Dental team from Boston University serves up smiles in Mexico

By Fred Michmershuizen, Online Editor

A team of volunteers from Boston University Henry M. Goldman School of Dental Medicine (GSMD) recently conducted an outreach trip to Teacapan, Mexico, in which more than 250 underprivileged children were screened and treated.

The outreach program is called Project Stretch.

“This was my fifth mission and my third time in Teacapan,” said Kathy Held, assistant director of extramural programs at GSMD and longtime Project Stretch volunteer. “Each year I say, ‘I can’t get any better than this, so I will quit while I’m ahead,’” but each year has proven to be as unique and wonderful of an experience as the last one.”

Other GSMD team members included Clinical Assistant Professor Dr. Frank Schiano, Robin Yamaguma and Ismael Montane. According to Held, the team worked both effectively and efficiently.

“Dr. Schiano was a machine, providing more treatment with his partner, RN and Dental Assistant Cree Bruins, than anyone of us could fathom,” Held said. “While Dr. Schiano was reading the child’s records, Cree was preparing the child for treatment — they were a great chair-side team.”

“Robin and Ish took turns working outside, where they primarily concentrated on performing exams and atraumatic restorative treatment on deciduous teeth using hand instruments and glass ionomer filling material,” Held said. “They also took turns working inside, where they had a fully operational dental unit to complete procedures, including extractions, amalgams and composites on permanent teeth.”

“Ish worked like a real trooper through the day and Robin was always so gentle with the children,” Held said. “After an extraction one child turned to her and gave her a big hug. I was so proud of them.”

“I was so impressed with the organization of Project Stretch in Teacapan,” Schiano said. “They have made tremendous progress over the last six years, growing from a small mission providing preventive services to a near-fully equipped dental clinic offering more involved and comprehensive restorative care. Perhaps the biggest reward was seeing the successful efforts of previous teams, which helped me realize the difference we were making in the lives of these children and their families.”

Readers replied

We garnered a lot of feedback from an article that ran in the No. 12 edition and which also appeared online. Take a peek to see what readers had to say about ‘Where have all the periodontists gone?’ by Louis Malcmacher, DDS, MAGD.

→ See pages 3A–6A

(Photos/Faberphoto, Dreamstime.com)
Associations seek health care provider exemption from financial reform legislation

By Fred Michmershuizen, Online Editor

As lawmakers in the nation’s capital debate proposed financial services reform legislation, the nation’s leading dental associations are asking Congress to exempt health care providers from oversight by a proposed new federal agency.

According to the American Dental Association (ADA), the Academy of General Dentistry (AGD) and other groups, the proposed Consumer Financial Protection Agency, which is part of the financial regulatory reform legislation currently under consideration in the Senate, would lead to unnecessary costs and increased administrative burdens for practitioners without any benefit to their patients.

The ADA, AGD and about 20 other associations recently sent a joint letter to key lawmakers who are working on the proposed legislation asking that they exclude their professions from the new agency.

As currently written, the Restoring American Financial Stability Act of 2010 would subject health care providers without any benefit to their patients to key lawmakers who are working on the proposed legislation asking that they exclude their professions from the new agency.

As written, the letter states that “though the provisions are intended to clarify the limitations and exclusions of the bill, we believe they actually raise more questions than they may be interpreted as applying to health care practitioners who regularly charge interest and allow patients to pay in installments” (subparagraph B).

In addition, we remain concerned that the term ‘engaged significantly’ in subparagraph (C) is not defined and could lead rulemakers to include those providers who utilize those payment options for the benefit of their patients.”

The letter also states, “Given the scope and reach of the bill’s language, health care practitioners would, we believe, be covered by the legislation leading to unnecessary costs and increased administrative burdens for practitioners without any benefit for our patients.”

“While we recognize and thank you for including committee report language that speaks to this issue, specifically mentioning a health care provider group (dentists) as not intended to be covered; ultimately the report language falls short of ensuring that all health care practitioners will be exempt from the law,” the letter continues.

In addition to representatives from the ADA and AGD, also signing the letter were representatives from the American Academy of Oral & Maxillofacial Pathology, the American Academy of Pediatric Dentistry, the American Academy of Periodontology, the American College of Prosthodontists, the American Medical Association and the Hispanic Medical Association.

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 opt out) please send an e-mail at database@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.
Dear Reader,

I am happy to report that Dental Tribune has received many provocative responses (some of which appear below) to the opinion piece by Louis Malcmacher, DDS, MAGD, “Where did all the periodontists go?” in the Vol. 5, No. 12 edition.

Personally, I am still here and I didn’t know that the rest of us had gone anywhere, but I guess that, too, can be a topic of provocative discussion.

First off, let me acknowledge that the piece was supposed to be labeled as our new Opinion section, but due to a production error, the article retained the Practice Matters section label. However, even without the correct section label, the piece achieved our goals for it: it got people writing us with their responses.

The goal of the new Opinion section is to give dentists a forum in which to agree, disagree, discuss and inform, and given the response to the first article, it has certainly achieved this goal.

Thankfully, we live in a country where our Constitution guarantees us the right to free speech. You should feel privileged to exercise that right and send in a response to future Opinion section articles should you be moved to do so.

That being said, Malcmacher’s article is especially provocative because he discusses an approach that allows patients to determine the dental treatment that they will receive based on the patients’ own habits, rather than depending on evidence-based facts, proven knowledge and objective clinical results.

Best Regards,
David L. Hoexter
Editor in Chief

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Best Regards,
David L. Hoexter
Editor in Chief
From: Dr. Eric Hamrick  
Sent: Tuesday, May 11, 2010  
To: Louis Malcmacher  
Subject: Where have all the periodontist gone

Good afternoon, Dr. Yowza. I wanted to briefly comment on your article. I am a practicing, board-certified periodontist who has been in private practice for 26 years. I teach one day a month with the residents at the Medical University of South Carolina School of Dentistry, and also lecture on the topics of periodontics and implant therapy to study clubs both locally and nationally.

I enjoyed your article, as I thought the title was very appropriate for our current time in dentistry. What I stress to periodontists, especially the younger ones, is the need for practice diversification. In my practice, here are some of the procedures I provide for my referring doctor’s patients:

- Basic periodontal therapy, including the LANAP procedure, where it is appropriate.
- Mucogingival surgery, including a number of different procedures on both teeth and implants.
- Implant therapy for both edentulous and partially edentulous patients. This includes multiple types of bone grafting procedures, except for extra-oral grafting (from hip or tibia).
- PAOO, OR Wilkodontic surgery.
- Uncovery of impacted teeth as part of orthodontic therapy.

Where I think our profession has failed our patients the most in regard to providing good, comprehensive care, especially periodontal care, is that dentists for the most part have lowered the standard in regard to how they define periodontal health. Just because someone has been through scaling and root planning doesn’t mean they are automatically stable. My experience is that very few dentists do a good re-evaluation to determine what has happened, and they just assume the patient is OK.

As you mentioned in your article, some patients are better served by having the guarded teeth extracted and replaced with implants to reach the goal of periodontal health and stability; however, economics often dictates treating some questionable teeth in an effort to keep the dentition intact, which often requires surgery of some form, including the LANAP procedure.

I think there will always be the need for periodontists, as I don’t think too many general dentists are going to tackle the entire list above. Although there is some overlap with us and oral surgeons, I simply say let the general dentist in any given area use the specialist he or she thinks is best for patients and their needs.

Thank you for taking the time to read my comments.

Sincerely,
Eric Hamrick  
Periodontics of Greenville  
One Charis Drive  
Greenville, SC 29615  
(864) 271-4330  
info@periogreenville.com

Either way, my mission is to get a discussion going and this article certainly did that. All the best! Thanks and have a great day!

Louis Malcmacher DDS, MAGD  
27239 Wolf Road  
Bay Village, Ohio 44140  
(440) 892-1810  
www.commonsensedentistry.com

Hi, Eric, thanks so much for your comments.

I have gotten a lot of responses to this article, many periodontists ranging from “periodontists should only do evidenced-based periodontal therapy and the rest is bogus,” that I was “crazy and lasers don’t work at all” and “LANAP is a bunch of hooey” to e-mails like yours.

Either way, my mission is to get a discussion going and this article certainly did that. All the best! Thanks and have a great day!

Louis Malcmacher DDS, MAGD  
27239 Wolf Road  
Bay Village, Ohio 44140  
(440) 892-1810  
www.commonsensedentistry.com
Subject: Re: Where did all the periodontists go?

Dental Tribune International
From: Dr. Stuart J. Froum
Sent: Monday, May 10, 2010
To: dryowza@mail.com
Cc: r.goodman@dental-tribune.com

Dear Dr. Malcmacher,

I am writing in response to your commentary in the Dental Tribune posted [online] on May 7, 2010, titled “Where did all the periodontists go?” In answer to this question, I would say “We’re still here.” Your observation that there have been changes in all specialties (you cite orthodontics, endodontics and periodontics in your article) is of course accurate. Any specialty that has not undergone change in light of all of the new emerging information, technologies and materials would certainly be failing our patients and profession.

One of the most significant changes in the periodontal specialty has been that clinical diagnoses, treatment planning and treatment procedures are now decided, wherever possible, on evidenced-based data and controlled clinical studies as reported in peer-reviewed scientific literature. As such, your reporting that you are being told by many periodontists whom you “spoke to over the last couple of years” that “they would rather remove teeth and place implants than actually treat patients through traditional periodontal surgery and try having them maintain their dentition” is quite disconcerting.

As a periodontist who treats patients in private practice, and as a clinical professor in the department of periodontology and implant dentistry at New York University Dental Center who teaches periodontics and implant dentistry to periodontal residents in training, I feel that the periodontists you are quoting are, at the very least, misguided and should be made aware of a number of facts that may change their opinions.

First, by and large, most of the periodontists I meet in my lectures and travels around the country realize the value of attempting to save a tooth or teeth that can be retained in a healthy functional and an esthetic state.

In fact, traditional periodontal treatment including both non-surgical and surgical techniques, have very high success rates in accomplishing this goal as shown in longitudinal studies (see Hirshfeld and Wasserman, J Perio 1978; Oliver J, West Society Perio 1969; Goldman MJ et al., J Perio 1986, etc.) over 20–50 years. It has been known for over three decades that periodontal surgery, when not followed by good professional and personal care, will in many cases fail (Nyman et al. J Clin Perio 1977).

That is why successful surgical treatment designed to save teeth requires meticulous and regular professional maintenance, Becker et al. (J Perio 1984) and others have shown that when this maintenance is provided, a surgical approach to treatment of moderate and advanced periodontitis is highly successful. Patient compliance, even when not optimal, must be reinforced by frequent maintenance and recall. This requires a team effort by the referring dentists, hygienist and periodontist, which

To extract teeth and place implants is not the panacea that you and those periodontists that you spoke to believe it is. First, the 94 percent implant success rates you quote should be qualified. You mean a 94 percent implant survival rate because success implies implants that lose no more than 0.2 mm of bone per year following final restoration and remain esthetically pleasing to the patient.

By the way, these long-term survival rates that are often quoted are based on use of implants with surfaces that are no longer available (i.e., machined surface implants) and no longer being placed. Therefore, to compare long-term success of implants versus treated teeth is not possible because long-term data on currently used implants is lacking.

However, as I stated above, there are many long-term studies showing...
ing natural teeth, when treated with traditional periodontal surgery, have excellent long-term prognoses (Lindhe and Nyman, J Clin Perio 1984). The fact that implant surfaces and designs are changing so rapidly makes it difficult to find any comparable long-term statistics for implants currently being placed.

Moreover, currently used implants, like natural teeth, can and do develop bone loss (peri-implantitis), which has been documented to be more prevalent than formerly believed.

In fact, in a recent consensus report and literature review authored by Lindhe and Meyle and published in the Journal of Clinical Periodontology 2008, they cite two cross-sectional studies documenting that peri-implant mucositis occurred in 80 percent of the subjects and in 50 percent of the implant sites. Peri-implantitis was identified in 28 percent and greater than 56 percent of subjects and in 12 percent and 45 percent of implant sites, respectively.

This was corroborated by a more recent study (Koldstand, J Perio 2010) that documented a prevalence of peri-implantitis of 11.5 to 47.1 percent. This, combined with the results of two long-term studies (Pjetursson, 2004), who reported that 38.7 percent of patients had complications in the first five years after implantation; and Lang (2004), who reported that biological and technical complications with implant-supported restorations occurred in about 50 percent of the cases after 10 years in function — should dispel any beliefs that implants are a trouble-free panacea when compared to retention of teeth that require periodontal treatment.

As for your contention that new procedures, i.e., wavelength optimization of periodontal and implant therapy (WPT) and the LAPIP procedure (Koldstand, 2009) and Nd:YAG (neodymium: yttrium aluminum garnet) laser present minimal invasive alternatives for patients who want to keep their teeth without “heavily invasive periodontal surgery,” I again refer to the dental profession’s reliance on evidence-based data before recommending new treatment modalities. I ask you: Where’s the proof that these modalities are as or more effective than what has been proven through evidence?

Before using a new modality, any dentist should have histological, clinical and long-term proof that these procedures are effective. Many therapies are “minimally invasive” but useless for effective periodontal treatment.

Dr. Malcmacher, I’ve been performing and teaching periodontal therapy for over 35 years and have seen trendy, minimally invasive and “easy” therapies fall by the wayside when clinically tested in randomized controlled studies. The Keyes technique, many time released local antibiotics (i.e., chlorhexidine in a gelatin chip, tetracycline fibers, doxycycline hyclate in a polymer carrier or minocycline microspheres) and even lasers were tested scientifically and found to yield little, if any, improvement over traditional scaling and root planning (without surgical therapy).

Utilizing ineffective therapies to avoid traditionally effective ones oftentimes results in progression of the disease around teeth that, when finally referred to a periodontist, are truly hopeless and have no other option but extractions.

However, the proper use of surgical regenerative procedures, with a variety of grafts and membrane barriers, have shown that bone and soft tissue that had been lost due to periodontal disease can be regenerated and questionable teeth saved. This has been well documented over the last 50 years.

New products, i.e., tissue healing modulators, growth factors (BMP-2) and even stem cells, are promising additions to currently proven materials and techniques but require evidence-based research, which in many cases is currently being performed before being recommended as replacement materials.

I feel that general practitioners and periodontal specialists should be co-therapists in patient treatment. The decision to extract or attempt to save a tooth should be made by the dental team, not by one quarterback. I feel the periodontal specialist is in the best position to advise the referring dentist of the risks, options and treatment required to save a tooth or teeth. I don’t see many patients who come to my office or the New York University Dental Center clinic who would rather have an implant than a healthy functioning tooth. That’s why I advocate saving teeth, and periodontists are trained to save teeth.

There certainly are circumstances where extraction and implant placement is indicated and, here too, periodontists should be part of the team involved in these decisions and procedures. Periodontists have always been involved with soft- and hard-tissue esthetics around teeth and implants, and certainly have the experience and expertise in both areas. It would be best for the patient and treating team to be on the same page when it comes to knowing the options, risks, benefits, anticipated results and potential complications before any implant treatment option is considered.

You concluded with the statement: “You are the dental clinician, so it is for you, the periodontist and the patient to decide.” I couldn’t agree more, but the decision should be based on sound evidence-based data that is currently available rather than promises or hype from any company with minimal scientific long-term data to back up their claims.

So again, to answer your question, “Where did all the periodontists go?” “We’re here and available for a team approach to predictable dentistry.”

I urge you and your readers to attend the Joint Periodontal-Restorative Dentist Conference that will be held in Chicago in April 2011 to see first hand how this collaboration can work. I have already submitted a book I edited, “Dental Implant Complications — Etiology, Prevention and Treatment,” that will be published by Wiley-Blackwell within the next two months (www.wiley.com/WileyCDA/WileyTitle/productCd-0470508413.html).

The latter is a comprehensive textbook discussing potential implant complications and how to avoid them. This should be of interest to all dental practitioners be they general dentists or specialists. The book emphasizes the team approach to avoiding unwanted complications and results. If you have any questions or comments, please do not hesitate to contact me.

Best Regards,

Stuart J. Froum, DDS, PC
• Diplomate of the American Board of Periodontology
• Diplomate of the International Congress of Oral Implantology
• Diplomate of the American Board of Periodontics and Implant Dentistry
• Clinical Professor and Director of Clinical Research Dept. of Periodontology and Implant Dentistry at New York University College of Dentistry

New York, N.Y. 10019-5404
Tel. (212) 336-4209
www.drsstuartfroum.com

Based on your excellent response and the many others I received from dentists and periodontists on both sides of the “implant vs. teeth” controversy, I feel that the article has succeeded in bringing the discussion to the forefront.

Thanks and have a great day!

Louis Malcmacher DDS, MAGD

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@dentaltribune.com. If you would like to mail any comments to your subscription (name, address or to opt out) please send us an e-mail at databases@dentaltribune.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.
It is that time again for nearly 9,000 dental professionals from around the globe to unite in Seattle for the 123rd annual Pacific Northwest Dental Conference (PNDC), to be held June 17 and 18.

Brought to you by the Washington State Dental Association (WSDA) and recognized as one of the premier dental conferences in the country, the PNDC offers two days of continuing education in the beautiful Pacific Northwest.

ADA members can acquire up to 14 C.E. credits and attend any lecture they want by purchasing a full conference badge for $265–$305 and staff may register for $175.

While other dental meetings throughout the nation charge per lecture, PNDC attendees have access to more than 50 speakers and 60 lectures at no additional cost.

The PNDC offers affordable, quality education for the entire office. Check out some of this year’s highlighted speakers (see image).

However, for a complete listing of speakers and course descriptions, please visit www.wsda.org/pndcschedule.

In addition to top-notch C.E., the PNDC offers an array of other activities to keep attendees busy. With a robust exhibit hall that features more than 300 exhibiting companies, attendees will have the opportunity to shop the latest and greatest in dental products as well as try their luck at huge prize giveaway drawings throughout the conference.

To register or for more information, please visit www.wsda.org/pndc or call (800) 448-3368.

The PNDC looks forward to seeing you in Seattle! 🌟

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**Speaker list**

- Dr. Pascal Magne & Michele Magne: Operatory-Laboratory Endeavor in Esthetic Adhesive Restorations
- Dr. David Clark: Composites and Restorative Dental Materials
- Dr. Gerard Kugel: Esthetics, Laminate Veneers and Whitening
- Dr. Brian Mealey: Periodontics, The Oral-Systemic Connection
- Dr. M. Nader Sharifi: Removable Prosthodontics
- Dr. John West: Rotary Endodontics
- Dr. Brad McPhee: Implants
- Dr. James Grisdale: Soft Tissue Grafting and Implants
- Dr. Norman Sperber: Forensic Dentistry
- Dr. John Molinari: Infectious Disease, OHSA and Infection Control
- Cynthia Fong: Air Polishing and Ultrasonic Debridement
- Dr. Gregory Psaltis: Pediatric Dentistry and Stainless Steel Crowns (with Dayna Dayton)
- Jill Taylor: Esthetic and Restorative Dental Hygiene
- Shannon Pace: Esthetic Dental Assisting and Temporaries
- Mary Govoni: Dental Assisting and Dental Materials for Hygienists and Assistants
- Dr. Linda Niessen: Geriatrics and Women’s Health
- Dr. Rhonda Savage: Communication, Front Office and Practice Management
- Susan Gann: QuickBooks and Embezzlement
- Katherine Eitel: Leadership and Front Office Communication
- Debbie Castagna & Virginia Moore: Payment Arrangements and Practice Management
- Dr. Bart Johnson: Pharmacology and Sedation
- Bob Gray: Memory Retention
- Dr. Marc Cooper: Practice Management

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2010 FNDC, to be held June 10-12 in Orlando, offers three days of education, new technology — and fun!

By Fred Michmershuizen, Online Editor

The 2010 Florida National Dental Convention (FNDC) will be held June 10 to 12 at the Gaylord Palms Resort and Convention Center in Orlando. The theme of the meeting is “Approach to Success: Piloting Your Way to Dental Excellence.”

Organized by the Florida Dental Association, the meeting offers three days of education not only for dentists, but for administrative staff and hygienists as well.

“The FNDC Committee plans years in advance for each FNDC, and I think we have a great slate for 2010,” said Neil H. Torgerson, DMD, general chair of the Committee on the Florida National Dental Convention.

New at this year’s FNDC is a Dental Assistant Roundtable, a course in which dental assistants will be introduced to new products and techniques.

And for practitioners who have always wanted intensive training but haven’t been able to commit to a weekend residency, the FNDC has established mini-residencies in the most sought-after areas.

The FNDC is offering three-day mini-residencies in implants and endodontics. The FNDC is also offering a two-day anatomy and dissection course.

Educational highlights

The meeting will offer 115 continuing education courses, including 81 lectures, 25 workshops, three mini-residencies and two master series.

“This year’s meeting has everything you and your team need to sharpen and hone your skills,” said Charles Llano, DDS, program chairman of the meeting.

“As I planned this program, I kept in mind the need for all of us to continue to grow and educate ourselves in order to be the best in our profession. Getting a dental degree is just the beginning — the learning continues throughout our career.”

Some of the educational highlights include the following courses:

- **Facial Aesthetics for the Dental Practitioner**
  - **Friday, 8 to 10 a.m.**
  - This course, led by Richard Joseph, DMD, is a presentation on concepts of facial esthetics, proportion, balance, “hallmarks of beauty” and the terminology of aging.
  - Current facial cosmetic procedures for rejuvenation will be reviewed. Special emphasis will be given to the areas of lip and peri-oral procedures that will be of interest to dentists.
  - This will serve as an introduction to neurotoxins and dermal fillers and a primer for attending a hands-on workshop.
  - The cost of the course is $60.

- **Neurotoxins and Dermal Fillers for Facial Rejuvenation**
  - **Friday 10:30 a.m. to 1 p.m.**
  - This hands-on workshop led by Richard Joseph, DMD, will include a two-hour didactic lecture and three and a half hours of hands-on instruction in administering neurotoxins and dermal fillers.
  - Participants will need to have a volunteer present for the hands-on portion of the workshop.
  - The cost of this workshop is $2,495.

- **Successful Implants**
  - **Thursday, Friday and Saturday from 8:30 a.m. to 4 p.m.**
  - This mini-residency, led by Dennis Thompson, DDS, MS, will prepare participants to implement the use of a system that prevents bone and tissue loss around anterior implants.
  - In addition, it will allow participants to utilize a single implant to attach to natural teeth (an implant/tooth bridge).
  - The cost of this course is $1,895.

- **Hi-Tech Endodontics in the 21st Century**
  - **Thursday and Friday, 8:30 a.m. to 4 p.m., and Saturday from 8:30 to 11:30 a.m.**
  - In this course, led by Samuel O. Dorn, DDS, PA, and Kenneth J. Zucker, DDS, MS, participants will be introduced to the usage of many new endodontic techniques and instruments from a variety of manufacturers.
  - Participants will have exposure to many of the most popular nickel titanium instrument systems as well as several different apex locators, ultrasonic, irrigation and obturation devices.
  - In addition, attendees will have the opportunity to complete endodontic procedures on extracted teeth, plastic blocks and anatomically accurate acrylic teeth models using the dental operating microscope, and visualize the final results using digital radiography.
  - The cost of this course is $1,895.

- **The TEAM Approach to Implant Dentistry**
  - **Thursday, Friday and Saturday, 8:30 a.m. to 4 p.m.**
  - This mini-residency, led by Will Martin, DMD, MS, and James D. Ruskin, DMD, MD, is intended for dentists who desire to increase their knowledge of the restorative and surgical phases of implant treatment for their patients.
  - The clinical management of the patient from consultation, treatment planning, surgical placement of implants in the mandible and maxilla, peri-operative and postoperative care and complications will be reviewed.
  - The cost of this course is $1,895.

Other educational tracks

In addition to the course highlights mentioned above, the meeting will also offer educational tracks for administrative assistants and dental hygienists.

“Whether you come for one day, or all three, the courses are there to help you master your profession,” Llano said.

FNDC Exhibit Marketplace

According to meeting organizers, nearly 450 exhibitors will share their knowledge and expertise, as well as the latest and most innovative products, services and dental technologies, in the FNDC Exhibit Marketplace.

“Our exhibit hall is filled with exhibitors waiting to show you all the latest in technology and materials for your practice,” said Torgerson. “It is a one-stop shopping experience for all that dentistry has to offer.”

Meeting attendees are encouraged to take advantage of convent ion specials, learn about the latest products and place on-site orders.

In addition to hundreds of presentations, demonstrations and products, the FNDC exhibit hall will also feature table clinics, C.E. verification stations and a variety of fun activities.

The exhibit hall hours are as follows:

- **Thursday, June 10:** 9 a.m. to 5:30 p.m.
- **Friday, June 11:** 9 a.m. to 5:30 p.m.
- **Saturday, June 12:** 9 a.m. to 3 p.m.

**Friday in Paradise**

The FNDC will also offer plenty of fun. A “Friday in Paradise” event will be held in the Gaylord Palms atrium on Friday afternoon and evening.

There will be live music, dancing and entertainment for kids — including still walkers and balloon artists. Everyone is invited, and the tickets are free.

More information about the meeting is available online at www.floridadentalconvention.com.
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Urban Tucson—6 Ops, 3 Equipped, 1 Hygiene, GR $90K #12110
Tucson—1,000 active patients, GR $65K, Asking $50K. #12116
CONTACT: Mark Hadfield #480-251-5838

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Cicero Heights—6 Ops, 1,500 sq ft, 2-3 days hygiene #14311
Fresno—5 Ops, 1,500 sq ft, GR $115,000. #14320
Modesto—4 Ops, 1,500 sq ft, GR $165K. #14322
Northern CA—Paso Robles Practice, 1,100 sq ft, GR $76K. #14326
Northern CA—Wine Country Practice—2 Ops, 1,500 sq ft, GR $95K. #14329
Porterville—6 Ops, 2,000 sq ft, GR $228,000. #14321
Red Bluff—6 Ops, 2009 GR $1,000, Hygiene 10 days a week. #14325
San Diego City Heights—3 Chair office, Pan X-ray, intra Oral Camera #14321
San Francisco—Patient Base for Sale—Owner Deseased #14312
Torrance—GR $450K, 1,680 sq ft, 2 Equipped, 3 Avail Chair Office #14320
CONTACT: Dr. Dennis Hoover #800-519-5458

CONNECTICUT
Fairfield Area—General practice doing $800K. #11605
CONTACT: Dr. Peter Goldberg #415-610-2929

GEORGIA
Atlanta Suburbs—3 Ops, 2 Hygiene Rms, GR $95K #19125
Atlanta Suburbs—2 Ops, 2 Hygiene Rms, GR $112K #19128
Atlanta Suburbs—3 Ops, 1,270 sq ft, GR $430K/yr. #19131
Atlanta Suburbs—Pediatric Office, 1 Op, GR $420K #19134
Duluth—GR $1.5M, Asking $825K #19107
Macon—3 Ops, 1,635 sq ft, State-of-the-art equipment #19133
North Atlanta—3 Ops, 3 Hygiene, GR $76K #19132
Northern Georgia—13 Ops, 1 Hygiene, Est. for $300K #19110
Southern Georgia—7 Ops, 3 Hygiene Rms, GR $72K #19133
CONTACT: Dr. Jim Cole #404-315-1573

ILLINOIS
Chicago—3 Ops, GR $300K, Sale Price $410K #22120
Chicago—Multi Specialty Practice 14 ops, TRN Growth #22121
1 HR SW of Chicago—5 Ops, 2007 GR $440K. 28 yrs old #22125
Chicago—3 Ops, GR $300K, 3-day work week #22119
Galena—GR100K, located in Historic Bed & Breakfast Community #22129
Western Suburbs—5 Ops, 2,000 sq ft, GR #1.5MM #22130
CONTACT: Al Brown #630-781-2176

INDIANA
Southern Indiana—General Dentist seeking practice purchase opportunity #29012
CONTACT: Joe Paul #317-297-0198

MAINE
Waterville—High End Practice GR $900K —Bidig also for sale #29013
CONTACT: Peter Goldberg #207-690-2290

MASSACHUSETTS
Boston—2 Ops, GR $250K, Sale $175K #30112
Western Massachusetts—5 Ops, GR $1 Mill, Sale $340K #30116
CONTACT: Dr. Peter Goldberg #617-690-2930
Boston—2 Ops, 1 Hygiene, GR $100K #30125
Middlesex County—7 Ops, GR Mid $100K #30120
New Bedford Area—4 Ops, GR $50K #30110
CONTACT: Alex Lovak #617-240-2582

MICHIGAN
Suburban Detroit—2 Ops, 1 Hygiene, GR $210K #11105
Ann Arbor Area—Low Overhead—Well Run Practice GR $600K #30112
CONTACT: Dr. Jim Davis #586-530-0800

MINNESOTA
Crown County—4 Ops, Sale Price $142K #32204
Fargo/ Moorhead Area—1 Op, GR $185K #32107
Minnesota—Mobile Practice, GR $730K #32108
Twin Cities—Move-in & Practice Immediately GR $800K #32109
CONTACT: Mike Minor #612-961-2152

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Eastern Central Mississippi—10 Ops, 4,665 sq ft, GR $1.5M #31303
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CONTACT: Sharon Mascevic #848-788-4071

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Woodstock—2 Ops, Building also available for sale, GR $600K #44112
CONTACT: Dr. Don Cohen #848-450-4044

Syracuse—4 Ops, 1,800 sq ft, GR over $700K #44110
CONTACT: Matty Hare #315-263-1313

New York City—Specialty Practice, 3 Ops, GR $500K #41109
CONTACT: Richard Zelkin #718-831-0224

Suburb of Syracuse—Great Practice, Growing Community, GR $662K #11117
CONTACT: Donna Bambrik #515-650-0664

NORTH CAROLINA
New Hanover County— Practice on the coast, Growing Area #42145
Lake Norman Area—High Productive Practice, Desirable Location #2152
Pittsboro—Small Community Practice, Stand alone old age, downtown, 3 ops #32158
Raleigh, Cary, Durham—Doctor looking to purchase #42137
CONTACT: Dorothy Hunger #919-948-1555

OHIO
Medina—Associate to buy 1/3, rest of practice in future. #44150
North Central—GR $65K, 4 Ops, Well Established #44155
Northeast—GR $80K, 5 Ops, Well Established #44157
CONTACT: Dr. Dan Moorhead #440-325-8003

PENNSYLVANIA
Chester County—High End Practice, 4 Ops, Digital, FFS + a Few PPOs #47144
Lackawanna County—4 Ops, 1 Hygiene, GR $155K #47138
Lancaster County—Very Established Practice, Newly reorganized #47159
Montgomery County—Spectacular Office, 2,000 sq ft, 4 ops— #47196
Philadelphia County (NE)—4 Ops, GR $500K+, Est 25 years #47144
CONTACT: Sharon Mascevic #584-788-4071

SOUTH CAROLINA
Hilton—Dentist seeking to purchase a practice producing $500K a year #49103
CONTACT: Scott Carringer #704-414-1796
Columbia—7 Ops, 2200 sq ft, GR $175K #49102
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CONTACT: George Lare #865-414-1377

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FDI teams up with OSAP to improve global patient safety standards

The FDI World Dental Federation is participating in an official review of the WHO Patient Safety Curriculum Guide in cooperation with the Organization for Safety and Asepsis Procedures (OSAP), International Federation of Dental Educators and Associations (IFDEA) and other leading global medical profession associations.

Patient safety is an emerging discipline, aiming to prevent errors in patient care and to identify opportunities for improving patient outcomes. According to the WHO Research Priority Setting Working Group on Patient Safety, tens of millions of patients worldwide suffer disabling injuries or death due to unsafe medical care every year.

The multi-professional WHO Patient Safety Curriculum Guide was first published in 2009 to provide medical schools with guidelines for teaching patient safety, and has since been downloaded by more than 1000 institutions in 100 countries.

In growing recognition of the harms caused by health care, the WHO initiated a review of the Guide and invited the FDI World Dental Federation to participate as a primary partner in the project, together with the International Council of Midwives and other members of the World Health Professions Alliance (WHPA), International Council of Nurses, International Pharmaceutical Federation and World Medical Association. Professors Takashi Inoue and Nermin Yamalik, of the FDI Education Committee, will be contributing to the review. Details are expected to be finalized during a consensus meeting at the 2010 OSAP Annual Symposium in June.

FDI explores preventive dentistry at 2010 AEEDC Dubai

Representatives from the FDI World Dental Federation, including Dr. Roberto Vianna, FDI president, were recently in Dubai for the 2010 UAE International Dental Conference & Arab Dental Exhibition (AEEDC Dubai), where they participated in the AEEDC Conference Program, the Gulf Cooperation Council Preventive Dentistry Conference and the 7th Annual Arab-Asian Scientific Dental Congress.

The Global Caries Initiative (GCI) was first conceived during the Rio Caries Conference in July 2009, where conference attendees — including leading experts in epidemiology, cariology, dental education, prevention and change management — conceded there is a need to establish a broad alliance of key influencers and decision-makers to effect fundamental change across health systems and in individual behavior in order to eradicate caries worldwide by 2020.

Departing from this objective, the FDI World Dental Federation embarked upon a global consultation process to assess the potential challenges and impact of introducing a preventive model to existing systems for caries management.

The most recent seminar took place at the 2010 AEEDC Conference Program: Dr. Julian Fisher, FDI associate director of education and

FDI Corporate Partners Meeting in Chicago

The annual FDI Corporate Partners Meeting took place at the end of February during the 145th Chicago Dental Society Midwinter Meeting. FDI President Dr. Roberto Vianna opened the meeting, welcoming and thanking FDI corporate partners for their unwavering support, particularly in view of the economic challenges still affecting businesses worldwide.

Joining the FDI president at the meeting were FDI President-Elect Dr. Orlando Monteiro da Silva; Councilor Dr. Kathryn Kell; Executive Director Dr. David Alexander; and other full-time FDI professional staff from the finance, communications and congress departments.

Alexander presented a detailed report of ongoing FDI activities and achievements in 2009, including the introduction of a new FDI website, preparations for the 2010 Annual World Dental Congress in Salvador da Bahia, Brazil, future congress venues, progress on the Global Caries Initiative and a summary of internal process improvements across the organization.

Alexander reminded participants of the critical importance of partnership between the FDI World Dental Federation and the dental industry, encouraging an “open dialogue, which strengthens our relationship and brings mutual benefits to both parties.”

The presentations portion of the meeting included a financial review by Jerome Estignard, FDI director of finance and operations, who summarized the 2009 year-end results and budget forecasts for 2010 and beyond.

The annual FDI Corporate Partners Meeting is held in the first quarter of each year, alternating venues between the Chicago Dental Society Midwinter Meeting and the International Dental Show in Cologne, Germany.
Members’ Corner
Dr. Michael Glick: outstanding scientist and clinician

In this interview with World Dental Communiqué, Dr. Michael Glick discusses his work with the FDI World Dental Federation and his views on the role of the dental profession in oral and general health.

In October 2009, you were appointed dean of the University at Buffalo School of Dental Medicine. What attracted you to this role and what do you hope to achieve?

This position is a chance to have an impact with respect to dental education and, consequently, the future of dentistry: to build on the best of what we’re doing and take it to the next level. I am proud to be a dentist.

But, first and foremost, I see myself as a health-care professional. There is a small but growing trend within the context of GCI to enhance overall health by providing medically based point-of-care screening in dental offices. In fact, last year I coordinated a seminar at the ADA Annual Session that was a hands-on course for dentists in office-based medical screening. There is a small critical mass developing that is eager to improve oral health-care delivery and education is where it all begins.

You dedicate a lot of time to the FDI World Dental Federation as chairman of the science committee. What motivates you to participate in organized dentistry at the inter-national level?

Working with the FDI World Dental Federation is an opportunity to make a difference, and I gladly give my time to help bring about positive change in the way the dental profession is perceived; for instance, in re-evaluating how we provide care or providing care to people who do not have access.

The structural complexity of our profession can be complicated, which further emphasizes a need for unity at the international level in order to make any progress.

What does the FDI World Dental Federation bring to the world of dentistry?

The FDI is the largest dental organization in the world, bringing together representatives from many different countries as a unified, global voice of dentistry. This gives us the privilege and opportunity to make a huge impact through the profession: to act as the facilitator for change.

For example, in caries prevention, the FDI is leading the Global Caries Initiative, a profession-led project with the goal of significantly diminishing the prevalence of caries worldwide by 2020.

Other recent projects, such as the Oral Health Atlas and Dental Ethics Manual, are further examples of practical tools produced by the FDI that dentists can use in their countries to support advocacy and awareness around oral health.

You recently attended the FDI mid-year committee meetings in Geneva. What are some of the areas of focus for the science committee in 2010?

This year, the Science Committee wants to focus on setting a research agenda to respond to major global oral health-care issues. We also want to proactively generate collaboration between researchers in different parts of the world and partner with organizations working toward the same goals, such as the International Association for Dental Research (IADR).

As chairman, I see my role as a facilitator: that is, does the committee work reflect the mission and vision of the FDI? This is a question I ask myself when embarking on a new initiative. Another area of focus for the committee is science and evidence behind policy. To this effect, we are working to design FDI scientific statements that will help underpin policy and provide FDI members with valuable scientific resources.

How do your many responsibilities relate to your personal vision in oral health?

All of my work, whether as the dean of a dental school, editor of IADA or the chairman of the science committee, reflects my philosophy about health. I am lucky to have the opportunity to have a voice in sharing these beliefs with a larger group. But I see many examples of how dentists make a difference in their community at so many levels — such as extending free care. Every little bit makes a difference.

Dr. Michael Glick is dean of the University at Buffalo School of Dental Medicine in the United States. He currently serves as chairman of the science committee for the FDI World Dental Federation.

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Donna J Abernathy
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The mouth as construction site

Art 4 Your Practice offers handmade 3-D art for dentists

By Robin Goodman, Group Editor

How did this company get its start?

Cathy Howard: The owner of the company, Mark Sanford, who is an audiologist, was at an audiology convention and met the German people who make this art for the hearing world and promote it worldwide, and he really liked the art. They were new in promoting and had done quite a bit in Europe, but had no representation in the U.S. Mark said that he wanted to promote this for them in the U.S. because he was already attending the major hearing shows.

I worked for Mark full-time as his bookkeeper, as we have five audiology offices in the Bay Area. He asked me to help with the project because he wanted to expand into the dentistry art because there are so many dentists. So that's how we started in the dental business. He’s sent me to all these dental events and I've been having a fabulous time.

When I was in Chicago, our German partner joined us there, and taught me a lot of how they do things over there to produce the art.

How long have you worked with Mark then?

It's been 10 years already and I still do the bookkeeping. So this is so much fun for me to get out of my little office and meet with people.

How would you describe this art to a dentist who might say, “Why would I want 3-D art in my practice?”

It’s completely different than what most people would call dental art, specifically because it’s 3-D. You have your shadowboxes, which you can hang on a wall, or your showcase pieces that can go on a counter or shelf or table.

The theme of this artwork is the mouth as a construction site, which is why there is scaffolding, men working and the plans or blueprints of the worksite. Thus, it's akin to the dentist being the construction worker on someone’s teeth.

What I think makes it most unique is that it takes the dental business, which can be rather scary for some people, and makes it more consumer friendly, fun and light.

They’re very well made and there is a considerable amount of detail in each one, which draws people to the piece and makes it easy to spend a lot of time looking at just one piece. General dentists and specialists buy them for their offices and homes, and dental labs buy them as well.

They are also a memorable gift and they can be personalized to a certain degree. For example, we can make these into business card holders and add a brass plate with the dentist’s name.
Dr. Michael Mulvehill (from left), Dr. Suzanne Coulver, Dental Assistant Vicki Boyd and RDA Kayla Noriega drove down from Arcadia, Calif., to attend the CDA meeting in Anaheim, Calif., for just one day.

Terry Aldredge of Henry Schein Dental and Lynda Stallworth, RDH, of Los Angeles stopped for a chat on the exhibit hall floor.

Anthony ‘Rick’ Cardoza, DDS, and Joyce Galligan, RN, DDS, pause for a candid photo during the midday break for their lecture on ‘Emergency Preparedness: The Role of Dental Professionals.’

The men in blue (that would be the U.S. Navy’s blue) are (from left): John Safar of Las Vegas, Stephen Chartier of Las Vegas and Patrick Parson of Alexandria, Va.

Bryant Irawan is still a student, but aspires to be a dentist like his father and attended the meeting with him (OK, I confess, it was the iPad that caught my attention!).

Photos & Captions/Robin Goodman)
Plak Smacker announces the release of its new adult brush, the Ultrafine Toothbrush.

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Plak Smacker: new ultrafine toothbrush

(PHOTO/PLAK SMACKER)

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(PHOTO/VELOPENEX)

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Esthetic rehabilitation
Using provisional restorations to improve results in complex restorative cases


The esthetic rehabilitation of patients with a functionally compromised dentition frequently involves a multidisciplinary approach incorporating several different treatment modalities.

A correct esthetic and functional diagnosis with an appropriate treatment plan as well as careful material selection and application are critical factors in the successful restoration.

The following case presentation demonstrates a multi-disciplinary approach to re-create an esthetic smile in a female patient with a functionally and esthetically compromised dentition.

Patients requiring prosthodontic rehabilitation often have multiple concerns (esthetic, functional and health) and have left rehabilitation for some time due to fear, cost and time constraints. It is the goal of treatment to provide an esthetic and functional dentition with minimal maintenance over the long term.

Treatment planning & procedures
The primary objective was to re-create an esthetic smile and to establish a functional occlusion. This would involve orthodontic, periodontal and restorative modalities.

Periodontal treatment. The patient underwent a preliminary treatment plan that included professional oral hygiene and reinforcement of oral hygiene practices.

Orthodontic treatment. In order to correct the tipped and drifted mandibular teeth that were a consequence of missing teeth.

Diagnostic wax-up. This allows the team to preview the desired esthetic appearance. The diagnostic wax-up provides guidelines of the desired treatment and a blueprint for the final restorations. This wax-up also allows the manufacture of putty keys for provisionalization and reduction guides for the preparation process.

Gingival recontouring. A 940 nm diode laser (Biolase EZlase) was utilized to improve soft-tissue esthetics. Periodontal bone sounding was performed to ensure that biologic width was not invaded and then gingival tissues were lasered to improve the gingival contour, symmetry and gingival zeniths.

Preparation. For all-ceramic crowns it is recommended that an axial reduction of 0.8 mm to 1 mm and an occlusal reduction of 2 mm be made as these materials need a certain thickness to withstand masticatory and parafunctional stresses.

Finish lines are recommended to be chamfers or 90-degree rounded shoulders to provide sufficient bulk at the margins and allow the transfer of stresses adequately around the margins.

To minimize stress concentration within the restoration, all line angles should be rounded, all sharp edges smoothed, and boxes and grooves and “butt” type shoulders are contra-indicated.

Impression procedure. The use of a double zero retraction cord (Ultrapack #00, Ultradent) was placed into the gingival sulcus as a first cord and then a retraction paste, Expasyl (Kerr), was then placed over the first cord.

The correct use of this retraction paste should see blanching of the gingival tissues as the paste is extruded into the gingival sulcus. An impression was made with a polyvinyl siloxane material (3M Imprint 5).

Maxillo-mandibular relations. The Kois Dento-Facial Analyzer System registers and transfers the patient’s occlusal plane as well as tilts in the occlusal plane in three planes of space to the articulator related to an average 100 mm axis-incisal distance. This allows orientation for esthetic positioning of the anterior teeth in relation to the midline of the face and ensures correct orientation of the incisal plane.

Provisionalization. The provisional restorations are duplicated from the diagnostic wax-up that incorporates the proposed changes. It allows the patient a “test run” of the final result by allowing her to see a preview of the planned result. This is an essential step in the planning process.

The aims of provisionalization are as follows.

Health: pulpal protection and periodontal health and gingival stability.

Function: the provisional restorations can be used to assess and alert if there are any occlusal and phonetic problems with the proposed changes. The pronouncing of “V” and “F” sounds should create a light contact between the central incisor and the “wet-dry” line of the lower lip.

Esthetics: provisional restorations can be used to assess the basic shade to be chosen, incisal edge dis-

Fig. 1: Smile photograph showing asymmetry in smile, maxillary cant, slanted midline, negative buccal corridor and poor axial inclinations.

Fig. 2: Retracted frontal photograph.
play, form and shape of teeth, dental midline location, lip support, parallelism of incisal plane to inter-papillary line as well as the curvature of lower lip.

Evaluation of esthetics provided by the provisionals at this stage is crucial in guiding the patient to the amount of display necessary for an aesthetic smile. The provisional crowns were constructed with Protemp 4 (3M-ESPE), a bis-acryl resin composite. All contours were kept curvaceous and smooth with space made available for the patient to use interdental cleaning aids due to the provisionals being totally splinted together.

The patient is given instructions on oral hygiene during the provisional phase and is asked to return in two to three days time for final approval. I recommend this delayed approach of assessing the provisionals as the patient is not pressured into deciding if she likes the provisionals on the day of preparation. The patient is often anaesthetized with associated facial palsy and cannot adequately assess esthetics at this time.

Patients will also often ask friends and family about the proposed changes and the extra time allows the patients to accustom themselves to the new “look.”

If the provisional restoration requires modifications, the provisionals can be adjusted and an impression then made for communication to the ceramist of the additional changes.

Cementation. The crowns are received back from the laboratory and tried in the mouth. I prefer not to use local anesthetic for the patient to approve the final esthetics before cementation.

However, if local anesthesia is required, an alternative technique is to use the ANSA local anesthetic block technique so that the injection achieves pulpal anesthesia of the central incisors through the second premolar without collateral numbness of the face and facial muscles of expression.

This is best achieved with a computer-controlled injection system such as the Wand (Milestone Scientific) that delivers a virtually painless palatal injection.

Once the patient is happy and approves the final esthetics, the restorations are prepared for cementation.

The patient returned to the office one week later to allow a final examination of the esthetics, phonetics and occlusion.

Conclusion

The esthetic rehabilitation of a patient with a functionally compromised dentition frequently involves a multidisciplinary approach. The proper sequence and planning involving periodontal, orthodontic, aesthetic and restorative treatment is required with communication between the whole team, from the patient and ceramist to the treating clinicians.

The use of provisionalization is a significant factor in achieving a successful esthetic outcome for both the patient and the treating clinicians.

Fig. 3: Orthodontic treatment to upright tipped teeth and correct occlusal plane.

Fig. 4: Gingival recontouring completed.

Fig. 5: Crowns sectioned to allow insertion of Christensen crown remover for removal.

Fig. 6: Use of Expasyl for hemostasis and retraction.
patient and dental team. Provisionalization allows patients to preview their future teeth, enabling them to assess the esthetic and functional changes. Invaluable information can be learned in regards to esthetic factors including incisal display, buccal-lingual position of teeth, smile line, shade, and in addition, functional criteria can be assessed with phonetic and occlusal changes.

Fig. 7: Use of Kois Dentofacial Analyzer to align midline and incisal plane.

Fig. 8 (at left): Patient has returned after two to three days for review of provisionals to ensure approval of change in shape, color and other desired changes before final crowns are made.

Fig. 9: Palatal view of all-ceramic crowns.

Fig. 10: Frontal view of completed all-ceramic crowns.

About the author

Dr. Christopher C.K. Ho lectures on esthetic and implant dentistry in Australia and other countries. He teaches at several universities within Australia and the United Kingdom, and is a faculty member for the Global Institute for Dental Education. Ho has a referral-based private practice in prosthodontic and implant dentistry in Sydney, Australia.
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The many sides of xylitol

By Sandra Berger, RDH, BS

What is xylitol? How does it work? How long has it been around? How does it benefit me? Where do I find it? What is it good for? These are some of the questions I am asked by my patients, friends and even cashiers when I mention xylitol. One of the most common questions I hear is, "What is xylitol?"Xylitol is a naturally occurring sugar substitute, and is now readily available at retail outlets. This availability makes it much easier for patients to incorporate it into their daily schedule, and as a result, reap the multi-sided benefits.

Xylitol was once only found in health food stores, however, it has become much more mainstream and is now readily available at retail outlets. This availability makes it much easier for patients to incorporate into their daily schedule, and as a result, reap the multi-sided benefits.

What is Xylitol?

Xylitol, a naturally occurring sugar substitute, is clinically proven to be a natural enemy of bacteria. Xylitol is often referred to as wood or birch sugar because it was typically manufactured from birch trees. However, today xylitol is mainly extracted from corncobs. This is more practical considering the vast amount of xylitol that is being produced and consumed. Other natural sources of xylitol include plums, strawberries and raspberries.

Pure xylitol looks like sugar because it has a white crystalline appearance and it even tastes like sugar. However, it has 40 percent less calories than sugar. Only one-third of the absorbed xylitol gets metabolized in the body.

How does it work?

Over 400 strains of bacteria inhabit the human mouth. Sugar is one of the major energy sources for these bacteria and helps them proliferate. When these sugars are consumed, acid is produced, creating a highly acidic environment in the oral cavity that demineralizes enamel and makes it vulnerable to attack by bacteria, leading to tooth decay.

Because xylitol is a five-carbon polyol, it is not metabolized by mouth bacteria, and as a result, no acids are produced in the mouth that can cause tooth decay.

The sweetness also stimulates saliva flow, which neutralizes any acids that have been formed and rinses away excess sugar residue. Xylitol helps keep an alkaline environment in the oral cavity that is inhospitable for mouth bacteria. Thus, xylitol is both non-cariogenic in that it does not contribute to caries formation, and it is cariostatic because it prevents or reduces the incidence of new caries.

Xylitol actually reduces the amount of plaque and the number of Mutans streptococci (MS) in plaque.

How long has it been around?

German chemist Emil Fisher and French chemist M.G. Bertrand first discovered xylitol in the late 1800s. The first attempt at producing xylitol was made in 1966 by a German company. In 1970, the first commercial xylitol products were introduced in Japan. Today, xylitol is produced in over 70 countries worldwide. Xylitol is manufactured from birch trees. However, today xylitol is mainly extracted from corncobs. This is more practical considering the vast amount of xylitol that is being produced and consumed. Other natural sources of xylitol include plums, strawberries and raspberries.

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Dear Reader,

The dental profession in the United States is becoming more aware of the benefits of xylitol. At this point, dental publications, live educational courses and online courses are buzzing with the good news about xylitol, the amazing five-carbon natural sugar.

While dental professionals around the globe have been endorsing xylitol for many years, the United States has been slow to hop on the bandwagon. One of the reasons for this lag is the United States needed the right xylitol products to be available, and usage directions to be more clearly defined.

Now the products are here and the usage is simple: Use pure xylitol as an alternative to ordinary toothpaste, mouth rinses, chewing gum, mints and canker sores. Following such a plan will ensure the recommended five exposures per day. This can mislead patients into thinking they are getting the benefits of xylitol and has been for a long time.

There are also companies producing high-content xylitol products that market to the dental industry. Dental offices can order products direct from the companies and have them on hand to give or resell to patients.

Xlear, a company based in Orem, Utah, offers direct ordering, but it has also recognized the disconnect between the dental and health food industries. To help mend this situation, Xlear has implemented the “Bridging the Gap” initiative. This program has been designed to connect dental offices and their patients with local health food stores. These connections are being made by a team of hygienist’s hired by the company to operate as product educators.

Product educators visit dental offices on behalf of each store. These representatives drop off samples of xylitol products, offer education and inform the office of the nearest store offering 100 percent xylitol sweetened products. On the other side, each store knows which offices have been connected with their store and “Bridging the Gap” has been put into motion.

This is networking at its best! Hygienists are taking their career in a new direction, knowledge is being shared, referrals are going back and forth between dental offices and health food stores, more xylitol products are being purchased and used, and the bottom line is people are getting healthier. Isn’t this what our profession is all about?

If you would like more information regarding how to get your office involved in “Bridging the Gap,” contact Xlear National Sales Manager Chad Thomas at chad@xlear.com. In addition, as you’ve likely already noticed, this month’s article focuses on the many sides of xylitol.

Best Regards,

Angie Stone, RDH, BS

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Xylitol was not manufactured in a crystalline form until World War II, when war-associated sugar shortages created the need to find alternative sweeteners. Early on, xylitol was primarily used in diabetic diets and infusion therapy for burn and shock patients as well as for postoperative patients in Europe and Asia. It was when further study into xylitol's biological properties, including dental, that large-scale production was needed.

Industrialized xylitol manufacturing began in Finland in the early 1970s in the form of gum and mints. It quickly became a daily part of Finnish life. Over the next 35 years, global awareness of the significant advantages xylitol offers continues, as does the variety of items that contain the substance.

How much do I need?

It was previously thought that the benefits of xylitol were dose related, not frequency related. However, researchers from the University of Washington did a series of studies in order to potentially substantiate these responses on Mutans streptococci’s prevalence and possible reductions with xylitol. The effect levelling off between 6.88 grams and 10.32 grams xylitol over three and four administrations per day. These results confirmed previous suggestions regarding xylitol dosage and frequency of consumption.

A dose range of 6 to 10 grams divided into at least three consumption periods per day is necessary for xylitol to be effective with chewing gum as the delivery system.

Thus, the frequency is as important as the amount of xylitol used.

Where do I find it?

Many products in local grocery stores contain xylitol. The easiest to find are gum and candy, but check the ingredients. Just because one flavor or type contains xylitol does not mean that all types of gum from that manufacturer will contain it.

Health food stores will carry a larger selection of products, such as mouthwash, toothpaste, mints, individual packets to use in coffee/tea, bulk packaging to use in cooking, nasal sprays and neti pots.

Search the Internet for brands and then ask your local pharmacy, grocery or health food store to stock the product. Many items may also be ordered directly from the manufacturer.

Are there any disadvantages?

Xylitol was approved by the U.S. Food and Drug Administration (FDA) in 1963, and it has no known toxic levels or serious known side effects for humans; up to 40 grams per day have been noted with little more than a mild laxative effect. Nonetheless, it should be mentioned that it may be dangerous if consumed by pets, such as dogs and cats.

Conclusion

Prof. Jason Tanzer summed things up best: “Xylitol is inhibitory to the metabolism, growth and plaque formation by Mutans streptococci ... xylitol is conducive to remineralization of initial carious lesions ... I have full confidence that these data distinguish xylitol from any other sugar substitute.”

Xylitol is a low-glycemic sweetener and is metabolized independently of insulin. Xylitol does not cause the sharp increase in blood sugar levels or the associated serum insulin response, which is usually seen following consumption of other carbohydrates. Because of this and the dental and medical benefits it provides, xylitol can be recommended as a sugar-free sweetener suitable for diabetics as well as for the general population seeking a healthier lifestyle.

References

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The frequency of application is as important as the amount of xylitol used.

About the author

Sandra Berger graduated from Ohio State with her RDH and a BS in education. She is the New Jersey clinical specialist for Oral DNA Labs, a salivary diagnostic company.

Berger is currently vice president and C.E. chair of NJDHA. She is a recipient of the Sunstar RDH Award of Distinction 2007, member of AmyRDH Listers and Career Fusion Alumni 2009 and 2010.

Mutans streptococci to increasing frequency of xylitol chewing gum use: a randomized controlled trial. BMC Oral Health 2006, 6:6.
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