Diagnose this: white lesions
The first in a series on the different types of mucosal and soft-tissue pathologies. ► page 64

How to reach practice goals?
Learn what has the most impact when it comes to achieving your practice’s goals. ► page 74

New products and more
Take a peek at some products that might be unfamiliar to you. ► pages 19A–22A

Retired orthodontist gives $4 million to East Carolina University School of Dentistry

By Fred Michmershuizen, Online Editor

Dr. Ledyard E. Ross, an 84-year-old retired orthodontist, has pledged $4 million to East Carolina University (ECU) School of Dentistry. The gift, one of the largest in the history of the university, will be used for student scholarships, faculty research and other academic enterprises.

Ross is a 1951 graduate of ECU (then called East Carolina College). He has been a supporter of several academic and athletic initiatives at the university since establishing his dental practice in Greenville. He is a member of the Leo Jenkins Society and Order of the Cupola.

Ross attended Greenville High School and Hardbarger Business College before being admitted to East Carolina College. He graduated from Northwestern University Dental School with a DDS in 1953, and he received a master of science degree in orthodontics in 1959 from UNC-Chapel Hill. He served in the U.S. Marine Corps First Marine Division from 1945 to 1946.

His financial gift comes at a wel-

Crown or same-day onlay?

Patients want to replace their old amalgam fillings, but they want to do it conservatively, consistently, efficiently, predictably and economically — and they want to do it in one visit. Review the advantages associated with indirect laboratory-processed composite resin posterior restorations and see the case study presented by Dr. Lorin Berland.

► See pages 10A–13A

EDA is recommending that dental professionals make the following Earth Day resolutions to reduce waste and pollution.

Use an amalgam separator
Even if you don’t place amalgams, you still need an amalgam separator, according to the EDA. In a typical

► page 2A

5 ways dental practices can reduce waste and pollution

Dr. Ledyard E. Ross, a retired orthodontist, stands before an artist’s rendering of the new building that will house the School of Dentistry at East Carolina University. The building will bear his name. (Photo/Cliff Hollis, ECU News & Communication)
Cloth sterilization wraps and pouches and reusable cloth patient bibs and barriers, popular in high-tech and spa practices, help dentists significantly reduce their environmental footprint. When a paper-plastic pouch is the best solution, separate the paper from the plastic and recycle it appropriately, the EDA says.

**Detoxify your infection control processes**

Using the right non-toxic, biodegradable cleaner and disinfectant is an important component of pollution-preventing infection control, according to the EDA.

Line cleaners and cold sterile solutions such as glutaraldehyde are a significant source of pollution from the dental industry and contribute to poor indoor air quality.

Modern dentistry has eliminated the need for cold sterilization, and there are several environmentally safe line cleaners on the market.

Making a switch to the non-toxic option will keep your office in compliance with hospital infection control standards while eliminating the “dental office smell” that patients hate, the EDA says.

**Take digital images**

Dental radiographs are an important component of pollution-preventing infection control. “Detoxify your infection control processes” to help dental professionals become litter-free while maintaining the highest infection control standards.

Tell us what you think!

Do you have general comments or criticism you would like to share? Is there a particular topic you would like to see more articles about? Let us know by e-mailing us at feedback@dental-tribune.com. If you would like to make any change to your subscription (name, address or to quit out) please send us an e-mail at dstubs@dental-tribune.com and be sure to include which publication you are referring to. Also, please note that subscription changes can take up to 6 weeks to process.

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Dental museum adds exhibit

By Fred Michmershuizen, Online Editor

The National Museum of Dentistry, located in Baltimore, has added a new exhibit that will help teach the public about the American College of Dentists, the oldest national honorary organization for dentists.

The gold-plated mace and torch that have been used in American College of Dentists membership ceremonies for nearly 70 years are among the highlights of the new exhibit. The display also features an American college of Dentists' Fellowship pin, key and rosette. Also on view is the William J. Gies Award, which recognizes college fellows who have made outstanding contributions to the advancement of the profession.

“The National Museum of Dentistry preserves and celebrates the history of the dental profession,” said Jonathan Landers, executive director of the museum. “This is the perfect place to showcase these fragile and magnificent historic symbols of such a respected organization in dentistry.”

The American College of Dentists is the oldest national honorary organization for dentists. It was founded to elevate the standards of dentistry, encourage graduate study, and grant fellowship to those who have done meritorious work. Membership in the American College of Dentists is by invitation only.

There are more than 7,400 fellows, who are selected based on their contributions to organized dentistry, oral health care, dental research, dental education, the profession and society. Long regarded as the “conscience of dentistry,” its mission is to advance excellence, ethics, professionalism and leadership in dentistry.

“We are honored to have the mace and torch on view at the National Museum of Dentistry,” said Dr. Stephen Ralls, executive director of the American College of Dentists. “They represent an important historical link to key leaders of dentistry from the early 20th century onward.”

About the mace and torch

When the American College of Dentists was founded in 1920, a symbolic light—the torch—was designated to signify the role of the college as a source of enlightenment and guidance. The torch was crafted in 1939 by the Gorham Silver Co. of Providence, R.I., to serve as a symbol of office.

The fluted staff, more than two feet long, is made of gold-plated bronze and decorated with ribbons engraved with the names of the founders of the American College of Dentists. “They represent an important historical link to key leaders of dentistry from the early 20th century onward.”

Two Egyptians holding the ends of an open scroll, is supported by depictions of 11 Egyptian scholars and a modern graduate.

To visit the museum

The National Museum of Dentistry is an affiliate of the Smithsonian Institution. Other exhibits include George Washington’s false teeth, vintage toothpaste commercials and hands-on displays that are meant to educate visitors of all ages about the power of a healthy smile.

The museum is located at 31 S. Greene St., not far from Baltimore’s Inner Harbor. Admission is $7 for adults, $5 for seniors and students with ID, $5 for children age 5–19, and free for ages 2 and younger. It is open Wednesday through Saturday from 10 a.m. to 4 p.m. and Sunday from 1 to 4 p.m. The museum is closed Mondays, Tuesdays and major holidays.

More information about the museum is available by phone, at (410) 706-0800 or online, at www.smile-experience.org.

(Source: National Museum of Dentistry)

The gold-plated mace of the American College of Dentists, at right, is now on display at the National Museum of Dentistry in Baltimore. (Photo/National Museum of Dentistry)
CareCredit®, a patient payment program, continued its support as founding donor of the American Dental Association Foundation Give Kids A Smile® expansion fund with its fourth consecutive $100,000 donation. The donation was made at the Give Kids A Smile National Advisory Board meeting, Feb. 24 in Chicago.

The American Dental Association’s Give Kids A Smile program has two objectives: first, to enable dental teams to provide free dental care, screening and education to underserved children; and second, to raise public awareness that the children of this country deserve a better health-care system that addresses their dental needs.

In 2009, with the help of CareCredit’s contribution, grants were awarded to the Hispanic Dental Association (HDA), the National Dental Association (NDA) and Oral Health America. The HDA is using its grant to fund local dental student-led oral-health programs in Los Angeles, Dallas and Boston.

The NDA is enhancing the Deamonte Driver Dental Project and Los Angeles, Dallas and Boston.

The NDA is enhancing the Dea monte Driver Dental Project and has assembled its Dentists in Action network, including the Aesthetic Dental Group, the National Dental Associates, the American Dental Association Foundation and other dental organizations.

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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.
The purpose of this quiz, and the ones to follow, is to assist you in understanding the different types of mucosal and soft-tissue pathologies with different colors (red, white, mixed red/white) and other pigmented lesions seen in the oral cavity.

There has been a trend to ignore the overall examination of the oral-cavity and concentrate more upon the chief complaint a patient presents.

In this process we often don’t take advantage of the so-called “mirror of general health.” We can always take a little more time to overview the entire oral cavity, including the oral mucosa.

Please feel free to contact me with any feedback or questions you may have.

Part 1: case study
A 45-year-old, healthy man visited his dentist for tooth pain and was informed that his mouth contained “disease in disguise.”

Upon oral examination, buccal-mucosa showed hyperkeratotic white, slightly elevated, diffuse patchy lesion extending toward the commissures of the mouth on the left side.

The lesion was non-scrapable in nature.

The patient had a habit of smoking five to six bidis (a crude form of cigarette used in India) a day for the past four years.

1) What provisional diagnosis would you make of this lesion?
   a. Leukoplakia
   b. Linea alba
   c. Lichen planus
   d. Leukoedema
   e. Candidiasis

See page 15A for the answer.
Looking for ‘love’ in all the wrong places

Which aspect of your practice has the most impact on your bottom line?

By LouisMalemacher, DDS, MAGD

As a practicing dentist and a dental consultant, I know exactly where dentists are coming from when they describe their daily challenges to me. I hear routinely from dentists about all kinds of problems they are experiencing.

Every dentist that I talk to wants to know how to get more new patients, how to properly market their practice, how to be faster and more efficient clinically, how to reduce overhead, how to motivate more patients to bigger and bigger treatment plans and a whole host of other issues that are constantly on a dentist’s mind.

Dentists will spend all kinds of money on books, tapes, consultants, marketing programs, newsletters and all sorts of other things that they think may improve a particular part of their practice. Most dentists who are looking for these solutions are always, as I like to say, “looking for love in all the wrong places.”

Dentists often overlook the most obvious and impactful part of their practice: the dental team that they work with every single day.

The team

Having a great dental team will significantly improve all aspects of your dental practice immediately and for the long term. Having a great dental team solves so many of the issues and the challenges that dentists face every single day.

Do you want more patients? Your dental team should be out there asking everybody they know if they need a dentist as well as every single patient that comes through the door about referring their own families and friends as new patients to the practice.

Do you want to market your practice better and more efficiently? Having great dental team members who will carry your message with them into every single treatment room will accomplish that.

Do you want to motivate patients to more comprehensive dentistry and more elective dental procedures such as Aurum Ceramics Cristal Veneers? A great dental team will take the time to plant seeds in patients’ minds about what dentistry can accomplish, and these staff members are the most effective communication team you could possibly have.

It always amazes me that a dentist will spend thousands of dollars on a computerized education system that will describe dental procedures when a talented dental assistant can do the same thing with that human and personal touch. By the way, that doesn’t mean that digital education materials aren’t useful.

If your dental team members are poor communication skills, your office will never reach its full potential. Staff appreciation is one of the most overlooked, inexpensive and easiest ways to begin to develop a great dental team.

The team members

Do you want to reduce your overhead? A great dental team will certainly help you accomplish this by streamlining so many of the inefficient processes that occur in daily dental practice and will help the dentist accomplish dental treatment much faster, easier and better.

Do you want to improve your cash flow and account receivables? A great dental team is the road to success in every dental office in every single aspect you could possibly imagine.

Valued partners in success

I see dentists wasting their time and money buying into all kinds of gadgets, toys, scams and supposed “systems for success” when they should be spending their time, energy and effort developing and motivating their valued staff members.

Every week when I am giving a lecture, for the most part, I can see immediately who the more successful dentists are just by looking at the audience in the first two minutes of the lecture. The most successful dentists I know and that I see at my lectures are the ones who have their dental team members sitting right next to them at the events they attend.

If you, as a dentist, go to a lecture and want to learn about something new or want to institute a new system in your office and you attend the lecture alone and then return to the office, your staff members will not have the same enthusiasm that you developed or the same initial level of interest.

You must then force this new idea down their throats, to which they become resentful. Success in this scenario is going to be limited, but more likely will not happen. It frustrates me because I know the solution is really so simple.

Look at your dental team members as the valued partners in success that they really are. Staff appreciation is one of the most overlooked, inexpensive and easiest ways to begin to develop a great dental team.

It may surprise you to know that in many major studies in employee relations, money is not the most important factor to employees. No. 1 is staff appreciation and No. 2 is having a pleasant place to work in.

If your dental team members also realize they are fulfilling a mission of improving peoples’ lives through excellent oral health that also gives them a great sense of purpose.

You could pay a dental assistant $100 per hour, but if she is miserable in the work environment, your office will never be successful. You could pay your front desk team member $100 per hour, but if you have never invested in having him develop the necessary skills to talk to patients, your office will not be successful.

If you pay your dental hygienist $100 per hour and she is just a housekeeper with no communication skills, your office will never reach its full potential.

Being in the ‘people’ business
Ultimately, dentistry is a people business. To be successful in this field, you have to love people and hire people who love people. If you hire people who love people, your office will become a different place.

Stress in dentistry is caused by the people who work in your office who are stressing themselves, you and your patients. Once your patients are stressed, they will stress you even more.

Hiring the right staff is the first step along the road to a happy office. The next steps include working with your team members and constantly training them and yourself in how to do better clinical dentistry, how to be better communicators, how to serve and how to achieve all of your goals together.

This has so frustrated me as I lecture to thousands of dentists a year that I have some resources on my Web site, www.commonsensedentistry.com, about building the best dental team ever.

You need to know how to hire, evaluate and give a bonus to great team members. You must lead and motivate team members with your vision of what you want your practice to be. It really is this simple: if you have a great dental team, you will have a great office!

The simple road to success
Stop wasting your time and money on all the schemes and supposed shortcuts out there that you think may improve your office from the outside in.

Hire, develop and motivate a great dental team by learning leadership skills and build your office from the inside out. It doesn’t help you at all to get 100 new patients per month if your team members do not have the capability or the interest to properly build relationships with your patients.

You, as a dentist, typically spend 50, 40 or 50 hours per week in your dental practice — it is equally as easy to be happy there as it is to be miserable. Life is too short to spend your time in a miserable situation.

In addition, what does your office team look like? Do they have great smiles, are they well groomed, do they dress nicely and cleanly? This says a lot about your practice.

If you are looking to build an esthetic practice, patients are more apt to accept treatment plans from team members (and dentists!) who have a great looking smile and great facial esthetics.

Now that nearly 10 percent of dentists are providing Botox and dermal fillers, it is not just about the teeth anymore in the dental office and the same is to be said about facial esthetics.

I often joke that Botox is the secret to staff retention — once you provide this to your team, they will never leave you because this is a repeat procedure.

Yet the street here runs both ways — it helps build your practice when everyone looks their best — they feel better about themselves from a self-esteem perspective, they transmit a more positive image and treatment acceptance will go up.

If your dental office is a place that loves to work with people, that attitude alone will solve so many of the issues that have frustrated you throughout your career.

When we consult with dental offices and turn their team members around, and make them great and sincere communicators, the office becomes a stress-free, high-producing, low-overhead, fun place to work for everyone.

It is amazing what a little appreciation and respect will do in motivating and building a great dental team.

It is the quickest and straightest road to dental practice success.

A great dental team can …
• help market your practice more efficiently.
• help motivate patients to accept treatment recommendations and elective procedures.
• help improve cash flow and account receivables.

Dr. Louis Malcmacher is a practicing general dentist in Bay Village, Ohio, and an internationally known lecturer and author known for his comprehensive and entertaining style.

An evaluator for Clinicians Reports, Malcmacher has served as a spokesman for the AGD and is president of the American Academy of Facial Esthetics.

You may contact him at (440) 892-1810 or e-mail dryowza@mail.com.

You can also see his lecture schedule at www.commonsensedentistry.com where you will find information about his Botox and dermal filler live patient hands-on training, practice-building audio CDs and free monthly e-newsletter.
When It’s Time to Buy, Sell, or Merge Your Practice
You Need A Partner On Your Side

ALABAMA
Birmingham—2 Ops, 2 Hygiene Rooms, GR $675K #10108
Shaw Low—2 Ops, 2 Hygiene Rooms, GR in 2007 $645,995
Phoenix—General Dentist seeking Practice Partnership
Nashville—4 Ops, 3 Hygiene Rooms, GR $410K
Contact: Dr. Jim Cole @ 404-513-1373

ARIZONA
Artzow—Doctor seeking to Purchase General Dental Practice. #21101
Shaw Low—2 Ops, 2 Hygiene Rooms, GR $185,995
Phoenix—General Dentist seeking Practice Partnership
Tucson—2, 1,800 active patients, GR $950K, Asking $950K
Contact: Tom Kimbrel @ 602-516-3219

CALIFORNIA
Alturas—5 Ops, GR $611K, 3 1/2 day work week #14279
Alvina—2 Ops, 1,400 sq. ft., GR $777K #14972
Bakersfield—3 Ops, 1,300 sq. ft., GR $1,065,500 #14209
Great Basin Area—4 Ops, 1,800 sq. ft., GR $763K #14304
Modesto—7 Ops, GR $1,040,567 #14283
Modesto—12 Ops, GR $1,697,000, Name location for 10 years #14289
Monterey—3 Ops, GR $840K #14188
Napa County—4 Ops, 1,500 sq. ft., GR $595K #14295
Pine Grove—Nice 3 Ops fully equipped office/practice GR $111,000 #14169
Porterville—6 Ops, 2,000 sq. ft., GR $2,289,000 #14291
Red Bluff—8 Ops, 6,000 sq. ft., GR $1,000,000, Hygiene 10 days a week #14252
Contact: Dr. Dennis Hoover @ 805-519-3595

CONNECTICUT
Fairfield Area—General practice doing $800K #16106
Southington—2 Ops, GR $250K #16111
Wallingford—2 Ops, GR $600K #16113
Contact: Dr. Peter Goldberg @ 203-680-2910

FLORIDA
Miami—5 Ops, Full Lab, GR $835K #18117
Jacksonville—2 Ops, GR $135K #16111
Jacksonville—4 Ops, 3,000 sq. ft., 7 Ops, 8 days hygiene #18118
Contact: Donna Wright @ 800-730-8883

GEORGIA
Atlanta Suburb—2 Ops, 2 Hygiene Rooms, GR $500K #19125
Atlanta Suburb—2 Ops, 2 Hygiene Rooms, GR $500K #19128
Atlanta Suburb—1,270 sq. ft., GR $436,365 #19131
Atlanta Suburb—Pediatric Office, 1, Op, GR $426K #19134
Dublin—GR $1 Million, Asking $825K #19107
Macomb—3 Ops, 1,625 sq. ft., State of the art equipment #19103
McKinney—2 Ops, 2 Hygiene Rooms, GR $675K #19132
Northeast Atlanta—1 Op, GR $573K #19129
Northern Georgia—4 Ops, 1 Hygiene, Ext. for 43 years #19110
South Georgia—4 Ops, 2 Hygiene Rooms, GR $722K #19133
Contact: Dr. Jim Cole @ 404-513-1373

ILLINOIS
Chicago—4 Ops, GR $370K, Sale Price $461K #22126
1 Hr SW of Chicago—5 Ops, 2007 GR $440K, 28 years old #22123
Chicago—2 Ops, GR $600K, 3 day work day #22119
Gurnee—GR $180K, located in Historic Bed & Breakfast Community #22120
Western Suburbs—5 Ops, 2-3200 sq. ft., GR Approx $15,5MM #22120
Contact: Al Brown @ 630-781-2176

MARYLAND
Southern—11 Ops, 5,500 sq. ft., GR $1,880,692 #29101
Contact: Sharon Maccari @ 410-788-0711

MASSACHUSETTS
Boston—3 Ops, GR $252K, Sale $179K #30122
Boston Southshore—3 Ops, GR $300K #30125
North Shore Area (Essex County)—3 Ops, GR $200K #30126
Western Massachusetts—3 Ops, GR $1 Million, Sale $514K #30115
Contact: Dr. Peter Goldberg @ 617-680-2910

MICHIGAN
South Detroit—2 Ops, 1 Hygiene, GR $300K #31025
Midland—7 Ops, GR $450K #30120
New Bedford Area—6 Ops, GR $200K #30119
Contact: Alex Loucks @ 617-210-2162

MINNESOTA
Crows Wing County—4 Ops, GR $21204
Fargo/Moorhead Area—1 Op, GR $185K #32307
Central Minnesota—Mobile Practice, GR $735K #32108
Twin Cities—Grow n & Practice Immediately GR $800K #32210
Contact: Mike Minor @ 612-961-2132

MISSISSIPPI
Eastern Central Mississippi—10 Ops, 4,695 sq. ft., GR $1.5 Million #51101
Contact: Donna Wright @ 800-730-8883

NEVADA
Reno—Free Standing Bldg., 1,500 sq. ft., 4 Ops, GR $756K #37106
Contact: Dr. Donna Haker @ 800-519-3595

NEW JERSEY
Marlboro—Associate position available #9102
Mercer City—3 Ops, Good Location, Turn Key, GR $191K #91111
Contact: Sharon Maccari @ 410-788-0711

NEW YORK
Brooklyn—3 Ops, Fully equipped, GR $175K #41113
Woodstock—2 Ops, Building also available for sale, GR $600K #41112
Contact: Dr. David Cohen @ 646-460-3034
Syracuse—3 Ops, 1,800 sq. ft., GR over $700K #41107
Contact: Mary Harv @ 315-265-4315
New York City—Specialty Practice, 3 Ops, GR $500K #11111
Contact: Richard Zalkin @ 646-861-6215

NORTH CAROLINA
Charleston—2 Ops, 5 Equipped #47142
Foothills—5 Ops #42122
Nashville—General Dental practice, 3 Ops, GR in 2007 #523K #42134
New Hanover County—Practice on the coast, Growing Area #42147
Raleigh, Cary, Durham—Dentist looking to purchase #42127
Contact: Barbara Harke; Parker @ 919-948-1555

OHIO
Medina—Associate to buy 1/3, rest of practice in future #44150
North Central—GR $650K, 5 Ops, Well Established #44159
North Central—GR $700K, 5 Ops, Well Established #44157
Contact: Dr. Dave Monteith @ 440-623-8037

PENNSYLVANIA
Northeast of Pittsburgh—3 Ops, Victoriana Mansion #1,000,000 #44357
Contact: Dan Scan @ 412-853-0357
Lackawanna County—4 Ops, 1 Hygiene, GR $515K #47115
Chester County—High End Office, 4 Ops, Digital, FB & a few PPO #47161
Philadelphia County (NE)—4 Ops, GR $500K+, Ext. 25 years #47114
Contact: Sharon Maccari @ 410-788-0711

RHODE ISLAND
Southern Rhode Island—4 Ops, GR $850K, Sale $468K #48102
Contact: Dr. Peter Goldberg @ 617-680-2910

SOUTH CAROLINA
Hill—Dentist seeking to purchase a practice producing $500K a year #91010
Contact: Scott Carringer @ 704-814-4796
Columbia—7 Ops, 2,200 sq. ft., GR $675K #49102
Contact: Jim Cole @ 404-515-1573

TENNESSEE
Elizabethton—GR $333K #51107
Memphis—Largest practice the area GR $82 Million #51112
Suburban Memphis—Anchoring Practice in Area GR $1 Million #51113
Contact: George Lane @ 615-741-1427

TEXAS
Houston Area—GR $1.1 Million w/ad, net income over $500K #52103
Contact: Donna Wright @ 800-730-8883

VIRGINIA
Greener Rappahannock Valley—2,500 sq. ft., GR $942K updated equipment #51113
Contact: Bob Anderson @ 804-640-2573

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"The trend in dentistry today is clearly toward more esthetic and less invasive. Indirect resin and ceramic inlays and onlays are not only compatible with this trend, but fulfill very nicely the restorative void between fillings and crowns," wrote Ronald D. Jackson, DDS, FAGD, FAACD (Cosmetic Tribune, Dec. 2008).

Regarding durability, esthetic inlays and onlays are not new anymore. They have a track record and it is good. With today's materials, longevity is mainly a matter of diagnosis, correct treatment planning and proper execution of technique.

The problem with replacing old amalgams with tooth-colored composites is they are difficult, inconsistent and unpredictable. Yet, the warranty on these 30-, 40-, 50-year-old silver fillings is running out. We have to remember that amalgam technology is more than 150 years old.

At that time, people lost their teeth a lot earlier and died a lot earlier, too. Now, however, we have a large segment of the population that is more older than 50 and growing — and they want to keep their teeth feeling good and looking good.

Let's think like our patients. Our patients want to replace these old amalgams, but they want to do it conservatively, consistently, efficiently, predictably and economically — and they want to do it in one visit.

So, what are the advantages of indirect laboratory-processed composite resin posterior restorations?

Restorations fabricated in this manner look better, undergo less shrinkage, help restore the strength of the tooth, have minimal porosity and excellent marginal integrity, and they have smoother surfaces that are kinder to the gums and result in less plaque accumulation. They are very durable and can be done in one visit.

Patients appreciate avoiding the inconvenient, uncomfortable and expensive second appointment. No second appointment means no temporaries, no emergency visits, and best of all, healthy tooth structure is preserved.

By contrast, replacing amalgam restorations with direct posterior composites, especially ones involving an interproximal surface, are difficult for the patient as well as the dentist.

For many reasons, these direct composite replacements frequently prove to be inadequate, especially over time.

The inherent problems of isolation, the large bulk of composite required and the layered curing of the composite, as well as the effects of shrinkage, all affect contacts, occlusion, margins and postoperative tooth sensitivity.

Gold will always be an excellent restoration for posterior teeth, but due to appearance, mass and an increasing price, it is becoming more unacceptable in today's image-conscious society.

The prep

This patient came in with a dental emergency. The filling had fallen out of his broken, lower right molar the day before he was going overseas for three weeks on business. He wanted a "quick and permanent solution" (Fig. 1).

The tooth was anesthetized. Next, a FenderWedge (Directa Dental) was used to further isolate the involved tooth, protect the adjacent interproximal surface and pre-wedge the teeth for optimal contacts (Fig. 2).

The Isolite (Isolite Systems) was placed to obtain a dry and illuminated field. We used caries detector to ensure complete decay removal (Fig. 3). The tooth was then micro-etched, etched and desensitized with HemaSeal and Cide (Advantage Dental Products, Inc.).

Two layers of self-etching bonding agent (OptiBond All-In-One Unidose, Kerr Dental) were applied to provide reduced postoperative sensitivity and high dentin bond strength. This was then air-thinned and light-cured.

Flowable composite (Premise Flowable, Kerr Dental) was added to the internal walls and

**Crown or same-day onlay?**

Take a look at the advantages of indirect laboratory-processed composite resin posterior restorations

By Lorin Berland, FAACD

**Fig. 1: #30 pre-op.**

**Fig. 2: FenderWedge in place.**
floor, creating an even floor and filling in undercuts that were originally prepared for caries removal and amalgam retention (Fig. 4).

After the tooth was insulated, the prep was refined with a flat-end cylinder, fine-grit, short Shank diamond. Two Identic hydrocolloid impressions (Dux Dental) were taken to make the onlay in the lab (Fig. 5).

**Lab work**

After disinfecting the impressions, the assistant immediately poured them with MACH-SLO (Parkell) and based them with a rigid, fast-setting bite registration material such as Blu-Mousse (Parkell) (Fig. 6).

Within two minutes, we had a silicone working model on which to build the onlay (Fig. 7). The undercuts were then blocked out with a waxer, paying special attention to avoid the margins (Fig. 8).

Starting with the Premise Indirect (Kerr Dental) dentinal shades and ending with incisal shades, the onlay was incrementally fabricated.
Fig. 6: Basting the poured impression.

Fig. 7: Silicone model.

Fig. 8: Model with undercuts waxed.

Fig. 9: Finishing the onlay.

Fig. 10: Onlay finished and polished.

Fig. 11: Expasyl prior to seat.

Fig. 12: Expasyl and FenderMate prior to seat.

Fig. 13: Adapting FenderMate.

Fig. 14: Seating onlay.

Fig. 15: Final onlay.

(Photos/Provided by Dr. Lorin Berland)
The onlay was then placed in the Premise curing oven (Kerr Dental). In approximately 10 minutes, the onlay was ready to be finished with various finishing burs (Fig. 9).

The onlay was polished for a high shine and then checked on the model to verify accurate interproximal contacts and margins (Fig. 10).

**Seating the onlay**

When seating the onlays, the Isolite (Isolite Systems) was reapplied for isolation, ease of placement and patient comfort during cementation of the onlay.

Prior to cementation, Expasyl (Kerr Dental) was gently packed into the sulcus, creating a dry space between the tooth and tissue without any risk of rupturing the epithelial attachment (Fig. 11).

The aluminum chloride dries the tissue, reducing the risk of sulcal seepage and contamination.

The FenderMate (Directa Dental) was then inserted beneath the interproximal floor to slightly separate and isolate the adjacent teeth and to help facilitate seating the onlay (Fig. 12).

The Expasyl (Kerr Dental) was rinsed off thoroughly and FenderMate (Directa Dental) was adapted to the adjacent interproximal surface with a condenser (Fig. 13).

The enamel and composite core were then etched for 15–30 seconds.

A single component fifth generation adhesive (OptiBond Solo Plus Unidose, Kerr Dental) was applied in two coats and air-thinned until there was no more movement.

Flowable composite (Premise Flowable, Kerr Dental) was dispensed into the prepped tooth prior to inserting the onlay into the tooth.

The FenderMate (Directa) was removed and the onlay was further seated using a condenser with gentle pressure.

Complete seating was facilitated using the contra-angle packer/condenser (Fig. 14).

An explorer is helpful in removing excess flowable before curing.

The restoration was cured from all angles, starting at the interproximal gingival floors where leakage is most likely to occur.

Occlusal flash and excess flowable composite was “buffed” with a short flame carbide while the interproximal margins were adjusted with bullet or needle carbides.

A Bard Parker #12 scalpel was used to remove interproximal cement.

Once the proper occlusion was established, a diamond-impregnated point and/or cup was used to polish the restoration (Fig. 15).

**Conclusion**

There are certainly clear advantages for both the patient and the dentist when doing indirect composite resin restorations.

These restorations have helped me save my patients’ teeth, time and money.

Over the last 20 years, I have tweaked, updated and modified these restorations in terms of techniques, materials and equipment.

These restorations not only save time and conserve healthy tooth structure, they are a valuable service to provide to your patients.

Wherever you practice, however you practice, these restorations are durable, esthetic, economical and very much appreciated!
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MAC
FUNCTIONAL COMESTICS

3) Match the pattern to the appropriate lesion.

Part 1: case study
A 45-year-old, healthy man visited his dentist for tooth pain and was informed that his mouth contained a “disease in disguise.”

Upon oral examination, buccal-mucosa showed hyperkeratotic white, slightly elevated, diffuse patchy lesion extending toward the commissures of the mouth on the left side.

The lesion was non-scrappable in nature.

The patient had a habit of smoking five to six bidis (a crude form of cigarette used in India) a day for the past four years.

1) What provisional diagnosis would you make of this lesion?
   a. Leukoplakia
   b. Linea alba
   c. Lichen planus
   d. Leukoedema
   e. Candidiasis

Answer: A provisional diagnosis of homogenous type of oral leukoplakia was made.

Now let's explore step-by-step given the patient's information and assemble all the clues together to arrive at a diagnosis.

Clue No. 1
Age/sex/general health = 45-year-old healthy man

2) Each of the lesions below is found in a patient that falls into this age/sex category. Match the lesion to the appropriate sex/general health category.

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Sex/general health</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Candidiasis</td>
<td>1. Male predilection</td>
</tr>
<tr>
<td>b. Lichen Planus</td>
<td>2. Female predilection</td>
</tr>
<tr>
<td>c. Leukoedema</td>
<td>3. Commonly seen in a debilitating and malnourished group of society</td>
</tr>
</tbody>
</table>

Clue No. 2
Pattern = Hyperkeratotic white, slightly elevated, diffuse patchy lesion extending toward the commissures of the mouth.

5) Match the pattern to the appropriate lesion.
Pattern
a. Thin elevated white line at the occlusal plane
b. White patch or plaque (homogenous type)/mixed red and white lesion (non-homogenous type)
c. White “milk curd” (pseudomembranous type)/white patch or plaque (hypertrophic type)/red (atrophic type)
d. Milky white alterations of the buccal mucosa, bilateral
e. Raised thin white lines in arcuate pattern (reticular type)/white elevated plaque (plaque type)/red (erythematous) areas with thin striae at the periphery (atrophic and erosive type).

Lesions
1. Leukoplakia
2. Linea alba
3. Candidiasis
4. Lichen planus
5. Leukoedema

We can narrow down the various specific clinical types of the lesions and exclude linea alba from the differential diagnosis (D/D):

D. Leukoplakia (homogenous type)
B. Lichen planus (plaque type)
C. Leukoedema
d. Candidiasis (hypertrophic/pseudomembranous type)

Clue No. 5
Is the lesion scrapable (S) or non-scrapable (NS)?
4) Mark scrapable (S) or non-scrapable (NS) next to each lesion.
   a. Leukoplakia
   b. Linea alba
   c. Lichen planus
   d. Leukoedema
   e. Candidiasis

Clue 4
Smoking five to six bidis per day for the last four years.
5) Mark smoking (SK) or non-smoking (NSK) next to each lesion.
   a. Leukoplakia
   b. Linea alba
   c. Lichen planus
d. Leukoedema
e. Candidiasis

Thus, we now have four D/ Ds to work upon (excluding linea alba). Other features that help in reaching a diagnosis:

Stretch: Leukoedema will fade away.

Antifungal treatment: Candidiasis will be cured.

Site: Plaque type of lichenplanus is most often seen on the dorsum surface of the tongue.

It is generally nodular in nature with or without areas of reticular type of lichen planus around it.

Most clinicians can easily distinguish lichen planus from leukoplakia; however, if you have difficulty in doing so or are in doubt, please do a biopsy.

Foremost, the biopsy is done to diagnose. It is also completed to discover any dysplastic features associated with lichen planus.

In this case, a biopsy was done for the lesion and the histopathological diagnosis made was moderate epithelial dysplasia.

Part II: Digging deeper
Let’s explore your knowledge of oral leukoplakia.
6) Mark true (T) or false (F) next to the following statements.
   a. A predominantly white lesion of the oral mucosa that cannot be characterized as any other definable lesion.
   b. It is a pure clinical term and has nothing to do with some specific histology.
   c. The etiology proposed includes tobacco, alcohol, candidiasis, electrogalvanic reactions and (possibly) herpes simplex and papillomavirus have been implicated.
   d. True leukoplakia is most often related to alcohol usage.
   e. Oral hairy leukoplakia is a type of leukoplakia with hair-like projections on the buccal mucosa.
   f. It has two main clinical types. Homogeneous type: lesions are white, uniformly flat and thin and exhibit shallow cracks of the surface keratin. Non-homogeneous type: lesions are mixed, i.e., red and white with nodular or verrucous type of growth.

Histology assessment
7) Mark true (T) or false (F) next to the following statements.
   a. It may show atrophy or hyperplasia (acanthosis) and may or may not demonstrate epithelial dysplasia.
   b. The majority of leukoplakias will not show dysplasia and correspond to the hyperplasia category.
   c. The dysplastic changes typically begin in the superficial zones of the epithelium.
   d. The higher the extent of epithelial involvement, the higher the grade of dysplasia.

Treatment and prognosis
8) Mark true (T) or false (F) next to the following questions.
   a. For the persistent lesion, definitive diagnosis is established by tissue biopsy.
   b. Definitive treatment involves surgical excision or cryosurgery and laser ablation. Total excision is aggressively recommended when microscopic dysplasia is identified, particularly if the dysplasia is classified as severe or moderate.
   c. Non-homogeneous lesions carry a lesser risk of malignant transformation than homogenous lesions.
   d. It has a variable behavioral pattern but with an assessable tendency to malignant transformation.

About the author
Dr. Monica Malhotra is an assistant professor at the Sudha Rustagi Dental College in India and also maintains a private practice.
In 2008 she was presented with a national award for the best scientific study presentation by the Indian Association of Oral and Maxillofacial Pathology.
Malhotra completed her master’s in oral pathology at the Manipal Institute, India, in 2009.
You may contact her at drmonicamalhotra@yahoo.com.
After more than a year in the making, the American Academy of Cosmetic Dentistry (AACD) is pleased to release its new logo and identity package to dental professionals and patients worldwide.

The new AACD brand is the culmination of a comprehensive organizational assessment in order to solidify the academy as the pre-eminent resource in cosmetic dental education and information.

“It is an exciting time at the AACD. The academy is continually growing and adjusting to advance excellence in our profession through responsible esthetics,” said Michael R. Sesan, DDS, AACD president.

“The new AACD brand represents a combination of the scientific foundation of the organization with an eye toward the future of cosmetic dentistry.”

Responsible esthetics

In 2009, AACD established a new mantra of Responsible Esthetics, which forms the foundation for the new AACD.

“AACD will demonstrate that we unequivocally stand for the practice of responsible esthetics. The academy will be the primary dental resource for patients as they strive to maintain their health, function and appearance for their lifetime.

“The academy will clearly state and acknowledge that esthetic dentistry must complement the overall general and oral health of the patient, and do no harm. “Our members will strongly encourage that treatment decisions are based on the foundation of evidence-based protocols combined with sound clinical judgment. The academy will strongly encourage that cosmetic dentistry integrates interdisciplinary medical and dental treatment to enhance outcomes and minimize the loss of healthy human tissue.

“Our members will champion and provide minimally invasive treatment protocols, when and where appropriate, that are consistent with the long-term health and needs of the patient. AACD will encourage the utilization of innovation in technology and materials to deliver dentistry that is predictable and long lasting.”

About the AACD

The AACD is the world’s largest non-profit membership organization dedicated to advancing excellence in comprehensive oral care that combines art and science to optimally improve dental health, esthetics and function.

Composed of nearly 7,000 cosmetic dental professionals in 70 countries around the globe, the AACD fulfills its mission by offering superior educational opportunities, promoting and supporting a respected accreditation credential, serving as a user-friendly and inviting forum for the creative exchange of knowledge and ideas, and providing accurate and useful information to the public and the profession.

ADA unveils new Web site design

Enhanced for easier access to comprehensive, online oral health information

After a year and a half of extensive research, planning and design, the American Dental Association announced the unveiling of its new, enhanced Web site, ADA.org, encompassing the latest elements of Web development technology.

“The new ADA.org represents the collective input from our members and provides enhanced navigation tools for easier access to the wealth of oral health information we have online,” said Dr. Ronald L. Tankersley, ADA president.

“This information includes tools needed for practice management and continuing education as well as news about the latest developments in oral health care.”

Source for professional information and enhanced Find-a-Dentist feature

ADA.org is the dentist’s source for professional oral health information. For example, under the following tabs: “Professional Resources,” members will find an updated Member Center with a dental practice hub that includes tips and tools to thrive in challenging economic times.

An enhanced Find-a-Dentist feature, with updated profile information and photos, will also enable colleagues and patients greater opportunities to connect with each other.

“Education and Careers” includes information about licensure and education and online C.E. opportunities.

“Science and Research” features evidence-based dentistry resources and dental standards.

“Advocacy” addresses the ADA’s advocacy efforts on behalf of the dental profession on Capitol Hill and in state capitols across the country.

Many ADA members refer patients to ADA.org for oral health information. Housed under “Public Resources,” the redeveloped site will continue to offer news and extensive development on hundreds of dental topics, ranging from basic dental care to baby’s first tooth to gum disease to tooth whitening.

These topics also include an extensive video collection of various oral health subjects. The public also will find the site easier to navigate, making it more effective and easier for consumers to obtain needed oral health information.

“Refinements to ADA.org will continue as we build on our efforts to make our general and proprietary oral health information easily attainable for ADA members,” said Tankersley. “This will assist members in offering the highest level of patient care and maintaining thriving practices.”

About the ADA

The not-for-profit ADA is the nation’s largest dental association, representing more than 157,000 dentist members. The premier source of oral health information, the ADA has advocated for the public’s health and promoted the art and science of dentistry since 1859.

The ADA’s state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive.

The ADA Seal of Acceptance has long been a valuable and respected guide to consumer dental care products.

The monthly Journal of the American Dental Association (JADA) is the ADA’s flagship publication and one of the best-read scientific journal in dentistry.

For more information about the ADA, visit the association’s Web site at www.ada.org.
Heraeus will host a number of educational sessions during the upcoming 26th annual AACD Scientific Session, which takes place from April 27 to May 1, in Grapevine, Texas.

The AACD meeting convenes world-class clinical leaders, dental professionals and journalists to discuss and showcase the latest and most progressive advancements in cosmetic dentistry.

“Once again, Heraeus has designed an impressive breadth of programs and hands-on workshops that will allow attendees to explore new clinical techniques, test-drive innovative materials and interact directly with leading clinicians and educators.

“The AACD applauds its ongoing dedication to education,” said Dr. Michael Sesemann, 2009-2010 AACD president.

“All of our programs and hands-on workshops feature cutting-edge content, techniques and materials,” said Sonny Serreno, director of program and product development for Heraeus.

“We hope that these programs both inspire and enable dental professionals to provide an even higher level of patient care.”

Heraeus supported program presenters and topics include:

Tuesday, April 27
• Drs. John Cranham and Albert Komikoff Interdisciplinary Solutions to Functional-Esthetic Problems
• Dr. John Cranham and Shannon Pace, DA, II Diagnosis and Case Presentation: The New Patient Experience
• Pinhas Adar, MDT, Dr. Steve Chu, Adam Mielezsko and Bradford Patrick, BSc Perfection in Dental Restorations … Is It Achievable?
• Understanding Light Dynamics and Translucency with Fully Synthetic Ceramics
• Dr. Jimmy Eubanks Composite or Porcelain for Superior Esthetics

Wednesday, April 28
• Dr. Robert Marcus Smile Design with Composite: An Aid to AACD Accreditation (hands-on workshop)
• Dr. Brian LeSage Minimally Invasive Dentistry: Minicure with Composites (hands-on workshop)

Thursday, April 29
• Dr. Joyce Bassett Maximize Your Esthetic Results through New Concepts in Preparation Design (hands-on workshop)
• Dr. John Weston Anterior Composite Bonding: Creating Esthetic Success (hands-on workshop)

Friday, April 30
• Dr. Michael Koczarski Anterior Direct Composite Restorations — Exquisite Beauty from a Practical Approach (hands-on workshop)
• Dr. Susan Hollow Optimal Provisional Techniques for Thin, Conservative Veneers (hands-on workshop)
• Dr. Corky Willhite Transitional Bonding: Major Esthetic and Dental Changes in One Visit Using Composite (hands-on workshop)
• David Little, DDS Esthetic Implant Retained Overdentures (hands-on workshop)

For more information on the AACD Scientific Session or any of these programs visit www.aacd.org. For more information on Heraeus, visit www.heraeus-kulzer.com or call (800) 431-1785.

(Source: Heraeus)

DTSC symposia on world tour

Earn C.E. credits online

The Dental Tribune Study Club is an educational-based online community that inspires new possibilities while creating greater expectations in online learning.

Dental Tribune has scoured the world to find dental meetings with a proven platform for education, communication and development. The following are premier_setters and topics include:

- April 16-18: IDEM — International Dental Exhibition in Singapore
- April 26 and 27: Dental Salon, Moscow, Russia
- June 9-12: Sino-Dental, Beijing, China
- Sept. 2-3: FDI World Congress, Salvador da Bahia, Brazil
- Sept. 23-25: CEDE Poznan, Poland
- Oct. 3-5: DenTech, Shanghai, China
- Nov. 28-Dec. 1: Greater New York Dental Meeting, New York City

During each meeting, a leading panel of specialists will offer ADA C.E.-accredited lectures covering various dental specialties. Participation is free for show attendees, but pre-registration is recommended for preferred seating.

‘Getting started in …’ Webinars

Each “Getting started in …” program includes up to five successive Webinars that provide a thorough introduction to the techniques, products and practice management impact in that field of dentistry. Each webinar will include a one-hour presentation followed by a live Q&A session between the online audience and the speaker. Participants receive up to five C.E. credits and attendance is free for the first 100 registrants.

The 2010 schedule is as follows:

- May 22: Getting Started in CAD/CAM
- May 29: Getting Started in Implants
- July 24: Getting Started in Digital Imaging
- Aug. 14: Getting Started in Endodontics
- Aug. 27: Getting Started in Lasers

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Discussion forums

DTSC offers discussion forums focused on helping today’s practitioners stay up to date.

With the ability to share resource material from colleagues, networking possibilities are created that go beyond borders to create a truly “Global Dental Village.”

Further, the site offers a growing database of case studies and articles featuring topics that are important to today’s dental practitioners.

We encourage you to share your cases for review with like-minded practitioners with the chance to win free tuition for C.E.-accredited Webinars.

Registering as a Study Club member is free and easy. We encourage you to visit www.DTStudyClub.com and join the community.

For additional details, please contact Julia Wehkamp at j.wehkamp@dtstudyclub.com or (416) 907-9836.
Directa CoForm
Matrix system provides transparent corner matrices, convenience and versatility

"Sealed surfaces and surfaces finished solely by a matrix were approximately 10 times less rough than after other finishing procedures. "The sealer failed to cover the whole composite surface. The unfinished and sealed surfaces lost their shine three to seven days after placement in the mouth."**

Directa's CoForm matrix system is a unique set of pre-formed transparent matrices made of celluloid plastic that are specifically designed to deal with composite restorations around difficult incisal edges and tooth fractures.

The matrices conform easily to the patient's dentition to provide a natural-looking restoration. They are applied over the cavity after etching and bonding with a slight movement to avoid air bubbles.

When securely in place, excess composite should be removed.

A prime benefit of utilizing CoForm is that the device aids pressure to force composite material into cavities and etched tubes.

There is little waste involved when using CoForm compared to using disposable matrices.

Light curing is carried out through the transparent surface of the CoForm matrix.

CoForm's convenient ready-cut mesial and distal corners do not adhere to composite so that they are very easy to remove without causing any drag after the restoration has been light-cured.

The product is available in four sizes to accommodate almost any clinical application: canine, anterior and first molars.

Packaging is a handy clinical dispenser with a simple size selection system to find a suitable form, thus providing ease of use for the clinician.

Directa is a privately owned Swedish dental manufacturer that was founded in 1916. It is one of the fastest growing manufacturers of dental products.

Other Directa products include FenderMate, FenderWedge, Luxator Extraction Instruments, PractiPal Tray System and ProphyPaste CCS.

Pulpdent Embrace Pit and Fissure Sealant

A recent study published in the Journal of Dentistry concluded that Pulpdent Corporation's Embrace® Pit and Fissure Sealant had the longest lasting antibacterial activity of those studied.

The study, "Antibacterial surface properties of fluoride-containing resin-based sealants," was conducted at The University of North Carolina at Chapel Hill School of Dentistry.

The aim of the study was to determine the antibacterial properties of three resin-based pit and fissure sealant products.

The sealants were tested in both an agar diffusion assay and a planktonic growth inhibition assay using Streptococcus mutans and Lactobacillus acidophilus.

Embrace retained antibacterial activity against both bacteria over time.

While all the materials tested were capable of contact inhibition of L. acidophilus and S. mutans growth, the authors concluded that Embrace had the longer lasting antibacterial activity when in solution, especially against S. mutans.

Pulpdent manufactures high-quality products for the dental profession, including adhesives, composites, sealants, cements, etching gels, calcium hydroxide products, endodontic specialties and bonding accessories.

For more information call (800) 277-0073 or visit www.pulpdent.com.

The VibraJect Retrofit Kit

The VJR3RK model is the VibraJect® retrofit kit that comes with two rechargeable batteries, power cord, charging unit and control knob.

This kit will convert the standard Model VJ2002 (with replaceable batteries) to a rechargeable kit.

Upgrading to the rechargeable kit is recommended for clinicians administering more than 50 injections per week to save the cost of purchasing replacement batteries.

For more information on the VibraJect product line, please address your e-mail inquiries to sales@itldental.com.

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You can access the most recent edition of Dental Tribune, Cosmetic Tribune, Hygiene Tribune, Implant Tribune and Ortho Tribune as ePaper.

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Do you speak a language other than English? If so, you can also access foreign language ePapers of all our international editions (Croatian, Bulgarian, French, German, Greek, Hungarian, Italian, Korean, Polish, Russian, Spanish and more!). Drop in for a "read" anytime!
J. Morita USA partners with TDO

J. Morita USA, world leader in 3-D imaging, has announced a strategic partnership with TDO, a quality-centered endodontics organization, for complete 3-D imaging and software integration.

TDO’s practice management software is one of the most comprehensive and widely used endodontic software in the world. TDO users can now seamlessly incorporate any Morita 3-D unit into their practice with full compatibility.

Morita’s i-Dixel software, standard with all Morita 3-D units, has been programmed for a direct connection to the TDO environment. Patient files are comprehensively integrated, allowing for easy access between programs in one window to maximize productivity. Selected slice images can be transferred to TDO with a single click of the export icon.

“Morita is committed to enhancing our customers’ 3-D capabilities,” said Kei Mori, vice president of technical engineering.

“Our industry-leading hardware, combined with this sophisticated software program, offers a powerful, digital solution to manage 3-D data and improve return on investment.”

Morita’s 3-D imaging units have been demonstrated in clinical studies to offer the highest clarity available in the industry, coupled with the lowest dosage.

TDO users can choose from a wide range of 3-D models from three product lines including Veraviewepocs 3-D, Veraviewepocs 3-De and 3-D Accuitomo. All units come standard with i-Dixel software and offer complete, automatic TDO integration.

Morita has a long history of innovative solutions for the endodontic market with products such as Root ZX, one of the world’s best selling apex locator since the early 1990s.

“Partnering with a high-level, quality-focused organization like TDO fits very well into our core competencies,” commented Steven White, senior vice president of sales and marketing.

“Our commitment to TDO further demonstrates Morita’s ability to understand and respond to the evolving needs of endodontists worldwide.”

“TDO users will now be in a position to bring class-leading, 3-D images into their system with the click of a button.”

For more information, contact J. Morita USA at (877) JMORITA (566-7482). Visit www.jmoritausa.com to learn more about Morita 3-D units and to view video of key opinion leaders’ comments and sample clinical images.

About J. Morita USA

J. Morita USA services North American dental professionals on behalf of one of the world’s largest manufacturers and distributors of dental equipment and supplies, Japan-based J. Morita Corp. The North American office was established in 1964 and is headquartered in Irvine, Calif. J. Morita USA is one of the leading companies in the dental market offering innovative and high quality 3-D/pan/ceph imaging units, delivery systems, small equipment and consumable dental supplies.
C-VAC dry suction system

R.E. Morrison Equipment, the manufacturer of BaseVac Dental Dry Suction Systems, announces its compact C-VAC dry suction system for small dental offices.

Traditional dry vac systems require large air flows to cool the pumps, meaning a two operatory office is often too small for a dry vac pump.

The BaseVac C-VAC 4.10 has been engineered to provide strong suction (up to 25 Hg) without the need for oil or water.

Compact, powerful and quiet, this two operatory dry vac will provide two dentists or a single dentist and hygienist with dependable suction.

The unique design integrates the rotary vane pump into the air water separator creating a remarkably small footprint.

BaseVac designers took care to position all piping connections at the back of the system for easy tight-to-wall installation.

The C-VAC 4.10 is powerful enough to be installed on systems with all sizes of pipe.

Based on feedback from practicing dentists, the high-efficiency air/water separator was designed to drain captured liquids every time the pump is turned off, eliminating the need for messy and difficult cleaning.

BaseVac Dental Systems offers a full range of dental suction equipment.

For more information, visit www.basevacdental.com or contact R.E. Morrison directly at info@remequip.com and (800) 668-8756.

Fight oral cancer!

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id you know that dentists are one of the most trusted professionals to give advice? Thus, no other medical professionals are in a better position to show patients that they are committed to detecting and treating oral cancer.

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerselfexam.com. This new Web site was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations. Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

Conducting your own inspection of patients’ oral cavities provides the perfect opportunity to mention that this is something they can easily do themselves as well. You can explain the procedure in brief and then let them know about the Web site, www.oralcancerselfexam.com, that can provide them with all the details they need.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?
Kank-A launches soothing beads

Mouth pain can occur at anytime throughout the day, and treating the problem while away from home isn’t always convenient. The best products provide a tailored solution to localized pain, but can be difficult to use on the go.

Kank-A Soothing Beads™ provide two benefits: effective, comfortable relief for all-over-mouth pain and a form that is easy to carry and discreet to use.

Kank-A Soothing Beads are comfortable, smooth balls that melt in the mouth to deliver maximum strength medication (15 mg benzocaine per five-bead dose). Kank-A Soothing Beads can be rolled around the mouth for all over relief or held in one spot for concentrated treatment.

Each five-bead dose is individually packaged on a perforated card (like many over-the-counter caplets), making it easy to leave some at home, work or in any other location that’s handy throughout the day.

The beads are designed to deliver effective relief without excessive numbing and are ideal for use on gum irritations, mouth burns, canker sores, orthodontic appliances and dentures.

With a suggested retail price of $5.49–$7.99 for each 15-dose pack, Kank-A Soothing Beads will be available in May at food and drug stores nationwide.

Kank-A offers a full line of products designed to provide solutions tailored to specific oral pain needs. Each product offers maximum strength benzocaine to ease pain, other beneficial ingredients and unique application systems that deliver relief to sore spots.

Kank-A SoftBrush® is a super-effective treatment for toothaches and gum pain. It offers a dual-relief formula combining the maximum level of benzocaine (20 percent) with an active oral astringent, zinc chloride, for fast, deep pain relief. Its unique, pen-shaped applicator and soft brush tip make it easy to apply gently and comfortably anywhere in the mouth, especially between teeth and around braces. Kank-A Softbrush retails for $5.49–$7.99.

Professional Strength Kank-A Mouth Pain Liquid has received the ADA Seal of Acceptance for its effectiveness in the relief of canker sores and has long been the ideal treatment for pain caused by canker sores and other mouth sores.

Kank-A Liquid provides maximum strength medication for a liquid or gel (20 percent benzocaine), while forming a long-lasting film that protects sores from further irritation. The protective coating holds the anesthetic in contact with the sore and acts as a barrier against further irritation. Designed for precise, convenient dispensing, Kank-A Mouth Pain Liquid has a built-in applicator, allowing consumers to easily place the medication where it’s needed. Kank-A Liquid retails for $5.49–$7.99.

For additional information about Kank-A products, visit www.Blistex.com.

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