



“Letter to the Editor”

AAOMR Position Paper Lacks Foundation, Harmful to Dental Profession

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Note from the Editor: This “letter to the editor” was submitted to the Journal of Oral Surgery Oral Medicine Oral Pathology Oral Radiology.

“If all you have is a hammer, everything looks like a nail.” This familiar expression refers to our common tendency to see the world through our own biased viewpoint. And so it also apparently goes for the American Association of Oral and Maxillofacial Radiology (AAOMR). We could not help but react with surprise and disappointment upon reading the editorial appearing in the June, 2012 edition of the Journal of Oral Surgery, Oral Medicine, Oral Pathology entitled, “Position statement of the American Academy of Oral and Maxillofacial Radiology on selection criteria for the use of radiology in dental implantology with emphasis on cone beam computed tomography.”¹

“...the authors have apparently failed to take into account...the lack of evidence based science demonstrating improved patient outcomes with 3-D CBCT, nor documented harm to patients if not utilized.”

Among a number of questionable statements and opinions found throughout the document, one prophetic proclamation stands out as an obvious misconception to those who practice clinical dentistry on a daily basis. Found in the abstract portion of the paper, the AAOMR recommends that “...cross-sectional imaging be used for the assessment of *all* dental implant sites and that CBCT is the imaging method of choice for gaining this information.”

However, the authors have apparently failed to take into account a number of important facts in reaching such a conclusion. Paramount among these would be the absence of controlled studies or data to support the advisory opinion. Despite the lack of evidence based science demonstrating improved patient outcomes with 3-D CBCT, nor documented harm to patients if not utilized, the statement is nevertheless made for the world to accept and to live by as if it were

proven and authenticated doctrine.

The authors also fail 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, and without the need for 3-D imaging.

A typical implant site with an obvious lack of bone on the facial aspect, as one example, does not require 3-D imaging to impart the knowledge that a bone graft is required on the facial aspect. Simple inspection and palpation, as well as direct visualization during surgery is more than adequate to acquire this information. Conversely, a site with obvious sufficient ridge width, height of bone above the inferior alveolar nerve, or beneath the sinus floor, does not require 3-D imaging.

Adequate appreciation for the location of the mental foramen or the nature and extent of the lingual concavity of the mandible is also not “rocket science,” nor should it require 3-D imaging science, as such structures are readily apparent to the adequately trained and experienced clinician.

Clinical exam, adequate 2-D imaging, appreciation of anatomy and proper implant techniques, thorough planning and communication with the restorative dentist and/or well-made guide stents have proven to be more than adequate for clearly *most* implant sites or cases, without the need for the added radiation and cost of 3-D CBCT.

Perhaps what is most striking to those reading the AAOMR paper is the choice of the word, “*all*,” and the phrase, “*all implant sites*.” It is most interesting that in a 2000 AAOMR position paper, “some form of cross sectional imaging” was

recommended for “*most* patients receiving implants.”² In the span of just over ten years, however, the advisory opinion has been inexplicably elevated from that of “*most...implant patients*” to “*all implant sites*.” However, this change was apparently made with no rationale nor scientific evidence to justify it other than the “increased use” and “availability” of CBCT.

Of equal or greater concern than the missing science in such claims, and especially when published in the format of a position paper, would be the resultant negative impact it may have on the entire dental profession from a purely legal perspective, while imparting a potentially harmful message on several levels.

Among these include the implied concepts that (1) we, the readers, may be misled to believe that unless each of us purchase a CBCT for our practice and/or fail to use or offer the study for myriad procedures, and most notably in this case, dental implants, we may be practicing beneath the standard of care, negligent, and/or at a higher risk for being success-

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fully sued, (2) plaintiff attorneys are provided an unprecedented new arsenal of ammunition to use against us in the courtroom, and as a result, (3) our own defense attorneys are left unable to defend us should we experience a negative patient outcome in the absence of our using this particular technique, which others have inferred or implied – no matter how unjustly or wrongly so – as being tantamount to “standard of care.”

Although an advisory opinion or “guideline” promulgated by a dental specialty trade organization, such as AAOMR, is not the legal equivalent of a “standard of care,” the dental profession is placed in a position of significantly higher risk of plaintiff attorneys being all too happy to interpret and present it as such to others, especially in courts of civil litigation to unknowing and unsuspecting lay juries.

This same legal concern has been the subject of recent liability carrier seminars attended by defense attorneys from around the country, in which articles circulating in our dental literature with similar messages have been singled out and criticized (including at least one cited as a reference in, and another by one of the authors of, the AAOMR paper) as inaccurate, harmful to dentistry, and clearly, they would be legal efforts of our defense attorneys.³⁻⁶

Credible information was shared in the seminar presentations which (a) questioned the necessity of, or increased benefits derived from, CBCT for the majority of clinical or surgical applications in dentistry, especially when weighed against increased radiation risks and cost to patients, (b) questioned the paradigm shift toward CBCT, simply because it has become more widely available, and more strongly marketed to dentists, and (c) questioned the motivation of proponents of the “CBCT-as-standard-of-care” position.

Leading academicians have questioned the pendulum of dental imaging swinging so rapidly toward 3D CBCT. Vincent Kokich, Chairman of Orthodontics at the University of Washington, and among the specialty’s most highly respected teachers and mentors, wrote an editorial in a leading refereed orthodontic journal questioning whether we have “truly identified the ...benefits of 3D imaging,” especially when weighed against the added radiation risks and cost, or whether proponents’ claims that the information gained exceeds that of conventional imaging in a meaningful way so as to improve patient outcomes.⁷

Granted, there are, no doubt, many new and emerging technologies used today in medicine in dentistry - including 3-D imaging and CBCT – which are truly *invaluable* adjuncts in diagnosis, treatment planning, and patient care, when indicated for select cases.

However, to categorically opine that it be used for “*all*” cases? One cannot help question the extent to which this “misguided guideline” is based on documented scientific knowledge as opposed to the self-serving interests of a few “hammers” in search of the proverbial nail.

We feel it is the responsibility of organizations representing specialties of dentistry, such as AAOMR, to put forth information which can be assured as verifiably accurate, while steering clear of proclamations which may pose unforeseen risks or harm to others who practice within our dental profession.


A small glimmer of hope may be found in the final statement within the opening abstract of the AAOMR paper. “This document will be periodically revised to reflect new evidence.” One can only hope that this process will begin now.

Continued on next page “References”


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