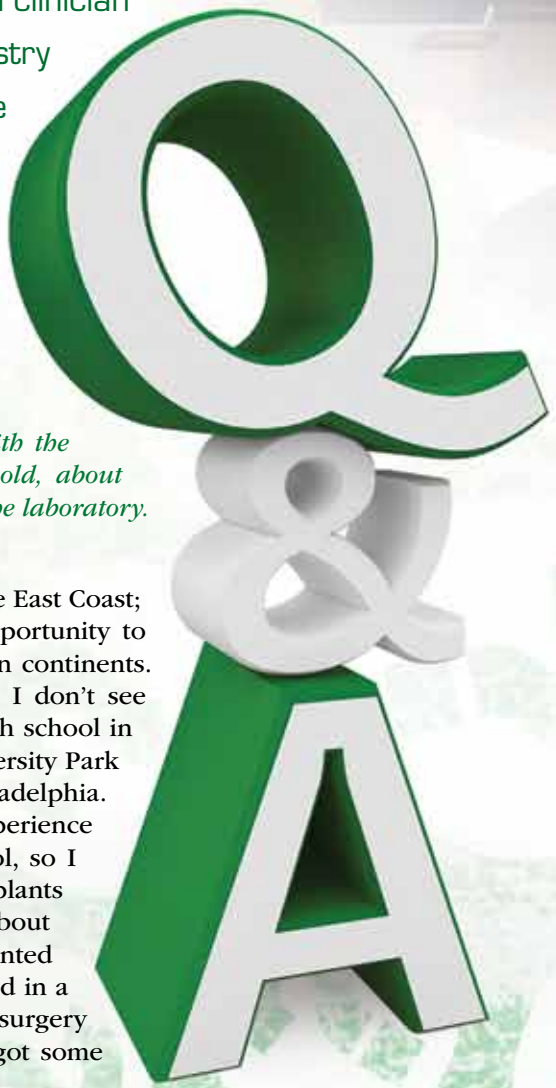
Implant Q&A:

An Interview with Dr. Darrin Wiederhold

Go online for in-depth content

Interview of ***Darrin M. Wiederhold, DMD, MS***
by ***Bradley C. Bockhorst, DMD***

Dr. Darrin Wiederhold is an accomplished dentist and a new member of the Glidewell Laboratories clinical team. In this exclusive interview, he outlines the preparatory steps a clinician can take to successfully incorporate implant dentistry into their practice. He also discusses his experience with the new Inclusive® Tapered Implant System and Inclusive® Tooth Replacement Solution, and shares his vision for upcoming educational courses at the Glidewell International Technology Center.



Dr. Bradley Bockhorst: *Today we will spend some time talking with the newest member of the Glidewell clinical team, Dr. Darrin Wiederhold, about some of the projects and technologies we've been working on here at the laboratory. Darrin, can you tell the Inclusive audience a little bit about yourself?*

Dr. Darrin Wiederhold: Sure, I'd be happy to. I'm originally from the East Coast; a Pennsylvania boy. My dad worked for the CIA, so I had an opportunity to travel throughout my childhood and live in or visit six of the seven continents. I haven't made it to Antarctica yet, but being a lover of the sun, I don't see myself heading that way anytime soon. When I graduated from high school in Indonesia, I came back to Pennsylvania, went to college up in University Park and then to Temple University School of Dentistry down in Philadelphia. When I finished dental school, I had already started to get some experience with implants. I became interested in surgery during dental school, so I started to take some courses to prepare for possibly placing implants as a restorative dentist or, ultimately, as an oral surgeon. I was about 99 percent sure I wanted to do oral surgery when I got out, but I wanted to be 100 percent sure before I made that commitment, so I enrolled in a GPR program up in Buffalo, New York, that had an extensive oral surgery component. I got a chance to do a lot of trauma cases and even got some

early exposure to implants there. I decided that it was absolutely what I wanted to do. So, I applied and was admitted into an oral surgery residency program at the University of Kentucky at Lexington. I was there a year and had just finished my intern year when, for personal reasons, I had to withdraw from the program and take some time off. Two years later, I came back and did a second year of GPR down in Kentucky as their chief resident. So I had an opportunity to do about three years of additional training after dental school.

BB: *That brings up an interesting question. There's a lot of interest among general dentists in starting to place implants. I think just like doing any other kind of procedure, whether it is wisdom teeth extractions, root canals or ortho, you have to make sure you're well trained, confident and competent before you start doing it. Now, they don't necessarily have to go through two GPRs and an oral surgery residency, but what are your thoughts as far as what general dentists should do in preparation for starting to place implants?*

DW: I don't know that they need all of that additional training, but you do want more than just a weekend course. You really want to take a comprehensive course that's going to expose you to bone physiology, make sure you're familiar with all the terminology, allow you to do some live surgeries and develop your treatment planning skills. You want to become proficient in those aspects and work as much as you can.

You really want to take a comprehensive course that's going to … allow you to do some live surgeries and develop your treatment planning skills.

BB: *There are some excellent implant courses out there, such as those at the Misch International Implant Institute and the AAID MaxiCourses®. The Implants A-to-Z course at UCLA with Drs. Sascha Jovanovic and George Perri is also a great course.*

DW: Absolutely. If you have the opportunity and can invest in one of the yearlong courses, do it. Essentially, you can't get enough education. That's the takeaway here. Gaining understanding of the fundamentals is crucial. You really want to be proficient beyond just having a good sense of your surgical skills, the bone morphology and the anatomy in that area.

Beyond that, though, I would say, managing cases postoperatively is imperative. You hope every case you do is going to be flawless, but complications can arise, and the more cases you do, it's inevitable that you are going to encounter some challenges and difficulties. It's important to work at becoming increasingly proficient and minimizing those complications, so when they do arise, you'll have a good sense of how you're going to handle the situation and can keep levelheaded during the surgery if you do encounter a problem. If you have a solid foundation to draw from and something unexpected comes up, you'll have fewer sleepless nights.

BB: *So the key is knowing how to manage complications. Or, even better, how to avoid them by recognizing them ahead of time. Another recommendation might be to have a mentor.*

DW: Sure, if you have the opportunity to shadow someone — an oral surgeon, a periodontist or a general dentist who has extensive experience placing implants — you can shadow them in their office, watch them, and have them with you while you're doing several of your cases.

Additionally, I would say the number one thing would be case selection. You want to make sure that the first few cases you do are what you would consider "the ideal." These cases are going to be the most straightforward, and will, hopefully, present you with the least challenges so that you can develop your skills, confidence and competence. Having that safety net in place, with a mentor or someone you can shadow, makes the process a lot easier.

The number one thing would be case selection. You want to make sure that the first few cases you do are what you would consider "the ideal."

BB: *OK, so we've got the correct amount of education. We've found a mentor and those ideal cases. Now what? What's the ideal first case a clinician should be looking for?*

DW: I would say a maxillary first premolar. It affords all the surgical challenges that come with the maxilla, whether it be the sinus or avoiding the adjacent teeth. It allows you to work in the less dense bone, so it's less forgiving and you have to be more proficient with it, but it gives you easy access without the esthetic challenges of an anterior tooth. So, if you can round up a good number of maxillary premolar cases out of the gate, really get your hands wet, then repetition is the key. If it seems like they're getting too easy — that's a good sign. It means you're developing your skills and comfort level. Once you get that true sense of confidence in yourself and your cases are going well, then it might be time to branch out to an anterior tooth or a molar. You really can't put a number on it, but the more "straightforward" cases you can do will really go a long way toward increasing your chances for success.

BB: *I think that goes back to a key point: having a mentor who can provide surgical backup. It's about knowing what cases you're comfortable with and what you should refer out. That way, if you run into a problem, you've got somebody who has your back as far as helping you through those cases.*

DW: Right. The thing that you gain most from those experiences is the ability to recognize when you're in over your head a little bit, perhaps. There are people out there who are great at it, who have a natural instinct for it and can take right to it. But every day someone runs into a challenge that they either haven't experienced before or they're a little uncomfortable handing, or it's something that they just would rather not deal with. So, when you are presented with a case that's too challenging, there's no shame in referring it out. Anyone out there who has had that experience and feels comfortable handling those challenges only got that way by having gone through it themselves. There's no reason to feel that this is a knock against you as a surgeon in any way. It's just recognizing that you haven't seen this before, and figuring out how you're going to handle it.

BB: *It's part of your learning curve.*

DW: Absolutely.

BB: *One of the main things that you've been doing since you joined us is placing Inclusive® Tapered Implants. Can you tell us a little bit about what you think of that system compared to other ones you have worked with in the past?*

DW: Sure. The system has all the advantages that the test of time has proven with implants of old — the internal hex being the most popular connection out there in dentistry. It's got a thread design that maximizes your initial stability and helps promote osseointegration. It's intuitively very easy to use. Anyone who has had experience with any of the large systems out there is going to be very comfortable using it and is going to be able to transition into Inclusive Tapered Implants very easily.

BB: *It's a system put together by a very experienced team. We have a lot of engineers and technicians who actually came from the implant industry. Key to being the first laboratory to introduce an implant system, though, is that we can encompass a full package. We can help with everything from planning the case to the final restoration, which leads into one of the major projects we've been working on, which is the Inclusive® Tooth Replacement Solution. Can you tell us a little bit about that?*

DW: It's basically a comprehensive package that has the full Glidewell expertise and experience behind it. In addition to the implant, the dentist receives up front a prosthetic guide, a custom healing abutment, a custom temporary abutment and BioTemps® provisional crown (Glidewell Laboratories) to provide early contouring of the soft tissue, a matching custom impression coping, as well as the final prosthesis. So, the entire process from start to finish — from implant placement to the definitive restoration — is controlled, very predictable and optimal in terms of improving your chances of success. It's a comprehensive package that you have laid out before you, before you ever get started. I think clinicians are really going to take to it.

BB: *Right. I think core to this solution is versatility. At implant placement, you'll have a custom healing abutment that was made for you pre-surgery, a custom temporary abutment, a BioTemps crown and a matching impression coping. A surgical specialist who has a restorative-driven surgical practice can start sculpting those soft tissues correctly, making it easier for his restorative dentist. He can then either immediately provisionalize it, or he can put the healing abutment on it. And later, he can send that custom impression coping to the restorative dentist, who can then transfer those contours correctly to the laboratory. One of the biggest challenges for the lab is clinicians using narrow, round impression copings, and then trying to make an anatomically shaped tooth. This issue is core to the Inclusive Tooth Replacement Solution, so maybe you can expand on that.*

The entire process from start to finish — from implant placement to the definitive restoration — is controlled, very predictable and optimal in terms of improving your chances of success.

We're excited about all the upcoming courses, and how we can gear them toward general practitioners and specialists alike to work hand-in-hand with us to improve their efficacy and efficiency.

DW: Sure. For general practitioners who are doing both the surgery and the restorative procedures, it's certainly a comprehensive package. If you are a surgical specialist looking to develop your referral base, then you have the advantage of being able to communicate to your general practitioner: "I'm not only going to place the implant for you, I'm going to start the restorative process. I'm going to place the healing abutment for you, so it can begin the soft tissue contour, to make your life much easier down the road — predictably." It is something that can be easily reproduced. And the additional components can be forwarded to the restorative dentist, as you mentioned. When the time comes, they can place the custom impression coping that matches that emergence profile that's been developed. So, there's predictability and a great sense of continuity there. It's also a great builder for a referral base for specialists who want to help out in the process beyond just placing implants.

BB: *And then, ultimately, it provides the final restoration — a superior restoration — which means better patient care.*

DW: Absolutely.

BB: *Let's move on to other technologies: guided surgery. Can you tell us what your background was before and what you're doing now with digital treatment planning and guided surgery?*

DW: I've been doing guided surgery for about six months now, since coming to Glidewell. Prior to that, I was doing freehand almost exclusively — reflecting a flap, going in there and eyeballing it, and performing the surgeries. The guided surgery is great, though. Not only does it allow you to take advantage of Cone Beam CT scanning capabilities, but it also allows you to anticipate if there's going to be a need for a graft, whether you have enough available bone, or if there are any structures you need to avoid. So, the guided surgery has been very useful as far as minimizing flaps when necessary, as it virtually eliminates flaps. The postoperative healing period is certainly much better. It gives you peace of mind that is unparalleled. If you have the knowledge, going in, of where the structures are, where the adjacent roots are, the apices, the sinus, the alveolar nerve — whatever it might be — it's just an extra tool that gives you that confidence.

BB: *Right. It provides something not only for the person new to placing implants, but also for the experienced surgical specialist who is using that three-dimensional view and planning everything so they don't have those surprises when they go into it. Digital treatment planning is one of those things we can offer with our service, and it ties in with CBCT.*

There are other technologies we've been working with as well. Can you tell us a little bit about intraoral scanning?

DW: You know, one of the greatest things about working at Glidewell is that we get the opportunity to play with all of the latest and greatest technologies. CBCT technology is a big component of those recent developments. We have a PreXion 3D unit that we use. Intraoral scanners, I think, are also going to be a standard in the future. We're certainly moving toward a digital era, and if we can eliminate the need for impression material, it cuts down on costs. If we have the ability to communicate and upload the images to the Glidewell laboratory right away to get started on the prosthesis, it reduces the turnaround time. It's just a much more comfortable experience for the patient overall, and helps to ensure the best possible product for the dentist and, ultimately, for the patient, which is most important.

BB: *A colleague of mine refers to Glidewell as a Dental Disneyland because of all the technologies we have here. Any technology that's on the market is, literally, in production here — and in production in a big way — so you can get an education here quickly.*

To wrap things up, another large role you're going to have with us is running courses at the Glidewell International Technology Center. Can you talk about how we're going to use these technologies to show dentists how they can easily incorporate them into their private practices?

DW: Absolutely. We offer the opportunity to take courses on the lab's premises. These are not courses designed to make a novice into an expert implantologist — again, you want to make sure you get those comprehensive, extended courses prior to coming in — but they're an adjunct, something they can build on. For those who feel comfortable doing implants already, this is a way of streamlining everything for them, to make things easier for them and the patient.

We're going to be doing courses that address specifically the Inclusive Tooth Replacement Solution program. That certainly is going to help doctors down the road. Alternatively, we're hoping to offer courses in both mini implants and our conventional-diameter implants that we're launching. These courses are intended to familiarize clinicians and staff with the Inclusive system, and how it can benefit them in their practices. We're going to have some courses on CBCT technology, offering the opportunity for folks who may not have access to that technology, or who are on the fence about it, to come in and see the benefits it can provide them. I know you are going to be doing digital treatment planning programs to expose folks to that technology. So, we're excited about all the upcoming courses, and how we can gear them toward general practitioners and specialists alike to work hand-in-hand with us to improve their efficacy and efficiency — and ultimately perform better dentistry for their patients.

BB: *Very good. I sure appreciate having you here. Welcome aboard!* **IM**