Why Implants Are Retrieved

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As osseointegration becomes more widely utilized as an adjunct to support, retain, or stabilize dental prostheses, we have seen an increase in the number of complications—to the point where what was once uncommon now warrants constant attention and has even become the theme of some scientific conferences. These changes beg the question, "Why are complications more prevalent today than they were 30 years ago?"

The recipe for successful osseointegration requires three key ingredients: the patient, the implant, and the clinician. Thirty years ago, our patients were biologically similar to our patients today; the *Homo sapiens* species has not evolved much in 30 years. Similarly, the oral implant "species" has also not evolved much. Admittedly, the proliferation of implant manufacturers, surface modifications, designs, connections, platforms, abutments, luting agents, and materials has grown, yielding a few new subspecies as the corporate landscape pushes the field forward with great speed, inspiring innovation in order to appease patients and clinicians and please shareholders. Notably, all of today's subspecies present a rougher surface compared to the machined or polished implants of years past.

Although all three ingredients are interrelated, it is the characteristics of the clinician pool placing and restoring implants that has changed, by far, the most in the past 30 years. Whereas the clinician pool was predominantly filled with specialists and/or those with considerable formal training in the use of implants, today, nonspecialists with limited training dominate the "implant dentist" landscape. Today, we have two distinct species of clinician placing and restoring implants—distinct by virtue of key identifying features—their experience, their knowledge, and their competence. It is, therefore, not surprising that we are seeing more complications with implant therapy.

Of course, humans are particularly adept at deflecting blame, and clinicians are no different. When presented with a complication, we often blame the patient or our referring colleague or the implant. Indeed, our standard term for implant retrieval is "implant failure"—a clever and convenient guilty verdict we chose to place against an implant. In all honesty, we should acknowledge that implants do not fail—they are merely retrieved, often as a consequence of our clinical inadequacies.

In the osseosufficiency model, when the combination of patient, clinician, and implant reaches the threshold necessary to promote and perpetuate osseointegration, the foundation for successful therapy has been laid. Osseoinsufficiency, and the complications that ensue up to and including implant retrieval, represents a condition seen with growing frequency. If implants are chosen by the clinician and patients are treatment-planned and treated by the clinician, perhaps we clinicians should not only receive credit when things go well but also accept that we are the primary etiologic factor in unsuccessful therapy.