Training in Implantology and Decision-Making Practices Regarding Edentulism: An Internet-Based Survey

Raphael Assous, DDS, PhD  
UFR Odontologie, Université de Paris, Paris, France.

Laurent Delprat, PhD  
Research Center in Health Law and Private Law, Université de Paris, Paris, France.

Adeline Braud, DDS, PhD  
Laboratory of Orofacial Neurobiology, Université de Paris, Paris, France; Odontology Center, Hôpital Rothschild, AP-HP, Paris, France.

Purpose: To evaluate the first-choice treatment options proposed to edentulous patients and the rationale behind them using an internet-based survey conducted among a sample of French dental clinicians.

Materials and Methods: From July to December 2018, an internet-based survey was conducted among a sample of 2,000 dental practitioners in order to assess first-choice treatment options proposed to edentulous patients. A total of 349 responses were received, and 310 questionnaires were included for analysis.

Results: The majority of clinicians proposed a maxillary complete denture (CD) (59.7%) and mandibular implant overdenture (45.2%) for edentulous patients. Almost 30% of practitioners proposed a CD as the first-choice option for mandibular edentulous patients. Binary logistic regression showed that the likelihood of proposing implant therapy in the maxilla was significantly increased for male practitioners (OR = 2.041, 95% CI = 1.231 to 3.385, \( P < .05 \)) and for clinicians who had further training in implantology (OR = 2.301, 95% CI = 1.354 to 3.917, \( P < .05 \)). In the mandible, the likelihood was significantly increased for clinicians who graduated 10 to 19 years ago (OR = 5.312, 95% CI = 1.331 to 21.208, \( P < .05 \)), had further training in implantology (OR = 2.246, 95% CI = 1.121 to 4.500, \( P < .05 \)), had expectations of comfort and stability (OR = 11.810, 95% CI = 5.289 to 26.372, \( P < .001 \)), and proposed the treatment according to national and international recommendations (OR = 3.252, 95% CI = 1.208 to 8.755, \( P < .05 \)).

Conclusion: The research results suggest that proposing either a CD or implant restorations for treatment of edentulous patients depends on training and specific skills in implantology.


Edentulism is a frequent condition that concerns 7.6% of the worldwide population.\(^1\) Although the rate of edentulism is decreasing in high-income countries, its prevalence still ranges between 2.1% and 14.3% in Europe.\(^1\) In France, the prevalence of edentulism was recently estimated to be at 9.8% of the overall population.\(^1\) Options for edentulous patients include no treatment, conventional complete dentures (CDs), implant-retained overdentures, and implant-supported fixed partial dentures. More than 10 years ago, the prevalence of edentulous people with CDs in both the maxilla and mandible varied between 3% and 13% within European countries.\(^2\) Most edentulous individuals report satisfactory function with CDs; however, CDs may generate complaints related to retention, stability,\(^4\) and denture-induced mucosal traumatic lesions.\(^5\) Advances in implantology have contributed to improving the oral comfort of edentulous patients\(^6\) and their oral function.\(^7,8\)

Many factors could influence patients’ perspectives on and motivations for replacing missing teeth. People who complain of poor chewing function, poor speech, pain, and esthetic dissatisfaction with CDs are more inclined to seek implant treatment.\(^9\) Surprisingly, the probability of desiring implant treatment is lower in edentulous people than in partially dentate subjects.\(^10\) Many reasons may be advocated...
when refusing an implant prosthesis, including cost or concerns about surgery. However, when cost is removed as a decision factor, 36% of edentulous patients still refuse implants for retaining their mandibular dentures. From a clinical point of view, a preference for combined maxillary and mandibular implant-retained or -supported prostheses is mostly reported (45.5%), but combined maxillary and mandibular CDs or a maxillary CD opposed to an implant-retained or -supported prosthesis are also preferred treatment options for 39.3% and 13.4% of edentulous patients, respectively.

Adequate counseling and information about treatment options may also have an important influence on patients in the decision-making process. Proposing the most appropriate care for edentulous patients relies on appraising a wide range of factors, such as clinical factors, patient values, available research evidence, evidence-based guidelines, clinical experience, technical skills, and medico-legal implications. Evidence-based criteria have been proposed for implant treatment planning in maxillary and mandibular edentulous patients. Despite the high satisfaction ratings with maxillary implant prostheses, the overall ratings with implants are not significantly greater than with CDs. Specific indications for maxillary fixed-implant therapy should therefore include denture instability, intolerance for palatal coverage, or persistent gag reflex. The rationale for placing implants in the edentulous mandible is to improve retention, masticatory ability, comfort, and patient satisfaction. In 2002, an expert-based consensus stated that: “The evidence currently available suggests that the restoration of the edentulous mandible with a conventional denture is no longer the most appropriate first choice prosthodontic treatment.” Considering functional performance, patient satisfaction, cost, and clinical time, a two-implant overdenture is currently considered the minimum standard of care for mandibular edentulous patients. An implant-retained overdenture is also recommended as first-choice standard of care for the edentulous mandible by the French High Authority of Health.

Dentists’ skills in implantology should include the design and delivery of implant-supported restorations, as well as knowledge of and limited clinical experience in surgical procedures. According to the Association for Dental Education in Europe (ADEE), new graduates should be competent at describing the indications, contraindications, principles, and techniques of surgical placement of osseointegrated implants. Implant therapy is currently part of the undergraduate curriculum in European dental universities. In France, however, Nicolas et al (2009) revealed that implantology-related skills are underrepresented in dental foundation training, which may limit implant therapy practice. In this context, further training in implant surgery or restoration may influence decision-making regarding treatment for edentulous patients. An internet-based survey was conducted among a sample of French dental clinicians to evaluate first-choice treatment options proposed to edentulous patients and the reasons behind them.

**MATERIALS AND METHODS**

After obtaining institutional board clearance, an internet-based questionnaire with an accompanying letter explaining the purpose of the survey, the procedures involved, and that participation was confidential and anonymous was sent between July and December 2018 to 2,000 dental clinicians working in Île-de-France. The questionnaire (see Appendix I in the online version of this article at www.quintpub.com/journals) focused on professional attitudes toward maxillary and mandibular edentulism, with items related to treatment options the respondent would be willing to provide to a healthy patient and the criteria for decision-making.

The following questions addressed first-choice treatment options:

- Which treatment option would you first propose to a healthy maxillary edentulous patient? (response options: CD; implant overdenture [IO]; implant-fixed prosthesis [IFP]; other)
- What would be your reasons to propose it? (response options: patient’s clinical conditions, such as age, previous experience with dentures, bone resorption, saliva conditions, or available time; expectations of comfort and stability; your skills in implant therapy; your professional habits; national/international recommendations)
- Which treatment option would you first propose to a healthy mandibular edentulous patient? (response options: CD; IO; IFP; other)
- What would be your reasons to propose it? (response options: patient’s clinical conditions; expectations of comfort and stability; your skills in implant therapy; your professional habits; national/international recommendations)

Questions regarding demographics sought to collect the respondent’s background information, including gender, age, year of graduation, continuing education, primary practice location, and legal status. All responses were voluntary, anonymous, and confidential.

**Statistical Analyses**

All answers were transferred to Excel worksheets, and statistical analyses were performed using the commercially available software SPSS 11.5 (IBM). Pearson chi-square test was used to test for any statistically
significant relationships between the variables and the first-choice options. A stepwise binary logistic regression analysis (backward Wald method) was used to sequentially identify categorical variables associated with implant treatment proposal. Proposal of dental implants was considered a dependent variable in the regression model. Significance levels were set at $P < .05$.

**RESULTS**

A total of 349 dental practitioners took part in the survey (response rate 17.4%). Data were missing for 39 respondents. The remaining 310 complete questionnaires were included for analysis (the available data represented 15.5% of the questionnaires sent to dental clinicians). The main characteristics of the sample are detailed in Table 1. As confidentiality was respected throughout the course of the survey, no further analysis was performed for nonrespondents. As shown in Fig 1, the majority of clinicians proposed a maxillary CD and mandibular IO for edentulous patients. Patients’ clinical conditions were mostly cited as the reason and informed 69.7% and 70.6% of clinicians for the maxilla and mandible, respectively. Other reasons were advocated for justifying the maxillary and mandibular first-choice proposals, including expectations of comfort and stability (59.3% and 56.1%, respectively), national and international recommendations (30.2% and 38.1%), skills in implantology (32.9% and 37.7%), and professional habits (39.5% and 27.7%). Other reasons, such as cost-benefit ratio or time spent, were also freely cited for mandibular proposals (1.3%).

First-choice proposals for the maxilla and mandible were significantly related to self-perceived skills in implant therapy (respectively: $\chi^2 = 8.188, P < .05$; $\chi^2 = 24.244, P < .001$), professional habits ($\chi^2 = 13.210, P < .05$; $\chi^2 = 47.752, P < .001$), and comfort and stability ($\chi^2 = 37.897, P < .001$; $\chi^2 = 100.710, P < .001$) (Table 2). Mandibular first-choice proposals were also significantly related to patients’ clinical conditions ($\chi^2 = 25.620, P < .001$) and national/international recommendations ($\chi^2 = 71.139, P < .001$). Some practitioners’ characteristics, including gender (maxilla and mandible, respectively: $\chi^2 = 17.789, P < .001$; $\chi^2 = 11.287, P < .05$), age (mandible: $\chi^2 = 37.019, P < .001$), year of graduation (mandible: $\chi^2 = 39.326, P < .001$), continuing education (maxilla and mandible, respectively: $\chi^2 = 85.592, P < .001$; $\chi^2 = 60.918, P < .001$), and practice location (maxilla: $\chi^2 = 19.319, P < .05$), were also significantly related to first-choice proposals (Table 3). Binary logistic regression showed that the likelihood of proposing implant therapy for maxillary edentulous patients was significantly increased for male practitioners (OR = 2.041, 95% CI = 1.231 to 3.385, $P < .05$) and for clinicians who had further training in implantology (OR = 2.301, 95% CI = 1.354 to 3.917, $P < .05$) (Table 4).

Moreover, regression analysis showed that clinicians who graduated 10 to 19 years ago (OR = 5.312, 95% CI = 1.331 to 21.208, $P < .05$), who had further training in implantology (OR = 2.246, 95% CI = 1.121 to 4.500, $P < .05$), who had expectations of comfort and stability

![Fig 1](image-url) Distribution of first-choice treatment options according to arch. IFP = implant-fixed prosthesis; IO = implant overdenture; CD = complete denture.
CI = 1.208 to 8.755, \( P < .05 \) were more likely to propose implant therapy to mandibular edentulous patients (Table 4).

(OR = 11.810, 95% CI = 5.289 to 26.372, \( P < .001 \)), and who proposed the treatment based on national and/or international recommendations (OR = 3.252, 95% CI = 1.208 to 8.755, \( P < .05 \)) were more likely to propose implant therapy to mandibular edentulous patients (Table 4).
Some factors, however, may influence the response rate. The response rate might have been improved by sending postal reminders accompanied with a printed questionnaire or by personal contact, although this would constitute evident bias. Although nonresponses may generate serious bias in studies based on data collected through internet surveys—especially ones with a low response rate, as the chance exists that the sample from which data are collected may be unrepresentative of the population of concern—nonresponse rate analysis was not performed in order to respect the confidentiality of the participants. Some features of the study sample, including the prevalence of women, of practitioners aged over 65 years, and of employees, are nevertheless consistent with the characteristics of dental practitioners working in Île-de-France. As comparative data between respondents and nonrespondents are lacking, the present results should, however, be considered with caution.

It was firstly observed that a CD was mainly proposed as the first-choice option for the maxilla, while the IO was the most frequently proposed treatment for the mandible. In that respect, almost 60% of clinicians proposed the CD for replacing the teeth in the maxilla. Provision of new CDs has been shown to improve self-reported oral health–related quality of life and satisfaction in maxillary edentulous patients. The high rate of clinicians proposing CDs is also not surprising among French clinicians, as national guidelines recommend a resin-based CD as a first-choice treatment for maxillary edentulous patients. Nevertheless, maxillary IFPs and IOs were cited as first-choice treatment by, respectively, 25.5% and 14.6% of clinicians. From a clinical point of view, the survival rate of a maxillary IO is 93%, and the cumulative implant prosthesis survival rates with a maxillary IFP reach 93% to 100% after a 5-year follow-up period. Implant-retained and -supported prostheses, are, however, more costly than CDs. Satisfaction with a maxillary IO is not significantly higher than with a CD, which may limit its indication. A maxillary IFP may also be restricted to specific clinical indications, such as in the case of denture instability and lack of retention, patient gag reflex, or intolerance for palatal coverage. Such outcomes could explain the tendency.

### DISCUSSION

The present survey aimed to obtain the first-choice options proposed to edentulous patients and the influence of further training in implantology on the decision-making process via an internet-based questionnaire. Internet-based surveys are known to offer low collection and administration costs, pertinent scope for recruitment, and ease of data collection and analysis. Compared to postal mail or telephone, online methodology is perceived as an easy way to conduct surveys, with response rates reaching in theory over 80%. Some factors, however, may influence the response rate of online surveys of dental clinicians, including the interest of the participants, the survey structure, the communication methods, the promise of a reward, and the assurance of privacy and confidentiality. The present response rate reached only 17.4% of the sample, with three follow-up reminders sent after the initial notification, which is slightly lower than recently observed with dental graduates. It can, however, be suggested that the recurrent requests to complete online questionnaires, the increased workloads, and/or the lack of time and/or importance of the topic of the survey may explain the low response rate. The response rate might have been improved by sending postal reminders accompanied with a printed questionnaire or by personal contact, although this would constitute evident bias. Although nonresponses may generate serious bias in studies based on data collected through internet surveys—especially ones with a low response rate, as the chance exists that the sample from which data are collected may be unrepresentative of the population of concern—nonresponse rate

### Table 4: Logistic Regression Model for Association Between Implant Therapy Proposal and Clinician Characteristics/Treatment Rationale in the Maxilla and Mandible

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SD</th>
<th>χ²</th>
<th>P</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maxilla</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male clinician</td>
<td>0.714</td>
<td>0.258</td>
<td>7.651</td>
<td>.006</td>
<td>2.041</td>
<td>1.231</td>
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<td>Further training in</td>
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<td>.002</td>
<td>2.304</td>
<td>1.354</td>
</tr>
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<td>implantology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outer suburbs practice location</td>
<td>-0.562</td>
<td>0.303</td>
<td>3.431</td>
<td>.064</td>
<td>0.570</td>
<td>0.315</td>
</tr>
<tr>
<td>Immediate suburbs practice location</td>
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<td>0.301</td>
<td>6.121</td>
<td>.013</td>
<td>0.474</td>
<td>0.263</td>
</tr>
<tr>
<td><strong>Mandible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged 50–59 y</td>
<td>0.787</td>
<td>0.450</td>
<td>3.069</td>
<td>.080</td>
<td>2.198</td>
<td>0.911</td>
</tr>
<tr>
<td>Graduated 10–19 y ago</td>
<td>1.670</td>
<td>0.706</td>
<td>5.590</td>
<td>.018</td>
<td>5.312</td>
<td>1.331</td>
</tr>
<tr>
<td>Further training in</td>
<td>0.809</td>
<td>0.354</td>
<td>5.212</td>
<td>.022</td>
<td>2.246</td>
<td>1.121</td>
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<td></td>
</tr>
<tr>
<td>Outer suburbs practice location</td>
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<td>0.482</td>
<td>8.638</td>
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<td>0.242</td>
<td>0.094</td>
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<tr>
<td>Immediate suburbs practice location</td>
<td>-1.228</td>
<td>0.479</td>
<td>6.574</td>
<td>.010</td>
<td>0.293</td>
<td>0.115</td>
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<tr>
<td>Professional habits</td>
<td>-1.551</td>
<td>0.384</td>
<td>16.295</td>
<td>.000</td>
<td>0.212</td>
<td>0.100</td>
</tr>
<tr>
<td>Expectations of comfort and stability</td>
<td>2.469</td>
<td>0.410</td>
<td>36.280</td>
<td>.000</td>
<td>11.810</td>
<td>5.289</td>
</tr>
<tr>
<td>National/international recommendations</td>
<td>1.179</td>
<td>0.505</td>
<td>5.448</td>
<td>.020</td>
<td>3.252</td>
<td>1.208</td>
</tr>
</tbody>
</table>

| **B** = unstandardized regression coefficient; **SD** = standard deviation; **CI** = confidence interval; **OR** = odds ratio. |
for the majority of clinicians to choose a CD rather than implant therapy for maxillary edentulous patients.

The edentulous mandible seems to be the most preferred indication for implant placement for European clinicians. According to French policies, implant therapy is also considered a first-choice treatment option for the edentulous mandible. Seventeen years ago, the first international consensus about treatment options for the edentulous mandible promoted the two-implant overdenture as the minimum standard of care based on patient-based outcomes. In this context, it was almost reasonable to observe that clinicians cited mainly implant therapies when replacing mandibular teeth in healthy patients, with 45.6% proposing IOs and 26.1% proposing IFPs. From a clinical point of view, IOs show high cumulative implant and prosthetic survival rates over time and significantly improve prosthesis retention. Alternatively, implant survival rates with a mandibular fixed prosthesis reach more than 99%. Finally, mandibular implant-retained and -supported prostheses are 2.4 times to 6.25 times more costly than CDs, while the initial treatment and maintenance costs with IOs are lower than with implant-supported prostheses. Consequently, IOs seem to be the most cost-effective treatment for mandibular edentulous patients. What was more surprising was that almost 30% of clinicians proposed a CD as a first-choice option for mandibular edentulous patients. It may be argued that mandibular CDs often generate complaints related to comfort and stability, and thus dissatisfaction.

The present analyses revealed that treatment options were affected by gender, suggesting that it may play a role in decision-making with edentulous patients. McKay and Quiñonez (2012) previously pointed out differences between male and female clinicians and suggested that women may be more inclined to make decisions based on their personal values, sympathy, or tact than men, who based their decisions more on rational or objective reasons. Women tended to more frequently propose CDs (72.9% of women vs 51.8% of men for the maxilla, and 22.4% of women vs 35.3% of men for the mandible) and less frequently propose IOs and IFPs (27.2% of women vs 47.6% of men for the maxilla, and 64.7% of women vs 77% of men for the mandible). This finding may be in accordance with the fact that gender was previously found to be a predictor of implant-related skills and thus dissatisfaction.

The present results first suggest the importance of postgraduate clinical experience, further training in implantology, and rationale for proposing implant therapy in decision-making regarding edentulous patients. The present findings also seem consistent with the fact that chance of proposing implant therapy was significantly reduced when the choice was made according to professional habits. Complaints related to mandibular CD instability or discomfort may be frustrating and time-consuming. It may therefore be supposed that clinicians experiencing difficulties and complaints with a mandibular denture would require implant-related skills and thus propose implant therapy. On the contrary, satisfactory clinical outcomes with removable dentures may lead practitioners to propose CDs. This seems consistent, since complementary analyses showed that the chance of proposing a CD as a first-choice treatment option for the edentulous mandible would be increased for practitioners with no further training in implantology (OR = 2.246, 95% CI = 1.121 to 4.500, P < .05), with a practice located in the immediate or outer suburbs (respectively: OR = 3.415, 95% CI = 1.336 to 8.733, P < .001; OR = 4.128, 95% CI = 1.604 to 10.625,
P < .05), and according to their professional habits (OR = 4.714, 95% CI = 2.220 to 10.009, P < .001).

The present results then support the hypothesis that implant surgery and/or prosthodontic teaching is under-represented in the undergraduate curriculum. According to the ADEE, European graduate clinicians should be competent in establishing and maintaining oral health, such as restoring defective, nondefective, and/or missing teeth to acceptable form, function, and esthetics; planning and performing all common prosthetic procedures, including tooth preparation and impression-taking; and understanding and applying the biomechanical principles of fixed and removable prostheses commonly used to replace missing teeth.42 In France, removable denture instruction is mainly represented in the second year of the initial course in dentistry through lectures, practical exercises, and clinical practice, including CD fabrication. Graduates should moreover have supporting competencies related to the application of evidence-based treatment, description of the risks, benefits, and long-term consequences of using osseointegrated implants within an overall treatment concept, description of the principles and techniques involved in the use of osseointegrated implants for restorations, and description of the indications and contraindications, principles, and techniques of surgical placement of osseointegrated implants.42

In the two past decades, many universities have promoted predoctoral implant dentistry programs.43,44 Implant therapy is currently part of the training of European dental undergraduates.45 Some French dental universities encourage lectures and preclinical and clinical experience in surgical placement of oral implants and implant prosthetics in undergraduate education. Previous experiences have demonstrated that preclinical simulation may improve students’ self-confidence in managing implant therapy.46,47 Despite recent improvements in implant dentistry courses offered to undergraduates, an initial course in implantology may moreover still suffer from limited staff, time, and funding.45 As a consequence, implantology teaching is often perceived as being underrepresented within dental schools.23 New graduates may thus suffer from a lack of clinical experience related to implant placement and prosthetic management of edentulous patients requiring implant therapy. Moreover, although most students perform surgical interventions such as crown lengthening and tooth extractions under the supervision of a senior teacher, only a few carry out implant placement by themselves. Since 2011, French residents in oral surgery or in oral medicine can benefit from additional courses in oral implantology surgery, ranging from straightforward to advanced implant-specific procedures.45 Preclinical training and clinical treatment of edentulous patients under close supervision during treatment planning, the surgical placement of implants, and the prosthetic restoration delivery could help students improve their knowledge and skills in implant surgical and restorative procedures.47,48 IOs provided by UK dental students during initial courses achieved levels of satisfaction and quality of life improvement similar to those placed by experienced prosthodontists,49 which suggests the feasibility of clinical training of undergraduate students in implant therapy for edentulous patients.

Some clinicians who took part in this survey did not benefit from any training in implantology during their dental curriculum. It can be presumed that clinicians who graduated after 2002 learned about national and international recommendations related to the treatment of edentulous patients during their initial courses in dentistry. It may also be supposed that clinicians who graduated more recently gained an insight into implant therapy through the recent promotion of implantology during initial courses in dentistry. When they graduate, a large portion of clinicians may require further training in implantology, as 60% of clinicians who took part in the study followed a postgraduate private or academic course in implantology. Postgraduate education aims to prepare clinicians for performing specialized implant treatment. At the postgraduation level, there are also plenty of courses and pathways to implant-related skills in Europe.45 In France, oral implantology can indeed be appraised through postgraduate programs and continuing professional development, including oral surgery, periodontics, and prosthodontics courses, which contribute to a wide range of levels of clinical competencies.

CONCLUSIONS

Further training may play a pivotal factor in first-choice options proposed by clinicians to edentulous patients. Proposing implant therapy as a first-choice treatment option in edentulous patients appears to depend on demographic features, postgraduation clinical experience, further training in implantology, and compliance with professional recommendations. Promoting international consensus recommendations and the instruction of implant therapy or clinical experience with dental implants among new graduates may therefore increase the proposals of implant therapy to mandibular edentulous patients, thus improving their quality of life.

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Author contributions: R.A. collected the data; L.D. supervised the survey; A.B. conceived and planned the survey, performed the statistical analyses, and wrote the manuscript.
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APPENDIX I

1. Vous êtes:
   a) Un Homme
   b) Une Femme

2. Vous êtes âgé de:
   a) 20 à 29 ans
   b) de 30 à 39 ans
   c) de 40 à 49 ans
   d) de 50 à 59 ans
   e) de 60 ans et plus

3. Vous êtes diplômé en chirurgie dentaire depuis:
   a) Moins de 5 ans
   b) Entre 5 et 9 ans
   c) Entre 10 et 19 ans
   d) Entre 20 et 29 ans
   e) 30 ans et plus

4. Vous êtes titulaire:
   a) D’un diplôme universitaire (DU) en implantologie/chirurgie implantaire/prothèse sur implant
   b) D’une formation privée en implantologie/chirurgie implantaire/prothèse sur implant
   c) Autre (précisez):
   d) Aucune formation spécifique

5. Vous êtes:
   a) Titulaire de votre cabinet
   b) Collaborateur libéral ou associé
   c) Salarié
   d) Autre (précisez):

6. Vous exercez:
   a) À Paris
   b) En Petite couronne (92, 93, 94)
   c) En Grande couronne (77, 78, 91, 95)

7. Quand vous devez prendre en charge un patient présentant un édentement complet mandibulaire, en bon état de santé général, vous proposez en première intention:
   a) Une prothèse implanto-portée
   b) Une prothèse complète à complément de rétention implantaire
   c) Une prothèse complète amovible conventionnelle
   d) Autre:

8. Quels critères orientent votre choix ?
   a) Les paramètres liés au patient (âge, ancienne prothèse, degré de résorption, salive, disponibilité, dimension financière du traitement…)
   b) Vos compétences en chirurgie implantaire ou en prothèse sur implant
   c) Vos habitudes professionnelles
   d) Les résultats attendus en termes de confort ou de stabilité prothétique
   e) Le respect des recommandations bonnes pratiques et/ou le consensus de McGill
   f) Autre:

9. Quand vous devez prendre en charge un patient présentant un édentement complet maxillaire, en bon état de santé général, vous proposez en première intention:
   a) une prothèse implanto-portée
   b) Une prothèse complète à complément de rétention implantaire
   c) Une prothèse complète amovible conventionnelle
   d) Autre:

10. Quels critères orientent votre choix ?
    a) Les paramètres liés au patient (âge, ancienne prothèse, degré de résorption, salive, disponibilité, dimension financière du traitement…)
    b) Vos compétences en chirurgie implantaire ou en prothèse sur implant
    c) Vos habitudes professionnelles
    d) Les résultats attendus en termes de confort ou de stabilité prothétique
    e) Le respect des recommandations bonnes pratiques et/ou le consensus de McGill
    f) Autre: