Diagnose this …
Multiple lobulated reddish to bluish swellings over the tongue and lower lip. ▶ page 11A

Class II direct composites
Clinical solutions to common problems when placing these types of restorations. ▶ page 14A

AAE annual meeting
The event has a special focus on hot topics and controversies in endodontics. ▶ page 1B

GlaxoSmithKline taking zinc out of its denture products

By Fred Michmershuizen, Online Editor

GlaxoSmithKline (GSK), manufacturer of several versions of denture adhesive sold under the Super Poligrip brand name, recently announced it will introduce zinc-free versions of the products.

“While zinc is an essential part of the diet, recent publications suggest that an excessive intake of zinc-containing denture adhesives over several years may lead to the development of neurological symptoms and blood problems such as anemia,” a consumer advisory from the company reads.

“Neurological symptoms may include numbness, tingling or weakness in the arms and legs and difficulties with walking and balance.”

The company insists the products are safe when used as directed, but said that it is removing zinc as a precautionary measure for consumers who might use too much.

“Super Poligrip is safe to use as directed in the product label,” the statement reads. “The majority of consumers follow these directions. However, some consumers apply more adhesive than directed and use it more than once per day. Therefore, as a precautionary measure to minimize any potential risks to these consumers, GSK has voluntarily stopped the manufacture, distribution and advertising of these products.”

The new products will be clearly labeled on their packaging as zinc-free. GSK reported that it has discussed this situation with the FDA and that no further action is required.

Chile meeting a go despite earthquake

By Javier de Pison, Editor in Chief Dental Tribune Latin America

The director of Salon Dental Chile, the main dental expo in Chile, told Dental Tribune Latin America over the phone that the capital, Santiago, was only slightly affected by the recent powerful earthquake and that there was a tense calm in the nation, caught by surprise in the middle of the summer vacation.

Salon director Miguel Wechsler said that Chile’s “strict building code prevents damages” and that the event will continue as planned.

Heading to Atlanta this month?

Welcome to the Thomas P. Hinman Dental Meeting

The Hinmann Dental Meeting is known for its reputation of excellence, one that brings together the highest quality programming from the leading authorities in the field of dentistry.

▶ See pages 17A, 18A
Record level of support for 20th annual OHA Gala

Oral Health America (OHA), a non-profit organization founded in 1955 and headquartered in Chicago, held its 20th annual gala and benefit on Feb. 24 at Chicago’s historic Union Station. Nearly 900 guests participated in silent and live auctions to benefit OHA while networking with fellow professionals before the Chicago Midwinter Dental Meeting.

The event raised more than $400,000 — the highest amount in the gala’s 20-year history — for OHA’s programs that bring healthy mouths to life.

Proceeds from the auctions support Smiles Across America® (SAA), an OHA program that assists oral disease prevention services in schools for children who are unable to obtain routine dental care due to lack of resources, low literacy or language barriers. The program was launched in Chicago in 1994 with the Chicago Department of Public Health, Chicago Public Schools and community partners, and now reaches 90 treatment partners in 27 states. Through 2009, SAA has provided $1.5 million in funding.

The gala was sponsored by DentalQuest, Patterson Dental, Ivoclar Vivadent, Midmark, I-800 DENT-TIST, Colgate-Palmolive, Henry Schein Dental, Chicago Dental Society, Belmont Publications, SciCan, National Dentex, Philips Sonicare, Unilever, Mr. and Mrs. Bernard J. Beazley, Burkhart Dental Supply, ConFirm Monitoring Systems, Argen Corporation, Tokuyama Dental, DENTSPLY International, GC America, DentalEZ Group and OralDNA.

Dentalcompare donated the production of a video, shown for the first time at the gala, that highlights the impact of OHA’s SAA program. The video makes the case for oral health’s importance to overall health, and OHA’s support of community-based efforts to ensure that children get a healthy start through having a healthy mouth. The video can be accessed at www.dentalcompare.com/video_view.asp?videoId=328.

OHA’s mission is to change lives by connecting communities with resources to increase access to oral health care, education and advocacy for all Americans, especially those most vulnerable. For more information about Smiles Across America or any of OHA’s programs, visit www.oralhealthamerica.org.

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Top tips to prevent tooth grinding

By Keri Kramer, Chicago Dental Society

How are Americans dealing with these difficult economic times? If you ask dentists, they’re taking the stress out on their teeth. In the fall of 2009, the Chicago Dental Society surveyed more than 250 of its members to see if stressing about the economy was wreaking havoc on patients’ oral health.

Nearly 75 percent of dentists surveyed said their patients reported increased stress in their lives. And 65 percent of dentists said they have seen an increase in jaw clenching and teeth grinding among their patients.

Jaw clenching and teeth grinding, or bruxism, can be a temporary nuisance during stressful times that causes headaches and sleep problems, but it can also cause lasting problems for your teeth and gums. It can lead to muscle inflammation, broken teeth or even damaged dental work, such as crowns and fillings.

Dentists are sharing the following tips with their patients to help them cope with the pressures of the world — before their teeth pay the price:

1. Take a pain reliever. If grinding and clenching is causing you headaches and muscle soreness in your jaw, take an anti-inflammatory medication, such as Advil or Aleve, shortly before bedtime.
2. Massage. Try massaging the muscles along your jaw line, from the joint near your ear all the way to your chin to relieve jaw soreness.
3. Avoid caffeine. Coffee may help you get going in the morning, but caffeine combined with stress can lead to increased muscle tension. Increase your consumption of water. If cutting caffeine completely from your life won’t work for you, at least try to avoid it within several hours of bedtime.
4. Meditate. Try a yoga class to achieve some relaxation. Even taking a moment before bedtime to do some deep breathing can be a big help.

5. Wear a mouth guard. If you have serious grinding and clenching issues, talk to your dentist about a mouth guard to wear at night.

The Chicago Dental Society recently held its 145th annual midwinter meeting, which brought more than 30,000 dental professionals to Chicago in February. The meeting is a forum for dentists to learn about new products, technologies and methods.

Business Center attendees.

The president of the Chile Dental Association, Dr. María Eugenia Valle, was in California when the quake struck her country and said in an e-mail that she was very nervous because she was there with her three young grandsons, unable to fly to Chile.

The executive secretary of the association, Dr. Patricio López, said from Santiago that the narrow geography of Chile has made it difficult to assess the total damage because there are no alternative roads to the main ones to travel south.

The city most affected by the quake was Concepción, 311 miles (500 kms) south of the capital. After some initial riots caused by the closing of the main supermarkets there, the government said that order was restored in the city.

Salon Dental Chile Director Miguel Wechsler at the Salon Dental Chile expo entrance in 2009.
The Institute of Medicine Committee on Oral Health Access to Services was tasked to study the access to oral health for the nation’s 167,000 private practice dental professionals. The committee members, to protest the IOM’s continued failure to include representatives of the private practice dental community on either of its two oral health panels, “ADA protests the IOM’s continuing failure to include representatives of the private practice dental community on either of its oral health panels,” Tankersley said. “We respect the experience and knowledge of the committee members, but the nation’s 167,000 private practice dentists represent some 92 percent of professionally active dentists in the United States. Without them, there can be no significant impact on access to oral health care, regardless of the delivery system.”

Tankersley went on to outline the ADA’s efforts to address ways to improve access for underserved populations.

“The ADA believes that oral health depends on preventing oral disease,” he said. “The nation will never drill and fill its way out of this problem. Our efforts to improve access to care have taught us that there are many contributing factors and barriers to the problem. Some are economic and others environmental. Some are direct and others indirect. Some are related to the individual and others to the provider. The ADA has been on the vanguard of advocating access solutions.”

Tankersley cited the following ADA initiatives as examples:

- Designing and implementing a pilot program for its prevention-focused Community Dental Health Coordinator, a community health worker with dental skills now active in Philadelphia, rural Oklahoma and Indian tribal areas.
- Convening an Access to Dental Care Summit in 2009 for a broad range of 144 stakeholders to identify short- and long-term ways to improve oral health for underserved populations.
- Creating a Public Health Advisory Committee to provide a formal presence within the ADA to receive input on issues of public health significance.
- Convening the 2007 American Indian/Alaska Native summit to collaboratively address the unique needs of these populations.
- Implementing an initiative to address oral health needs of the vulnerable elderly, one outcome of which will be the introduction of federal legislation.
- Seeking to increase collaboration among private practice dentists and those working in federally qualified health centers and other dental safety net clinics, where about 69 percent of the dentists are members of the ADA.
- Lobbying for virtually every federal program that could effectively improve access for the dentally underserved.

While the current dental delivery system serves most Americans well, we must work together to extend that system to the most vulnerable among us, who are at the greatest risk for developing oral disease,” Tankersley said.

He said the ADA believes there are many ways to help prevent oral disease:

- To rebuild the public health infrastructure and expand adequately funded safety-net programs, including Medicaid.
- To increase community-based prevention programs.
- To promote oral health literacy.

“Our current dental public health infrastructure is insufficient to address the needs of the underserved, and the gap between needs and the ability to address those needs is growing,” Tankersley said.

Best smiles at Oscars?

By Fred Michmershuizen, Online Editor

We’ve all heard of the best and worst dressed lists that fashionistas compile after the annual Academy Awards ceremony. Now, there’s a list of the celebrities who flashed some of the best (and worst) smiles on the red carpet.

Dr. Catrise Austin, owner of VIP Cosmetic Dentistry in New York City, calls herself a “celebrity dentist.” She compiled her “Best Male Celebrity Smile” after the annual Academy Awards ceremony. Now, there’s a list of the celebrities who flashed some of the best (and worst) smiles on the red carpet.

The award for “Best Male Celebrity Smile” went to playful Hollywood hunk George Clooney.

Austin recommended heartthrob Zac Efron — who reportedly transformed his smile before becoming a superstar by closing his gap with porcelain veneers — for rocking a “very sexy white smile.”

Meryl Streep showcased a dazzling white smile along with her beautiful white dress. “From head to toe she was simply gorgeous,” Austin said.

At least one celebrity, however, did not fare so well.

Morgan Freeman, whose teeth looked like they “desperately needed a boost of teeth whitening to brighten his dull yellow smile,” received the award for “A Smile Not Worth a Million Dollars.”

Teeth whitening is the No. 1 requested cosmetic procedure in cosmetic dentistry practices across the nation, said Austin, who also recommended either porcelain veneers or clear removable braces such as Invisalign or Clear Correct to make Freeman’s teeth straighter.

Another celebrity who could show improvement, Austin said, was Miley Cyrus. While the teen superstar has an “overall nice smile,” Austin noted that her teeth appeared to be a bit asymmetric as one front tooth actually hangs a tiny bit lower than the other.

Austin recommends that a simple procedure such as tooth recontouring or perhaps redoing the upper front veneers will put the smile of the popular singer and actress back on the A-list.

Austin, who is based in New York City, calls herself a “celebrity dentist.” Her goal is to offer her patients Hollywood-inspired smiles.

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Give feedback or face backlash

By Sally McKenzie, CEO

It’s likely you realized early on that as the owner of your practice, there are many hats you must wear. You are, after all, “the boss.” You are the one your team looks to for direction, guidance, mediation, fairness, etc. And for many dentists, it’s those “other duties as assigned” that create the biggest headaches in running a practice.

Employees are a needy bunch. You have to tell them what to do. They often require additional training. They can be mercurial. And one particularly frustrating characteristic of most employees — they want regular feedback from you, their boss. If only signing the paychecks was all that was required to effectively manage a team. Now you need a solid set of skills, a strong sense of integrity and professionalism and a willingness to encourage excellent performance through motivation, accountability and, yes, plenty of constructive feedback.

Most dentists pat themselves on the back if they give employees feedback once or twice a year. “Feedback” as many view it would be that perfunctory exchange that is commonly attached to the annual salary review.

If there are no problems, most likely the dentist tells the employees they are doing a fine job, slaps a couple extra percentage points on the paycheck and quickly strikes this routine matter off the to-do list. “There, that’s done. Now on to real work!”

Or perhaps you are one of those who reasons that if the employee gets a paycheck and isn’t shown to the door that is feedback enough in your book. “If I wasn’t happy they’d know it. Why would I need to give any more feedback than that?” If that’s your story, you’re probably filling vacancies in your office rather regularly.

Maybe your idea of feedback is dropping a subtle hint here or there. The dirty instruments pile up in the sink and you stick a post-it-note above it with a frowning face.

Or let’s say, you’re looking at a record shortfall in income this year and you casually mention in a staff meeting that money is a little tight. This isn’t feedback because:

• It doesn’t help the collections coordinator understand that she needs to increase over-the-counter collections immediately.

• It doesn’t tell the scheduling coordinator that the scheduling to meet production goals is established for a reason.

• The staff members leave the meeting assuming everything is fine where they are concerned. After all, if money were a serious problem surely you’d do more than mention that things are a little tight.

• Meanwhile, you are sure the team is going to take some real steps to improve their performance. (Yet, this is, in fact, not true.)

Vague generalities don’t work and they don’t constitute feedback. So how does the dental practice actually incorporate effective feedback into its systems?

First, drop the notion that feedback is part of the performance/salary review. They are separate issues. Performance rewards must be based on performance measurements, but that is another article.

**Daily dose**

Constructive feedback should be given and received daily to help employees continuously fine tune and improve the manner in which they carry out their responsibilities. Feedback given and received constructively is a professional pixie dust for the employees. It’s that unseen magical ingredient that helps them to improve and to grow. It’s also the dentist’s most vital tool in shaping and guiding average employees into effective, high-performing team members.

But expecting anything constructive or positive to come out of occasional doses of feedback is like having a patient who brushes his teeth occasionally yet expects to have excellent oral health. It simply doesn’t happen.

Verbal feedback can be given at any time, but it is most effective at the moment the employee is engaging in the behavior that you either want to praise or correct. If Sue at the front desk negotiated payment from the ever difficult Mrs. Jones with the deft and political acumen of a highly trained peace keeper/financial genius, tell her!

Similarly, if her handling of a situation is not consistent with the prac-
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Feedback is the jewel in the crown of employee development. Employees want to know what they are doing well, what they need to improve, and where they can make a difference. Whether you receive it poorly or with enthusiasm, feedback is valuable and necessary for personal and professional growth. Here are some key points to consider when handling feedback:

1. **Be Open-Minded:** Feedback is not about you; it is about improving the situation. It is an opportunity to learn and grow.

2. **Seek Multiple Sources:** Feedback should come from various perspectives, including peers, superiors, and customers. This broadens the scope of understanding.

3. **Anonymity:** Feedback must be anonymous to ensure employees feel safe in expressing their thoughts. This is crucial for authentic dialogue.

4. **Immediate Action:** Address feedback promptly to show commitment to improvement.

5. **Follow Up:** Regularly check in with employees on feedback to see progress and celebrate successes.

6. **Encourage Feedback:** Create a culture where feedback is valued and expected. This encourages continuous improvement.

7. **Positive Feedback:** Recognize and reward good performance to reinforce positive behavior.

8. **Constructive Criticism:** Provide feedback in a non-confrontational manner, focusing on the issue rather than the person.

9. **Seek Feedback:** Regularly seek feedback from employees for self-improvement.

10. **Promote Growth:** Use feedback as a tool to foster development, not as a source of criticism.

By embracing feedback and using it as a tool for growth, you can create a more productive and satisfied team. Remember, feedback is an investment in your team's success.
understand that the senior dentist’s own patients judge their clinical competence by non-clinical factors, such as personality, gentleness, office appearance, etc. It is generally not possible to assess clinical competence until a year or more of actual clinical procedures performed by the new dentist are reviewed.

Unless the transition is preceded by a period of employment prior to the actual ownership change, the dollar value of that practice represents a significant portion of their financial assets. For most dentists, ownership of their dental practice is the major focus of their energy expenditures, financial situation and professional lives.

Years of blood, sweat and tears, coupled with the relationships formed with both staff and patients, have caused dentists to form a deep-seated emotional attachment with their practice. For many, the senior dentists must understand they will not be able to address the clinical competence issue. Senior dentists must accept the fact that the only control they have over this subject is the fact that the new dentist has been tested and licensed.

Determining the transition plan

The first step in formulating a transition plan involves an appraisal of the practice. The information gathered and evaluated during the appraisal process will aid in determining available transition options. These options may include (1) an outright sale, (2) role reversal sale, (3) partnership, (4) merger or (5) production acquisition transaction.

In addition, the appraisal will typically provide a comparison with other practices involved in transitions, thereby allowing an understanding as to how salable this particular opportunity might be.

Finally, the appraisal should also provide ideas regarding enhancing the value of the practice and its desirability as a transition candidate.

Locating a competent transition consultant

The next step is locating a competent transition consultant. A transition consultant is one who understands the entire transaction, the various types of transitions, contractual matters, the operational issues of running a dental practice and the need to have the relationships of the buyer, seller, staff and patients intact after the deal is done.

The best source for these individuals is word-of-mouth referrals and/or recognized reputation. They may be a national or regional “transition guru,” the dentist’s personal accountant or another accountant who restricts his/her practice to health-care providers and is familiar with the health-care transition field or an experienced local dental practice broker.

Some of the dental supply companies also have knowledgeable consultants who have been assisting in transitions for years. The transition consultant will help the dentist identify various aspects of his/her transition. Questions that need answers include the dentist’s financial ability to retire and his/her personal transition goals.

For example, how long does the dentist wish to stay on as an associate and/or remain available to aid in the transition process? What is the best way to accomplish these goals? The transition consultant will help answer these questions and more.
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Phenomena- General Dentist Seeking Practice Purchase Opportunity #12108
Phoenix- 3 Ops - 3 Equipped, GR $515K+, 5 Working Days #12113
North Scottsdale- General Dentist Seeking Practice Purchase Opportunity #12109
Urban Tucson- 6 Ops- 4 Equipped, 1 Hygiene, GR $90K 12512
Tucson- 1,800 active patients, GR $850K, Asking $900K #12110
CONTACT: Tara Kimbell @ 602-516-3219

CALIFORNIA
Alturas- 3 Ops, GR $611K, 3 1/2 day work week #14279
Atwater- 2 Ops, 1,080 sq ft, GR $177K #14307
El Sobrante- 5 Ops - 3 Equipped, 1,300 sq ft, GR $515K #14302
Fresno- 5 Ops, 1,000 sq ft, GR $514,000 $425K #14306
Greeter Auburn Area- 4 Ops, 1,800 sq ft, GR $765K #14304
Madera- 7 Ops, GR $1,721K $617K #14283
Modesto- 12 Ops, GR $1,197K, Same loc for 10 years #14289
Modesto- 3 Ops, GR $690K w/adj. net income of $546K #14108
N California Wine Country- 4 Ops, 1,500 sq ft, GR $905K #14295
Pine Grove- Nice 5 Ops fully equipped office/practice #111500 #14305
Porterville- 6 Ops, 2,600 sq ft, GR #225M #14302
Red Bluff- 8 ops, 2008 GR $1M Hygiene 10 days a wk. #1428
CONTACT: Dr. Dennis Hopper @ 800-519-5358
Riverside- Hygiene, 1,000 sq ft, GR $120K #14265
Grass Valley- 3 Ops, 1,500 sq ft, GR $714K #14272
Redding- 3 Ops, 2,200 sq ft, GR $14329
Yuba City- 3 ops, 4 days h/w, 1,200 sq ft #14873
CONTACT: Dr. Thomas Wagner @ 516-812-3255
Rancho Margarita- 4 Ops, 1,200 sq ft, Take over lease #14341
CONTACT: Thinh Tran @ 949-533-8508

CONNECTICUT
Fairfield Area- General practice doing $900K #16106
Southbury- 2 Ops, GR $255K #16111
Wallington- 2 Ops, GR $600K #16114
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Chicago- 9 Ops, GR $707K, Sale: Price $611K #22126
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CONTACT: Sharon Montezeti @ 410-788-4071

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NEW JERSEY
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CONTACT: Sharon Montezeti @ 609-788-4071

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Woodstock- 2 Ops, Building also available for sale, GR $500K #41112
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CONTACT: Mary Harr @ 315-265-1333
New York City- Specialty Practice, 3 Ops, GR $500K #41110
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NORTH CAROLINA
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Raleigh, Cary, Durham- Doctor looking to purchase #21427
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OHIO
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CONTACT: Dr. Mark Moorehead @ 440-825-8037

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CONTACT: Dan Shinn @ 412-855-0557
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RHODE ISLAND
Southern- 4 Ops, GR $750K, Sale $400K #48102
CONTACT: Dr. Peter Goldberg @ 617-680-2930

SOUTHERN RHODE ISLAND
FALLS- Doctor seeking to purchase a practice producing $150K/year #49105
CONTACT: Scott Carriker @ 704-841-4796
Columbia- 7 Ops, 2200 sq ft, GR $678K #49102
CONTACT: June Cole @ 404-313-1573

TENNESSEE
Elizabethton- GR $335K #51107
Memphis- Large profitable practice GR $2M #51112
Surburban Memphis- Leading practice in area, GR $1M #51115
CONTACT: George Luke @ 865-614-1527

TEXAS
Houston Area- GR $1.1M widiast at net income over $500K #52103
CONTACT: Dr. John Wright @ 800-730-8883

VIRGINIA
Greater Roanoke Valley- 2500 sq ft, GR $892K updated equipment #53111
CONTACT: Bob Anderson @ 804-640-2573

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the dentist’s preferred timetable? Are there any preliminary steps required to enhance the value of the practice? Which method of transition has the greatest chance of successful completion?

Make a plan outline
The answers to these questions should result in a brief written outline of the plan. The topics should include:
(1) goals,
(2) a timetable,
(3) appraised value,
(4) anticipated post-tax and sale’s expense net sale proceeds,
(5) planned transition options and
(6) a list of consultants to be involved.

The plan should also contain an action plan for completion of any activities that will enhance the value of the practice or increase the chances the practice will be selected by prospective new dentists.

Understanding that an inactive practice loses 5 percent of its value per week, an important part of the plan should also include a list of people to be called in the event of an unanticipated career-ending disability or death.

A letter of instructions to family members should be included that lists those contacts and stresses the urgency to act expeditiously in transitioning the practice. A part of the plan needs to include sharing this letter and plan with designated family members.

Many dentists, especially if incorporated, will execute a power of attorney authorizing a specific individual to immediately begin transition proceedings if required due to a dentist’s death.

When and how to start
If an appraisal has not been completed or updated within the past two years, this is the first step. Developing an exit strategy plan, even if it is years away, should also begin as soon as the appraisal is completed.

A stockbroker will advise that one should set a target sale price the day one acquires a stock. Similarly, the exit strategy is part of the dentist’s preferred timetable?

Are there any preliminary steps required to enhance the value of the practice? Which method of transition has the greatest chance of successful completion?

Make a plan outline
The answers to these questions should result in a brief written outline of the plan. The topics should include:
(1) goals,
(2) a timetable,
(3) appraised value,
(4) anticipated post-tax and sale’s expense net sale proceeds,
(5) planned transition options and
(6) a list of consultants to be involved.

The plan should also contain an action plan for completion of any activities that will enhance the value of the practice or increase the chances the practice will be selected by prospective new dentists.

Understanding that an inactive practice loses 5 percent of its value per week, an important part of the plan should also include a list of people to be called in the event of an unanticipated career-ending disability or death.

A letter of instructions to family members should be included that lists those contacts and stresses the urgency to act expeditiously in transitioning the practice. A part of the plan needs to include sharing this letter and plan with designated family members.

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Diagnose this ...

**Identify the swellings**

By Drs. Anil Ghom and Anuja Holani, India

A 58-year-old male complains of multiple lobulated reddish to bluish swellings over the tongue and lower lip for the last two years.

No associated pain or paraesthesia, no history of discharge and no history of trauma except for the discomfort caused by lobulated masses. The patient has an unremarkable medical history; no known allergies; and is not taking any medications.

**Extra-oral examination**
Lobulated masses of deep reddish to bluish lesions seen over lower lip.

**Intra-oral examination**
Lobulated masses of deep reddish to bluish lesions seen over lower lip and tongue region. The lesions are soft in consistency and have a smooth surface.

**Questions**
1) The clinical differential diagnosis may include:
   a) Hemangioma
   b) HIV-related lesion
   c) Lymphphangioangioma
   d) Drug allergy
   e) Multiple mucosal neuromas

2) Which of the following diagnostic tests may be useful (circle all that apply)?
   a) Pressure test
   b) Serology
   c) Biopsy

**Turn to page 12A for the answers**

Welcome to a new topic area among the pages of Dental Tribune!

The thanks for this new topic area go to a number of oral pathologists who seek to expand their role in the dental community by writing for Dental Tribune. These authors will provide us with selected case studies to help educate our readers about the various oral pathology situations they might encounter in daily practice.

We hope you enjoy this new topic area and welcome your feedback at feedback@dental-tribune.com. In addition, if you would like to submit a pathology case for publication, please contact r.goodman@dental-tribune.com.
Identify the swellings

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   a) Hemangioma
   b) HIV related lesion
   c) Lymphangiomia
   d) Drug allergy
   e) Multiple mucosal neuromas

2) Which of following diagnostic tests may be useful (circle all that apply)?
   a) Pressure test
   b) Serology
   c) Biopsy

Answers
1) a
2) a

Going further...
The following tests were performed:
• Pressure test = positive
• ELISA test = negative
• Histopathology as shown below

5) The histopathological differential diagnosis is which of the following?
   a) Pyogenic granuloma
   b) Capillary hemangioma
   c) Hemangiopericytoma
   d) Hemangioendothelioma

4) Are the following statements about hemangioma true or false?
   a) Pressure test positive
   b) ELISA positive
   c) Histopathology shows endothelial proliferation
   d) Histopathology shows chronic inflammatory cell infiltrate
   e) Histopathology shows stag horn pattern of vascular channels

5) All of the following statements are true about hemangioma except:
   a) A true neoplasm
   b) Hamartoma
   c) Common in darker-skinned individuals
   d) Three times more common in females

6) Are the following statements about Hemangioma true or false?
   a) Hemangiomas are present since birth
   b) Hemangiomas are more common in the head and neck regions and rare in the oral cavity
   c) Hemangiomas can be seen centrally
   d) Central hemangioma can have sunburst appearance

7) Hemangioma is a feature of each of the following syndromes except:
   a) Struge-Weber syndrome
   b) Rendu-Osler-Weber syndrome
   c) Kasabach-Merritt syndrome
   d) Gorlin-Goltz Syndrome

Discussion
Hemangioma is a hamartoma. It is never seen at birth but develops within the first year of life. It is more common in the head and neck regions and rare in the oral cavity. It is more common in females. Its occurrence is more frequent in white-skinned individuals. It can be seen centrally. Radiographically, central lesions can have a sunburst or honeycomb pattern.

Histopathologically, it shows areas of endothelial proliferation. Hemangioma is associated with many syndromes like Struge-Weber, Rendu Osler Weber, Kasabach–Merritt.

Treatment modalities includes injection of sclerosing agents, intraleral injection of corticosteroids, flash lamp pulsed dye laser and embolization.

Answers
3) b; 4) a) true, b) false, c) true, d) false, e) false; 5) c; 6) a) false, b) true, c) true, d) true; 7) d

About the authors
Dr. Ghom has more than 12 years of experience in the areas of teaching oral medicine and radiology and conducting scientific research. He has published textbooks on oral medicine, oral radiology and oral pathology as well as a mini atlas of oral medicine.

Ghom is also the editor in chief of the Journal of the Indian Academy of Oral Medicine and Radiology.

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Dr. Anuja Holani, professor, Department of Oral Pathology, M.I.D.S.R. Dental College, Latur, Maharashtra, India
Changing dentistry 4mm at a time.

Over 10,000 new users have made SureFil® SDR™ flow one of the fastest-growing products.

Since launching SureFil® SDR™ flow in September 2009, over 10,000 dentists have tried the first and only bulk fill flowable posterior composite. What’s even more impressive is that over 90% of them said they would continue to use it. SureFil® SDR™ flow has self-leveling handling that provides excellent cavity adaptation, and it can be bulk filled in 4mm increments, dramatically streamlining your posterior restoration. Contact your DENTSPLY Caulk rep or visit www.surefilsdrflow.com to learn more.
Class II challenge

Clinical solutions to common problems when placing Class II direct composites

By Robert Lowe, DDS, FAGD, FICD, FADI, FAGD

Direct composite restorations that involve posterior proximal surfaces are still a common finding in many dental patients.

Unlike dental amalgam, which can be a very forgiving material technologically and can be condensed against a matrix band to create a proximal contact, proper placement of composite restorative materials presents a unique set of challenges for the operative dentist.

The adhesion process itself is well understood by most clinicians as far as isolation and execution, however, there are some steps in the placement process that cause difficulty and ultimately lead to a less than desirable end result.

In this article we will look at three specific areas: management of the soft tissue in the interproximal region; creation of proximal contour and contact; finishing and polishing of the restoration.

Management of the interproximal gingival tissue

The most common area for the adhesion process to fail is the proximal gingival margin. Compounding this problem is the inability to gain access to the area to effect a repair without removal of the entire restoration.

As stated by Dr. Ron Jackson, bonded restorations are unique in that minor defects (decay or microleakage) at the marginal interface can often be “renewed,” or repaired by removal of the affected tooth structure and repaired with additional composite restorative material. Because of the bond of the restorative material to enamel and dentin, the recurrence is usually self-limiting. This is not true with metallic restorations that are not bonded to tooth structure. However, if the defective area is at the proximal gingival margin or line angle, access is not possible.

Therefore, precise marginal adaptation of the direct composite restorative material and the seal of this margin in the absence of moisture or subluxar fluid contamination is of paramount importance.

However, whether due to the subgingival level of decay and/or gingival inflammation, it can be difficult to seal the gingival margin with a matrix in the presence of blood.

Proximal contact and contour

Another challenge for the dentist has always been to re-create contact to the adjacent tooth and, at the same time, restore proper interproximal anatomic form given the limitations of conventional matrix systems.

The thickness of the matrix band and the ability to compress the interproximal ligaments of the tooth being restored and the one adjacent to it can sometimes make the restoration of proximal tooth contact arduous at best.

Anatomically, the posterior proximal surface is convex occlusally and concave gingivally. The proximal contact is elliptical in the buccolingual direction and located approximately one millimeter apical to the height of the marginal ridge.

As the surface of the tooth progresses gingivally from the contact point toward the cemento-enamel junction, a concavity exists that houses the interproximal papilla.

Conventional matrix systems are made of thin, flat metallic strips that are placed circumferentially around the tooth to be restored and affixed with some sort of retaining device.

While contact with the adjacent tooth can be made with a circumferential matrix band, it is practically impossible to re-create the natural convex/concave anatomy of the posterior proximal surface because of the inherent limitations of these systems.

Attempts to “shape” or “burnish” matrix bands with elliptical instrumenation may help create nonanatomic contact, but only “distorts” or “indents” the band and does not re-create natural interproximal contours.

Without the support of tooth contour, the interdental papilla may not completely fill the gingival embrasure, leading to potential food traps and areas for excess plaque accumulation. Direct Class II composite restorations can present even more of a challenge to place for the dentist because of the inability of resin materials to be compressed against a matrix to the same degree as amalgam, making it difficult to create a proximal contact.

Finishing and polishing composite restorations

Direct composite material does not carve like amalgam, although many clinicians wish that it did! Unfortunatley, this means that most posterior composites are carved with a bur.

This is not part of the finishing and polishing of the restoration. It must be remembered that cuspal forms are convex and cannot be carved with a convex rotary instrument that imparts a concave surface to the restorative material.

Composite should be incrementally placed and sculpted to proper occlusal form prior to light curing. The finishing and polishing process is done to accomplish precise marginal adaptation and make minor occlusal adjustments.

Rubber abrasives further refine the surface of the composite, and surface sealants are used to gain additional marginal seal beyond the limitations of our instrumentation.

Case report

The patient shown in Figure 1 presented with radiographic decay on the mesial proximal surface of tooth No. 3. The operative area is isolated using an OptiDam (Kerr Have). The decay is minimal, so the operative plan is to keep the preparation very conservative.

After removal of the decay and completion of the proximal and occlusal cavity form, the operative area is isolated with a rubber dam in preparation for the restorative process. Figure 2 clearly shows that the proximal gingival tissue was abraded during cavity preparation and there is evidence of hemorrhage. It is not advisable to try and “wash” the hemorrhage away with water and quickly apply the matrix band.

Even if this is successful, it is
likely that blood will infiltrate into the preparation in the gingival area and make etching and placement of the dentin bonding adhesive without contamination impossible.

An excellent way to manage the proximal tissue hemorrhage quickly and completely is to apply Expa-syl (Ker) to the area, tap it to place with a dry cotton pellet, and wait one to two minutes (Fig. 3).

Using an air-water mixture, rinse away the Expa-syl leaving a little bit of the material on top of the tissue, but below the gingival margin of the preparation (Fig. 4).

The Expa-syl will deflect the tissue away from the preparation margin, maintain control of any hemorrhage and facilitate placement of the proximal matrix without the risk of contamination of the operative field.

Class II preparations that need a matrix band for restoration will require rebuilding of the marginal ridge, proximal contact and often a large portion of the interproximal surface.

The goal of composite placement is to do so in such a way that the amount of rotary instrumentation for contouring and finishing is limited. This is especially true for the interproximal surface.

Because of the constraints of clinical access to the proximal area, it is extremely difficult to sculpt and correctly contour this surface of the restoration. Proper reconstitution of this surface is largely due to the shape of the matrix band and the accuracy of its placement.

After removal of caries and old restorative material, the outline form of the cavity preparation is assessed. If any portion of the proximal contact remains, it does not necessarily need to be removed. Conserve as much healthy, unaffected tooth structure as possible.

If the matrix band cannot be easily positioned through the remaining contact, the contact can be lightened using a Fine Diamond Strip (DS25F, Komet USA). The Composi-Tight Matrix System was chosen to aid in the anatomic restoration of the mesial proximal tooth morphology of this maxillary first molar.

The appropriate matrix band chosen is one that will best correspond anatomically to the tooth being restored, and also to the width and height of the proximal surface.

The height of the sectional matrix should be no higher than the adjacent marginal ridge when properly placed. Because of the concave anatomic shape, the proximal contact will be located approximately one millimeter apical to the height of the marginal ridge.

The Composi-Tight Matrix Forceps are used to place the selected sectional matrix band in the correct orientation in the proximal area. The positive grip of this instrument will allow for more exact placement than a cotton plier, which could damage or crimp the matrix band.

The sectional matrix band (Garson Dental Solutions) is positioned over the preparation margin to provide access to the proximal area.
and placed using the Composi-Tight Matrix Forceps to the mesial proximal area of tooth No. 14 (Fig. 5).

The orientation of the band and the positive fit make precise placement possible, even in posterior areas with tight access.

Next, the gingival portion of the band is stabilized and sealed against the cavosurface margin of the preparation using the appropriate size.

WedgeWand flexible wedge (Fig. 6)

The size of the WedgeWand® flexible wedge should be wide enough to hold the gingival portion of the matrix band sealed against the cavosurface of the preparation, while the opposite side of the wedge sits firmly against the adjacent tooth surface.

To place the wedge, the Wedge Wand is bent to 90 degrees where the wedge meets the handle. The flexible wedge can now be placed with pressure conveniently, without the use of cotton forceps, that often can be very clumsy. Once the wedge is in the correct orientation, a twist of the wand releases the wedge.

The G-Ring® forceps are then used to place the Soft Face™ 3D Ring into position. The feet of the Soft Face 3D Ring are placed on either side of the flexible wedge and the ring is released from the forceps.

The force of the 3D Ring causes a slight separation of the teeth due to periodontal ligament compression. The unique pads of the Soft Face 3D ring hug the proximal morphology of the buccal and lingual surfaces of the adjacent teeth, while at the same time creating an unbelievably precise adaptation of the sectional matrix to the tooth cavosurface margins (Fig. 7).

Once the sectional matrix is properly wedged and the Soft Face 3D Ring is in place, the restorative process can be started.

A 15-second total-etch technique, 10 seconds on enamel margins and five seconds on dentin surfaces, is performed using a 37 percent phosphoric etch.

The etchant is then rinsed off for a minimum of 15 to 20 seconds to ensure complete removal. The preparation is then air-dried and treated with AcQuaSeal desensitiser (AcQuaMed Technologies) to disinfect the cavity surface, create a moist surface for bonding and begin initial penetration of HEMA into the dentinal tubules.

A fifth generation bonding agent (Optibond Solo Plus, Kerr) is then placed on all cavity surfaces. The solvent is evaporated by spraying a gentle stream of air across the surface of the preparation. The adhesive is then light cured for 20 seconds.

The first layer of composite is placed using a flowable composite (Revolution 2, Kerr) to a thickness of about 0.5 mm.

The flowable composite will “flow” into all the irregular areas of the preparation and create an oxygen-inhibited layer to bond sub-

**Fig. 8:** The composite restoration is completed prior to removal of the matrix band. Placement of the matrix precisely reconstructs the proximal tooth form.

**Fig. 8a:** The restoration immediately after matrix removal.

**Fig. 9:** The pointed Q-Finisher carbide finishing bur is used to make minor occlusal adjustments and refine the restorative margins.

**Fig. 10:** The ultra-fine pointed composite finishing bur is used to further refine and finish the restoration’s adjusted areas.
sequent layers of microhybrid material.

After light curing for 20 seconds, the next step is to layer in the microhybrid material. First, using a unidose delivery, the first increment of the microhybrid composite (Premise, Kerr) is placed into the proximal box of the preparation. A smooth-ended condensing instrument is used to adapt the restorative material to the inside of the sectional matrix and preparation. This first increment should be no more than 2 mm thick. After light curing the first increment, the next increment should extend to the apical portion of the interproximal contact and extend across the pulpal floor. Facial and lingual increments are placed using an H134Q-Goldstein Flexithin Mini 4 (Hu-Friedy). A #2 Keystone brush (Patterson Dental) is lightly dipped in resin and used to feather the material toward the margins and smooth the surface of the composite.

Figure 8 shows the restoration after completion of the enamel layer prior to matrix band removal. The Composi-Tight Matrix Forceps were used to remove the sectional matrix after removal of the flexible wedge and Soft Face 3D Ring.

The Composi-Tight™ 3D Ring reduces flash to a minimum. Finishing and polishing were accomplished using Q-Finisher Carbide Finishing Burs (Komet USA). Typically, three grits and, correspondingly, three different burs are used to finish composite materials. With the Q-Finisher system, the blue-yellow striped bur with its unique blade configuration does the work of two burs with one.

An excellent surface quality on composite and natural tooth is achieved due to the cross-cut design of the cutting instrument.

The small, pointed (H154Q-014) Q-Finisher was used to make minor occlusal adjustments on the restorative surface as needed and to smooth and refine the marginal areas of the restorative material where accessible (Fig. 9). The fine, white stripe ultra-fine finishing bur (H154UF-014) was used in the adjusted areas for precise fine finishing (Fig. 10). Komet Diamond Composite polishing points (green, polishing; and gray, high shine) were then used to polish and refine the restorative surface (Fig. 11).

Once polishing is complete, the final step is to place a surface sealant (Seal and Shine, Pulpdent) to seal and protect any microscopic imperfections at the restorative marginal interface that may be left as a result of our inability to access these areas on the micro level. Remember, an explorer can “feel” a 50-micron marginal gap at best. Bacteria are 1 micron in diameter. The purpose of the Seal and Shine is to fill these areas. Figure 12 shows an occlusal view of the completed Class II composite restoration.

**Conclusion**

A technique has been described:

1. to control proximal tissue bleeding prior to matrix placement with Expaxyl (Kerr),
2. utilize a sectional matrix system (Composi-Tight™, Woodpecker-Wand, Garrison Dental Solutions) and a nanofilled microhybrid composite (Premise, Kerr) to create an anatomically precise proximal surface, and
3. use the Q-Finisher, two-bur composite finishing system (Komet USA) to finish then polish with diamond composite abrasives (Komet USA), refining marginal integrity without destroying occlusal anatomical form.

The interproximal surface has been re-created with natural anatomical contour and has a predictable, elliptical contact with the adjacent tooth.

With proper occlusal and proximal form, this “invisible” direct composite restoration will service the patient for many years to come.

**About the author**

Robert A. Love, DDS, FDS, FICD, FICD, FADI, FADCI, maintains a private practice in Charlotte, N.C. A diplomate of the American Board of Aesthetic Dentistry, Lowe lectures internationally and is chairman of Advanstar Dental Media’s continuing education advisory board. He can be reached at (704) 364-4711 or at bob@lovedds@aol.com.
In addition, a dentist reception will be held on Saturday night and an auxiliary reception on Friday night. With live music and buffets filled with the most appetizing foods, attendees will get to spend time catching up with friends and colleagues and dancing into the wee hours of the night.

Technical exhibits
Hinman’s 90,000-square-foot exhibit hall will feature the leading dental industry companies, sharing the latest products and services in the dental field. The hall will not only feature nearly 400 leading industry companies, but will again include the Hinman Eatery, where attendees can take a break and grab something to eat and drink without having to leave the convention center and search for other options.

In addition, Hinman has heard many attendees say that they want more time in the exhibit hall that doesn’t conflict with the course schedule. On Saturday, there will be two hours of dedicated time in the exhibit hall when attendees don’t have to worry about missing a course and can devote more time to visiting their favorite booths.

The exhibit hall floor will be open on Thursday from 10 a.m. to 6 p.m.; Friday from 9 a.m. to 6 p.m.; and Saturday from 9 a.m. to 4:30 p.m.

Meeting attendees can start their exhibit hall visits with complimentary morning and afternoon snacks each day. Snacks and drinks will be available in the rear seating areas while supplies last.

In the afternoon each day, cocktail bars will be open for attendees to purchase drinks. The exhibit hall will also offer the following:

- **C.E. opportunities:** Meeting attendees can sign up and receive C.E. credit for attending courses offered by the American Dental Assistants’ Association. (These courses are limited attendance.)
- **Cyber café & C.E. printing station:** Attendees can search for exhibitor products, check e-mail, access the Internet and print out C.E. certificates.
- **Daily prize drawings:** Attendees can register to win a $500 American Express gift certificate by dropping the appropriate prize ticket in the Exhibit Hall tumbler.
- **Free food:** Each day, complimentary morning and afternoon snacks will be available in the rear seating areas while supplies last.
- **Hinman Dining Dollars:** Attendees can redeem Hinman Dining Dollars for special values with food vendors in the Hinman Eatery and those located throughout the exhibit hall.
- **Hinman Eatery:** A central location offers food available for purchase and free wireless Internet access.
- **Hinman table clinics:** Attendees can earn one hour of C.E. credit by attending six table clinics.
- **Show specials:** Some exhibitors will offer show specials, offered only to 2010 Hinman attendees.

**Atlanta attractions**
For those who are looking for something to do after attending courses and visiting the exhibit hall, Atlanta is considered one of the most exciting cities in the country. There are plenty of places to eat, shop and visit, including the following:
- Atlanta Botanical Gardens
- Atlanta History Center
- Braves Museum & Turner Field
- Fernbank Museum of Natural History
- High Museum of Art
- Jimmy Carter Library & Museum
- Margaret Mitchell House
- Martin Luther King Jr. National Historic Site & Sweet Auburn District
- Piedmont Park
- The Children’s Museum of Atlanta
- The Fox Theatre
- Underground Atlanta
- Woodruff Arts Center
- Zoo Atlanta

More information on the Hinman meeting is available online at [www.hinman.org](http://www.hinman.org).
Want to update your knowledge of implants?

Can’t make it to Heidelberg, Germany, for the eigth annual “Update Implantology” at the Steigmann Institute? Not to worry!

You can still catch the high-quality implant program, covering the most current topics in implantology. This meeting is geared toward new implantologists who want to update their knowledge of implants.

The program features a panel of renowned international speakers, who will share their recent findings and methods about surgery and prosthetics.

The FIZ Heidelberg e.V. and young implantologists developed this program to specifically provide an overall perspective on the new developments in implant dentistry.

Collaborating with different societies, a neutral view on established therapeutic methods and updated treatment aspects are offered.

Participants will learn tips and tricks to use immediately in their daily practice. The workshops and the pre-congress will provide a deeper insight on methods to improve everyday skills.

Take advantage of DT Study Club’s online version of this event in the course Update Implantology VIII. The program begins at 7:20 a.m. EST, Friday, March 26, and at 5 a.m. on Saturday March 27.

If you sign up for the live event, you will also have 50-day access to the recorded archive of each lecture (which means you can sleep in on Saturday and watch the courses you missed at another time).

The online course fee is $265, which is a 50 percent discount from the regular course fee.

All congress lectures will be simultaneously translated into English from German.

Friday, March 26
• 7:20–7:50 a.m. EST
  Dr. Frank Kistler, Landsberg
  Socket preservation as an alternative to immediate implant placement
• 7:50–8:20 a.m. EST
  Dr. Thomas汉瑟, Olsberg
  Hard- and soft-tissue management with predictable results: guidelines to esthetical and functional implant success
• 8:20–8:50 a.m. EST
  Dr. Jordi Gargallo-Albiol, Barcelona
  Immediate loading: Where are the limits?
• 8:50–9:05 a.m. EST
  Discussion

The program ends at 10:45 a.m. EST.

For additional information, please visit www.dtstudyclub.com.
Remember when you were little and you lost a baby tooth? The toothfairy was very real to you then, an airy apparition who visited you overnight and left something wonderful under your pillow.

Some people believe they’ve outgrown the toothfairy, that she has become obsolete. Not so fast: the toothfairy has evolved into someone we can all believe in.

Today’s toothfairy has transitioned from simply rewarding children for their lost teeth to a very important role of helping children retain their permanent teeth, have beautiful smiles and enjoy healthier lives.

This little mystical icon has become a dedicated champion in the fight against the No. 1 chronic childhood illness in our country: pediatric dental disease.

Now a revolutionary Superhero armed with a powerful message, she is not just any toothfairy; she is America’s toothfairy.

For many years caring dental professionals, including pediatric dentists, dental hygienists and other health-care groups, have worked tirelessly to bring dental treatment and preventive therapies to underserved children.

Despite their efforts, however, pediatric dental disease continues to increase in America, causing pain and suffering for millions of children.

Dental disease affects us all
Children with untreated dental disease may find it difficult to eat, sleep and speak clearly, which affects their ability to concentrate in school, make friends and develop the social skills necessary to be successful adults.

It is a progressive disease, and children’s suffering worsens as they get older. They can experience chronic pain, and they can face gum disease, broken or lost teeth, abscesses, infections and even risk of death.

Until recently there was little emphasis on the connection between the mouth and a person’s overall health. Studies are now widely available that link tooth decay to heart disease, stroke, diabetes, pneumonia, poor pregnancy outcomes, secondary infections and dementia. But that is only part of the inherent risk. There is also a logical progression associated with this disease:

A child experiencing mouth pain may have difficulty eating a balanced diet with foods such as vegetables and grains, which are notoriously harder to chew.

Additionally, a child suffering from pediatric dental disease is often not able to chew properly or long enough to promote good digestion, resulting in the loss of valuable nutrients.

Malnutrition because of dental complications ultimately leads to poor growth development, weakened bones and muscles, allergies, inability to concentrate, emotional problems and other systemic health ailments not immediately recognized as being linked to tooth decay.

According to the U.S. Department of Health and Human Services, more than 51 million school hours and 164 million hours of work are lost each year due to dental related absences.

The number of Americans without dental insurance is almost three times the number of those lacking medical coverage, and uninsured
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children are two and a half times less likely than insured children to receive dental care. When these neglected mouths finally demand attention it is often through emergency room treatment, costing taxpayers millions of dollars each year for a disease that is largely preventable.

Information released by the Coalition on Oral Health Care estimates that for every $1 spent on oral health preventive measures, as much as $50 is saved in emergency and restorative treatment expenditures.

Overall higher health-care costs and insurance premiums, lower productivity levels of the workforce and even costs related to an elevated crime rate are a price we all pay when children with dental pain go untreated.

It’s easy to see the need for a certain kind of magic to fight pediatric dental disease. Fortunately, the toothfairy has evolved into America’s toothfairy and she is coming to the rescue.

America’s toothfairy: delivering hope

The National Children’s Oral Health Foundation is America’s toothfairy, a non-profit organization solely focused on eliminating America’s most common chronic childhood illness — pediatric dental disease — through comprehensive treatment and preventative and educational initiatives.

America’s toothfairy (www.americastoothfairy.org) serves as a national resource for health-care professionals and individuals alike. Whether they are currently working to combat this devastating and preventable disease or looking to join the fight.

The organization raises public awareness of pediatric dental disease and the lifelong health complications associated with it, while supporting an affiliate network of non-profit oral health programs providing comprehensive care to underserved children across America.

In less than four years, America’s toothfairy has delivered more than $6 million in valuable product contributions and direct funding to affiliate partners, touching the lives of more than 1 million children nationwide! Because generous corporate underwriters cover all operational expenses, every additional dollar contributed to America’s toothfairy is allocated to programs giving children a healthier future.

The toothfairy has long been a symbol of the magic of childhood, a mystical figure only materializing as a child lay peacefully asleep, dreaming of the gifts to be found under his or her pillow the next morning.

Over 4 million children in America are suffering right now from oral pain so severe it keeps them up at night. For those children, and for anyone concerned with the healthy growth and development of our nation’s most valuable resource, National Children’s Oral Health Foundation has created America’s toothfairy.

She is a symbol of change: an educator, preventer, protector and, perhaps most importantly, a source of hope for children everywhere.

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Coupled with the market’s only air-cushioned swivel, these handpieces provide unmatched maneuverability, free from drag caused by the tubing. This series of handpieces comprises the Bora turbine, characterized by its extraordinary power, and the Prestige turbine, fitted with one of the smallest heads available on the market. In addition to the lightweight carbon fiber core and luminous LED light, Bien Air’s Swiss-made Blackline handpieces utilize dual-optic glass rods, triple-separated air and water spray for perfectly balanced cooling, long-lasting ceramic ball bearings, an anti-heat push button and a vibration-free chuck assembly.

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Plak Smacker has announced the latest addition to its line of toothbrushes: the Splash Brush. The Splash toothbrush is available in four bright colors: orange, blue, purple and green.

This toothbrush has a comfortable, contoured handle for easy grip while brushing. The soft bristles add to the comfort of the Splash Brush and provide gentle massage to the teeth and gums. Patients are sure to rave about this brush. For more than 20 years, Plak Smacker has been focused on introducing new, innovative products to help patients feel good about a trip to the dental office.

For more information or to place an order, please call (800) 558-6684 or visit www.plaksmacker.com.

Pentron Clinical Technologies product manager Jeremy Grondzik said, "Ideal handling characteristics together with the ability to instantly light cure to a depth of 10 mm puts the clinician in complete control of the core build-up procedure from start to finish."

Once cured, Build-It Light Cure performs just like the original Build-It FR, meaning it sets to a rock-hard consistency that cuts like dentin. Non-sticky, sculptable handling that enables quick and easy adaption to tooth structure and the post are made possible by way of a proprietary new BisGMA-free resin.

To satisfy individual dispensing preferences, Build-It Light Cure Core Material is available in both a syringe and single dose delivery option.

Build-It Light Cure Core Material is one of the latest innovations from Pentron Clinical, an established leader in the dental consumables industry, offering a wide variety of affordable products to suit your restorative needs. As one of the pioneers of fiber post and nano-hybrid composite technologies, Pentron Clinical continues to demonstrate its commitment to the technological advancement of dentistry.

The company’s portfolio of innovative and award-winning dental products includes: Fusio™ Liquid Dentin, Bond-1® SF Solvent Free SE Adhesive, Mojo® Light Cure Veneer Cement and FibreKleer® Posts. For more information, call (800) 551-0285 or visit www.pentron.com.

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**Early Bird Registration Deadline:**

30 April, 2010
The adjacent tooth is innocent

By Jan Johansson, DDS

When composite was first introduced for Class II fillings, the most common matrix technique used was the same as that for amalgam, a stainless-steel band wrapped around the whole tooth in conjunction with a retainer. There are many problems with this technique: attaining a good contact point, the retaining ring dislocating the position of the teeth, leakage of material and cervical overhang.

Major studies have concluded that during preparation for Class II fillings, in more than 60 percent of cases the adjacent teeth suffer damage unless adequately protected.

The recent global focus on minimally-invasive dentistry has greatly increased interest in tissue preservation. There has also been a strong interest in being able to prepare and complete Class II fillings with a both faster and safer technique and method.

In 2004, the Swedish dental manufacturing company Directa AB developed both a preparation protector, FenderWedge®, and a sectional matrix system, FenderMate®, to meet the urgent demands for a modern, more efficient and safer protection and matrix system.

FenderWedge is a stainless-steel matrix plate to protect the tooth, affixed to a soft plastic wedge, the wedge that compacts the gingival papilla. During preparation, the wedge has a separating effect on the teeth — “pre-wedging” — simplifying insertion of the matrix. FenderWedge is available in four sizes to accommodate interdental spaces, XS, S, M and L, and are color-coded for identification.

FenderMate is a combined section matrix and wedge that may be inserted buccally or lingually. The matrix has a pre-contoured curvature to adapt to the tooth and a pre-formed contact point. It reduces the possible risk of excess filling material remaining on surfaces, especially cervically, under the contact point.

Thus, the contact is achieved directly during application and the whole process is simple, fast and safe. FenderMate is available for left or right application and has a regular or narrow attached wedge. It is also color-coded for ease of identification. FenderMate can accommodate around 60 percent of all Class II cases.

Dr. Johansson has been a dentist and private practitioner in Stockholm since 1968. He is a member of the board of the Swedish Dental Society and chairman of Dental Vision, an independent group of 400 dentists working for dental clinical development. Since January 2008, he has been at Directa AB, as a consultant, advising on product development.

Botox/dermal filler injections

Botox and dermal filler injections have been recently introduced to the dental field and are performed by a growing number of dentists worldwide.

These injections were a major education training course at the 2009 Greater New York Dental Meeting. They will be included in the education program of the 2010 AEEDC meeting in Dubai, expanding worldwide awareness of these procedures for dentistry.

Botox injections can be used for dental treatments such as TMJ and implantology. Dermal fillers can be used when dealing with asymmetrical lips, minimizing underlining skeletal discrepancies and many other uses.

To administer Botox and dermal filler injections, the mouth and lip area need to be anesthetized. A common method is to give an infraorbital nerve block injection. This can be a painful injection if a device such as VibraJet® is not used to block the pain.

Dr. Louis Malcmacher, a leading opinion leader in the United States for Botox and dermal filler injections for dentistry, has used VibraJet and provided this endorsement: “Infraorbital and VibraJet is great for that and any regular dental injections.”

For more information on VibraJet, visit the ITL DENTAL Web site at www.itldental.com.

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World dental implant and bone graft market to top $4.5b by 2012

Global sales of dental implant systems — fast becoming the preferred restoration for replacement of missing or extracted teeth or as supports for dentures, crowns and bridges — are expected to maintain double-digit growth over the next five years, soaring to more than $4.5 billion, according to "Implant-Based Dental Reconstruction: The Worldwide Dental Implant and Bone Graft Market," second Edition, a new study released from Kalorama Information.

Sales of dental implants and abutments rose more than 15 percent in 2006 alone, reaching nearly $2 billion, led by Europe, where the popularity of implants saw sales peaking at $760 million, or 42 percent of the global market.

Advanced bone grafting and regeneration techniques have radically expanded the possibilities for implant-based restorative dentistry. World sales of dental bone grafts reached $150 million in 2006, up 12 percent over 2005. The report projects the use of bone grafts will more than double by 2012 with revenues reaching $266 million.

Grafting techniques are making it possible to expand the candidate pool for implants to include a sizable population of edentulous patients who were poor candidates for dental implantation due to severe bone resorption.

"The most closely watched global market research and development projects in dental bone grafting today involve bone morphogenic protein [BMP] products. BMPs have the potential to transform the bone grafting market and surpass all other products on the market including synthetic substitutes, allografts and demineralized bone matrices," notes Anne Anscomb, the report’s author.

"With the announcement in March that the FDA approved Medtronic’s InFuse Bone Graft for certain oral maxillofacial and dental regenerative bone grafting procedures, the future of BMP and increased use of grafts and implants looks very promising."

Implant-Based Dental Reconstruction includes revenue forecasts for each segment through 2016, global market share for four geographic regions, more than 35 tables and figures with detailed market data, reviews of new products and computer-aided dentistry and reimbursement trends.

It can be purchased directly from Kalorama Information by visiting www.kaloromainformation.com/Implant-Based-Dental1199457. It is also available at MarketResearch.com.

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Dentist population could contract by 2012

Recent survey projects that retirement and career changes could outpace the number of dental graduates

If current trends continue, getting an appointment with a dentist might become more challenging in coming years. A recent survey by the independent research firm The Long Group, and sponsored by the not-for-profit Delta Dental Plans Association, found that the dentist population could begin to contract as early as 2012.

Researchers looked at current dentist retirement rates and at survey responses from dentists who expressed a desire to make a career change within the next five to 10 years and compared those numbers with the current dental school graduation rate.

Projecting these trends into the future, the study found that the 2009 dentist population of approximately 179,600 will increase through 2011 but retirement and career changes could outpace dentist school graduation beginning in 2012.

By 2019, the dentist population could be smaller by nearly 7,000, assuming consistent dental school graduates of 4,500 annually.

“As more people acquire dental coverage through an employer, an individual policy or through some form of government-assisted program, it is crucial that dentists are available to actually see and treat them,” said Kim E. Volk, president and CEO of Delta Dental Plans Association.

“With more than 132,000 dentists participating in our network, we’re interested in helping affect, not just monitoring, these trends,” said Volk.

Groups such as Delta Dental and others are having success attracting dentists to underserved areas and are providing prospective dentists with some hope that they won’t leave school with insurmountable debt.

According to the American Dental Education Association, graduates of dental school enter the workforce with an average of $170,000 of debt. Increasingly, a dentist who is willing to practice in a federally designated
Grow your dental practice

Three ways to start doubling your growth right now, even if you've hit a plateau

By Jay Geier

How would you like to double your practice growth? How would you like to double your net income? Of course you would! But what we want and what actually happens are two different things.

When you first started your dental practice, you felt the excitement. You experienced large percentages of growth for the first few years. Then your dental practice became stagnant.

You're not seeing growth in your dental practice now. Your “adjusted gross income” and “net income” decreased to the point where it depresses you to look at the numbers on your tax return.

You have hit a plateau, and it is commonplace for all businesses, including dental practices, to hit a plateau at some point in their life. Many will hit multiple plateaus.

I completely understand why hitting a plateau or even a decline in business would depress you. It’s because you’re seriously feeling the squeeze. You discovered that your expenses don’t plateu just because your income has flattened or declined.

• Your staff wants more money.
• You need more space.
• You need to purchase updated and emerging technologies and equipment.
• It takes more money to run your practice.

Not only do your expenses rise at the office, but they rise at home too. You’ve got kids, private schools, bigger houses, insurance, higher taxes. So how can you as a dental practice owner get off the plateau, take your business to the next level and make more money?

Get the right training, skills and resources you need to build your business

Look, you’re either on plan, off plan or you don’t even have a plan. If you have been in practice for any significant amount of time and you are not investing heavily in your practice, I wouldn’t be surprised if you’re experiencing a plateau in your business right now.

You see, if you’re not learning better ways to build your practice then you are just doing the same thing over and over again. How is that going to solve your problem and take your practice to the next level? It isn’t.

Get the right employees: implement a ‘no mediocre employee’ tolerance policy

With so many people unemployed today, you can find top talent. There is no reason why you have to accept mediocre performance.

Remember, you get what you deserve.

If you hire mediocre employees or if you keep mediocre employees, then you deserve to get mediocre or subpar results along with the gray hair you’ll get for dealing with these people.

In addition, it doesn’t take much effort to hire the right staff. In fact, I have a hiring system that allows you to hire new staff with less than 60 minutes of your time.

Get a ‘no excuse’ mind-set

If you want to shorten the lifespan of your plateau, then you need to stop being your own worst competitor. I mean this in the most caring, loving way. You make and accept too many excuses for why you can’t get new patients.

For example, you blame the recession. Yes, many small and large businesses are failing. However, we’ve doubled our business in this economy. I have clients who’ve been practicing dentistry for 35 years and they had their best year ever in 2009.

A few of these top performers are Michiga — one of the hardest hit states during the recession. If they can get new clients and double their practices, so can you.

Yet, you have to adopt what I call the “two-economy system” mind-set that accepts no excuses.

If I define the two-economy system as putting yourself in a bubble where the economy is good, and keeping everything out of the bubble that you don’t have control over.

Thus, unlike most dentists who let all of the negative energy ooze into their office and into their existence, I reject it like the plague.

I adopted the policy that you get what you deserve; there are no excuses. I haven’t made an excuse in 20 years.

If I get a bad result, I probably deserved a bad result. It’s that simple. So, I don’t make excuses. I just say, “I got what I deserved, and I need to figure out why and how I’m going to fix it so I get a better result next time.”

If you can figure out what actions and efforts it takes to deserve more, then “Bingo!” You can get it.

If you make excuses about your ability to generate new patients, such as your town or the economy or whatever other pathetic, whiny excuse you might have made in the past, you literally cannot do anything. It immobilizes you.

Want to start growing your dental practice?

Here are your next steps:

• Get the training you need.
• Adopt a “no mediocrity” tolerance policy.
• Don’t make or accept excuses.

When you complain, whine and moan, you take all the power out of your dental practice and completely destroy the mindset of your staff.

Remember, it starts with you. Are you ready to grow your dental practice?

About the author

Jay Geier says he adds 10 to 50 percent more new patients to his clients’ practices with little or no change to their marketing or advertising budget by simply leveraging their staff and getting them to focus on new patients as their No. 1 priority.

To see how your staff stacks up against your competition and more than 10,000 practices worldwide when it comes to turning prospects into scheduled appointments, take Geier’s new five-star challenge for free at www.schedulinginstitute.com.

Dr. Arrom McWilliams practices in rural Crawford County, Iowa, thanks in large part to the Fulfilling Iowa’s Need for Dentists (FIND) program, funded jointly by Delta Dental of Iowa and local business, government, health and civic organizations.

With a population of just more than 7,000, the city of Denison might not have been the first choice of a dentist looking to establish a practice.

“If it was not for the FIND program, Dr. McWilliams would be practicing in another community,” said Don Luensmann, executive director of the Chamber and Development Council of Crawford County.

A similar sentiment is expressed by leaders in other rural parts of the country.

“Our health-care providers play a key role in our community’s economy,” said Jeffrey Johnson, branch president of BankWest in Gregory, S. D., a town with fewer than 2,000 people. “Delta Dental’s loan repayment program is helping ensure that our city’s one dental practice remains open.

“These types of programs are proving to be a win-win-win,” said Volk. They’re a win for the dentist who needs to pay down debt, a win for the local economy and a win for the residents in need of care.”

Delta Dental member companies currently support dentist school loan repayment programs in Arkansas, Iowa, South Dakota, Maine, New Hampshire and Vermont. Delta Dental also invests millions of dollars in dental education throughout the country.

The not-for-profit Delta Dental Plans Association (www.dtdental.com) based in Oak Brook, Ill., is a national network of independent dental service corporations specializing in providing dental benefits programs to 54 million Americans in more than 89,000 employee groups throughout the country.

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