clinical articles • management advice • practice profiles • technology reviews

Volume 3 No 5

Implant PRACTICE • US

Dr. Robert Miller
Esthetic considerations in the replacement of a hopelessly involved central incisor using a staged approach

Drs. A. Dawood, S. Tanner, and T. Bereznicki
Implant abutment selection for single-unit or short-span bridgework

Practice Profile
Drs. Martin Kolinski and Tricia Crosby

Corporate Profile
Springstone℠

CE articles inside

Through the keyhole

Implant Practice US talks to Drs. Martin Kolinski and Tricia Crosby about their practice

Staff outing at the Kane County Cougars baseball game

What can you tell us about your background?

Martin Kolinski: I graduated as a periodontist in 1980 and went to work for my program director, Dr. Zigmund Porter. He was a great mentor. I was interested in dental implants in dental school, but at that time, there was not sufficient development in the field to make that a viable procedure in clinical practice. I first learned about the Brånemark research in 1984 and started taking classes wherever I could find them. I placed my first implant in November 1986 in a patient who was willing to undergo the procedure, despite the fact that he knew he was my first one. It was a rocky road for about 5 or 6 years dealing with failure, working with different systems, and learning the surgery so that restorative dentists would have as easy a time restoring them as possible. I did not feel competent placing them until about 1993, by which time I had done over 800 implants. Our practice increased with time, and by 1997, we were placing about 1,000 implants every year. Last year, with Dr. Crosby increasing her practice, we placed over 1,400 implants between us. Currently, we are both on staff at the University of Illinois at Chicago College of Dentistry, making contributions to both the graduate and undergraduate students.

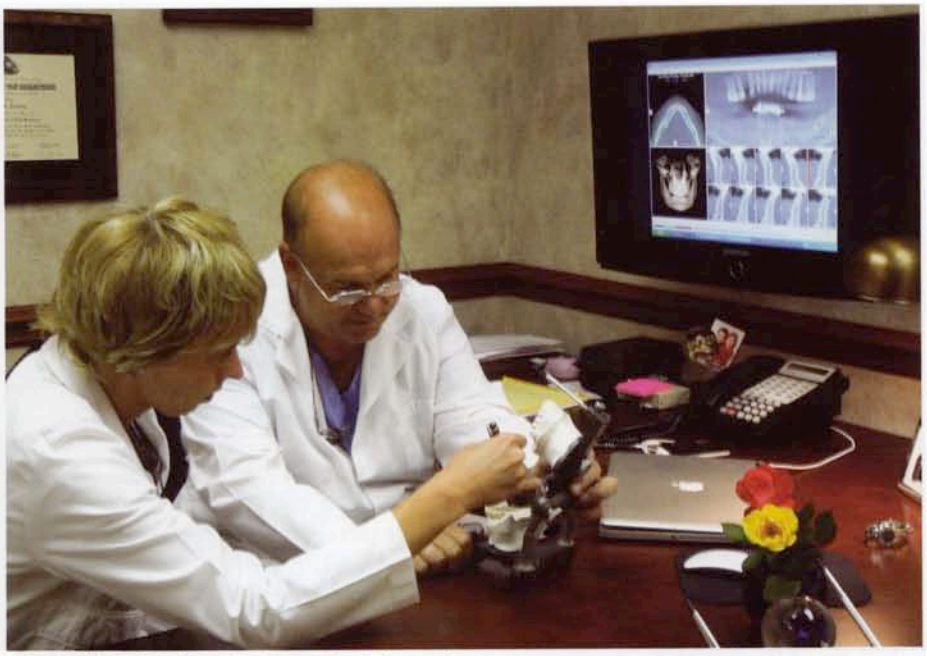
Tricia Crosby: I began my dental career as a dental hygienist. I attended the Kennedy-King dental hygiene program in Chicago whose classes and clinics happened to be located at the University of Illinois at Chicago College of Dentistry. I was fortunate that during my hygiene training, I had the opportunity to work with many of the college's faculty who encouraged me to advance my training by applying to dental school. I completed my general dental training as well as my periodontal residency at the University of Illinois and maintain a position there as a clinical professor in the department of periodontics. I am also a Diplomate of the American Board of Periodontology.

When did you become a specialist and why?

Martin Kolinski: I always knew I wanted to be a specialist because, to me, it is an easier job to be competent at one thing than a whole bunch of things. My hat is off to the general practitioner who has to try to keep up in so many areas


Dr. Martin Kolinski


Office manager Maria Kendall


Drs. Kolinski and Crosby reviewing a patient's diagnostic wax-up

of practice. Originally, I wanted to be an orthodontist; however, I realized I was no good at bending wires but was very adept at surgery. So, I decided on periodontics. This occurred in my junior year in dental school, when by good fortune, my week in the surgery clinic was the same week the seniors were off, and I was able to get a lot of experience in a short time.

Tricia Crosby: Specializing in periodontics was a natural progression for me coming from a dental hygiene background. However, it was my time spent rotating in the graduate perio department at the University of Illinois during dental school that convinced me that I wanted to be a periodontist. I was assisting on a case completed by a resident in which he had treated a woman with aggressive periodontitis with surgical and regenerative treatment. She cried when she told me how lucky she felt to still have her teeth and to not be wearing a denture. I knew then that I wanted to experience more of that.

Is your practice limited to solely implant dentistry, or do you practice other types of dentistry?

Drs. Kolinski and Crosby: Our practice is approximately 85% implant related and 15% periodontics. This is just how the referral base evolved over time. We started giving continuing education (CE) courses on a somewhat regular basis to restorative dentists in the area in 1997. We focus our education on cases that we have done in our own practice, so that the examples we show are "real life" dental experiences. In doing so, our referral base is composed of approximately 200 general dentists, orthodontists, endodontists, and a few oral surgeons. Because we have been in the area doing implants since 1986, our patient-referral base has been expanding as well. Our focus is to remain a practice that services a professional referral base, as opposed to moving away from that base to go directly to the public.

What systems do you use?

Drs. Kolinski and Crosby: Through the years, we have always tried to stick with a single system. This has allowed us to develop significant expertise in the restorative aspect of the system we use for our referral base. Additionally, by staying with a single system, we have allowed our referral base to become accustomed to a system and not have to relearn a new one every time they do a new case. This also allows for better inventory control for both the restorative and surgical offices. Currently, we are using Nobel Biocare's Replace® Select. For our narrow diameter implants, we have been using the BioHorizons® HA coated one-piece implant. We prefer the HA surface because there is less likelihood for failure during the temporization phase, and we have seen very few long-term problems with these implants.

Who inspired you?

Martin Kolinski: My mentor was Dr. Zigmund Porter, who was my program director in grad school and my first boss after I finished school. He was a CE fanatic and a great practice administrator as well. I am also inspired by many of the restorative dentists I work with. I watch the care that they take in doing the restorative aspects of their cases, and I want to do surgically for their patients what they do for them restoratively.

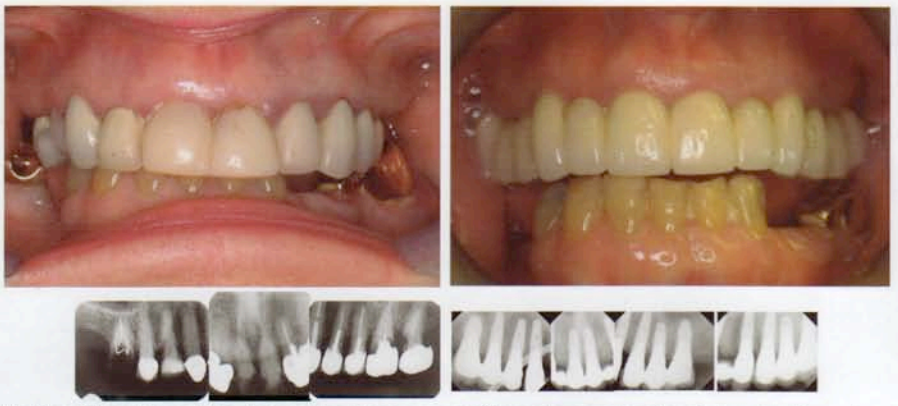
Tricia Crosby: Dr. Maija Mednieks was a biochemist in whose lab I worked during my dental hygiene training. She was the first to encourage and support my decision to apply to dental school and to pursue my Master of Science degree. The faculty in the graduate perio department at the University of Illinois was also inspirational to me. They were all excellent clinicians who were passionate about periodontics. I learned so much from them and am thankful for their dedication to teaching and to the residents.

What is the most satisfying aspect of your practice?

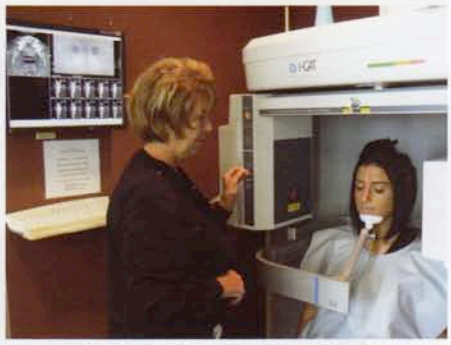
Drs. Kolinski and Crosby: The most satisfying aspect of our practice is seeing the final restoration of a full-arch crown-and-bridge or an All-on-4™/All-on-6 (Nobel Biocare™) case and the patients' reactions when they get their new teeth. There is no better feeling in the world than to see what you have done to change a patient's life in a positive way.

Professionally, what are you most proud of?

Martin Kolinski: Professionally, I am



Maxillary full-arch immediate placement and case: preoperative and post-restorative photo and radiographs



Dental assistant Pam Kaczmar prepares a patient for an i-CAT® cone beam scan

most proud of the fact that I have been invited to speak at the national meetings of the American Academy of Periodontology (AAP) and the Academy of General Dentistry (AGD) and have never solicited either one of these organizations to get on their programs. I am also very proud of the fact that we practice what we preach. There is no effort to hide the fact that some cases are not successful, but that is true of any practice. In my opinion, we learn more from our failures, or problems, than our successes. Furthermore, there is much about our patients that we cannot control, leading to outcomes that are totally unexpected. Professionally, we need more candor on the speakers' circuit and should have more practitioners on the podium who don't "speak for a living."

Tricia Crosby: I am proud to be part of the interdisciplinary team with the restorative dentists I work with. I believe that one of the keys to a successful outcome is good collaboration, and I am lucky to work with dentists who also value this aspect of patient care. I am also proud to be working with Marty Kolinski and proud of the direction we have taken our practice in these past few years with respect to full-arch rehabilitation and CE seminars.

What do you think is unique about your practice?

Drs. Kolinski and Crosby: We have built a practice using a single system and do not place abutments for the restorative dentist. We do a lot of CE for our restorative base, but it is not in the patient's best interest to "do it all" for the restorative dentist. Furthermore, it is not in the restorative dentist's interest to have that done either. Patients understand that if the restorative dentist's only function is to take an impression and seat a crown, they don't need to see them to have that done. If the surgeon can place the abutment, he or she can certainly complete the process. We help when needed, but we want the restorative dentist involved as much as possible.

What has been your biggest challenge?

Drs. Kolinski and Crosby: Overcoming the feeling of failure when the procedure has a negative outcome. There is so much that goes on with patients that we cannot control. As long as we know we did a good job in surgery, we can feel good about that. However, it takes years of experience to understand when a problem is surgeon-created versus one that results from poor patient response to treatment rendered. In fact, we believe that patient response to treatment is a very understudied aspect in evidence-based therapy. Poor patient response is difficult to quantify and, therefore, takes a backseat to implant design when it comes to looking at results of surgical treatment.

What is the future of dentistry?

Drs. Kolinski and Crosby: As a market, we believe the dental field has a good future. Our fear is that the emphasis on procedure-driven practices is overwhelming the ideal of treating patients well. There is too much emphasis on production and "doing it all," and not enough emphasis on collaboration and dividing responsibility for the good of the patient. It is hard to believe that dentists could be competent enough to treat all the orthodontic, periodontal, implant, endodontic, and restorative and cosmetic needs of all of their patients. As dentists, we enjoy a great reputation, and we need to be careful to protect that by doing procedures we are competent in and keeping our patients' best interests at heart.

Our tips for maintaining a specialty practice:

1. Practice with integrity. If you make a mistake, own up to it and take responsibility to make it right—no matter the cost.
2. Understand you are there for the restorative dentist, not the other way around. It is a huge privilege to have a fellow professional trust you to treat one of their patients, and we need to respect that.
3. Train your staff to understand #2.
4. Be a resource for your referral base. Take a lot of CE and provide a lot of CE using your own cases, when possible, to serve as examples of what your referrals can expect from you.
5. Communicate well and communicate often.

What are your hobbies and what do you do in your spare time?

Martin Kolinski: Golf, golf, and more golf!

Tricia Crosby: Spend time with my family and friends. I also enjoy gardening and landscape design, although I have a 4-month-old Bedlington terrier puppy who occupies most of my free time.

Top 10 List

1. i-CAT® (Imaging Sciences International)
2. DEXIS® Digital Radiography
3. Consult-PRO™ Dental Patient Education Software
4. SimPlant® software (Materialise Dental)
5. NobelGuide™ software (Nobel Biocare™)
6. Nobel Biocare™ implants
7. BioHorizons® One-piece 3.0 implant
8. Bio-Gide® collagen membrane (Osteohealth®)
9. Bio-Oss® (Osteohealth®)
10. Oragraft® FDBA (LifeNet Health®)