

Beyond the mystique of fixed prosthodontics

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Dear Editor, The contemporary prosthodontic world has glamorized fixed prosthetic rehabilitation to an extent that it has overshadowed its potential pitfalls.¹ While acknowledging the merits of fixed prosthodontics, the clinical limitations should never be dismissed during comprehensive treatment planning. Unfortunately, this important consideration is completely brushed aside for patient demand and financial incentives under the allure of fixed prostheses.

A systematic review of literature reveals that technical complications occur nearly twice as often in long-span fixed dental prosthesis (44.2%) as that of short-span (24.3%).² Similarly, precautions for placement of dental implants deserve careful consideration especially in certain medically compromised individuals where the implant placement can increase the risk of severe complications such as uncontrolled bleeding and risk of osteonecrosis.³ By the same token, patients with pre-existing neuropathic orofacial pain require meticulous assessment as placement of implants can potentially trigger neuropathic symptoms.⁴ A retrospective study conducted at Agha Khan University Karachi, Pakistan examined the implants that failed within five years, of the 220 implants 7 were failed owing to their placement in deficient bone volume.⁵ Despite the established findings, many patients are subjected to inappropriate treatment at the hands of unethical dentists who give false hopes of fixed teeth in clearly contraindicating clinical scenarios, eventually leading to biomechanical failures and questionable long-term prognosis. Correspondingly many patients with their unrealistic expectations often deter dentists from pursuing a comprehensive treatment strategy, ultimately doing a disservice to their own selves. Regrettably, fixed self-cure dentures are rampant in Pakistan because many patients desire a quick, non-removeable and cost-effective restorative option for their missing teeth eventually making them vulnerable to unqualified practitioners.⁶

The idea here is not incriminate dentists for their

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inappropriate clinical decision-making or patients for their unreasonable expectations out of treatment but to encourage a broader perspective. Patients and dentists should be open to alternative treatment strategies rather than insisting solely on fixed treatment possibilities which in certain clinical cases offer only short-term myopic gains. While fixed prostheses remain the gold standard in many clinical situations, their use must be guided by sound clinical judgment rather than patient demand or financial incentives alone. Prioritising patient centred care, but this should never be at the expense of violating fundamental prosthodontic principles. Remember, violation of prosthodontic principles will inevitably lead to a predictable biomechanical failure.

Clinicians are advised to obtain informed consent with explicit discussion of risks and alternative treatment options, conduct thorough pre-treatment assessments including bone density evaluation, use decision-support tools for patient selection, and prioritise continuing education in prosthodontic principles to ensure ethical, evidence-based practice.

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