THE PITFALLS OF DENTAL TOURISM

Written by **Dr M K Vasant**

Oops, it went up the nose and the bite is wrong! Manny Vasant looks at some sobering dental tourism stories

This article may be a useful tool for communication with patients who may be planning to travel abroad for dental treatment and particularly for those who seek opinion of UK dentists regarding their intentions. In this context, it may also be useful to refer to my article in next month's *Private Dentistry,* 'Success and Survival of Implants.'

Patients sometimes return from abroad with dental rehabilitations carried out in a short time period. Naturally patients are attracted to much lower costs and/or claimed expediency to carry out these procedures, whilst they also have a holiday in the sun. Without sounding condescending, it is fair to see that there is general consensus amongst my peers that while we see some excellent and good dentistry carried out abroad, a proportion of the work that we see amongst these 'dental tourists' is poor. It is quite possible that these tourists are attracted to this unique group of dentists at these tourist resorts where the emphasis seems to be on quick turnaround times rather than the quality of care.

At several international conferences, the author has had the pleasure of meeting dentists from some of these countries. It is appreciated that many responsible dentists from these countries are equally concerned about these infamous dentists with rushed and egregious treatment plans.

DR MANJUL (MANNY) K VASANT MBE
MGDS RCS (Eng), MGDS RCS (Edin), FFGDP (UK), FDS RCS (Edin)
Dr Vasant has worked in general dental practice since 1973 and is a registered Specialist in Prosthodontics who has given national and international lectures in restorative dentistry. He is a case expert for the General Dental Council and an examiner for various RCS Edinburgh and England examinations. He was awarded an MBE for services to dentistry in 2001.
WEBSITE: www.mkvasant.co.uk

This is not to say that dentists in the UK are superior in any way, and that all is always well in the UK. One only has to look at the GDC cases to know otherwise.

THE DRAWBACKS

First and foremost, by its very nature 'tourists' are going to in these countries for a short while. Hence there is a pressure from both parties to deliver the end product in a rush. As a result of this need to deliver the dentistry in short time scales, sound treatment planning and basic tenets of natural healing are often ignored. Needless to say, the dental tourists do not seem to have received the basic documentation, that UK regulators would consider mandatory for informed consent.

Secondly, intrepid dental tourists are probably not informed that complex dentistry is not a one-off commodity to be purchased. It is a service, which may be subject to repairs, and certainly will need regular professional and home maintenance. After all, one would not choose to buy a product if servicing was going to be an issue especially if the part was bolted into one's body and likely to cause biological problems, would they? When things go wrong, it may be more problematic and traumatic to remove these objects from the patient, as shown in the examples below.

Thirdly, in contrast to very robust General Dental Council regulations that exist in the UK to protect patients, dental tourists may not be afforded any protection whilst receiving dentistry abroad. And even if there is any protection, tourists may be not be familiar as to how to access it, particularly due to their limited stay at these places and also due to the language barriers when things go wrong. Dentists in the UK may therefore take solace from the knowledge that despite perceived over regulation by the profession (which urgently needs addressing as it is hurting the profession and patients alike), at least for our patients, there is a silver lining!

Finally and quite understandably, dentists and patients alike are beginning to experience that NHS trusts (for budgetary reasons) may refuse to undertake remedial treatment for those patients caught up in this predicament.

THE REALITY

The cases that we have documented here are from countries where it appears that regulation of dentistry is either non-existent or quite lax. The remit of this article is to show problems with dentistry carried out abroad so the author makes no apology for omitting to show any excellent work from abroad. This could be a separate article.

As discussed earlier, occasionally patients may ask for his/her dentist's advice prior to considering treatment abroad. On one occasion, the author had a phone call from a patient who having had a treatment plan from author's practice called from abroad requesting us to explain to his dentist (abroad) how to manufacture a milled crown (smart crown) to retain a chrome denture!

On separate occasion, a patient, having had a treatment plan from the author's practice, received treatment abroad and then returned to with multiple post-operative complications (see case 4). Quite innocently, he then asked if we could up write a rescue plan so that his new dentist abroad could put things right, as he would be prepared to do it for no fee! It would appear that the adage 'Once bitten, twice shy' does not have universal acceptance!

First and foremost, it is important for patients to recognise that dentistry - and in particular complex dentistry such as root fillings, crowns, bridges and implants - can have complications, whether done abroad or locally. Careful planning and managing patients' expectations are a very important part of the treatment. Patients must have a clear understanding of not only the risks ▶

and benefits but must also appreciate the shared responsibility between the clinician (sound planning and delivery) and the patient (maintaining good hygiene and returning for regular reviews) in the successful outcome of any complex dental treatment.

Hence, the advice to the patients to undergo this sort of work must be to seek a clinician within their easy access. After all, for implant cases, for example, screw loosening and de-cementations are not uncommon events, particularly during the temporisation stages. (The author hastens to add that it would be equally foolhardy to seek such complex work in the UK whilst a tourist here.)

On the other hand, routine treatment and emergency treatment where minimal complications are likely to happen or for reversible treatments, such as dentures, it may not be much of an issue and may indeed be beneficial. This is assuming that the health and safety aspects and infection control standards are on par with that in the UK.

The biggest problems are with elective and invasive procedures such as root canal treatments, crown preparations (where tooth tissue such as enamel, dentin and pulps may have been compromised) and dental implants, which are in the main irreversible.

CASE EXAMPLES

Here are some examples of cases we have come across where things have gone wrong. Recurrent themes that emerge in these cases are:

1. Lack of treatment to control primary disease (gum disease and caries) prior to embarking on complex elective treatments such as implants and bridges.
2. Total disregard for violation of important anatomical structures. It appears that patients are totally oblivious of the potential risks. And, when this has happened, they have not been informed about the mishap and possible sequelae.
3. Poor treatment planning particularly as regards to the biological costs to the oral tissues (ie indiscriminate elective root fillings and crown preparations).
4. Linking too many crowns and generally over-prescription of crowns. Amongst some dentists, there seems to be a misconception that linking several units is beneficial to the dentition. In reality, research shows that splinted units (other than for well designed bridges where this is unavoidable) hinders interdental cleaning and prevents diagnosis and treatment if one of the units becomes de-cemented in future. This is also more likely to happen in multiple units are linked together where there is differential mobility of units during function, for example, anterior teeth linked with posterior teeth.
5. Poorly designed restorations as regards cleansability: such as ridge-lap pontics particularly where acrylic has been used as a veneer material; or using unglazed porcelain to oppose natural teeth, which may contribute to gross wear of the opposing teeth.
6. Little or no attempt to teach the patients self-administered plaque control, particularly interdental cleaning.
7. Lack of diagnosis of obvious pathology or any attempt of treatment when things have gone wrong, for example, periapical pathology, bone loss and peri-implantitis.

CASE 1

(Figures 1-4)

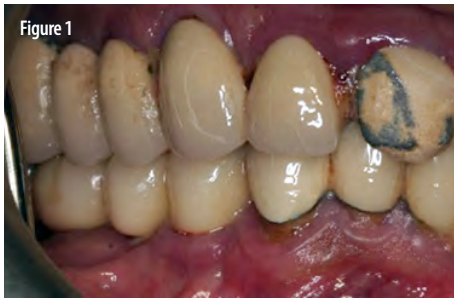
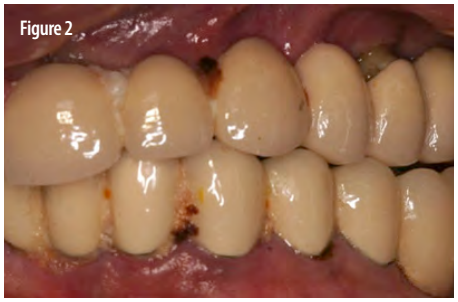


Figure 1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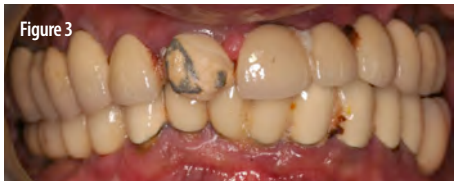


Figure 3

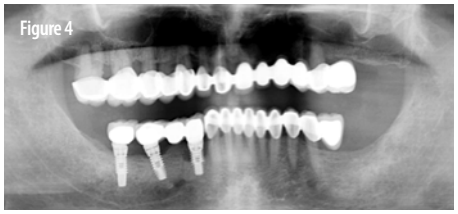


Figure 4

This patient went abroad after a routine examination with the author when periodontal treatment had been recommended prior to discussing any replacements for the missing teeth. No restorations were deemed necessary as such. Yet the patient returned with this scenario a few months later, whereby every single tooth had been electively crowned! The patient was in a lot of pain, particularly in the LR quadrant due to peri-implantitis and possible invasion for the ID canal. As can be seen all the teeth have been restored with crowns and linked together. Also as evident in the photographs, it is impossible to clean the teeth. It is hardly surprising that the periodontal health has deteriorated.

There is consensus view in literature that with long-span multiunit castings, there may be poor marginal fit due to distortions within the casting. This may then lead to potential problems of the pulp. Furthermore, flexure of the metal may result on chipping of the porcelain (as in this case).

CASE 2

(Figures 5-6)

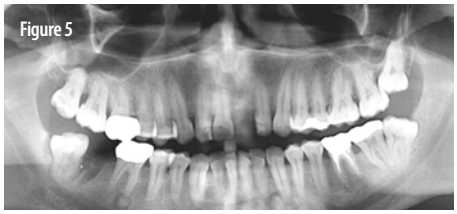


Figure 5

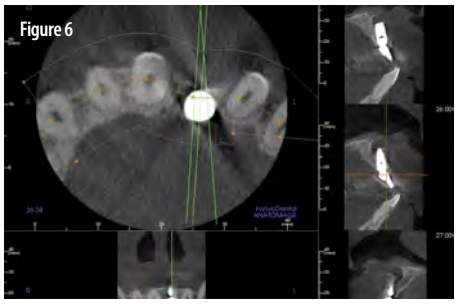


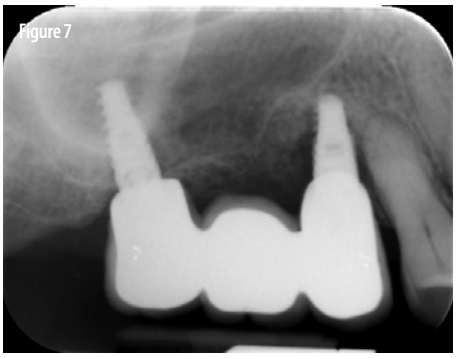
Figure 6

After consulting us (figure 5 shows a preoperative OPG), the patient went abroad and returned with a poorly placed implant. The preoperative photographs and radiographs suggest that this should have been a straightforward placement, as there is adequate bone volume. Unfortunately, due to inadequate planning and poor angulation, the implant encroached the nasal cavity (piriform fossae of the nose). The patient could palpate the bulge in the nose.

Preoperatively, the patient has a Class 1 relationship of the incisors. Due to poor positioning (as evident in the CBCT view) even with a severely angled abutment, at best the implant could have only been restored in a cross bite relationship. Apparently this relationship adversely affected his speech and the patient could not close the mouth properly. Hence, the crown had been removed soon after. Unfortunately, during the removal process, most of the abutment, including screw head, had also been ground down. This aggravated the situation as it would now complicate the removal of the rest of the abutment. The only real solution is leaving the implant unrestored (after removing the abutment using a 'rescue kit') or an explantation. Explantation of the implant

may also pose a serious risk of a oro-nasal fistula. Quite understandably, the patient is in no rush to seek remedial treatment although he has a missing tooth.

CASE 3
(Figures 7-9)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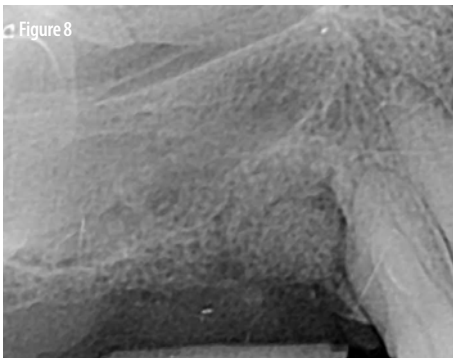
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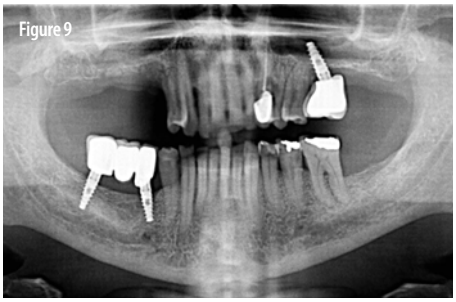


Figure 9

This patient was referred to the author with acute pain at UR5-UR7 site by his GDP. As visible on radiographs, the implants provided abroad during his shot stay had perforated into the antrum on both sides. Note that UR6 was placed where there was no vertical height available due to a low antral floor.

UR implants were removed and simultaneous surgical closure was undertaken to prevent a chronic oro-antral fistula. The patient has received intensive deep scaling and instructions of self-administered oral hygiene. Happily, the upper right quadrant has since healed uneventfully. UL6 implant has also invaded the sinus floor and has got peri-implantitis. In the LR quadrant both of the implants supporting the bridge have peri-implantitis. Therefore, in due course the rest of the implants are due for explantation.

CASE 4
(Figures 10-13)

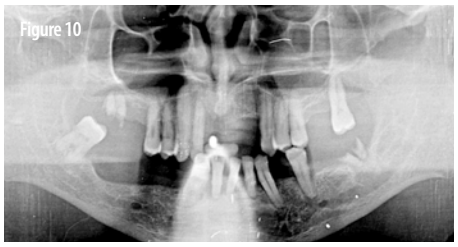
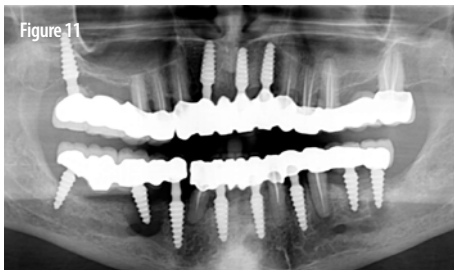


Figure 10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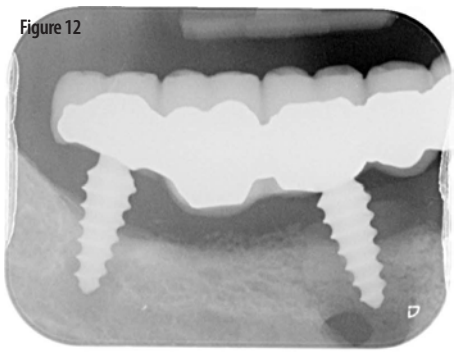
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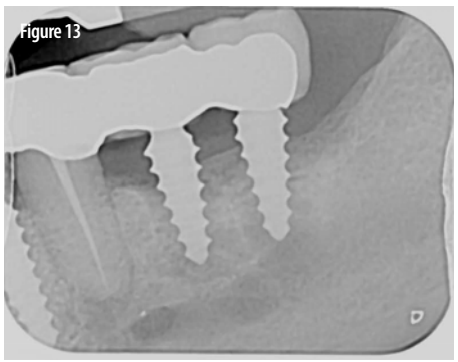
Figure 13

This patient has a history of diabetes and had raised blood pressure controlled with calcium channel blockers. Following a consultation, the author had recommended that he restore his oral health and gingival health before planning any implants.

Sadly, a year later he returned with various problems related to a full-mouth rehabilitation carried abroad in space of few days. Clearly the dental treatment had been rushed, without any reference to his diabetes and his medication (Calcium channel blockers are known to affect periodontal health). Clinical examination and post-operative radiograph revealed advanced and ongoing periodontal disease (deep pocketing), peri-implantitis of all the implants, suboptimal root canal fillings (most of which appear to have been done electively) and splinted crowns hindering plaque control.

As any dentist would be able to see, the remedial treatment would be extremely complex and expensive.

CASE 5
(Figures 14)

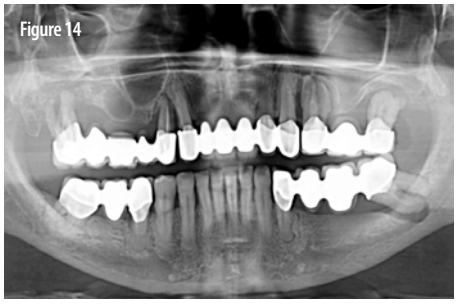
Figure 14

This patient returned to us about a year after having the treatment abroad. Clearly there was a lot of heroic dentistry without controlling primary disease first. There is evidence of gross periodontal disease with advanced bone loss and peri-apical pathology.

CASE 6
(No images supplied)

A patient returned for remedial treatment for implants placed abroad which were causing pain and his gums were feeling sore. On examination, in the edentulous upper jaw, eight poorly planned implants with little surrounding bone were noted. The lower anterior teeth had received splinted porcelain veneers - something we have never come across before!

SUMMARY

Our ethical, legal and moral responsibility must be to guide patients properly when faced with such questions. Unfortunately, there are many advertisements selling implants as quick fix for all dental problems, so-called 'teeth in day'.

There is no doubt that whilst there are cases where immediate placement and loading is indicated, 'teeth in a day', is still a misnomer because several appointments would and should have been made for diagnostics and for obtaining a valid consent. Besides, like any other restorative dentistry, the primary objective must be to remove primary disease first and to inform patients of the maintenance therapy, which forms an essential part of any complex dentistry. ●

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