse outcome than the second option that may be less desirable for the patient, but safer. Unfortunately, we can’t always avoid it. It may be the case for example that the patient can’t afford to pay for a replacement, or health and age factors mean they are unsuitable for alternative procedures. In some cases it may even be something as simple as the patient is adamant they don’t want to lose their tooth.

In endodontics I can think of numerous instances where a patient’s call for a “heroic” procedure can sometimes lead to the result being far worse than the initial complaint. If it works, then great – amazing – you’ve saved a tooth that most dentists would have signed to extraction. If it fails, however, then even extraction may have been a better option long term.

A good example of just this type of risky procedure might be apical surgery on a tooth with both an uncertain prognosis and a failing endodontic procedure. The surgery may involve removing a lot of buccal bone that may make an implant harder to do later should there be no healing.

**Herodontics**

Though the above may be a fairly straightforward example of “herodontics” there are other, less clear-cut cases as well. Sometimes we will be called to attempt herodontics to try and prolong the life of
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extensive and expensive treatment, such as resecting roots and teeth from larger bridges to keep the restoration going for longer in an elderly patient. Often we know that it’s a compromise – it’s fairly obvious what we’re waiting for!

With an aging population and life expectancy ever-increasing, compromises that we may have once made in a 65 year old we may now have to make in an 85 year old instead.

With patients on average living a lot longer than in the past, I do find myself increasingly dealing with patients in their 70s who ask me if it’s worthwhile spending money on a complex and risky endodontic procedure when it may be cheaper and easier just to have the tooth out instead. This poses something of a dilemma. If the patient were in their 50s say, you could outline with some degree of certainty the advantages and disadvantages of having a fully restored natural tooth for the next 20 years, as compared with a large gap. To have this discussion with a 70-year-old however, it may be a case that they will have a gap for a few more years, or they may yet live another 30 or more! The oldest patient I’ve treated for root canal therapy is 100 and she certainly didn’t want her tooth out!

**Genetics**

This then brings me on to the question of genetics. Before attempting herodontics to try and salvage a dodgy tooth, maybe we should ask the patient questions about their family background. Are their parents still alive? How old were their parents when they passed away? Though somewhat morbid, these sorts of questions may well help to gain a rough idea of life expectancy and whether to go for a compromise now and regret it later (in say 10 years’ time when the patient really is elderly), or to bite the bullet and do definitive treatment whilst the patient is fit enough to manage long periods in the chair but also to heal clinically.

When heroic procedures work, they can be fantastic; they can give a great feeling of satisfaction to the clinician and of course the patient benefits by retaining their tooth. But these things must be taken in careful consideration. Heroic procedures “beyond the normal call of duty” don’t always work, and if they fail, then sometimes the outcome will be worse than the initial complaint. For this reason we should always carefully weight up the risks, consider all the possible implications, and ask ourselves very seriously, “what’s the worst that can happen?”

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**About the author**

Dr Michael Sultan BDS MSc DFO FICD is a Specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy’s Hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPD, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008 he became clinical director of EndoCare, a group of specialist practices. For further information please call EndoCare on 020 7224 0999, or visit www.endocare.co.uk