By Fred Michmershuizen, Online Editor

In an interview with Dental Tribune, Dr. J. Brian Allman, founder of the TMJ Therapy and Sleep Center of Reno, Nev., discusses obstructive sleep apnea (OSA) and the important role dentists can play in its diagnosis and treatment. Allman, whose mantra is “Airway is king and tongue volume is queen,” says he hopes all dentists become proficient dental sleep physicians.

What do dentists need to know about obstructive sleep apnea?

Dentists are first in line to screen patients for OSA and must embrace the responsibility to ask questions regarding sleep issues, understand this disease’s craniofacial anatomy by recognizing anatomic clues and, last, learn the signs and symptoms of this treacherous and pandemic killer.

Some of the more obvious clues are actually very simple two- or three- or four-piece puzzles. For example, if a patient — or more likely, the patient’s bed partner — harbors complaints of snoring and daytime sleepiness, it is highly likely a sleep breathing disorder patient is sitting in front of you.

If a patient is having difficulty controlling his or her blood pressure, with a third medication imminent, a referral to a medical sleep specialist is recommended. Patients waking several times during the night, having difficulty sleeping or reporting getting up several times during the night to urinate also warrant further questioning.

By beefing up patient questionnaires and adding relevant questions regarding sleep issues, morning headaches, snoring, familial sleep apnea history and discrimination, dentists can play a pivotal role in this pandemic killer.

UNE raises funds for new dental college

Thanks to the financial support of Northeast Delta Dental and other contributors, a new dental college is on track to be established in the northeastern United States.

The University of New England (UNE) recently announced the lead gift of $2.3 million from Northeast Delta Dental for the UNE College of Dental Medicine.

UNE plans to establish a college of dental medicine that will address both the issue of access to care and the need for more oral health professionals in the region. UNE’s College of Dental Medicine will emphasize community dentistry, dental public health and prevention, excellence in clinical dentistry, an integrated health-care system and advanced education.

Correcting bad impressions

As a technician, the next time you see a bad impression, take a step back. Before wasting all that time and work that goes into fabricating a restoration, it’s our duty to save us all the future headache and just make the phone call. We’ve found if you simply ask for a new impression, the dentist will send a new one uncontested.
How does obstructive sleep apnea differ from ordinary snoring?

Snoring is the thunder and OSA is the lightning. One is annoying, and the other one can kill. We must realize that snoring is an indication of an airway impediment, albeit benign, in the case of primary snoring, but linked to cerebrovascular and COPD complications, as might be suspected if the cacophony turn in to pathologic airway blockage during sleep. As we proceed through the continuum of sleep disruptions, we progress to severe apnea, leading to sympathetic nervous system over-activation, hypertension, stroke and other severe and lifethreatening metabolic consequences.

Why does it make sense for patients to contact a dental sleep apnea in the dental office?

Dentistry is standing on a volcano that has yet to erupt — dental sleep medicine practiced by well-trained dental sleep physicians. Dentistry must become a member of a collaborative multidisciplinary team to help manage OSA. By working together, dentists, sleep specialists, ENTs, allergists, cardiologists, neurologists and other medical specialists can provide the best, most effective therapy that patients will comply with.

For example, the gold standard for treating severe OSA is continuous positive airway pressure [CPAP], whereby air is used to splint open a collapsing airway to maintain a sleeping person’s open airway. Unfortunately, while this therapy is effective, not all patients are tolerant, and oral appliances can effectively be used as an adjunctive alternative.

In our clinic, by working with local medical sleep specialists, we use oral appliances to help improve CPAP compliance rates by stabilizing the mandible, resulting in lower necessary air pressures, which is often the cause of CPAP non-compliance.

In 2006, sleep specialists published OSA therapy guidelines recommending oral appliances be prescribed for patients with mild and moderate OSA. One problem is there are not enough trained dentists. Our medical colleagues are often unaware of a competent colleague to refer patients to, but we’re working to educate more and more dentists to provide these collaborative services.

What kinds of appliances are available to treat people with obstructive sleep apnea?

There currently are several appliance designs, such as the Somnomed line of disposable items that are easy to fabricate and adjust. Also, due to the dramatic increase in OSA appliance interest, several new appliance designs waiting for FDA approval. I am excited to see how much creative innovative energy aimed at “building a better mouse-trap.”

Applications that maximize jaw comfort and hard- and soft-tissue stability and minimize appliance bulk, crowding the tongue, and main design issues — are all worth looking at. At this time, there is no one appliance that can do it all.

You have developed a seven-appointment oral appliance therapy scheduling and billing protocol. Will you summarize and brief the benefits to dentists in using this protocol?

First of all, dental sleep medicine (DSM) should be practiced in part, by every dentist worldwide. Practicing DSM suggests a wide spectrum of clinical involvement. Dentists are at the very least, should screen and refer for appropriate medical diagnosis those patients identified with obvious signs and symptoms of OSA.

Dentists interested in becoming multidisciplinary members of OSA management teams can learn to provide oral appliances and follow-up with training. My goal is for all dentists to integrate DSM protocol, whether as a referral first line identifier or as a multidisciplinary therapist.

Two of the biggest roadblocks for general dentists are developing dental office infrastructure and medical billing strategies. DSM is confusing for most dental offices and medical insurance companies as a dental service is provided to manage a medical condition.

Dental office billing personnel seeking reimbursement from commercial medical insurance companies for medical procedures is not widely understood and is often a discouraging source of frustration resulting in abandoning DSM practice. In an effort to streamline integration of what should be a routine general dental procedure, a seven-appointment oral appliance protocol was developed.

By applying our seven-appointment model, which includes dental procedure recommendations and medical billing examples for each of the consultation, impression, delivery and follow-up appointments, dental offices can hurdle the initial difficulties in DSM medicolegal regard. Fortunately, the business of dental sleep medicine has been neatly packaged to get offices started on the right track. I’m not implying that billing is not without its difficulties and that our protocol is magic, but by creating an office model that can be duplicated, more offices will be successful and more patients will be successfully managed.
approach to dental education and population-based health research.

Kathleen Taggersell, director of marketing and communications at UNE, said the dental college is in its fund-raising stage of planning and that UNE must first secure the funds to make the college a reality.

“Our estimated project start-up costs are $15 million, and hiring of senior faculty and administrators to prepare for accreditation, curriculum, recruitment and clinical affiliations would begin in 2011, with an anticipated first class in 2012,” Taggersell told Dental Tribune.

“Centralized early education of dental students will take place at our Portland campus and third-year practice at the college’s Portland teaching clinic,” Taggersell said. “Students will then have fourth-year extensive community-based clinical experiences in Maine, New Hampshire and Vermont.”

Northeast Delta Dental is the largest provider of dental benefits in Maine, New Hampshire and Vermont. Its gift is the largest to date that UNE has received in support of the establishment of a college of dental medicine, which reflects Northeast Delta Dental’s tri-state commitment to this initiative.

“Good oral health and access to oral health care are two significant public health concerns,” said Tom Raffio, president and CEO of Northeast Delta Dental, announcing the financial contribution.

“Northeast Delta Dental is proud to provide this leadership gift in support of the UNE College of Dental Medicine,” he said.

Delta Dental Plan of Maine has donated $2 million, the Northeast Delta Dental Foundation provided a $100,000 grant and Delta Dental Plan of Vermont and Delta Dental Plan of New Hampshire have recently awarded an additional $100,000 each in support of the college, bringing the total gift to $2.3 million.

“This substantial and incredibly generous gift from Northeast Delta Dental provides a huge boost to our effort to make the UNE College of Dental Medicine a reality,” said Harley Knowles, UNE vice president for institutional advancement.

The Maine legislature in April approved a $5 million bond package that goes to voters Nov. 2 for the purpose of increasing access to dental care in Maine. Of that $5 million, $3.5 million is to be used for a community-based teaching dental clinic affiliated with or operated by a college of dental medicine to be matched by $3.5 million in other funds.

Another $1.5 million is to be used to create or upgrade community-based health and dental care clinics across the state to increase their capacity as teaching and dental clinics. “If voters approve the referendum, UNE will be in a strong position to compete for the $3.5 million to be used for a college of dental medicine clinic,” Taggersell said. 

— Fred Michmershuizen, Online Editor

The University of New England’s campus in Portland, Maine, is where the College of Dental Medicine will be located. (Photo/University of New England)
Pilot safety protocol could help dentists reduce errors

Pilots and dentists have more in common than one might think: Both jobs are highly technical and require teamwork. Both are subject to human error where small, individual mistakes may lead to catastrophe if not addressed early.

A dental professor at the University of Michigan (UM) and two pilot-dentists believe that implementing a checklist of safety procedures in dental offices similar to procedures used in airlines would drastically reduce human errors.

Crew Resource Management empowers team members to actively participate to enhance safety using forward-thinking strategies, said Russell Taichman, UM dentistry professor and director of the Scholars Program in Dental Leadership.

Taichman co-authored the study, “Adaptation of airline crew resource management (CRM) principles to dentistry,” which will appear in the August issue of the Journal of the American Dental Association.

Airlines implemented CRM about 30 years ago after recognizing that most accidents resulted from human error, said co-author Harold Pinsky, a full-time airline pilot and practicing general dentist who did additional training at UM dental school.

“Using checklists makes for a safer, more standardized routine of dental surgery in my practice,” said David Sarment, a third co-author on the paper. Sarment was on the UM dental faculty full time before leaving for private practice. He is also a pilot and was taught to fly by Pinsky.

CRM checklists in dentists’ offices represent a major culture shift that will be slow to catch on, but Pinsky said he thinks it’s inevitable.

“It’s about communication,” Pinsky said. “If I’m doing a restoration and my assistant sees saliva leaking, in the old days the assistant would think to themselves, ‘The dentist is king, he or she must know what’s going on.’ But if all team members have a CRM checklist, the assistant is empowered to tell the doctor if there is a problem. “Instead of dentists saying, ‘Don’t ever embarrass me in front of a patient again,’ they’ll say, ‘Thanks for telling me.’”

At each of the five stages of the dental visit, the dental team is responsible for checking safety items off a codified list before proceeding. Pinsky said that while he expects each checklist to look different for each office, the important thing is to have the standards in place.

Studies show CRM works. Six government studies of airlines using CRM suggest safety improvements as high as 46 percent. Another study involving six large corporate and military entities showed accidents decreased between 36 percent and 81 percent after implementing CRM.

In surgical settings, use of checklists has reduced complications and deaths by 36 percent. Many other industries — hospitals, emergency rooms and nuclear plants — look to the airline industry to help craft CRM programs, but dentistry hasn’t adopted CRM, said Pinsky.

For the next step, the co-authors hope to design a small clinical trial in the dental school to test CRM, Taichman said.

For more on Taichman, visit www.dent.umich.edu/pom/faculty/links/rtbio.

For more on UM dentistry, visit www.dent.umich.edu.
AGD and AGD Foundation provide free oral health care in New Orleans

Nation of Smiles,
One Smile at a Time

event provides care for 181 patients

The Academy of General Dentistry (AGD) and the AGD Foundation recently teamed up with the Louisiana State University (LSU) School of Dentistry to hold an outreach project. The event provided underserved residents of New Orleans with free dental care from volunteer dentists, hygienists and dental assistants from around the nation.

The event, called Nation of Smiles, One Smile at a Time, was the first of its kind for both the AGD and the AGD Foundation. It brought together more than 140 volunteers from around the country and provided care for 181 patients from New Orleans. Patients received a wide range of treatments, from extractions to restorations.

Upon reviewing the procedures that were completed that day, and based on a general range of fees accepted for each procedure, it is estimated that between $70,000 and $100,000 of free oral health care was given, averaging approximately $500 per patient.

"It is difficult to put a price on giving back to a vibrant community such as New Orleans, and it was our pleasure to be there for the AGD’s first outreach program," said AGD President Fares Elias, DDS, JD, FAGD. "Our members went above and beyond to ensure that each patient received quality care, and it was an immense honor to treat the patients at LSU’s facility."

Patients were scheduled for treatment through multiple charitable New Orleans organizations, including the Ozanam Inn, Grace House and Dream Center and its affiliates. In addition to supplying free care, the AGD is now responding to requests from some patients who are interested in follow-up and post-operative care.

"Being able to provide the residents of New Orleans with a new outlook on their oral health is one of the most rewarding elements of this project," said AGD Foundation Immediate Past President Mark Buczko.

"Some patients reported not visiting the dentist for more than 20 years, and spearheading a project that has opened patients’ eyes to quality, accessible care is what the AGD Foundation is all about."

The outreach event in New Orleans was held on July 8.

(Source: AGD)
The Red Flags Rule

By Stuart Obermann, Esq.

The Federal Trade Commission (FTC) announced that on Jan. 1, 2011, businesses, including dental offices, must begin complying with the “Red Flags Rule.”

Although the FTC has issued numerous extensions regarding the implementation of the Red Flags Rule, it is important that every dental practice understand at least the basic intent of the Red Flags Rule.

This rule is designed to deter identity theft, which is becoming a growing problem in business. Innocent victims have had their credit cards, social security numbers and other personal information used by criminals to rack up huge debts, causing major financial and legal issues for these victims.

Dentists will be required to comply with the new federal regulations, and many are asking what this will entail.

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The Act
This act, created by the Federal Trade Commission, was passed in January 2008. Originally, the act was to be enforced by Nov. 1, 2008. However, due to opposition, the deadline has been extended to Jan. 1, to give creditors and financial institutions more time to implement written identify theft programs and to give congress more time to further contemplate the issue.

The Red Flags Rule was based on section 114 and 315 of the Fair and Accurate Credit Transactions Act (FACTA).

The FACTA was enacted to help prevent identity theft, restore credit histories, improve consumer access to credit information, enhance the accuracy of consumer report information, limit the use and sharing of medical information in the financial system, improve financial education and protect employee misconduct.

The FACTA directed financial regulators to enact rules requiring creditors and financial institutions to implement programs identifying, detecting and responding to patterns of activity that could indicate identity theft.

The act defines financial institutions as any entity that holds a “transaction account” belonging to a consumer, and creditors as any entity that extends or renews credit (or arranges for others to do so). The term creditor includes any entity that permits deferred payments for goods or services.

Many dentists may be surprised that they fall under the description of a creditor in this act. The rule employs a broad definition for creditor. Accepting credit cards does not in itself make a business a creditor.

However, if your dental practice receives payment after your service is completed, then you are considered a creditor. In addition, if a dental practice allows installment plans, arranges for the patient to obtain credit to pay for services through a financing company or accepts insurance where the patient is ultimately responsible for payment, the practice will qualify as a creditor.

A red flag
A red flag is an event, a document or an attempted transaction that is indicative of a possible identity theft. This red flag should alert the dental practice (or other business) that someone is not who he (or she) says he is.

In the context of a medical facility, red flags may include an individual falsely claiming to be a patient known by the dental staff, an unknown person lacking personal identification or refusing to provide essential information about his/her identity, or someone unwilling to provide contact information.

In addition, discrepancies between the patient’s medical records and the patient’s physical condition should be a red flag alerting dentists and assistants of a possible identity theft.

Documents that should be considered suspicious include papers that appear to have been altered,
To comply with the Red Flags Rule, a dental practice is required to:

- adopt a written policy intended to identify red flags,
- explain how red flags will be detected,
- detail procedures to be followed after detecting a red flag,
- create procedures describing the administration of the program (including training and evaluation of the program’s success).

Conclusion

Many dentists are concerned about the implementation of the Red Flags Rule as they have never experienced an issue of identity theft and would like to avoid the expense of complying with this act.

Dentists do not want implementation to interfere with the personal, trusting dentist/patient relationships that they have worked so hard to foster.

The FTC has responded to these arguments, stating that the Red Flags Rule is intended to be flexible and that a red flags plan for a dental office is only required to address issues that a dental practice encounters in its operation.

At this point, it is uncertain exactly how the FTC will move forward on this issue.

However, rest assured that some version of the Red Flags Rule will be implemented and every dental office (large or small) must be prepared.

Stuart J. Oberman, Esq., has extensive experience in representing dentists during dental partnership agreements, partnership buy-ins, dental MSOs, commercial leasing, entity formation (professional corporations, limited liability companies), real estate transactions, employment law, dental board defense, estate planning and other business transactions that a dentist will face during his or her career.

For questions or comments regarding this article, visit www.dentalattorney.com.

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Is the ‘silo effect’ putting you and your practice out to pasture?

By Sally McKenzie, CEO

Ann does her job, Caroline does hers, Danita always seems to be busy doing hers. Everyone is working independently. So, what’s the problem? It’s known as the “silo effect,” and it occurs in the workplace when individuals are focused almost exclusively on their own areas.

Think of farm silos: they stand next to each other, each performing their individual functions, but there is no link between them. That’s not a problem out on the farm; however, in the workplace it’s a different story.

This silo effect can occur in the dental practice when there is a lack of communication and common goals among the different areas—the clinical staff and the business staff, the dentists and the hygienists, etc. It is perhaps a new twist on the old workplace problem of the right hand not knowing what the left hand is doing.

Each person is performing his or her job with little understanding of the big picture or how all of the systems are intertwined. Individuals are given tasks to achieve, but there’s minimal focus on overall goals or teamwork.

The business employee unknowingly schedules the emergency patient at a time that puts significant strain on the dentist and the assistant. The dentist recommends a patient pursue an extensive treatment plan not realizing that the patient already carries a significant balance on his account.

The collections coordinator is supposed to increase collections, when the dentist is receiving accounts. “I can’t control accounts but is frustrated by the dentist’s supposed to increase collections, creating and communicating his/her vision and goals for the practice. For some, this is a significant hurdle to overcome. After all, dentists are not trained to create visions or develop goals for systems they scarcely understand, let alone lead teams.

Dentists are trained to treat patients. It’s certainly no wonder that for many dentists the sentiment is, “If I’m doing my job and the rest of the staff is doing theirs, what else do you need to do to run a practice?” You need a team, not silos.

Teams are driven by a common purpose, common goals and objectives, and are fueled by mutual respect and trust. They also must be nurtured over time and they must be rewarded for a job well done and redirected when they veer off course. How do you get there? As they say, every journey begins with the first step.

That begins with the dentist creating and communicating his/her vision and goals for the practice. For some, this is a significant hurdle to overcome. After all, dentists are not trained to create visions or develop goals for systems they scarcely understand, let alone lead teams.

Step No. 1: Communicate, communicate, communicate

You simply must express your practice goals and objectives to your staff. It is said that some two-thirds of employees do not know their employers’ goals or business philosophy.

Open the lines of communication with your team. Encourage ongoing discussion, feedback and problem solving from everyone. While you’re at it, make sure that every employee has a job description and understands his or her role.

Step No. 2: Detail job duties and expectations

Define the job that each staff member is responsible for performing. Specify the skills the person in the position should have. Outline the specific duties and responsibilities of the job. Include the job title, a summary of the position and a list of job duties. This can be the ideal tool to explain to staff exactly what is expected of them.

You’d be amazed by the number of employees who have little more...
than a vague idea of what the dentist expects. Too many are out there in their silos trying to figure it out on their own.

In addition, when job duties and expectations are not clearly defined, employees don’t take responsibility for their actions. The result is that the practice doesn’t have systems in place to solve problems and individuals waste valuable time backbiting, gossiping and wallowing in frustration.

Step No. 5: Ask the difficult questions

Resist the urge to be satisfied with simple answers. Look below the surface. Ask yourself every day what can be improved. Which system is not delivering the results it should? Why? What needs to be changed, adjusted and improved?

Remember, building a stronger team and better practice requires that you routinely question the way you and your staff do things. It is essential to improving problem-solving abilities in yourself as well as your staff.

Step No. 4: Encourage leadership as well as partnership

This may require that you let go of some of the very beliefs and behaviors that enabled you to achieve success in the first place. Where you’ve insisted on control, you may need to step aside and provide the opportunity for employees to step in and take a leadership role in order to improve specific systems. It likely means that everyone needs to be open to adopting new mindsets and skill sets.

It requires changing and adapting in order to realize the vision that you have for your practice, and it requires encouraging others to take risks and grow as professionals. All of this begins with taking an honest look at each person’s strengths and weaknesses. Ask each of them to work with each other in doing this and gather feedback from others on the team who will be honest and constructive.

Next, ask all members of the team to identify two or three of his/her greatest strengths and weaknesses. Ask each of them to work with each other in doing this and gather feedback from others on the team who will be honest and constructive.

Step No. 5: Show courage

Insist that employees set an example for one another. Individual employees seldom realize how their actions affect the behaviors of their teammates. Employees both consciously and subconsciously look to each other for positive or negative behavior examples.

If one person continually blames others when things go wrong, so too will others on staff. If one employee routinely comes in late, others will be more likely to do the same.

Negative behaviors reinforce the silos. Don’t ignore them; address them. Address the issues that don’t make you popular: problem employees, showing up on time, following the dress code and office procedures, treating each other and every patient with dignity, respect and patience.

With time, the silo walls will crumble as individuals discover the satisfaction of reaching goals, realizing a vision and having the pleasure of being a part of something bigger than themselves — namely, your team.

Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dental practitioners nationwide. McKenzie is also editor of The Dentist’s Network Newsletter at www.thedentistinwork.net; the e-Management Newsletter from www.mckenziemgmt.com; and The New Dentist™ magazine, www.thenewdentist.net.

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About the author
Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dental practitioners nationwide. McKenzie is also editor of The Dentist’s Network Newsletter at www.thedentistinwork.net; the e-Management Newsletter from www.mckenziemgmt.com; and The New Dentist™ magazine, www.thenewdentist.net.

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Diode lasers for periodontal treatment: the story thus far

The concept of using dental lasers for the treatment of periodontal disease elicits very strong reactions from both ends of the spectrum. Everyone has an opinion. Everyone is certain that his or her own opinion is correct, but the only certainty is confusion and the lack of clear direction in the concept of laser assisted periodontal therapy (LAPT).

Much of this uncertainty stems from not comparing “apples to apples” in terms of the type of lasers utilized and the way that studies are designed. Certain lasers are used specifically for soft-tissue treatment. These include the CO₂, Nd:YAG and diode lasers. Others can be used for both soft- and hard-tissue applications. These are the Er:YAG, Er and Cr:YSGG lasers. They must be compared within their own category.

Many of these lasers have been shown to provide periodontal treatment benefits. In order to achieve an element of clarity and simplicity on this very complex topic, the following discussion exclusively addresses the use of the diode laser for periodontal treatment.

A specific instrument

The diode laser has become an important tool in the dental armamentarium due to its exceptional ease of use and affordability. It also has key advantages with regard to periodontal treatment. The diode laser is well absorbed by melanin, haemoglobin and other chromophores that are present in periodontal disease.1 Thus, the diode specifically targets unhealthy gingival tissues. The laser energy is transmitted through a thin fiber that can easily penetrate into deep periodontal pockets to deliver its therapeutic effects.

The 2002 American Academy of Periodontology statement regarding gingival curettage proposes that “gingival curettage, by whatever method performed, should be considered as a procedure that has no additional benefit to SRP alone in the treatment of chronic periodontitis.”

Thus, the diode specifically targets unhealthy gingival tissues. The laser energy is transmitted through a thin fiber that can easily penetrate into deep periodontal pockets to deliver its therapeutic effects.

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An effective instrument: bactericidal

Periodontal disease is a chronic inflammatory disease caused by a bacterial infection. Hence, the bactericidal and detoxifying effect of laser treatment is advantageous in periodontal therapy.2 The diode laser’s bactericidal effectiveness has been well-documented.3 Moreover, there is significant suppression of A. Actinomyctemcomitans, an invasive bacterium that is associated with aggressive forms of periodontal disease that are not readily treated with conventional scaling and root planing (SRP).

A. Actinomyctemcomitans is not only present on the diseased root surface, but it also invades the adjacent soft tissues, making it difficult to remove by mechanical periodontal instrumentation alone.4,5 This necessitates the use of adjunctive antibiotic therapy.6 The diode laser provides a non-antibiotic solution.

A. Actinomyctemcomitans has also been found in atherosclerotic plaques,7 and there has been evidence to suggest that subgingival A. Actinomyctemcomitans may be related to coronary heart disease.8 This makes it even more compelling to seek methods to control this aggressive pathogen.

Wound healing

Diode lasers are very effective for soft-tissue applications including incision, hemostasis and coagulation.9 Many advantages of the laser vs. the scalpel blade have been discussed in the literature. These include a bloodless operating field, minimal swelling and scarring, and much less or no postsurgical pain.10

When laser surgical procedures are carried out, the surface produced heals favorably as an open wound without the need for sutures or surgical dressings.4 Studies have shown enhanced, faster and more comfortable wound healing when the diode laser is used in conjunction with SRP.7

An adjunct to scaling and root planing

There is very compelling evidence in the dental literature that...
The addition of diode laser treatment to SRP (the gold standard in non-surgical periodontal treatment) will produce significantly improved results. After SRP, the diode laser is used on the soft-tissue side of the periodontal pocket to remove the inflamed soft tissue and reduce the pathogens. Research has demonstrated better removal of the pocket epithelium compared with conventional techniques. Many studies have shown increased reduction of bacteria (especially specific periopathogens) when diode lasers are utilized after SRP. Significant improvement in decontamination and effective treatment of peri-implantitis also occurs with the addition of diode laser therapy. Gingival health parameters are significantly improved with the addition of the diode laser to SRP. Studies have shown decreased gingival bleeding, decreased inflammation and pocket depth, as well as decreased tooth mobility and decreased clinical attachment loss.

This improvement in gingival health remains more stable than with conventional SRP treatment alone and tends to last longer. Moreover, patient comfort is significantly enhanced during the postoperative healing phase with the addition of diode laser therapy. The research thus shows diode laser periodontal treatment to be an effective procedure. It is also a minimally invasive procedure. Patients are demanding less surgery and the diode laser provides the general dentist with an excellent means of keeping periodontal treatment in the general practice.

A safe instrument
Histological testing of roots where the diode laser was used after SRP demonstrated no detectable surface alteration to root or cementum. There were no signs of thermal side effects in any of the teeth treated. Many studies have specifically indicated no adverse tissue events, demonstrating the safety of the diode laser.

The diode laser's very effective bactericidal action on periodontal pathogens makes the adjunctive use of antibiotics unnecessary. This eliminates the problem of bacterial resistance and systemic side effects engendered by antibiotic use. The laser is a safer, more effective treatment.

The protocol thus far
The research cited above has demonstrated that the use of the diode laser after conventional SRP is superior to SRP alone. Various protocols have been developed by clinicians to incorporate this treatment into the busy dental practice. These protocols may be performed by the dentist and/or the hygienist as determined by the regulatory organization in the geographic location of the dental practice. Individual parameters vary depending on the clinician and the particular diode laser that is being used. However, most protocols do follow a simple formula.

The hard side of the pocket (tooth and root surface) is first debrided with ultrasonic scalers and hand instrumentation (Fig. 1).

This is followed by laser bacterial reduction and coagulation of the soft tissue (epithelial) side of the pocket (Figs. 2, 3).

The laser fiber is measured to a distance of one millimeter short of the pocket depth. The fiber is used in light contact with a sweeping action that covers the entire epithelial lining, from the base of the pocket upward. The fiber tip is cleaned often with a damp gauze to prevent the buildup of debris. Re-probing of treated sites should not be attempted for three months postoperatively (Fig. 4) because healing starts at the base of the pocket and the new tissue remains fragile for this period of time.

The power settings and time parameters are determined by the particular laser used. The diode laser clinician must take training on the specific laser that will be used in the practice to be fully able to implement laser assisted periodontal therapy.

With experience, the user will feel comfortable enough to adapt the protocol to his or her particular practice.

In the future, protocols will be modified and fine-tuned by various laser user groups after discussion of their experiences and results.

These results will be incorporated into new procedures that will bring laser-assisted periodontal therapy to a newer, more effective level.

The time has come
The time has come to embrace the routine use of lasers for the treatment of periodontal disease. The diode laser has been shown to be effective and safe for this purpose. If not now, when?
San Francisco meeting offers three days of education and new technology

CDA introduces new Thursday–Saturday schedule for courses and exhibits

By Fred Michmershuizen, Online Editor

The California Dental Association’s San Francisco meeting, CDA Presents: The Art and Science of Dentistry, will be held Sept. 9–11. In response to attendee and exhibitor feedback, the CDA is instituting a new Thursday through Saturday schedule, featuring three full days of courses and exhibits showcasing innovative products and services.

The new Thursday through Saturday show pattern will also apply to future CDA meetings, including those held in Anaheim.

Thousands of dental professionals are expected to convene to take advantage of C.E. opportunities, dynamic speakers, an impressive exhibit hall and plenty of networking. According to the CDA, the 2009 San Francisco meeting attracted 16,125 attendees, of which 4,625 were dentists.

Continuing education

CDA Presents offers an opportunity for attendees to fulfill continuing education requirements at a fast pace. The meeting’s workshops, free lectures and other C.E. opportunities are a convenient way for dental professionals to meet license renewal requirements.

The Dental Board of California recently adopted new continuing education regulations. The regulations no longer specify courses as Category I and Category II. The regulations, however, are specific regarding the content type and limit the number of credits for specific content areas.

To facilitate California licensed dental professionals in complying with the new regulations, CDA will identify each course’s content as either a “Core” or a “20%” course. This is very similar to the previous Category I and II and divides continuing education courses into two categories that are defined as follows:

• Core courses must make up a minimum of 80 percent of the credits in a renewal cycle. These courses include courses that directly enhance the licensee’s knowledge, skill and competence in the provision of service to patients or the community.
  • 20% courses can make up only 20 percent of the credits in a renewal cycle. These courses include courses considered to be primarily of benefit to the licensee.

For every renewal cycle, California state law requires licensed dentists and allied dental health professionals to complete two units in infection control and two units in the California Dental Practice Act. Licensees are also required to complete a course in basic life support.

Educational highlights

The following topics and speakers are among the highlights of CDA’s San Francisco meeting (see program guide for exact times and locations):

General dentistry: Victoria L. Wallace, CDA, LDA
  • “Team FABULOUS!” a Thursday workshop.
  • “Total Bonding! Simple and Easy Tips for a Great Adhesive Restoration,” a Friday morning lecture.
  • “Tooth Whitening at Its Best? Absolutely!” a Friday afternoon lecture.
  • “White Done Right With Custom Fit Trays ... Let’s Make Some Whitening Trays Workshop,” a Saturday workshop.

Esthetic dentistry: Brian P. LeSage, DDS, FAICD, and Edward A. McLean, DDS
  • “Esthetic Continuum Workshop,” a two-day workshop on Thursday and Friday.

Implants: Sascha Jovanovic, DDS, MS

Occlusion: Henry A. Gremillion, DDS, FAICD and DeWitt C. Wilkerson, DMD
  • “Two-Day Continuum Lecture: The Dynamics and Function of the Masticatory System: The Multiple (Inter) Faces of Occlusion,” a two-day lecture, Thursday and Friday.

Oral Pathology: John A. Szirky, DDS, Med
  • “Cases Only a Mother Could Love,” a Thursday and Saturday morning lecture.
  • “Drugs I Have Known and Loved for,” a Thursday afternoon lecture.
  • “Great Cases With New Faces,” a Saturday afternoon lecture.

Pediatric Dentistry: Jane A. Saxonman, DDS
  • “Managing the Developing Dentition,” a Friday morning lecture.
  • “Clinical Techniques in Pediatrics,” a Friday and Saturday afternoon lecture.
  • “Reinventing the Pediatric Alpha Pop,” a Saturday morning lecture.

Periodontics: Robert C. Fazio, DMD
  • “Antibiotics in Dentistry,” a Thursday morning lecture.
  • “Medicine and Dentistry,” a Thursday afternoon lecture.
  • “Periodontitis and Peri-implantitis: The Good, the Bad and the Ugly,” a Friday lecture.

Pharmacology: Harold L. Crossley, DDS, PhD
  • “Street Drugs Exposed: What Your Patients and Your Kids Are Not Telling You,” a Friday lecture.
  • “Avoid Liability: Know Your Patients’ Medications and Their Impact on Dental Treatment,” a Saturday lecture.

Practice Management: William Blatchford, DDS
  • “Leadership Challenge: Playing Your ‘A’ Game,” a Friday lecture.
  • “Conversations With Patients That Work,” a Saturday morning lecture.
  • “Growth Strategies: Marketing, Acquisitions and Transitions,” a Saturday afternoon lecture.

Restorative Dentistry: Mark A. Latta, DMD, MS
  • “Essentials for Creating Stratified Anterior and Posterior Direct Composites,” a Friday lecture.
  • “Direct Anterior/Composite Veneers/Posterior Resin Restoratives,” a Saturday workshop.

Exhibit hall

If you’re looking for the latest technology, products and services in dentistry, you need look no further than a CDA Presents. In all, the meeting will feature approximately 400 companies occupying 85,000 square feet of exhibit space on Thursday, Friday and Saturday.

The exhibit hall hours are as follows:

• Thursday from 10 a.m. to 6 p.m.
• Friday from 9:30 a.m. to 5:30 p.m.
• Saturday from 9:30 a.m. to 4 p.m.
• Exhibit hall happy hour is Thursday from 4:30 to 6 p.m.
• Family hours are daily from the opening of exhibit hall until noon.
• Child care is available at the Marriott Marquis Thursday and Saturday from 7 a.m. to 6 p.m.

The Spot

Again this year, CDA Presents will feature The Spot — a lounge for learning, networking and more. This interactive area is located in the exhibit hall.

Attendees can earn C.E. credit, see new products, plan an office renovation, check e-mail and even enjoy a cup of coffee while relaxing with friends.

The Spot will be open Thursday, Friday and Saturday during exhibit hall hours.

SF MOMA visit

On Friday evening, CDA members and their guests will enjoy exclusive entrance into SF MOMA from 7 to 10 p.m.

The evening will consist of a buffet that will serve as either a prelude for a dinner in San Francisco, or a light dinner for those who wish to...
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What to do in San Francisco

San Francisco is often called “Everybody’s Favorite City,” a title earned by its scenic beauty, cultural attractions, diverse communities and world-class cuisine. Measuring 49 square miles, this very walkable city is dotted with landmarks such as the Golden Gate Bridge, cable cars, Alcatraz and the largest Chinatown in the United States.

A stroll of the city’s streets can lead to Union Square, the Italian-flavored North Beach, Fisherman’s Wharf, the Castro, Japantown and the Mission District, with intriguing neighborhoods to explore at every turn.

Views of the Pacific Ocean and San Francisco Bay are often laced with fog, creating a romantic mood in this most European of American cities. The city has a colorful past, growing from a small village to a major city nearly overnight as a result of the 1849 Gold Rush. The writers of the “beat” generation, the hippies of the summer of love in the late 1960s and the large gay and lesbian population have all contributed to making San Francisco the place it is today.

The city is home to world-class theater, opera, symphony and ballet companies and often boasts premieres of Broadway-bound plays and culture-changing performing arts. San Francisco is also one of America’s greatest dining cities. The diverse cultural influences, proximity of the freshest ingredients and competitive creativity of the chefs result in unforgettable dining experiences throughout the city.

Golden Gate Bridge

Crossing the strait of the Golden Gate from San Francisco to the Marin headlands for 1.7 miles is the world-renowned Golden Gate Bridge, easily identified the world over by its orange color.

Opened in 1937, the bridge was built at a cost of $35 million in principal and $30 million in interest and 11 workers’ lives. The single-suspension span is anchored by twin towers that reach skyward 746 feet, and was once taller than any building in San Francisco.

To support the suspended roadway, two cables, each more than 7,000 feet in length and both containing 80,000 miles of wire, stretch over the tops of the towers and are rooted in concrete anchorages on shore. More than 10 years in planning due to formidable opposition, but only four years in actual construction, the Golden Gate Bridge brought the communities of San Francisco and Marin counties closer together.

Pedestrians — including wheelchair users and bicyclists — can go on the sidewalks of the bridge during daylight hours, but roller blades, skateboards and roller skates are not permitted. There are vista points on both north and south sides of the bridge with parking lots.

Alcatraz

Alcatraz and history go hand in hand. Once home to some of America’s most notorious criminals, the federal penitentiary that operated here from 1934 to 1963 brought a dark mystique to the Rock. The presence of infamous inmates, such as Al “Scarface” Capone and the “Birdman” Robert Stroud, helped to establish the island’s notoriety. To this day, Alcatraz is best known as one of the world’s most legendary prisons.

Many people, though, are unaware of the wealth of other stories to be learned on the island. Alcatraz is now home to rare flowers and plants, marine wildlife and thousands of roosting and nesting sea birds. Civil War-era buildings dotting the island give insight into the 19th century, when the island served as both a harbor defense fort and a military prison.

You can also see visible reminders of the American Indian Occupation that started in 1969 after the prison closed, highlighting an important milestone in the American Indian rights movement.

Fisherman’s Wharf

As San Francisco’s No. 1 visitor destination, Fisherman’s Wharf has a lot to offer out-of-towners and local Bay Area residents alike. The tangy salt air and fabulous views are just the beginning.

You’ll find the city’s freshest seafood at the wharf’s world-class restaurants. Cruises and tours also begin here.

Alcatraz and Fisherman’s Wharf are both part of the Golden Gate National Recreation Area.

By Oct 19, 1969, the Occupation was over. The American Indian Occupation that started in 1969 after the prison closed, highlighting an important milestone in the American Indian rights movement.

The Golden Gate Bridge, one of the world’s great suspension bridges. (Photo/Kerrick Jans, San Francisco Convention and Visitors Bureau)
Raising the bar again: dermal fillers and Botox/Dysport

Programs considered highlights of GNYDM, where pre-registration is free

In an effort to stand out and leap forward and to expand dental esthetic office procedures, the Greater New York Dental Meeting (GNYDM) will again offer educational programs such as Botox/Dysport and dermal fillers at this year’s 86th annual event.

With more than 59,166 attendees in 2009, the GNYDM is raising the bar for even higher dental educational opportunities, according to organizers.

This year, the GNYDM presents programs by CEO Dr. Bruce Freund and President Dr. Zev Schulhof, co-founders of the American Academy of Facial Cosmetics. These unique hands-on workshops introduce procedures on actual patients to teach attendees skills on how to use Botox/Dysport and dermal fillers. Both clinicians are renowned educators and have extensive experience in this specialty field.

Dr. John Halikias, general chair of the GNYDM, said: “Facial dermal fillers can greatly enhance the esthetics of anterior dental restorations. These injectables can alter the appearance of the lip, especially in those with ‘smoker’s’ lines around the oral cavity.”

Attendees will learn about the different types of facial fillers, such as Restylane, Perlane, Juvederm and Radiesse, which produce immediate results.

“There is some scientific evidence that certain TMJ pain symptoms can be alleviated with Botox/Dysport injections, which are neuromuscular relaxers,” Halikias said. “Therefore, dentists should be aware of these alternative treatment modalities.”

The GNYDM will accommodate the expected popularity of Botox/Dysport and dermal filler facial injectables by offering two Botox/Dysport programs and two dental filler programs during the course of the meeting.

Botox/Dysport and dermal fillers are on the “up and up” and gaining more publicity across the United States and worldwide, said Dr. Robert Edwab, executive director of the GNYDM.

“Participants will learn to use Botox/Dysport facial injectables for facial therapeutic and esthetic treatments, as well as to improve the appearance of the skeletal profile and lips to match the smile and dental esthetics of the individual patient.”

“They hands-on workshops are particularly unique from other programs and courses at dental meetings because they offer a live, up-close view of procedures right on patients at the exact moment they are happening.”

In addition, the GNYDM has added a second high-tech live dentistry arena to the mix. This year’s meeting will be like no other, according to the organizers, with two live dentistry arenas offering a combined total of 16 live programs.

In addition, there are more than 500 full-day and half-day seminars, essays and hands-on workshops attracting clinicians from around the world.

Pre-registration is always free, so visit www.gnydm.com and pre-register yourself, your staff and your family at no charge. Join the GNYDM in New York City from Nov. 26 through Dec. 1.

www.dental-tribune.com

What’s your specialty? Whichever area of dentistry you practice in, you will find articles of interest at www.dental-tribune.com:

General dentistry

How dentists who treat snoring and sleep apnea can save marriages and lives by Brock Rondeau
www.dental-tribune.com/articles/content/scope/specialities/section/general_dentistry/id/2589

Endodontics

Back to the egg: An evidence-based endodontic implant algorithm by Kenneth S. Serota
www.dental-tribune.com/articles/content/scope/specialities/section/endodontics/id/2602

Implantology

Precautions for using zirconia implant abutments by Moustafa N. Aboushelib and Rien van Paridon
www.dental-tribune.com/articles/content/scope/specialities/section/implantology/id/2534

Live demonstration during the hands-on Botox workshop at the 2009 meeting. (Photos/Provided by the GNYDM)

Attendees line up for their badges at the registration booth during the 2009 meeting.

A snapshot of the Live Dentistry Arena during the 2009 meeting.

DENTAL TRIBUNE | SEPTEMBER 2010 Greater N.Y. Dental Meeting 15A
Unlocking the secrets
Prof. Michael Lewis speaks on xerostomia at the International Symposium on Dental Hygiene in Glasgow

By Lisa Townshend, DT U.K. Edition

The international Symposium on Dental Hygiene (ISDH), held at the SECC in Glasgow, Scotland, was a truly international event with more than 1,500 delegates attending from all parts of the globe.

One of the most talked-about issues at the event was the rising occurrence of xerostomia in patients. So it was unsurprising that it was a packed room for Prof. Michael Lewis’ presentation, “The role of the dental hygienist in the diagnosis and management of dry mouth in association with GSK.”

Lewis is professor of oral medicine and associate dean for post-graduate studies in the school of dentistry at Cardiff University. He is also dean of studies in the school of dentistry at Cardiff University. He is also dean of the dental faculty and vice president of the Royal College of Physicians and Surgeons of Glasgow.

The lecture began with Lewis setting the scene for the lecture with his alternative title “Unlocking the secrets of saliva.” His aim was to inform delegates where saliva comes from, its components, the effects of reduced salivary production and what can be done to help patients.

Lewis explained that there are three major paired glands that produce 95 percent of saliva: the parotid (60 percent), the submandibular (30 percent) and the sublingual (5 percent). The rest is produced by more than 600 minor or accessory glands mainly found in the lips, cheek and palate.

Lewis detailed how salivary flow rate is neurally controlled: it is excited by taste and mechanical stimuli, but inhibited by feelings such as anxiety. With its importance in functions such as speech, as a buffer against acid attack, cleansing anti-microbial actions, etc., a reduced flow rate soon manifests as a problem. Symptoms often mentioned by patients include a lack of taste, difficulty in swallowing and increased effort when speaking.

As clinicians, immediate signs manifesting in the mouth include no saliva pooling in the mouth, frothy or cloudy saliva, sticky/erythematous mucosa, atrophic tongue dorsum, candidosis and angular cheilitis. One big marker for xerostomia, said Lewis, is the occurrence of cervical caries and failed restorations.

Xerostomia is often a complaint from patients with underlying causes, including drugs, Sjøgren’s Syndrome, radiotherapy, undiagnosed or poorly controlled diabetes, dehydration and the absence of salivary glands.

Moving from the theoretical, Lewis then discussed what clinicians can do for patients presenting with dry mouth. He stressed the importance of investigation into the causes of dry mouth for that patient to ensure any underlying condition has been identified or particular medication use is explored.

Means of investigation can include clinical exam (discussion with patient), appearance of patient (i.e., face, hands, gait), appearance of saliva, “mirror sticks test” (a dental mirror will often stick to the buccal mucosa if there is reduced saliva), salivary flow rate tests, haematological tests, sialography and labial gland biopsy.

Once the cause of the condition has been identified, it can then focus the minds of both clinician and patient on how to manage it, said Lewis.

For example, it may be possible to suggest a change in medication to one that does not list dry mouth as a side effect, or a diagnosis of diabetics should see improved glycaemic control on behalf of the patient and a resolution of dry-mouth symptoms. There are many salivary substances that can be recommended. Lewis described a few plus the benefits and disadvantages of using them.

The most graphic disadvantage was for Salinum, described as “like licking a cricket bat!” Oral-care systems such as the Biotène range have proved very popular with patients due to their formulation and ease of use.

Conclusion
Professor Lewis’ easy delivery style and obvious enthusiasm for the subject matter made this lecture a resounding success for me.

It was both informative and practical, allowing delegates to really think about the diagnosis and management of xerostomia in patients, as well as highlighting once more how the oral cavity can be a window into the overall health of the human body.

About the ISDH
The ISDH 2010 was organized by the British Society of Dental Hygiene and Therapy (BSDHT) under the auspices of the International Federation of Dental Hygienists (IFDH).

The venue for the event was the Scottish Exhibition and Conference Centre on the banks of the river Clyde in Glasgow. The ISDH 2010 is the only international symposium specifically for dental hygienists and dental therapists.
LUMINEERS Destination Education announces two new Las Vegas events

Combine Las Vegas and practice-changing continuing education and you get LUMINEERS Destination Education’s (DE) next two events at the new ARIA Resort & Casino in Las Vegas from Nov. 5–7 and May 27–29.

According to the organizers, LUMINEERS DE is redefining continuing education in a powerful way. Both the November 2009 program at the Hard Rock Hotel & Casino and the June program at the ARIA Resort & Casino were sold out.

More than 1,300 dental professionals attended these two programs and were wowed by the quality of both the education and the experience, organizers said, adding that dentists, dental assistants, hygienists, patient coordinators and front office team members all found a lot to learn.

The next program will feature the addition of Snap-On Smile, which is being supported by one of the largest TV campaigns in dentistry. The program will not only cover proper clinical training technique on the procedure but will also cover practice growth methods and give dentists the opportunity to sign up to receive patient referrals from the TV campaign.

“I’m not afraid to try new things, and this program was awesome!,” said Dr. Edward Wiener of Germantown, Tenn.

“This is what C.E. should be: high-quality instructors and education, along with meticulous attention to the overall experience. One thing that blew me away: We all got to go to every session together. By learning together, we came back ready to grow the practice together and got started right away.”

Since its inception in 2003, DE has focused on the possibilities represented by the minimal-prep LUMINEERS procedure to the dental practice. Today, the program has dramatically expanded to include Snap-On Smile, lesion detection, endodontics, implants and case and financial presentations.

And there is even more to come: more speakers and more breakouts. Organizers say the new LUMINEERS hands-on sessions and team member breakouts will be even more dynamic than before.

“LUMINEERS Destination Education events are structured to maximize practice-changing learning, but we never forget the quality of the experience,” said David Jordan, ASCR’s director of education.

“That’s why we’re always at the coolest resorts and feature outstanding entertainment. Great hands and motivating keynote speakers make this the team event for every practice. Work hard. Play hard. We’ll do our best to make both of those happen.”

Beginning this fall, a new two-day DE event will be offered in New York, Los Angeles, Miami and in many other destination locations, making it more convenient than ever to experience what DE has to offer.

Full program information, course dates, locations, speakers and more can be found at www.ascredu.org or by calling (805) 547-7996.

Exclusive content, such as pictures, video content and program promotions, can also be found on Facebook by searching “LUMINEERS Destination Education.”

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Beginning this fall, a new two-day
Muscling in on the truth

By Dr. Rohan Wijey, BOrth, Grad Dip Dent (Griffith)

Debate on the causes of malocclusion has been raging since the genesis of the orthodontic science, but has the answer already been found?

Various factions in the orthodontic tradition have declared the influence of both environmental and genetic determinants in malocclusion. Common consensus regard tooth position to be more environmentally influenced and skeletal development more genetically.

Genetic factors

Lauc et al. (2005) claim that genetic factors are significant in malocclusion, citing a number of twin studies. However, sibling genetic correlations are intrinsically fallacious in that they do not consider the influence of shared environments, which Garn et al. (1979) have termed the “co-habitational effect.” Nonetheless, certain traits do seem to be characteristic among family members, and a possible explanation is that all animals seem to inherit certain muscular functions. Wiley (1982) describes the mating ritual of the three spine stickleback, stating “the pattern and sequence of these movements is just as much a part of the genetic make-up of the fish as its body shape.”

Epidemiological studies of malocclusion show it does not follow Mendelian laws of inheritance. Mew (1986) cites the example of sickle cell anaemia, which provides near immunity to malaria. It has become endemic in populations where it is irrational to the genetic model for evolution.

Certainly, there is a quality of irrationality to the genetic model for the aetiology of malocclusion, but what is the answer?

Environmental factors

Evidence for environmental causes is formidable. Weiland et al. (1997) compared skulls from 19th century Austrian males with their contemporaries, finding that change in diet ensured the latter displayed significantly higher malocclusion scores. Corruccini and Lee (1984) reported that malocclusion was significantly worse in Chinese children born in the U.K. compared to their immigrant parents raised in less developed areas. Because genetic factors remained unchanged, the malocclusion in the offspring was attributed to diet, premature deciduous tooth loss from caries and oral respiration.

Corruccini and Beecher (1981, 1983, 1984) have also shown that a soft diet significantly increases dental and skeletal malocclusions in rats, macaques and primates. This is most likely due to less toxicity in muscles of mastication, resulting in compensatory overactivity in muscles of facial expression.

Perhaps most telling has been Harold’s series of experiments on primates in which induced oral respiration caused a range of malocclusions, but all included increased face height, steeper mandibular plane and larger gonial angle; in short, skeletal and dental discrepancies. Harold’s summation was that oral respiration was the trigger factor, but it is “deviant muscle recruitment” that directly causes maldevelopment.

The weight of the evidence, be it from the genetic or environmental school, seems to rest with muscle dysfunction being the cause of maldevelopment. Texture and nutritional value of diet has been shown to have an impact on toxicity of facial muscles, oral respiration causes “deviant muscle recruitment” and even from the genetic standpoint, the animal kingdom shows a marked tendency for muscle function (and dysfunction) to be inherited.

P.R. Begg’s seminal 1954 manifesto asserted that a lack of grit in modern diets results in less interproximal wear and subsequently more crowding. Although Begg believed that this environmental factor caused dental crowding, his theory was predicated on the belief that skeletal form is inherited and unmalleable.

Corruccini (1990), however, discounted this research and recognised that Begg’s own figures render his theory redundant because both crowding and attrition increase with age.

Despite being roundly refuted, Begg’s assertion still serves as the rationale and justification for orthodontists to shorten dental arches via extractions to this day.

This 13-year-old girl’s profile (Fig. 1) shows a severely underdeveloped mandible, with a subsequent overbite. The strain of the mentalis muscle also betrays a “reverse swallow” with mentalis activity, which is the cause of this skeletal malocclusion.

After six months of myofunctional appliance use and myofunctional therapy, the release of muscle tension has allowed the mandible to translate anteriorly, with seemingly spontaneous lower dental alignment also a happy bonus (Fig. 2).

In spite of the evidence, the industry holds the concept of muscular causes of malocclusion at arm’s length because it is acknowledged, then the moral imperative for big changes will be inescapable.

That time is now.

A complete list of references is available from the publisher.
A lasting solution for denture wearers

Atlas Denture Comfort secures new or existing dentures

Dentists often don’t look forward to having patients with dentures, according to Paul Homoly, DDS, president of Homoly Communications. When asked why, he replied that the procedure leaves both dentist and patient feeling bereft of lasting solutions: there is continuous need for repeated visits to the dentist for adjustments; patients endure discomfort and, worse yet, experience difficulty with everyday functions such as speaking, chewing, smiling or laughing. Even unwanted sounds, such as clicking or whistling, may be heard coming from the dentures.

All of this leaves people wearing conventional dentures feeling insecure and self-conscious. Denture wearers of any age could find themselves changing their daily routine — even choosing to avoid eating, speaking, or laughing. Even unwanted sounds, such as speaking, chewing, smiling or laughing, may be heard coming from the dentures.

Atlas Denture Comfort is a simple solution that was developed by Dentatus USA. This affordable, one-hour, chairside procedure will soon be the industry standard for securing and retaining either a patient’s new or existing dentures. Atlas Implants, approved for marketing by the FDA, are suitable for retaining lower dentures economically, regardless of the patient’s age.

The Denture Comfort Procedure consists of placing four Atlas narrow-body titanium alloy implants into the edentulous jaw anterior to the mental foramen. Then, Denture Comfort’s cushioning silicone, Tuf-Link®, is expelled into the denture to fit snugly over and around the short, dome-shaped heads of the Atlas implants so that the denture can be securely and confidently retained. The result is a comfortable fit and optimal retention, all without surgery, without bleeding and without bank-breaking expense.

Atlas Denture Comfort is the only system on the market today that eliminates the hardware typically associated with overdentures. The Atlas System uses no O-rings, no housings and no adhesives. The unique Tuf-Link silicone reline provides the retention to the implants for a stress-free denture, easy insertion, retention and removal.

This minimally invasive technique is easy for dentists to learn and implement, and may change the lives of your patients. Check out www.dentatus.com for upcoming hands-on workshops. Included in the tuition are a patient education model, complete patient start-up kit and marketing tools to help you get started.

Air-Flow perio: biofilm removal to the base of the pocket

With the Air-Flow handy perio, EMS is now penetrating into the subgingival area

According to the manufacturer, the innovative Air-Flow® handy perio is the first and only portable perio device that enables safe and effective removal of subgingival biofilm.

Based on the successful Air-Flow handy 2+ series and the Air-Flow Master, which was awarded an innovation prize, this handpiece again provides the dentist with an ergonomic masterpiece that EMS says is ideal for treating patients and enables the complete removal of biofilm.

The transparent dome and the power chamber have come out in pink. In this combination, the white, handy instrument is once again a genuine eye-catcher. Together with the Air-Flow powder perio, the single-use perio nozzle reaches down to the base of the periodontal pocket.

Biofilm impairs the removal of bacteria

Microorganisms establish themselves and multiply. The bacterial community develops its own protection: microbes come off and colonize new areas. In some cases, the body’s immune system is helpless. To prevent the penetration of microbes, the body triggers a bone deterioration process as an “emergency response.”

Because the biofilm protects the bacteria against pharmaceuticals, treatment has been very difficult to date. That is why EMS wants to mount an attack on damaging biofilm as part of subgingival prophylaxis treatment with an application summed up in the words “Air-Flow kills biofilm.” Using this method, dentists can also effectively treat the never-ending increase in the number of cases of peri-implantitis among implant patients and counter the impending loss of implants.
Scottsdale Center for Dentistry selects Isolite dental isolation

Isolite Systems’ award-winning Isolite dental isolation technology has been installed throughout the Scottsdale Center for Dentistry. The 65,000 square-foot, $50 million learning facility is equipped to world-class standards and is widely regarded as one of the premier, most trusted and most respected C.E. centers in the world.

The Isolite dryfield illumination tool is an intraoral dental isolation tool that combines the functions of light, suction and retraction into a single device, solving many of the frustrations that dental professionals deal with on a daily basis. Isolite gently holds the patient’s mouth open, keeps the tongue out of the working field, illuminates the oral cavity and guards the patient’s airway — all while continuously evacuating saliva and excess moisture.

The super-soft mouthpiece device used with the device makes for a more comfortable experience for the patient and allows dental professionals to complete procedures on average 30 percent faster.

Isolite dental isolation technology will be used in hands-on portions of Spear Education courses and CEREC at the Scottsdale Center for Dentistry’s advanced training courses.

“We are very selective about the equipment in use at the center, and any equipment we choose must align with our mission to provide world-class dental education. Isolite is unique in that it facilitates clinical excellence in dentistry, improves financial productivity of the dental practice and also provides for an improved experience for patients,” said Jeff Roe, executive vice president of the Scottsdale Center for Dentistry.

“Bringing this advancement in dentistry to our course participants is a perfect fit.”

Isolite dental isolation technology was installed throughout the center’s six operatory dental practices of the future and its 10-operator and 56-lab bench training facility.

The Isolite dryfield illumination has won extensive recognition in the industry, including being named a Dentaltown “Townie Choice Award” winner for five consecutive years, a REALITY 4-star product and winner of the “Dental Excellence Award: Best New Instrument” by DrBicuspid.com. Isolite Systems will be demonstrating its Isolite and Isodry® dental isolation systems at booth No. 501 during the California Dental Association conference, Sept. 9-11, in San Francisco.

Reducing intraoral injection pain levels

Study conclusions confirm VibraJect effectiveness

Two independent studies have confirmed the effectiveness of the VibraJect® dental needle attachment to block the pain of dental injections.

The first study by Fred Quarnstrom, DDS, et al. dealt with pain level comparisons resulting from usage of the Wand (Milestone Scientific) with those compared to usage of the VibraJect dental needle attachment with block injections given to subjects using conventional injection methods.

The second study by Queens University statistically measured and compared the amount of pain reduction experienced by patients given block injections of local anesthesia using the VibraJect dental needle attachment with block injections given to subjects using conventional injection methods.

The following excerpt is from one of these studies by Quarnstrom.

“A study by Fred Quarnstrom (DDS, FASDA, FICD, FAGD, Diplomate, American Board of Dental Anesthesiology, Diplomate, National Board of Dental Anesthesiology), Sun Hee Bang-Pastore (DDS), Ruth Woldemicael (MDM) and David Chen (DDS) compared the VibraJect® to a computer-controlled injection device to control pain for injection of local anesthesia.

“Nineteen injections were done with the Wand handpiece of the CompuDent® system by Milestone Scientific and 17 with the VibraJect by Vibraject LLC. Twenty-four were maxillary infiltrations and 12 were mandibular blocks.

“Patients reported the level of pain for the needle piercing their tissue, the injection of solution and their overall evaluation of the injection. No difference was seen for piercing the tissue, injecting the solution or overall report of pain.”

This study’s conclusion stated: “This study tends to indicate there is little difference in the pain perceived by a dental patient when injected using the VibraJect as opposed to injecting with the Wand.”

The second study is from Queens University, Belfast, Ireland, and reveals the following findings.

The study was conducted on 400 patients and showed that VibraJect statistically reduced the amount of “pain from 4.6 to 1.7, which is a pain level never statistically achieved before VibraJect.”

According to the Queen’s University study:

“Subjects receiving the conventional injection methods had a mean pain score of 4.6 (± 0.414) The VibraJect group had a mean pain score of 1.71 (±0.255) (P<0.05). Certain sites had larger decreases in the mean pain score using the VibraJect. These included the upper anterior segment infiltrations and lower right IDB injections.”

Conclusions: "The vibrating syringe attachment resulted in reduced pain levels on receiving intraoral injections."
Control excess occlusal forces on implants

T-Scan bite analysis protects your dental work

All known published research on articulating paper consistently shows that articulating paper marks do not predictably measure the force or time-sequence of occlusal contacts accurately. The modern implantologist needs a diagnostic device that can reliably determine aberrant occlusal force concentrations and contact time properties.

The T-Scan® III system is the only diagnostic device on the market that measures occlusal contact force and occlusal contact sequence. Objective data sets T-Scan apart from traditional occlusal indicators. The invaluable information it provides helps to easily diagnose and assess the balance of a patient’s bite. Full-color, 3-D graphics illustrate the forces evolving from first contact through closure, allowing the dentist to prevent general occlusal problems such as pain, gum disease, broken restorations, tooth loss, headaches and TMJ disorder.

In implant dentistry, combining the force and timing information helps to control potentially damaging forces. According to Carl E. Misch, “once the final prosthesis is delivered to the patient, many factors that influence marginal bone loss have already occurred.” At this point, he says, “occlusal overload is one factor most in control of the restorative dentist.”

During a complete arch implant prosthesis insertion, computerized occlusal analysis can be used to target regions of excessive force concentrations. This allows you to realign an unbalanced bite that will, under occlusal function, destabilize and torque the prosthesis. In mixed arch dentitions, the T-Scan’s time-sequencing capability ensures implant prostheses are loaded fractions of a second after neighboring natural teeth reach complete occlusal contact. Non-simultaneous contact avoids overloading of the segmental implant prosthesis.

Computer-guided occlusal adjustments better preserve the occlusal materials, abutment screws, all-ceramic abutments and the implant-bone interface, which cannot be accomplished with traditional occlusal indicators.

Dr. Chris Stevens published a case report on a patient treated with two implant fixtures. Radiographs revealed significant bone breakdown over time. Once an appropriate occlusal scheme was determined, it became evident that regeneration of the crestal bone was achieved. He concluded that articulating paper did not provide the vital information needed to appropriately prepare his implant prosthesis for long-term success.

The T-Scan system was recently selected by the Pride Institute for the “Best of Class” technology award in the diagnostic category. The T-Scan has proven to be so useful and accurate that many of the leading dental institutes, such as the Dawson Academy, Productive Dentist Academy, Dr. Dick Barnes Group, Esthetic Professionals and others, are incorporating the system into their curriculums.

To learn more about managing occlusal forces on implants with the T-Scan, join a live webinar, “Implant Preservation by Computerized Bite Analysis,” presented by Dr. Robert Kerstein, on Sept. 14. To register for this webinar, visit www.dstdyclub.com.

References
1. Carl E. Misch, Jon B. Suzuki, Francine Misch, and Martha Bidez; A Positive Correlation Between Occlusal Trauma and Peri-implant Bone Loss: Literature Support; Implant Dentistry/Volume 14, Number 2, 2005
Changing dentistry
one injection at a time

The BEST way to start every procedure!

The Science

- Increase Patient Comfort.
  Half of Americans avoid needed
dental care because of
fear of injection pain *

- Reduce Personal Stress.
  Almost 20% of dentists considered
changing professions due to the stress
of administering injections **

- Generate Patient Referrals.
  DentalVibe is the ultimate
practice builder

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Monitor the KPIs of your dental practice from your iPhone/iPod

Free app from Sikka Software allows appointments, key performance indicators and real-time benchmarking

iPhone Dental Practice Monitor (iDPM) v2.1 from Sikka Software, available exclusively at the Apple app store, can display appointments, benchmarking and key performance indicators from your practice automatically, and best of all, it’s absolutely free.

This enhanced version further simplifies accessing percentile benchmarking data from more than 6,400 installations of Sikka and key performance indicators for all major dental practice business ratios. You can also view details of the application, partners and breakthrough dental optimization applications.

Enhancements include the ability to automatically read appointments, procedures to be performed and expected production on your iPhone or iPod.

You can also review offline and online key performance indicators and benchmarking numbers in both tabular and graphical form.

Sikka continues to improve this application and plans to add many more capabilities in the future. Desktop Dental Practice Monitor (available free from www.dentalpracticemonitor.com) should be loaded on any user machine at the practice and appropriate authentication codes activated. All these applications and services are free.

“You don’t have to pay to see your patient appointments, key performance indicators, schedule, benchmarking and production values on your iPhone or iPod mobile device,” said Vijay Sikka, Sikka Software CEO.

With this dental industry appointments and KPI application for iPhone and iPod, Sikka extends its lead as a business optimization solution for the dental industry.

In the last six years, Sikka has introduced revolutionary on-demand products for business optimization, clinical benchmarking and fee optimization for the dental industry including its latest, www.FeeOnDemand.com and www.DentalPractice360.com.

iDPM has key capabilities and features including:

- Monitor your current and future two days of appointments and production
- Monitor your practice KPIs with the click of a button
- Online and offline capability
- Review latest percentile (national data) anytime and anywhere

iDPM for iPhone is available as a free download from Apple’s app Store on iPhone and iPod touch.

About Sikka Software
Sikka Software (www.sikkasoft.com) is a market leader for business optimization, business intelligence and business connection products for office-based health-care practitioners.

Designed to help the more than 1 million office-based health-care practitioners worldwide and with more than 6,400 installations, Sikka Software products maximize business profitability, establish clinical benchmarking, improve outcomes, provide optimized fee schedules and marketing campaigns and provide high return on investment through analysis of patients, insurance, supplies and demographics.

Sikka Software products are compatible with most practice management systems and financial systems in the United States and Canada.

A privately held company, Sikka Software is headquartered in Milpitas, Calif., with offices in the United States and India.
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SGS fees may be paid to some of the most highly regarded dental professionals in the industry to lecture and present our materials. Our instructors bring years of experience from a variety of dental backgrounds and their presentations are nothing short of outstanding. I am not suggesting that anyone wishing to attend any of our programs contact the various dental professionals involved in the SGS seminars and obtain seminars only if satisfaction is not completely satisfied. You must request a credit from the SGS representative handling the seminar. Credit for the course taken can be applied to future seminars or any SGS products and services.

14 CEUs

Don't Let A Sleep

- Dr. GY Yatros
Administering injections: your patient’s first impression

Making a great first impression provides the foundation for building a great relationship. In the dental office, the first impression that patients have when starting a new procedure can often influence a patient’s willingness to proceed with the treatment plan recommended by the dentist.

Dr. Steven Goldberg, an NYU graduate who operates a successful practice in Boca Raton, Fla., understands just how valuable the patient’s first impression is to his practice and invented a new dental instrument called the DentalVibe™.

With the knowledge that 18.8 percent of practicing dentists have considered a career change (Simon Study) because of the stress of administering anesthesia, and knowing that more than 50 percent of Americans put off going to the dentist because of fear, Goldberg invented an intra-oral device designed to reduce patient anxiety.

The device also offers increased comfort while simultaneously reducing the dentists’ stress level while administering the injection—especially the palatal and block injection.

DentalVibe’s research and development was inspired by the “Gate Control Theory of Pain.” Studies have proven that the brain can only recognize one sensation at a time when it comes to the transmission of pain throughout the body. DentalVibe has incorporated VibraPulse™ technology, which sends a series of pulsed vibrational impulses to the pain sensor in the patient’s brain.

The vibrations and pulses close the pain gate, therefore eliminating any opportunity for the pain of the needle penetration or the pain associated with the pressure of anesthesia within the tissue to reach the patient’s pain sensor.

“When I graduated dental school I recognized that I truly wasn’t 100 percent comfortable with the injection process. Although I used different techniques and products through the years, none really provided me with complete confidence or predictability.

“Seven years ago I started investigating alternative solutions, and through the idea and concept stage emerged the early prototype for the DentalVibe,” said Goldberg.

The early design called for the device to be manufactured with a brushed aluminum casing, but soon the look changed to a softer, more patient-friendly design. “I recognized that if the objective was addressing patient anxiety and comfort, then the instrument needed to appear friendly and non-threatening,” said Goldberg.

Eventually the company settled on a design that somewhat resembles a power toothbrush, hoping that patients would recognize DentalVibe as a friendly instrument.

DentalVibe is a perfect partner with the knowledge that 18.8 percent of practicing dentists have considered a career change (Simon Study) because of the stress of administering anesthesia, and knowing that more than 50 percent of Americans put off going to the dentist because of fear, Goldberg invented an intra-oral device designed to reduce patient anxiety.
for administering anesthesia as its sleek design works as an oral retractor, allowing for tremendous sightlines and access to the injection site. DentalVibe also incorporates an illumination feature that produces a beam of light into the injection area.

Since launching DentalVibe in February, the company said it has been receiving nothing but high praise from the dental community. According to the company, the early adopters who incorporated DentalVibe into their practices quickly recognized that patients embrace this new technology. Dentists found patients were asking about the DentalVibe as they returned for their next visit and kids were fascinated by the accessory toys that clip on to the end of the instrument for pediatric procedures.

The company said it has received inquiries from more than 90 different countries and had hundreds of dentists gather at its trade show booths in New York and Chicago. “There’s an obvious natural market for this instrument,” said Scott Mahnken, vice president of sales and marketing.

To expand the product’s awareness and to allow dentists to try DentalVibe, the company is offering a limited time in-office clinical trial. Dentists can try DentalVibe risk-free in their own office for 30 days. “We feel that once a dentist tries DentalVibe and witnesses the immediate impact it has on the practice that DentalVibe will be part of the standard of care for each patient,” said Mahnken.

DentalVibe is sold direct to dental offices and is not available through dental product distributors. Each office that purchases a DentalVibe is assigned an in-house dental professional. The dental professional is there to address any clinical or technical questions the office might have.

The learning curve for implementing DentalVibe into the procedure is minimal and most dentists are comfortable with the device within 10–15 minutes. DentalVibe is cordless and can operate on 110V or 220V, and it’s portable so you only need one per office.

Replacement comfort tips are available in two sizes, adult and pediatric, and there’s a selection of animal tops that can be mounted on the end of DentalVibe that are ideal for when you’re treating younger patients. Imagine rewarding younger patients with a gift for being good patients during the injection process. A few of the pediatric dentists using DentalVibe have reported that kids in their office are asking if they are getting a shot so that they can receive their toy animal gift.

According to the company, one visit to www.dentalvibe.com will show you that DentalVibe is being recognized as a revolutionary new dental instrument. With just a few months presence in the market, the company has attracted the attention of local news media. Several neighborhood dentists have already been featured on the local news and are seeing the benefits of new patient referrals.

DentalVibe is a unique instrument. It was designed to scientifically improve the injection experience for both the patient and the dentist. What the company didn’t realize is that it would become a “referral machine,” and also reduce cancellations because patients know the injection is no longer an issue, according to company representatives.

One new DentalVibe dentist said: “I was a creature of habit, and initially I was a bit hesitant to try DentalVibe. After using DentalVibe on a few patients, I immediately recognized there was less stress. Later, when I heard a patient sharing the experience with their relative in my waiting room, I knew I made a good decision.”

To learn more about DentalVibe call (877) 505-VIBE (8425) or www.dentalvibe.com.
Curve Dental, developers of web-based dental software, announced the release of CurveEd, a free web-based patient education software available to all dental professionals in August. Accessed at www.curveed.com, the software includes more than 60 professional 3-D videos and can be viewed on a PC, Mac, iPad or iPhone.

“We make dental software a simple experience,” said Jim Pack, CEO of Curve Dental. “Many offices don’t use patient education software because of high licensing costs combined with the heavy chore of installing, training, supporting, upgrading and backing up of additional server-based software. CurveEd solves all those problems.

“It is free, and because it is web-based, CurveEd simplifies the experience for the dental professional; there’s no installation, upgrade or backup worries, and the software is so easy to use there’s no need for expensive training or support. Providing the service at no charge makes it even easier for the dentist, hygienist or dental assistant to put it to use to the benefit of the patient and the practice.”

CurveEd provides more than 60 different dental patient education videos in 3-D in 11 different categories. Each video is professionally narrated, covering a wide range of topics from restorative procedures to cosmetic procedures to endodontics.

Created by a team of dentists, every video is accurate with regard to anatomy and procedure but is tempered with a light narrative and artistic style. Patient education helps dental professionals build trust by providing their patients with an understanding of their current oral health condition and proposed treatment and outcomes.

CurveEd allows the dental team to show patient education videos within the practice or send a web link to their patient via e-mail.

When a video link is sent by e-mail, CurveEd tracks which video link was sent to which patient and whether or not the patient opened the e-mail and clicked on the link to the video. Detailed tracking can help the practice build a comprehensive patient history and show proper jurisprudence.

As a web-based application, CurveEd can be used on a PC, Mac, iPad, iPhone and other similar mobile devices. To access the software, navigate to www.curveed.com and create a free account.

Once you have created an account, you access the patient education library from any computer with Internet access and a browser.

Registration requires little more than a name and an e-mail address. Initial registration provides the practice with access to about one-third of the library. By simply referring CurveEd to two colleagues, the dentist or team member will have instant access to the entire library while giving other dental professionals the opportunity to utilize the free service in their practices.

“You’ve been asked many times if the software really is free,” said Pack. “It really is free, which is remarkable given the value it can provide to any practice. A better educated patient base increases treatment plan acceptance ratios, which increases a practice’s productivity. “CurveEd’s mission is twofold: First, to provide a valuable tool that can advance proper oral care and treatment, and second, to give more dentists and staff a personal experience with web-based dental software.”

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www.curvedental.com

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Curve Dental
(888)-910-4376
www.curvedental.com
The future of dentistry lies within a microscope

By Dr. Stephen Johansen

The times they are a changin’. Sometimes it is difficult to determine if something is a fad or if it is the future. When I was in college, I walked by a computer lab filled with students and asked what they were doing. I was told they were using the Internet and sending e-mails. At the time, I say it as a fad and thought it would never last. I was wrong.

The first time I looked through a microscope to do a dental procedure, I had a very different reaction. I knew this was no fad; this was the future and it would transform the way general dentistry is performed. With time, I will be proven right.

My path to microscope-enhanced dentistry started with lower back pain. After only a few years in practice, I was suffering from musculoskeletal disorders due to poor posture and prolonged static positions. Basically, doing dentistry the old-fashioned way was wrecking my body. I was faced with either finding a new career or finding a new way to practice. Enter the world of microscope-enhanced dentistry!

The first time I looked into a scope I knew there was no going back. I was accustomed to practicing with 4.5x loupes, but the level of light and magnification possible with a microscope was a whole new world of vision. After a little due diligence, I decided as a general practitioner I would be well served with a scope having three levels of magnification.

More levels are nice, but I found myself using two levels about 90 percent of the time, and I liked the idea of a simple scope without a lot of clutter. Seiler’s IQ microscope with a ceiling mount was the perfect choice.

My posture improved, my health improved and, as a side note, the level of precision I was capable of improved dramatically. You cannot believe what you can see in a microscope while doing restorative dentistry! Sure, everyone knows you could have them all back, but the day you would get my scope would be to pry it from my dead hands. It is a game changer like no other piece of equipment I own. The future is here. I suggest you peek into a microscope and see it for yourself. ☯

Johansen practices in Sandy, Utah. You may visit him online at www.sjdentistry.com.

Join California Implant Institute

The California Implant Institute was developed in 2001 by Dr. Louie Al-Faraje to provide quality continuing education on the subject of dental implants and related topics using a hands-on approach. As director, Al-Faraje has trained more than 1,000 clinicians in a hands-on, yearly forum of education in implant dentistry.

Al-Faraje holds diplomate status at the American Board of Oral Implantology, fellowship status at the American Academy of Implant Dentistry and fellowship status at the International Congress of Oral Implantologists.

The California Implant Institute offers a one-year comprehensive fellowship program in implant dentistry. This program is made of four sessions designed to provide dentists with practical information that is immediately useful to them, their staff and their patients.

The four sessions combined offer more than 160 hours of lectures, laboratory sessions and live surgical demonstrations.

The goal of the faculty team, which is composed of some of the most respected instructors from the United States and around the world, is to provide you with comprehensive knowledge that will enrich your practice and improve your clinical skills so you can confidently perform predictable, prosthodontically driven implant dentistry.

**Session one topics**

During the first session of this one-year comprehensive hands-on implant training program, the following topics are covered: anatomy, bone physiology, patient evaluation for implant treatment, risk factors, vertical and horizontal spaces of occlusion, bone density, step-by-step implant surgical placement protocols, impression techniques, restorative steps for implant crown and bridge and more.

**Session two topics**

During session two, computer-guided implant placement and restoration using SimPlant® software, immediate-load techniques for single and full-arch cases, biology of osseointegration, miniimplants, bone grafting before, during and after implant placement and pharmacology will be discussed.

Implant prosthodontics for fully edentulous patients, high-water design, bar-overdenture, CAD/CAM designs, etc., will highlight the prosthetic portion of this session.

**Session three topics**

Advanced implant surgical techniques, such as alveolar ridge expansion with split cortical technique, guided bone regeneration, sinus lift through the osteotomy site and more, are covered in this session.

Hands-on pig jaw workshops using regenerative materials are performed by the class, and there are live surgery demonstrations by faculty. The restorative portion of this session will focus on biomechanical principles, biomaterials and implant occlusion.

**Session four topics**

This session will focus on sinus lift through the lateral window, ramus block graft and chin block graft as well as the J-Block grafting procedures. PRP and other advanced bone grafting materials such as rh-BMP2/ACS grafts with titanium mesh.

The final graduation examination and certification ceremony will conclude this comprehensive implant training program.

For more information or to register, please contact Jennifer Bettencourt at (858) 496-0574 or visit www.implanteducation.net. ☯
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The Aquacut Quattro will give you greater control and flexibility than any other piece of equipment you own. Some of its other benefits include:
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- no chipping or stress fracturing,
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The Aquacut Quattro and stand. (Photo/Provided by Milestone Scientific)
What You Don’t Know May Hurt Your Patients
THE OSA-TMD CONNECTION

Hundreds of millions of people of all ages around the world suffer from deadly obstructive sleep apnea; from infants to elderly. Obstructive Sleep Apnea (OSA) has been linked to Cardiovascular Disease, Cerebrovascular Insult, Endocrine Disorders and Obesity and our medical colleagues are asking for our help, NOW! OSA is considered a disease of craniofacial anatomy so the ONUS is on dentists to identify and help manage OSA sufferers.

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This three-day introduction to evidence-based Dental Sleep Medicine is designed to prepare dentists and their teams to confidently identify, refer and help co-manage patients with snoring and deadly obstructive sleep apnea. Participants will have the opportunity to learn about the relationships between sleep breathing disorders, neuromuscular dentistry and health. They can discover how to get started, immediately expanding their diagnostic acumen and scope of practice.

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Complex reconstruction changes a patient’s life

By Jim Arnold, DDS

After years of not smiling and experiencing pain with chewing at every meal, Carmen decided to do something significant to change her life.

My team and I were excited to meet her because we knew that our work could help give her the smile, comfort and dental health she had always wanted.

Carmen had seen examples of our work on our website, so she felt confident that she was coming to the right place for her care.

Despite her confidence in us, however, she was still nervous about having major dental work done.

We did everything we could to relieve her anxiety and make the process as easy and comfortable as possible.

Patient history

Several teeth had been broken because of abuse from a former boyfriend, and she had severe dental pain due to the trauma and resulting malocclusion. Carmen had been a model as a teenager, but she had rarely smiled since the teeth had been broken (Fig. 1a).

In fact, she was so self-conscious that she rarely opened her mouth in public, and she never showed her teeth in photographs.

After eight years of living with little hope, she hoped to regain her smile, self-confidence and faith in people because of her experience with us.

She cried with gratitude when I told her that we could help her to regain the confidence, chewing and a photo directory of the speakers.

For the 27th consecutive year, the American Academy of Cosmetic Dentistry (AACD) will assemble the world’s premier program of cosmetic dental educators. The 27th annual AACD Scientific Session, “The Rise of Collaboration,” will take place in historic Boston from May 18–21.

The focus will be on integrated, side-by-side learning for the entire dental team.

“Collaboration is the key to success on the modern dental team,” said AACD President Hugh Flax, DDS, of Atlanta.

“In order for dentists, technicians and team member to provide the comprehensive oral health care today’s patients demand, dental professionals must develop and refine their skills together.”

Collaborative learning in Boston

During the scientific session, attendees will learn the latest advancements in cosmetic dentistry through a variety of mediums intended to provide an in-depth, revolutionized learning experience.

Emerging technologies, new clinical techniques, team-based courses and practice management strategies are the basis for the world’s premier cosmetic dental continuing education event.

Large-scale lectures offer a multi-disciplinary approach to continuing education and a broad perspective on evolving treatment techniques in cosmetic dentistry.

The AACD’s in-depth, hands-on workshops are in high demand as attendees work one-on-one with esteemed educators alongside their colleagues. Materials and supplies are provided through corporate support.

Featured educators include:*

- Guiseppe Allais
- Stephen Chu, DMD
- Newton Fahl, DDS
- Willi Geller
- Harald Heymann, DDS, Med
- Frank Spear, DDS, MSD
- Dennis Tarnow, DDS
- Dennis Wells, DDS

*Speakers are subject to change.

(Source: AACD)

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(Source: AACD)
TV weatherman gets a smile makeover

By Fred Michmershuizen, Online Editor

Dr. Robin Rutherford, a cosmetic dentist with a practice called The Art of Dentistry located in Odessa, Texas, recently provided a smile makeover for Greg Morgan, a local TV meteorologist. The dental work was explained to viewers during a series that aired on CBS 7 News.

Viewers were able to witness one step of the dental treatment plan — from the initial examination to the completed transformation.

Before the procedure, Morgan spoke of his love for making a difference in people’s lives through laughter, but he also said he felt something was missing. “If I could feel more comfort—able in the way I smile, I could just do my job that much better,” Morgan told PWWEB.

In the final installment of the series, Morgan’s new smile was revealed. He said that his favorite part about the whole process was enjoying the reactions he received to his new look.

“Changing your smile can change your life,” Rutherford said.

The series aired every morning and evening for an entire week in the spring of 2010.

During the series, Rutherford was able to showcase the experience he gained while traveling through the United States studying with a number of leading cosmetic dentists practicing in the field today.

With access to such a wide base of knowledge, Rutherford said, he is able to provide comprehensive, quality dental care for nearly any patient regardless of the type of procedure required.

Rutherford works with a wide variety of techniques, which often include procedures such as dental implants or porcelain veneers.

Rutherford said the overall ease of the process was portrayed through Morgan’s upbeat personality and sense of humor as he was seen sharing his personal experience with viewers until the final smile was revealed.

We determined what she wanted her new teeth to look like, selecting shapes, embrasures, line angles and texture. We also decided on the desired colors and incisal transluency to be utilized.

Local anesthesia was administered so we could “sound” the bone to see how much gingival recession we could do. We were able to improve gingival symmetry with our laser, and we made new PVS impressions.

After reviewing restorative options with our ceramist, we decided to restore Carmen’s upper and lower arches with crowns and a bridge. Because strength and maximizing esthetics were both high priorities, we decided to use Empress (Ivoclar Vivadent; Amherst, N.Y.) crowns for teeth #4–#11 and #21–#29, and a Lava (5M ESPE) bridge for #12–#14. Her missing posterior teeth would be restored later with implants or removable partials.

**Initial periodontal protocol**

We began Carmen’s treatment by addressing her periodontal disease. Thorough oral hygiene instructions were given, scaling and root-planing appointments were scheduled immediately and she began rinsing with chlorhexidine twice daily. My hygienist thoroughly cleaned her teeth under local anesthesia in two visits. Then we reevaluated her peri-odontal health four weeks later at the follow-up cleaning.

She had already improved dramatically. Pocket depths decreased significantly (from 4 to 1 to 2 to 4 mm), bleeding upon probing was eliminated and her plaque score improved significantly. For the first time in many years, the gingival apparatus appeared to be pink and healthy. Now convinced of her commitment to maintaining her oral health, we proceeded with additional records to finalize our restorative treatment plan.

**Diagnostic records and the restorative plan**

Carmen’s needs were extensive, so we opted to perform full-mouth rehabilitation to restore her natural form, function and esthetics. New diagnostic models were made in order to facilitate creation of a full diagnostic wax-up.

We made an NTI appliance for her to wear for several nights in order to deprogram (or relax) her tense masticatory muscles. This allowed us to obtain a more accurate centric relation (CR) measurement. Facebow and stick-bite records were also made, and photographs were taken to aid our ceramist (Marv Stagg, Precision Dental Restorations [PDR]; Salem, Ore.). These records allowed him to accurately mount Carmen’s models for a full-mouth wax-up.

We reviewed photographs from several smile guides with Carmen to decide how to design her new smile.

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**First restorative appointment**

At the preliminary appointment, we evaluated the wax-up with Carmen, and we were all very pleased. We therefore proceeded with her restorative treatment.

We modified several teeth with reduction models provided by PDR so that we could preoperatively transfer the wax-up to the mouth with Luxatemp (Zenith/DMG; Englewood, N.J.). This gave us a tool for verification of our records, desired lengths of teeth, CEJ-to-CEJ measurements, proper canine and anterior guidance and occlusion.

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 articles about in Cosmetic Tribune? Let us know by e-mailing feedback@dental-tribune.com. We look forward to hearing from you!
The full-mouth Luxatemp mock-up also served as an ideal intraoral preparation guide so that depth cuts could be made into the Luxatemp and tooth structure. This allowed us to maintain even reduction and ideal orientation within the arch form. We segmentally prepared all maxillary teeth, making bite registrations (LuxaBite, Zenith/DMG) for the anterior, right side and left side, allowing us to maintain the new vertical dimension that had been established with the mock-up.

After the maxillary preparations were completed, we checked the preparation shades, took photographs and made a maxillary final impression.

We used the Sil-Tech stint to make ideal temporaries, and the CEJ-to-CEJ measurements and tooth lengths were again verified. Sequential bite registration records were again used while preparing the lower arch for the anterior and both posterior sections.

We systematically recorded the relationship from the lower to upper preparations and the lower preparations to the upper temporaries. This helped to ensure that all models could be easily cross-mounted by the laboratory and that the new vertical dimension was maintained.

We made the mandibular impression and temporized #21–#29 with Luxatemp. We then recorded the bite relationship between the maxillary preparations and the mandibular temporaries. After temporarily cementing the maxillary temps, we recorded the bite relationship between the upper and lower temp.

Facebook record and stick bites were also made, and photographs of each were taken. We completed the preparation appointment with photographs and PVS impressions of the temporaries (Fig. 5).

All of the relevant photos were sent to PDR on a disc, along with the laboratory prescription, impressions, bite registrations and models. We provided detailed instructions for completing her case.

**Trial period with temporaries**

Our goal was to restore Carmen to a Shimakoshi measurement of 17 mm to allow for ideal function, comfort and maximum esthetics. Her occlusion was restored to CR in the temporary stage, and she adapted to the temporaries very well.

If she had any issues with the increased vertical dimension, we could have adjusted her temporaries to a position of greater comfort while maintaining proper function.

Her self-confidence increased dramatically with her temporary restorations, and she found herself smiling more than ever. Carmen was looking forward to a new future filled with hope and happiness, and her inner joy was reflected on the surface.

**Seating the case**

Evaluation of her new restorations and the finished bite registration confirmed that the fit, lengths, esthetics, occlusion and color were all exactly as prescribed (Fig. 6).

When she arrived for her seat appointment, she was still very comfortable, so a little more than three months after our first consultation we were ready to deliver her beautiful porcelain restorations (Figs. 7–9).

We removed the maxillary temporaries and cleaned up the prepared teeth after administering local anesthesia. We tried in each restoration individually and collectively, and everything fit very well. The maxillary restorations also occluded well with the mandibular temporaries. After determining that we both preferred the translucent shade of RelyX (3M ESPE), the maxillary restorations were bonded utilizing standard bonding protocol and the “tack-and-wave” technique.

The maxillary restorations were fully seated at the same time and were individually “tacked” in with the Bluephase (Ivoclar Vivadent) curing light with tacking tip for one second each.

The standard tip was then used in order to “wave” across the arch for a few seconds on the facial and lingual sides, hardening the cement to the point where the gross excess could be simply removed.

Liquid Strip (Ivoclar Vivadent) was placed around all of the margins (to ensure that the oxygen-inhibition layer cured completely), we flossed carefully and final curing was completed. The lower arch was anesthetized, and maxillary cleanup was completed.

We removed the mandibular temporaries and utilized the same try-in and seating techniques that we used in the maxillary arch.

Occlusion was adjusted slightly, photographs were taken and post-operative instructions were given.

Seeing her new smile in the mirror elicited tears of joy for Carmen (Fig. 10).

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**About the author**

Dr. Jim Arnold serves on the advisory board for the Academy of Comprehensive Esthetics while balancing his time between three busy dental practices, his four children and triathlon training.

In 2008, the American Academy of Cosmetic Dentistry awarded Arnold with the Partners in Peace Award for his extensive work with the Give Back a Smile program.

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Digital radiography: Step out of the dark

By Carla Gantz, RDH

Are you in love with your dark room? Does the team fight over who “gets to clean” the processor? Will it break their hearts when they learn that they’ll never have to change the solutions again?

What about the controlled panic when someone realizes, “We’re out of film!” How many times have you gathered up your X-rays to mount only to discover these films are not your patient’s?

So why are you still using film? I’ve been in dentistry for 27 years, —14 years as an extended duty dental assistant and the last 15 years as an RDH. I can relate to the above, as the saying goes: “Been there, done that.”

Nine months ago, I changed to a chartless practice, which means digital radiography. What are my thoughts about going digital? I love it!

Please allow me to share some of my experiences, and hopefully, enlighten you about the benefits of digital radiography.

A little advice

We all learn from our mistakes so please learn from me. When using Eaglesoft software, you will need to pull up the X-ray section on the computer before you step out of the room and press the button, then to return and realize “zilch.”

Unless you are using a wireless sensor, the sensors are attached with a cable that connects to your computer. Don’t put the cable between you and the door.

Create this vision in your mind: I place the sensor in my patient’s mouth, ask him to bite down, turn for the door and then notice that the only way I’m making the door is by doing the limbo.

My first few of patients had the pleasure of watching me turn vari-

Caryn Loftis-Solie, RDH, of Sparks, Nev., was inaugurated as the 2010–2011 president of the Chicago-based American Dental Hygienists’ Association (ADHA) on June 29, at the association’s 87th annual session held in Las Vegas.

“Having the honor to serve as president of the American Dental Hygienists’ Association for the coming year should be both challenging and rewarding,” Solie said.

“With the changing landscape of oral health care in America, coupled with recent health care reform, there has never been a better opportunity for dental hygienists to utilize their education and training to their fullest potential in providing care to the public. I look forward to the opportunity of helping guide the ADHA through this period of change.”

Solie has served in numerous positions within the ADHA, including vice president, delegate, district XII trustee and as a member of the Board of Trustees.

For more information, please visit www.ADHA.org.
Dear Reader,

During my travels throughout the country, I have had the pleasure to come in contact with hundreds, if not a couple thousand, dental professionals. It is amazing to have this opportunity. I get to see professionalas in settings of continuing education courses, large state or national meetings as well as in their office environments.

While most of my contacts are with dental hygienists, recently I have been spending a few minutes at a time with front desk personnel as I act as a product educator for Xlear. As I act as a product educator for Xlear, as I act as a product educator for Xlear, I am received by our nation’s dental professionals. It is amazing to have this opportunity. I get to see professionals in settings of continuing education courses, large state or national meetings as well as in their office environments.

I am most delighted how well I am received by our nation’s dental receptionists, office managers, hygiene coordinators, etc. While the vast majority of staff give me a few minutes of their valuable time, there is something that baffles me. It appears as if the right hand doesn’t know what the left hand is doing.

By this I mean that when I ask if the hygiene team is talking about xylitol, desk personnel quite often tell me that they “have no idea what they talk about back there.” Or they say, “I only the receptionist, I don’t know what goes on in the back.” Imagine how excited they are to learn about the benefits of xylitol? They can’t believe there is a natural substance that can do so much for our oral health.

If I get a minute of the hygienists’ time, of course they know what I am talking about. The issue here is not what I am asking the front desk personnel and the hygiene team, but rather why the staff up front do not know what the staff in “the back” are educating and recommending to the office’s patients.

This is a situation in which many people are missing out on valuable information and the office has the potential to be losing big. It is imperative the “front” knows what is going on in the “back” and vice versa. Team members cannot support the mission of the office if they don’t know what each other is doing.

Patients will ask questions of team members regarding recommended treatment/home care/appointment recommendations/billing, etc., no matter what the role of the staff member is. Not being able to answer questions adequately can lead to lost production/revenue and, more importantly, patients.

Keeping the lines of communication open is not difficult. Consider talking about new procedures, products and protocols at a monthly meeting. This helps to assure every team member is aware of the implementation of anything new. This makes the team cohesive and able to talk to patients about things going on in every department of the office, not just in one area.

While it is not necessary to be able to fully explain everything in detail, it is essential every team member knows which products are being talked about, which services are being offered and what office policies are in motion.

Best Regards,

Angie Stone, RDH, BS

Have you been thinking ‘outside of the box’ and seeing wonderful results? If so, share your story with us and it might be featured in Hygiene Tribune! Please send stories to Group Editor Robin Goodman at t.goodman@dental-tribune.com.
ous shades of red when I realized my blunder.

Reasons to go digital
Some offices are not chartless, but have gone digital for other reason, such as the ability to e-mail radiographs to insurance companies and other professionals, instant images and an end to the dark room.

Ask the front office team how many times they’ve received a phone call from the insurance company request ing another X-ray? If you are still using conventional radiography and if you are not taking duplicates, you have nothing to send. With digital, no problem; we can send as many as they need.

Remember the hassle of rummaging through the chart whenever you want to compare X-rays? With digital, it’s just one click and presto! You have a list of all X-rays. Moreover, just think — you did this without changing your gloves.

Just like learning anything new, there is a short learning curve. You will need to ask for help more than once. We sometimes think, “Oh, I’ve been shown once I can do this.” There are no stupid questions compared to: “What happened to my X-ray?” The answer is: “Did you remember to save?”

Adjacent products
Because digital sensors are thicker than conventional film, you will need to purchase some products to keep your patients comfortable. If you choose to take the disposable route, may I suggest you check out DENTSPLY Rinn? DENTSPLY offers a disposable holder call the Uni-Grip®. The Uni-Grip is designed to take a phosphor plate, is easy to attach, uses color-coding to ensure correct positioning and may be discarded when done.

DENTSPLY also makes the XCP-DS® sensor position system that is fully steam autoclavable. The aiming rings, bite pieces and arms are all color-coded, not only to ensure correct positioning but also to save time with assembling (and we all need to save time).

Also, check out DENTSPLY’S XCP-DS disposable cord holder. It snaps on the side of the arm and holds that unruly, crazy cable.

Some people are not fond of the XCP position system, so test out the Eezee-Grip® and the Snap-A-Ray® holders that are available. The Eezee-Grip has a nice little cushion bite pad. It’s universal and all you do is insert the sensor and squeeze.

The Snap-A-Ray® works like the conventional Snap-A-Ray film holder but will not accommodate the Schick CDR Elite sensor.

Infection control
With conventional radiography you discard the film backing, and autoclave the XCP or Snap-A-Ray. With a digital sensor, you can use it repeatedly. Thus, you need a barrier to fit protect the patient’s soft tissue.

Because the sensors are thicker than film, and we already know how patients react when we need to take lower periapicals, sensor softness is a consideration.

New Wave Dental makes a cushion for the sensor. It’s an all-in-one barrier sleeve called Wrap-Ease® and can be purchased from Crosstex.

New Wave Dental also makes what are called Sensor Slippers® (also available through Crosstex), which are for when you are using the Snap-A-Ray or the Eezee-Grip and the sensor keeps slipping due to the barrier. The cushion prevents the slippage and at the same time creates a softer edge for the patient’s mouth. The company also has something called the Edge-Ease®, which adheres to the edge of the sensor barrier.

Indeed, New Wave Dental did not forget about patients that have a problem fitting on the XCP bite piece, so you can “trick” the patient by using Bitewing-Ease®. This barrier pad adjusts to fit all manufacturer’s sensor and folds to create a bite tab.

A final word
If you are not using digital radiographs, my advice is to start researching. Yes, expect to spend some money, but did you know that most offices use a conventional dental X-ray unit as the source for radiation?

Take into account that digital sensors are more sensitive to radiation and require 50 percent to 80 percent less of a radiation dose than film.* Even though we are using less radiation, the lead aprons are still needed to protect patients.

Can you tell I like digital radiography? Once I learned how to use the magnification feature, it occurred to me that I had been in the dark long enough. **


**About the author
Carla Gantz is currently a practicing dental hygiene clinician and treatment planner coordinator for the office of Dr. Thurman, Welborn and Cassidy in Glasgow, Ky. She is a 1996 alumni of Western Kentucky University, past president of the Kentucky Dental Hygienists’ Association and a CareerFusion member.

In addition, Gantz has been presenting webinars since 2006. You may contact Gantz at dso@scrtc.com.
ADHA meeting Las Vegas

No. 1: Caesars Palace lobby.
No. 2: ADHA registration desk.
No. 3: Eiffel Tower restaurant.

No. 4: Robert Boyd, DDS, chairman of the Department of Orthodontics at the Arthur A. Dugoni School of Dentistry of the University of the Pacific in San Francisco, speaks on ‘Improving Periodontal Health Through Orthodontic Treatment.’

No. 5: This line equates to a one hour and 45 minute wait to check into the Caesars Palace Hotel.
No. 6: The pool at Caesars Palace is a constant buzz of activity.

No. 7: Celebrity chef Danny Boome (left) with Dental Tribune America Group Editor Robin Goodman. Boome joined forces with Crest Pro Health System to host the ADHA Annual Session: P&G Oral Health Breakfast Event. Boome delivered a presentation on breakfast foods that are good for your oral health and demonstrated how to make the perfect omelet, a Morning Glory fruit salad and his super smoothie.

No. 8: It looks quite peaceful outside the students and new professionals room.
No. 9: A waterhorse statue outside the Caesars Palace Hotel.
No. 10: Despite the calm appearance outside its door (No. 8), inside the students and new professionals room is jammed with attendees enjoying themselves.

No. 1: Caesars Palace lobby.
No. 2: ADHA registration desk.
No. 3: Eiffel Tower restaurant.
No. 11: Attendees line up early for the opening of the exhibition hall. The line snaked down the hallway and around a corner.

No. 12: Colgate-Palmolive Academic Manager Judy O’Brien, RDH, (left) with Colgate-Palmolive Senior Manager of Professional Relations Karen A. Raposa, RDH, MBA. Raposa spoke on, ‘Bridging the Gap: Dental Treatment for Patients with Autism,’ during the meeting.

No. 13: Sharie Burch, RDH, MPH, EdS (left) and Audrey Ticknor, RDH, MA, speak on, ‘What’s the Big Deal About Meth and How do Hygienists Respond?’

No. 14: The chocolate fountain at Jean Philippe Patisserie in the Bellagio Hotel. The chocolate is inedible because it has a high oil content to keep it flowing.

No. 15: A close-up of one of the fish tanks at Beijing Noodle House No. 9 at Caesars Palace Hotel.

No. 16: Edward Haas and Eve, a 4-year-old Colombian boa constrictor that Haas rescued as part of his company Reptile R.E.P.S. (relocation, education and protection services). The company is a privately funded rescue organization that is open to any exotic animal in need, but specializing in reptiles. You may visit them on Facebook at REPTILE REPS, or e-mail Haas at reprilereps@yahoo.com for more information or to make a donation.

No. 17: The Bellagio Hotel water show attracts a crowd during the day and at night, when the waterfalls are lit up.
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