COMMENTARY

ACHIEVING OPTIMAL ESTHETICS IN A PATIENT WITH SEVERE TRAUMA: USING A MULTIDISCIPLINARY APPROACH AND AN ALL-CERAMIC FIXED PARTIAL DENTURE

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I think there are several aspects of the author's article that merit commentary. First, I congratulate him on identifying one of the major challenges of treating trauma patients: their need to be put back together psychologically. The woman cited in the article obviously underwent significant trauma with the loss of four anterior teeth, and in spite of all of the current advances in dentistry, we still do not have the ability to totally replicate the hard and soft tissue loss and tooth replacement for a patient with a defect as severe as hers. It is critical, as is pointed out by the author, that all practitioners recognize that patients need to be advised in advance that there are significant limitations to what can be done, and that we will do our best but there will likely be some compromise, specifically in soft tissue levels and almost certainly in papillary levels.

I also appreciate the author identifying the necessity to bring other disciplines to the management of a patient such as this. Often I see practitioners who attempt to develop a treatment plan that will allow them to try and correct a patient's problems by themselves with restorative dentistry or, once in a while, with soft tissue removal procedures. Patients such as this cannot be treated without an interdisciplinary approach. Patients with debilitative problems should see all the treating specialists and the restorative dentist prior to treatment. Moreover, the treating practitioners must generate an integrated treatment plan whereby everybody is involved from the beginning, with the sequencing, timing, and responsibilities well defined. It is critical to avoid the patient being sent to one specialist, who makes decisions and performs treatment, and then subsequently to another specialist, who makes his or her own treatment decisions, and so on. What often happens in such a scenario is that the patient returns to the restorative dentist, the other specialists wash their hands of their treatment, and the restorative dentist is left with a result that is not manageable. In many respects, that is what happened with this patient in the first phase of her orthodontic care.

Another aspect I would like to discuss relative to the clinical treatment options listed in this article is that the patient was given both options, one involving a fixed partial denture and ridge augmentation, and the other, soft and hard tissue augmentation with implants. I think it is important that readers recognize that had the author and the patient opted for the soft and hard tissue augmentation and the two implants side by side, the soft tissue result would have been significantly deficient relative to the interproximal tissue, in particular. And, with a significant defect such as this one, the most predictable result is the soft tissue augmentation and the fixed partial denture.

We certainly have more and more biologic information becoming available on the limitations of interimplant papillary heights above bone, and also significant data on the limitations of trying to vertically augment bone in a site such as this. Overall, I commend the author for both his recognition of the psychological problems with which the patient presented, and his choice of treatment plans and management. The final photograph of a beautiful smile is indicative of a very pleased patient.

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