

# RESPONSE TO EDITORIAL ON AN AAOMR POSITION PAPER

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**In their editorial**, Drs. Mufson and Ragan use the cliché “If all you have is a hammer, everything looks like a nail.” One might rephrase this as “If you are an oral maxillofacial surgeon, all you need is a panoramic.” In dentistry, unlike medicine, there is little evidence of science for some of the procedures we perform, and certainly very few precise protocols for those procedures. Unfortunately, dentistry is still more art than science. Some have even stated that “evidence-based dentistry” is really an oxymoron (the juxtaposition of two contradictory terms).

The two authors assert that the AOMOR position paper authors “failed to account for the fact that the overwhelming majority of dental surgical procedures performed on a daily basis, including removal or exposure of impacted teeth, sinus lifts, bone grafts, and yes also dental implants—especially in the hands of those with adequate training and experience—are performed successfully without the need for 3-D imaging”. It should be noted that none of these procedures, except implant imaging, requires any true level of precision. Oral maxillofacial surgeons can, because of their training in nature of their specialty, adequately perform flap procedures remove or recontour bone, and perform sinus lifts without precise measurements. Many, unfortunately, also think they can precisely and accurately place single or multiple implants with only a panoramic and “their hands.” It is sad to think that when an imaging modality such as CBCT is widely available, extremely precise, and capable of reducing patient morbidity from an implant procedure—even a single implant placement—and is not used<sup>3</sup>, and clinicians still think they do not need it.

Having examined the data volumes of over 13,000 CBCT cases, I can tell you I’ve seen hundreds of implants placed in locations, causing patient problems, which could have been avoided by simply using a better imaging modality than a panoramic. I’ve also been challenged by specialists who claim that there is no “case law” to prove to us that harm to the patient could have been avoided by using CBCT. While this is an accurate observation, it bears no resemblance to reality. There is no case law because these malpractice and negligence cases are settled out of court<sup>1</sup>. No dentist or dental specialist wants their name in the National Practitioner Database with a judgment against him or her for failing to use proper and appropriate imaging. This is the reality.

I have been involved in five such cases where damages to the patient could have been completely avoided by the appropriate use of CBCT for pre-surgical implant assessment. If I were the patient, wouldn’t I want 0.1mm accuracy, 1:1 anatomic reconstruction, and a surgical guide if necessary? Or would I choose a second surgical procedure because the initial one caused a perforation, parasthesia, or the need for implant retrieval from the antrum?

The authors’ arguments remind me of another quote, uttered in the House of delegates of the ADA, stricken from the record after an “in camera” session by ADA lawyers at an annual meeting on specialization (during the discussion on Oral and Maxillofacial Radiology as a new specialty),

“If we make radiology a specialty, then we (general dentists) will be held to a higher standard of care.”  
—*anonymous general dentist, ADA House of Delegates, year unknown.*

With all that said, I recognize the document was a position paper. The authors of the editorial recognized that “the document would be revisited periodically.” Dentists can choose to use a substandard, inferior imaging modality and “feel their way to success” if they wish. But, I submit, that these practices already increase their risk of litigation. It’s not “if” a mishap will occur—it’s “when”<sup>2</sup>.

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## REFERENCES

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3. Worthington P, Rubenstein J, and Hatcher D: The Role of Cone-Beam Computed Tomography in the Planning and Placement of Implants. *JADA*, 2010, Vol. 141, suppl. no. 3; pp: 19s-24s.