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Interview with Dennis P. Tarnow, D.D.S.

by Dennis P. Tarnow, D.D.S.
John F. Weston, D.D.S

Dr. Tarnow is Professor and Chairman of the Department of Periodontology and Implant Dentistry at New York University College of Dentistry. He has a certificate in periodontics and prosthodontics and is a Diplomate of the American Board of Periodontology. Dr. Tarnow has published numerous articles on perio-prosthodontics and implant dentistry and has lectured extensively both in the United States and abroad. He has a private practice in New York City.

Dr. Weston graduated in 1989 with OKU Honors. A commissioned officer in the U.S. Navy, he completed a hospital GPR in San Diego and served two years in support of Desert Storm. Dr. Weston earned his AACD Accreditation in 2001. He is a member of the AACD's Board of Directors and is an Accreditation examiner. Dr. Weston's practice emphasizes cosmetic dentistry and smile design. He is owner and director of Scripps Center for Dental Care, a multispecialty dental center in La Jolla, California.

The goal of this section is to provide insights into the thoughts and perspectives of some of dentistry's premier educators. In this issue, AACD Conference Advisory Chair Dr. John Weston (JW) interviews Dr. Dennis Tarnow (DT). Dr. Tarnow is scheduled to present at the AACD's 23rd Annual Scientific Session in Atlanta on Friday, May 18, 2007. For more information regarding Dr. Tarnow's presentation, log onto www.aacdatlanta.com.

JW: *Dr. Tarnow, you are one of the most influential teachers in the history of our profession and your name and research have become the gold standard for ideal esthetics and proper tissue management. Can you share any predictions you have about the future of esthetic dentistry?*

DT: The future of esthetic dentistry is very bright. The two fastest-growing areas in dentistry today are esthetics and implants. These two areas have grown at unprecedented rates over the past five years and will continue to do so for the near future. With baby boomers wanting to look and feel better and younger, it is clear that we are in the right profession at the right time.

JW: *Creating ideal esthetics involves the skills of multiple specialists. What advice can you offer about assembling a team and then sequencing patients for the best esthetic results?*

DT: I know that the AACD is composed mostly of general dentists. I think it is critical for each practitioner to be honest with himself or herself; they must know what they do well and where they need help from some-

one who has more training. This often is the hardest thing for someone to do; it requires self-assessment and a level of honesty that is extremely difficult due to our own prejudices about ourselves. A great team is imperative when handling sophisticated complex cases. An excellent generalist must have specialists in periodontology, oral surgery, orthodontics, and prosthodontics. Whether it is to check on the accuracy of one's treatment plan or to perform some of the work, it is critical to have people that can validate or be part of a treatment plan.

JW: *The more we educate ourselves about dental implants, it becomes obvious that there are many differences in philosophies, systems, and clinical approaches. In general, what methods or techniques do you believe help establish the best tissue esthetics, and why?*

DT: I always choose methods based on the "keep it simple, Stupid" (KISS) principle—I say that to myself all the time! That means that we should choose the most straightforward technique possible, without giving up any quality, to do the case. Simply put, it is not always the most difficult and complicated treatment that is the best. It also means that if you have something that looks good when you start, then whatever you do, try not to disturb it while you are fixing what is wrong. An example of this would be using papilla-saving incisions when they are in perfect shape.

JW: *There appears to be a trend that encourages tooth reduction and tissue contouring in an effort to solve cosmetic problems. How best can we incorporate orthodontics as an alternative to help achieve ideal tissue esthetics and conserve tooth structure?*

DT: There is no question that tooth reduction and tissue sculpting have a strong place in esthetic dentistry. However, like anything else in life, too much of a good thing is not always the way to go. I am very sad when I see patients who have had facings put on that looked better than their original teeth for a short time, but then started to show the periodontal problems due to overcontoured restorations. Swollen papillae and beefy-red tissues are not the result you want from a "quick fix." Orthodontics should be performed when the clinician thinks that the contours after reduction and tissue shaping will still not be cleanable. The diagnostic wax-up and try in are critical in this decision and should be used on every case. Invisalign® has certainly made this a little easier for patients as well.

JW: *It is obvious that technology has become an important part of our practices, and that virtual placement of implants seems to be the wave of the future. What are your thoughts about the advantages or disadvantages of computer-assisted implant placement, and how these systems can help create a better outcome?*

DT: Computer-assisted implant placement is fine, to an extent. However, the problem with trying to do teeth in an hour is that the position of the implant may be different from what was designed on the computer. This is because the angle of the implant may be similar, but the vertical height of the top of the implant may be different. This can occur because just one more (or less) turn of the implant screw will change all of the relationships to the adjacent teeth and implants. Therefore, rather than using computer-assisted placement for final bridgework in an hour, it should be used only for temporaries in an hour. This way, the clinician can make adjustments in the esthetics and phonetics if necessary. There also is a problem with putting in a big case with the final bridge, because if one key implant does not integrate, then the entire case (including all of the laboratory costs) will have to be repeated. Another problem is that if a tissue punch is used through the surgical template, it does not allow the clinician to put the tissue in a more coronal or apical position around the abutment. In addition, it takes away a beautiful piece of keratinized tissue that you may wish to have back if there is not much of it to start with. Computer-assisted placement of temporaries in an hour is the way to go.

JW: *It is well known that periodontal health and occlusion are interrelated. Can you share your views*

about the importance of a stable occlusion, and how it relates to esthetic success or failure of restorative cases?

DT: Occlusal stability is always a key to comfort and general stability. If occlusion is off, then the patient may put too much pressure on some anterior teeth. This could cause migration of teeth and opening of contact points; these spaces are clearly unesthetic to most people. All of our cases must have occlusal stability.

JW: *The Academy has a goal to provide "Excellence in Cosmetic Dental Education." Where do you feel we should be focusing our attention to better benefit our members and our patients?*

DT: We should all be focusing on the key biological and biomechanical principles in whatever we do. If we think like a mechanic, rather than in biologic terms, then the case will fail in the long run. We must never forget that we are doctors and that we are dealing with a biological system in which bacteria and occlusal forces are constantly attacking our work.

JW: *Can you give readers a brief preview of the exciting program you plan to present to our attendees in Atlanta?*

DT: The program that I will be giving in Atlanta will bring in both the clinical and biological principles that we must know to achieve consistently great esthetics. It's about all the little things that will add up to make our cases great—both early on and for years to come. I look forward to discussing the things that I have learned over the years to help my patients.

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