**Welcome to Cosmetic Tribune and Hygiene Tribune!**

Dental Tribune America has some big news to share with you this month. Earlier this year we gave you a little taste of Cosmetic Tribune during the AAD event and Hygiene Tribune during the ADHA event, but now these two new editions are making their permanent debuts as a part of the Dental Tribune weekly. Once a month you’ll benefit from entirely new content that will feature information from experts in the areas of cosmetic and hygiene.

We welcome your feedback, so please do not hesitate to share it with us!

**Cleft lip, cleft palate links to other congenital anomalies**

Oral clefts are the most frequently occurring birth defects in the United States, affecting 1-2 in every 1,000 births. What are the associations between cleft lip and/or cleft palate and other congenital anomalies, such as club foot, ear defects, anencephaly (disrupted formation of the brain and skull) or coronary heart disease? Do these patterns indicate that cleft lips and palates result from different mechanisms altogether, or are they variable severities of the same phenomenon?

A new study in The Cleft Palate-Craniofacial Journal analyzed more than 1,000 cases of newborns with multiple anomalies to differentiate between cleft lip and/or cleft palate and to determine their associations with other congenital anomalies. Six defects were found to be associated with cleft lip only. Three defects were associated with cleft palate only, including ear canal atresia and club foot. Anencephaly had the greatest association with all cleft types, which probably reflects its disruptive character. Spina bifida and VATER (vertebral, anal, rectal, tracheo-esophageal and renal) complex showed the most strongly negative associations with clefts of all types. The negative association between clefts and neural tube defects invites further investigation.

Coronary heart disease was the anomaly most often found in association with clefts, which is not surprising given that heart defects are the most common defect found in infants with multiple anomalies. Cleft lip and palate (CLP) is more likely to be associated with birth defects than cleft lip alone, which lends support to the notion that cleft lip and palate is a more severe presentation of the same anomaly; however, the patterns of specific defects associated with each condition indicate that different mechanisms and distinct pathways may be involved. Craniofacial defects involving the brain appear to be more associated with CLP, and cleft lip appears to be preferentially associated with ear deformities. (To read the entire study: www.alenpress.com/pdf/cpaj-45-05-523-532.pdf)

(Source: American Cleft Palate-Craniofacial Association)
Meeting on implants informs and inspires

By Michmershuizen, Managing Editor Endo Tribune

T he future of implant dentistry is bright. That was the message delivered at the Long Island Den-
tal Implant Symposium, held Sept. 17 at the Huntington Hilton in Melville, N.Y. The event featured presenta-
tions by three well-known speakers and was sponsored by Astra Tech and Town & Country Dental Stu-
dios. More than 50 dentists attended, according to organizers of the event.

Dr. Roger P. Levin, whose con-
sulting business, the Levin Group, is dedicated to helping dentists increase production and profitability while having fun at the same time, led off the day with a simple message. For-
get the bad news about the economy, he said. The public needs us, and the public wants us. And yes, people are still spending money on elective dentistry. Dentists who are smart — those who want to improve their own practices and their own lives — will embrace implant dentistry, which is undoubtedly going to be a big part of the future.

Levin’s advice, for those dentists who focus mostly on basic or com-
prehensive dentistry, is to implement an annual plan dedicated to increas-
ing the percentage of time devoted to cosmetic and implant dentistry.

“In my grandfather’s day, the basics were enough,” Levin said. “If you are not doing implants today, it is time to get started. Elective dent-
istry should be seen as a business within your business.”

The key, Levin said, is to under-
stand today’s new breed of patient. People now are increasingly affluent. Most are educating themselves on treatment options by visiting inter-
net sites before even walking into a practice. They feel pressure to look good, and more than anything they want convenience. “Whoever makes it easiest wins,” he said.

At the same time, Levin said, it is important to provide patients with various payment options, such as 5 percent off for cash up front, half up front and half by the end of the pro-
duct, or financing via credit. “Have a finance person whose job it is to get an option accepted,” he said. “The fact is that it always comes down to money.”

It’s also vital, Levin said, to edu-
cate each and every patient about the benefits of implants, so that if they ever lose a tooth they will think of you. “Everyone in your practice should be familiar with the benefits of implant dentistry,” he said. “Your office should ‘scream’ implants — your staff should be implant evan-
egelists.”

Levin said that when talking to patients about implants, it is impor-
tant to “speak English, not dental.” After all, he said, people just want to know five things: What is it? What will it do for me? How long will it take? How much does it hurt? How much will it cost? It is useful to use scripting, he said, to shift the conversa-
tion about elective dentistry from money to benefits. “Stop talking technical, talk benefits,” he said.

The good news, Levin said, is that advances like the Atlantis abut-
ment, manufactured by Astra Tech and made available through Town & Country Dental Labs, plus diagnostic tools like cone beam scanning, avail-
able from companies like i-dontics, make working with implants faster, easier and more profitable than ever before.

Dr. Julian Osorio, inventor of the Atlantis abutment, offered a presen-
tation on the thinking behind the patient-specific, CAD/CAM technol-
ogy that has dramatically simplified and improved the implant restorative process. Osorio explained how Atlant-
is abutments eliminate the need for final impressions and cut chair time in half. The final result, he said, is improved clinical outcomes for patients.

Dr. Alan A. Winter, co-founder, president and CEO of i-dontics, a company that provides digital cone beam scanning, explained why 3-D imaging is such an indispensable tool for the pre-surgical planning of dental implants.

Also participating in the daylong symposium was Cadent, a digital impression company whose iTero sys-
tem is designed to make restorations more predictable and better fitting.
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Join us at the Greater New York Dental Meeting!

First Dental Tribune Symposia to be held from Nov. 30 to Dec. 3

By Robin Goodman, Group Editor

People from around the world flock to the annual Greater N.Y. Dental Meeting, and with very good reasons beyond the fact that there is no registration fee. This year, Dental Tribune America has partnered with the meeting’s organizers to offer four days of symposia in the areas of endodontics, implantology, cosmetic and digital dentistry.

Each day’s morning session will feature a three-hour symposium on one topic that will be led by experts in the field. The afternoon sessions introduce attendees to Dental Tribune America’s educational concept of “Getting Started in … “.

The concept follows a proven European model where leading specialists provide a general overview of their specialty for those who are interested in “getting started in” that specialty. Each lecture will provide a thorough introduction to the techniques, products and practice management impact for each dental specialty.

The symposia are free for registered Greater N.Y. Dental Meeting attendees, but pre-registration is required. Also, due to limited seating, register early to ensure preferred seating.

If you are interested in tackling a new specialty area, Dental Tribune’s “Getting started in …” Symposia are an excellent place to start! For registration please visit www.gnydm.com or send an e-mail to info@gnydm.com. We look forward to seeing you in New York!

“Getting Started in …” Symposia Schedule

- Endodontics: Sunday, Nov. 30
- Implantology: Monday, Dec. 1
- Cosmetic: Tuesday, Dec. 2
- Digital Dentistry: Wednesday, Dec. 3

Electric hand-piece users: take notice

In March 2008, the FDA issued a MedWatch Safety Alert discussing patient burns from using improperly maintained handpieces. The article points to worn or poorly maintained speed-increasing handpieces (1:5 increasers). While proper maintenance for handpieces is very important, Daniel Call, customer service manager of Bien-Air USA, explains that the main reason electric handpieces have caused patient burns is because the handpiece has been used as a cheek retractor. This causes the button to touch the spindle moving at 200,000 rpm, creating friction and instant heat without warning.

Many practitioners have experienced the cap heating issue and have posted articles on the FDA Web site. You can test this cap heating theory by running a speed-increasing handpiece out of the mouth and lightly applying pressure to the cap with your thumb. You will notice that the push button cap will heat up within seconds.

Fortunately, Bien-Air has come up with a solution to this problem. The company has a unique, patented design that helps prevent the cap from overheating. All Bien-Air handpieces are equipped with a patented, anti-heating push button that restricts the contact of the push button to the moving parts inside the handpiece head, thus virtually eliminating the potential of push button getting in contact with the handpiece parts rotating at 200,000 rpm.

While it does not completely remove the threat of a heating cap if used as a cheek retractor, it gives significantly more warning than any other 1:5 handpiece on the market.

For a limited time, Bien-Air is offering a trade-in special to all users of electric handpieces. For more information, contact Bien-Air at (800) 433-2436.
Solution: credit recommendations provide insight to patient’s ability to pay

by Marla Merritt

Let’s face it, patient trends are changing. Whitening used to be just for the super-wealthy and braces were just for teenagers. Today, the average American adult is willing to spend thousands of dollars to improve his or her smile. These changes in patient trends have allowed dental professionals to increase revenues by offering a wide variety of costly treatments to a new generation of appearance-conscious consumers.

Just as patient care preferences are changing, so are patient payment preferences. Cost-conscious patients are exploring their options, literally “price shopping” costly dental procedures, by obtaining several quotes and researching payment options offered by various providers. As a result, consumers with good credit ratings expect no-interest financing — even on their dental treatments.

The problem is that most dentists do not offer office payment plans because they do not want to assume any risk. This often means patients are sent to look for third-party financing or are required to pay the full treatment amount up front. Either of these options can send today’s savvy consumer around the corner to your competitor.

A payment model that works for dentists too

For years, orthodontists have offered in-office payment plans while keeping delinquency rates low. They do this by scheduling the payment plan to end before treatment is completed or by assessing credit risk prior to offering a payment plan. By adopting these guidelines, your practice can confidently offer payment plans to your patients with very little risk to the practice.

The current economy has even the best paying consumers in a cash crunch. Coming up with “cash up front” for costly procedures may prohibit them from proceeding with treatment. Many of these consumers could afford treatment if the payment was spread out over time. By determining credit risk and extending a no-interest payment plan to credit-worthy individuals, your practice can see improved case acceptance and increased patient loyalty.

Here’s how it works

First, determine the treatment period and credit risk. If the treatment is limited to one or two office visits, it is crucial that you assess the risk associated with that patient. Because doctors aren’t typically trained in evaluating credit reports, consider a company like DentalBanc that will analyze the information and give you a concise assessment of the findings. DentalBanc’s credit inquiry does not affect the patient’s credit score — another advantage over third-party financing.

Once you know the patient has an acceptable risk level, offer an affordable monthly payment plan. Ask for a down payment that will cover most of your up-front costs then spread the remaining balance over three to 24 months. This is a great way to win the business of a patient that is a low credit risk, but doesn’t have the cash to pre-pay for a costly procedure.

If the treatment is going to be spread out over several months or years, ask for a 25 percent down payment and offer a payment plan for the remaining balance. The payment plan should end before the final treatment is completed. This payment option is perfect for Invisalign, braces or any other treatment that requires multiple office visits over time.

Beyond risk assessment

Once your payment plan has been established and accepted, you will need an efficient and profitable way to manage that payment. Be sure to check out Marla Merritt’s article in the next issue of Dental Tribune to learn how to offer payment plans without creating extra work for your staff.

Marla Merritt is the director of sales and marketing of DentalBanc, a payment management solutions provider. She can be contacted at (888) 758-0585, ext. 8304, or by e-mail at mmerritt@orthobanc.com.
Conscious sedation: building upon an inherent trust in dentists

By Robin Goodman, Group Editor

According to the most recent Gallop poll figures available (2006), dentistry is considered to be one of the most honest and ethical professions. While nurses are at the top of the list, dentistry ranks among the top five: nurses, pharmacists, veterinarians, medical doctors and dentists.

Patients implicitly trust their dentists, which makes dentists the best resource for patients to learn about how oral health affects overall health. Given the abundant messages over the last few years of how oral health greatly affects systemic health, one would hope that this knowledge would encourage patients to visit their dentists more often. So are patients listening?

If one considers that among adults in the United States as many as 75 percent experience dental fear ranging from mild to severe, it is clear that many aren’t even making it across the threshold of dental practice doors. Further, anywhere from five to 10 percent among this group have what is called dental phobia, a condition that causes them to avoid visiting the dentist at all costs.

In fact, a recent survey published by the Academy of General Dentistry showed that a whopping 31 percent of baby boomers never go to the dentist or only do so in an emergency. The survey, conducted by Opinion Research Corporation International (ORCI), queried 1,000 American adults in private households. If one considers that the baby boomer population is some 76 million strong, a mere 31 percent of that represents an astounding number of patients that dentists have yet to meet.

It’s not always the dentists themselves that these patients fear, it’s also the procedures the dentists perform and the instruments they use. A fear of needles or the sound of the dental drill, as well as difficulty becoming numb can compound the anxiety that keeps these patients from seeking a dentist’s care. Of course, invasive procedures, such as oral surgery, tend to cause more fear than less invasive ones like prophylaxis. So how can a dentist encourage this large segment of the population not currently seeking care to set foot into his or her practice?

First, a dentist can build upon the trust that patients inherently have by educating them about oral conscious sedation. A properly trained dentist can reassure his or her patients that oral sedation treatment can help them overcome their fears and anxiety by creating a calming, relaxing and safe dental experience.

Informing patients of the numerous other benefits of oral sedation is also helpful — such as enabling the dentist to complete more dentistry in a single visit, reducing postoperative pain, and leaving patients with little to no memory of their treatment due to the amnesic effects of many of the medications.

Having an appropriately trained team, both business and clinical, also facilitates the process by building trust and rapport with the patients. This aids in developing the long-term, trust-based, doctor-patient relationships necessary for helping patients complete full treatment plans.

Oral sedation dentistry has the ability to help millions of fearful patients currently avoiding care. The trust is already there, it is simply up to each individual dentist to build upon it.

For more information about oral sedation dentistry, visit DOCSeducation.org or call (877) 123-3627.
Tooth augmentation

By Sarah Kong and Larin Burland

This attractive and fashionable woman came to us seeking our assistance to improve the appearance of her smile (Fig. 1). She said, “It’s just not me!” Teeth #5 and #6 were part of a double abutment cantilever bridge for the pontic on tooth #7. Teeth #8 and #10 were implant crowns, and #9 was a porcelain crown (Fig. 2). All the restorative work was done more than two years ago in China. Although it was functional and healthy, the patient felt like her teeth looked old and unhealthy as they were short, dark, uneven and intruded.

The patient had seen other “cosmetic” dentists who wanted to re-do all her restorations, but she remembered the experience, although necessary, was not pleasant, and more important, she did not want to jeopardize these teeth, crowns and implants. At her initial consultation appointment, we did a mock-up of teeth #8 and #9 to see what her smile could look like if she decided to improve their look by building them out facially and increasing their length.

Then we showed her what her smile might look like with a mock-up to hide her lateral incisor a tooth augmentation procedure. She loved the way her teeth looked in the mock-up, but she loved even more the fact that we offered a way for her to preview her options! We also discussed the wear on her lower teeth and recommended veneer, composite, but she wanted to focus on her upper front teeth at this time.

We presented our patient with her treatment options, and because neither of us was looking forward to redoing these restorations, I suggested laboratory-fabricated, no-prep resin veneers. The resin was chosen over porcelain due to its more flexible properties. The brittle nature of porcelain would have been more likely to cause fractures due to the under

Is he a dentist? Is he the mayor? He is both!

An interview with the mayor of Ormond Beach, Dr. Fred Costello

By Robin Goodman

Group Editor

How long have you been a dentist and when did you become mayor of Ormond Beach?

I graduated from University of Iowa in 1974. After serving in the U.S. Air Force for three years, I moved to Ormond Beach in 1977 and entered private practice. I am blessed to have always enjoyed my chosen profession. I am 58 and still practice full time and expect to continue for another 10 years or so. After being interested in and involved in giving back to my community for many years — including serving as president of civic groups and of both the Volusia County Dental Association and Florida Academy of Cosmetic Dentistry and serving on and being chairman of both the Ormond Beach Planning Board and Development Review Board — I ran for Ormond Beach city commissioner in 1999 because the candidate I supported had health issues and was unable to serve. I did not support the vision of the other candidates. I had absolutely no intention to run for office. After serving as a city commissioner for three years, our mayor resigned to run for Volusia County Council and I was faced with the choice to run for mayor in 2002 or serve as a commissioner under the leadership of a mayor with whom I had significant disagreements. I am now in my fourth term and still enjoy the opportunity to shape the future of my chosen community!

Likability or capability, which is more important? Or are they both equally important?

Great question! I believe capability is by far more important … but you can’t get elected without likability. Bottom line, I believe likability gets you elected and capability keeps you in office. I am of the opinion that professionals should be more involved in community public service. I still prefer the public service description as opposed to the term politics for folks who are interested in serving and not in establishing a new political career. We professionals benefit from the credibility we have worked so hard to establish and the public knows we are in it for the right reasons and not for enhanced status or additional income … so voters already believe we are capable and hopefully they decide we are likable and they will elect us. It is a tough balance to keep up capability without morphing into self-promo. I have never referred to myself as “Dr. Costello” and I think most folks appreciate that I don’t think being a dentist should automatically give me an edge because I am a professional.

How does managing a city compare with managing a dental practice?

Ormond Beach has a population of about 40,000. Most Florida communities of our size have a city manager who runs the day-to-day operations of the government. Ormond Beach’s annual budget is about $100 million.

As the mayor and City Commission, we are in essence the chairman and board of directors who set the policy for the city manager — who functions as the president of the company and follows the directives of the board — and who is directly responsible to the city manager — who functions as the president of the company and follows the directives of the board — and who is directly responsible to the elected officials. So there really is a great deal of similarity. As mayor, I work with the commission to set policy and direct the city manager of Ormond Beach, and as a dentist, I work with my partner and associates to set policy and direct my dental practice office manager to carry out our directives. The main difference is that the bureaucracy of government means that we don’t do things very efficiently and government rewards longevity as opposed to merit, which can be very frustrating.

Any pearls of wisdom you can share with us from your work in dentistry and politics?

Whether in politics or dentistry, it’s all about making sure they are smiling when you’re done. Do the right thing for the right reason no matter what the consequences. Build on your strengths and staff your weaknesses. In other words, don’t try to do things others can do better; work to improve on what you already do well as that will energize you instead of frustrate you. Your team is an extension, and a reflection, of you … continually improve, elevate, refine and reward your team. My dental team of 12 and our Ormond Beach city employees of about 560 are considered to be outstanding! And we are always striving to get better!

Dentistry and public service both demand high integrity and commitment to excellence and a willingness to give more than expected in order to accomplish a defined objective. And both are rewarding to those who care more about improving the quality of life for others than about using every spare minute in a financially productive fashion. I am a believer that “to whom much is given, much is expected” and I have been given much so I try to give back more than is reasonably expected. I encourage all dentists to get involved in your local community public service arena, including elected offices. As you give, you will grow and get more out of it than you give to it.

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www.dental-tribune.com
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Cosmetic Dentistry Newspaper • U.S. Edition

See Tooth, Page 2

Fig. 2: Before close-up smile
Dear Cosmetic Dentists,

Welcome to the second edition of Cosmetic Tribune. Our first edition was dedicated to the annual AACD meeting in New Orleans this year. Starting with this edition, Cosmetic Tribune will now be a monthly publication.

Something we hope you will notice is that our clinical articles will primarily focus on the “Why?” behind the cases presented. This is because we want to share with you, our readers, the entire thought process that was involved with each case. We want to feature our authors’ work and understand why they made the choices they did.

What challenges did the clinician face? Were there cost or time restrictions placed upon the dentist by the patient? Were there any specific difficulties that required a unique solution? There are always different factors that affect why a certain path was chosen for a particular case and that is what we want to share with you.

Of course, these clinical articles will also present the “How?” This will be covered in brief, but still shared as concisely as possible. The reason for such brevity is that we want to concentrate on the pictures that best illustrate the situation.

In the future, Cosmetic Tribune seeks to feature the work of doctors who have “been there” and who can share their insight and unique case studies with fellow practitioners. Further, we want to feature the work of our readers so that we can all learn from one another.

We want to encourage all of you to submit articles on cosmetic dentistry cases you would like to share for future editions. If you are interested in publishing within our pages, please contact Group Editor Robin Goodman (r.goodman@dtamerica.com) and she can give you all the details. Also, if you have any feedback to share, we would both be glad to hear it, so please contact Ms. Goodman or myself directly (dberland@dallasdentalspa.com).

In short, I hope you enjoy the first monthly edition of Cosmetic Tribune and we look forward to hearing from you!

Sincerely,

Dr. Lorin Berland
Editor in Chief

Cosmetic Tribune
Fig. 14: Digital buck with patient’s before and after images.

To begin, we placed Expasyl (Kerr) on the facial gingiva to retract her tissues and liquid dam on the lingual interproximally, especially at the gum line to protect her existing restorations from loosening or coming off with the impressions. Full arch upper and lower PVS impressions as well as the digital images and selected smile specific instructions to accompany them were given to Dental Arts Laboratory in Peoria along with www.dentalartslab.com and the Dallas County Dental Society.

The impressions were then sent to Dental Arts Laboratory in Peoria (www.dentalartslab.com) along with specific instructions to accompany the digital images and selected smile design. Within two weeks, the no-prep resin veneers were ready to be seated (Fig. 7). For the seat appointment, dead foil matrix (DenMat) was used to isolate tooth #10 from #11, but no divider could be placed between teeth #6 and #7 since they were connected. Instead, liquid dam was applied and cured (Fig. 8). Next, the porcelain surfaces were prepared for bonding with the Groman Etch Master air abrasion unit to increase surface area and mechanical retention (Fig. 9). Because the margins of her porcelain restorations were below the gumline, hydrofluoric acid use was avoided to protect her gingiva. In this case, Interface (Apex) was used as an etchant and porcelain primer (Fig. 10). This was followed with Optibond Solo Plus air thinned on the porcelain (Fig. 11).

The four Premise indirect veneers were tried on with A-1 and B-1. Ultimately, B-1 Premise flowable composite (kerr) was used for the centrals and A-1 for the laterals to cement the restorations. I chose flowable composite rather than veneer cement to fill in any undercuts due to the non-prep nature of this case. The veneers were cured with the Kerr Demi Light at all angles. Because it is an LED, there is no heat generated that could result in sensitivity from over curing. The excess composite was removed with an American Eagle Gelato peri-odontal knife along the gingival margins (Fig. 12) and Axis Qwik Strip interproximally (Fig. 13). Because the margins of her previous restorations were taken to her high gum line, which was a bit uneven. Now her gum line appeared more symmetrical after having the resin veneers placed. Though she chose to wait to do her lower teeth, experience shows that she will do them in the future, especially after seeing how beautiful her upper teeth turned out. The patient loved her new smile!

When the case was finished, we took digital images of the patient’s new smile, both full face and close-up. This is a very important step, as patients tend to forget what their teeth looked like prior to the dental work. Being able to see their before and after images side by side helps them to appreciate the work that was involved in improving their smile.

Not only was an esthetic result achieved, the patient was able to keep her original restorations without damaging them. People forget what you say and people forget what you do, but they never forget how you made them feel. Digital communication in this manner serves as a constant reminder. And with a click of a button, they can share the experience with their family and friends (Fig. 14).

**Author info**

Dr. Lorin Berland is an internationally acclaimed cosmetic dentist and one of the most published authorities in the professional dental and general media. He is a Fellow of the American Academy of Cosmetic Dentistry, the co-creator of the Lorin Library Smile Style Guide; www.denturewearers.com; and the founder of Arts District Dentistry, a multi-doctor specialty practice in Dallas that pioneered the concept of spa dentistry. The American Academy of Cosmetic Dentistry honored Dr. Berland with the 2008 Outstanding Contribution to the Art and Science of Cosmetic Dentistry Award.

Dr. Sarah Kong graduated from Baylor College of Dentistry, where she served as a professor in restorative dentistry. She focuses on preventive and restorative dentistry, transitional, anesthesia and periodontal care. She is an active member in numerous professional organizations such as the American Dental Association, the Academy of General Dentistry, the American Academy of Cosmetic Dentistry, the Texas Dental Association and the Dallas County Dental Society.

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Products designed for dentists by dentists

An interview with Cosmedent Inc. co-founders Michael O’Malley and Dr. K. William “Bud” Mopper

By Robin Goodman
Group Editor

Back in 1982, some 25 years ago, Cosmedent opened an office in Chicago. Here you began to offer the first hands-on training and lectures devoted to composite resins. What were you both involved in at the time and what was the impetus behind this decision?

Mike: I was working for a dental consulting company when I met Buddy in 1980 to consult with him on one of his dental practices. Buddy and his friend, Dr. Norman Feigenbaum, were lecturing on the use of the new composite materials for esthetic dentistry. Over dinner, the two of us agreed to start an educational company dedicated to sharing our enthusiasm and knowledge of composite dentistry and showing dentists the remarkable things these materials could do for dentistry — for both the patient and the dentist.

In the earliest days we published “The Forum of Esthetic Dentistry,” a newsletter that promoted a dialogue among the first users of composite resins. We also continued to lecture across the United States and Canada, showing clinicians the vast possibilities of direct resin bonding as both a restorative material and a cosmetic procedure.

Dr. Mopper: In 1982, there was a total lack of reliable information about how to use composite materials. I was lecturing around the country showing dentists how to get the best results with these versatile materials. As a practicing dentist working with these materials every day, I realized that direct resin bonding offered the dentist an opportunity for a rewarding personal experience making patients feel better about themselves as well as a way to significantly increase their office revenues. This was the main reason that I became such an enthusiastic advocate of using composites in dentistry.

There is a saying that goes, “Necessity is the mother of invention.” In the case of Cosmedent, this applies to dentists as your products are created to meet their needs. You also clearly state that your products are created to meet their needs.

Dr. Mopper: This process works in this company by taking ideas and using them in practical application. Products are evaluated on a clinical basis considering ease of application, durability and final results. Cosmedent products stand the test of time because of their chemistry and quality control.

Would you explain how the Center for Esthetic Excellence (CEE) functions and what it offers?

Mike: The CEE focuses on teaching what we know best — how to work with modern resin materials to accomplish beautiful esthetic results. Courses are small, limited to 15 dentists, so there is always a lot of individual attention to problem solving and teaching current dental techniques. A hands-on experience is included with each class.

Dr. Mopper: The CEE is dedicated to teaching the bonding experience better than any other facility in the country. For those who want to learn the artistry of direct resin bonding, the CEE is the place to come. We consider ourselves a very motivational institution; we motivate clinicians to increase respect for themselves when they acquire the skill to be dental artists. Because cosmetic dentistry is not a part of the curriculum in dental schools, the CEE fills this void in the educational system and gives dental professionals a place to focus on current esthetic techniques.

Cosmedent’s Renamel Microfill has been the No. 1 rated composite for a remarkable 17 years, and it also has received REALITY’s Product of the Year award three times. Now you have expanded this line to include Renamel NANO. Would you tell me about this new product?

Dr. Mopper: Cosmedent had a nano composite from the beginning of the company, Renamel Microfill was the first true nanofill resin and continues to be recognized as the No. 1 composite in dentistry. Renamel NANO was recently developed with the handling properties and esthetics of a microfill and the strength of a hybrid, combining many of the best qualities of these products in a single use composite. Renamel NANO will provide excellent restorative results in all types of esthetic restorations, both anterior and posterior. Our Renamel NANO is also completely integrated to the Renamel Restorative System for dentists who prefer to use a layering technique.

Mike: Over the years we noticed a need in the marketplace for a universal composite that not only handled well, but also performed esthetically. Renamel NANO was really born out of this need. Renamel NANO was designed for the dentist who wants to use just one composite, but does not want to sacrifice on the end esthetic result.

Would either of you be willing to share some pearls of wisdom as Buddy. “Don’t believe everything you read.” If I had believed all of the early negativism surrounding composite dentistry, I would never have experimented with these materials and realized that they would change dentistry and my life forever. “You never get more satisfaction out of dentistry than what you do yourself.” Then you work directly with composite resin you feel a higher sense of gratification. This is your chance to really shine as a dentist as well as an artist. You can be as creative as you choose to be while remaining fresh and innovative. It will not take long for you to see the magic of composite dentistry when you place it in the hands of a motivated, enthusiastic advocate of using composites in dentistry.

Dr. Mopper: “Don’t believe every-thing you read.” If I had believed all of the early negativism surrounding composite dentistry, I would never have experimented with these materials and realized that they would change dentistry and my life forever. “You never get more satisfaction out of dentistry than what you do yourself.” Then you work directly with composite resin you feel a higher sense of gratification. This is your chance to really shine as a dentist as well as an artist. You can be as creative as you choose to be while remaining fresh and innovative. It will not take long for you to see the magic of composite dentistry when you place it in the hands of a motivated, enthusiastic advocate of using composites in dentistry.

I really share the same pearls of wisdom as Buddy. “Don’t believe everything you read.” Despite the popularity of cosmetic dentistry, there are still a lot of misrepresentations and faulty product claims circulating in our industry. Consumers are overloaded with information, making it very difficult to recognize what is real and what is not. It is therefore always important to ask questions, stay open-minded, and always think for yourself. “You never get more satisfaction out of dentistry than what you do yourself.” Although starting a business involves a lot of hard work and an extreme time commitment, there is nothing more satisfying. The excitement Buddy and I share towards our products and contribution to dental esthetics extends far beyond anything I could have imagined. “Nothing spreads joy better than a smile.” I have seen countless lives improve after a smile makeover. A beautiful, real smile radiates from the inside out. I am very proud of the role that Cosmedent played in fostering the success, innovation and growth of the cosmetic dental field.
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Coming Soon
Tobacco cessation intervention: Significance for the RDH!

By Carol Southard, RN, MSN

As one of the most accessible health care professionals, dental hygienists are in an ideal position to provide tobacco cessation services. The more intensive the intervention, the higher the quit rates, but even minimal tobacco interventions every three minutes—increase the proportion of tobacco users who quit and have a considerable public health impact. The United States Clinical Practice Guideline recommends that all clinicians provide every tobacco user at every encounter with at least minimal tobacco cessation intervention.

The regularly scheduled dental hygiene visit provides a unique opportunity to relay oral health findings to patient’s use of tobacco and provide cessation support. The efficacy of even brief tobacco dependence counseling has been well established and is also extremely cost-effective relative to other medical and disease-prevention interventions. With effective education, counseling, and support, hygienists can provide an invaluable service. Helping someone overcome a tobacco addiction may be the most broad-reaching health care intervention a dental hygienist will ever achieve.

Tobacco use

Tobacco use has long been identified as the leading preventable cause of illness and death, a fact established by the most substantial body of scientific knowledge ever amassed linking a product to disease. Tobacco claims one life every eight seconds, and kills one in 10 adults globally.

In the United States alone, cigarette use accounts for over 500,000 deaths each year. Smoking causes more deaths alone than AIDS, alcohol, accidents, suicides, homicides, fires and drugs combined.

Worldwide, 5 million people die each year from tobacco use. That number is projected to double by 2020, with more than 70 percent of those deaths occurring in developing nations.

Smoking is a known cause of multiple cancers, accounting for 25 to 50 percent of all cases of cancer, and approximately 170,000 cancer deaths every year in the United States. The types of cancer associated with tobacco use include those that affect the lung, mouth, nasal passages/nose, larynx, pharynx, breast, esophagus, stomach, pancreas, bladder, kidney, cervix and possibly the colon and rectum in addition to acute myelogenous leukemia.

In particular, smoking has been linked to 90 percent of cases of lung cancer in males and 78 percent in females. Smoking also significantly increases the risk for head and neck cancers (more than 500,000 people are diagnosed with these cancers every year). In general, individuals who smoke one pack per day increase their cancer risk by tenfold and individuals who smoke two packs per day increase their risk to 25 times that of a non-smoker.

In addition, smoking is a known cause of at least 25 percent of all heart disease and strokes, and no less than 90 percent of all chronic obstructive pulmonary disease (COPD). Smoking is a major cause of coronary artery disease, cerebrovascular disease, peripheral vascular disease and abdominal aortic aneurysm, and smoking is the most important risk factor for COPD. Only 5 percent to 10 percent of patients with COPD have never smoked. Once thought of as an “old man’s disease,” this disorder has become a major killer in women as well. The disease kills 120,000 Americans a year, and it is the fourth leading cause of death and is expected to be third by 2020.

Smoking during pregnancy causes spontaneous miscarriages, low birth weight, placental abruption, fetal heart defects, and sudden infant death syndrome. Babies born to women who smoke are more likely to be premature. Women, particularly those older than 35 years of age who smoke and use birth control pills, face an increased risk for heart attack, stroke and venous thromboembolism.

Other conditions that affect smokers include cataracts, macular degeneration, chronic cough, respiratory infections, damage to skin, poor oral health, low bone density, early menopause, gastroesophageal reflux, high blood pressure, type 2 diabetes, psoriasis, erectile dysfunction.

See Tobacco, Page 3
Dear Readers,

Welcome to Hygiene Tribune! As Dr. Lindow wrote in a previous issue of Dental Tribune, we need to “recognize that the hygiene team’s contribution is the true backbone of any thriving dental practice.”

To that end, we have launched Hygiene Tribune as a monthly insert for our Dental Tribune weekly.

Our purpose within these pages is to bring to our readers — both dentists and hygienists — information on topics that are of utmost importance to fostering an excellent working relationship between the hygiene team and the dentists they work with. In addition, we would also like to create an open forum that presents the current discussions on contemporary topics.

Although our foray into the world of hygiene begins with a few pages each month — which also makes us very selective of the content we feature — our intention is to increase the total number of pages moving forward.

We look forward to hearing any suggestions you might have for article topics, as well as hearing any general feedback you would like to share with us. Please do not hesitate to write me at rgoodman@dtamerica.com!

Sincerely,

Robin Goodman
Group Editor

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Winners announced for Zenith Dental’s RDH Under One Roof Sweepstakes

Englewood, N.J. – Zenith Dental, the visionary company with a 25-year tradition of introducing innovative and reliable restorative dental products and exclusive distributor of Kolorz™ and DMG-manufactured products, recently announced the winners of its 2008 RDH Under One Roof (UOR) sweepstakes.

Zenith was pleased to support this year’s RDH Under One Roof conference by hosting the sweepstakes that awarded two lucky winners a free trip to this year’s event, which took place July 5–Aug. 2, at the Chicago Hilton in Chicago.

Each winner received round-trip airfare, paid tuition to the RDH Under One Roof event, and a four-night stay at the Chicago Hilton. The sweepstakes was open to all registered dental hygienists and dental hygiene students who were currently enrolled in an accredited dental hygiene program.

The winners of the sweepstakes were Nancy Ferguson Brown, RDH, from Morganton, N.C. and Catherine Beth Lopez, RDH, from Waukesha, Wis.

Nancy Ferguson was extremely happy with the event. “I can’t tell you how thrilled I was with my RDH Under One Roof experience. I have over 29 years experience in public dental health, with a focus on children and the community. Attending UOR inspired me with new ideas and provided me with the latest information in dental technology and product innovation. I have to say, though, the underlying feeling of camaraderie among my fellow hygienists was my biggest reward!”

Thank you, Zenith, for providing the opportunity for professional growth, not only for me, but for all dental hygienists.”

Catherine Lopez shared the same sense of growth and camaraderie among her peers. “UOR was a wonderful experience for me. I have been a working hygienist for over five years, primarily practicing in a pediatric setting. I also temp in general practices and I volunteer at a local clinic. I had the pleasure of meeting with hygienists from all over the country. Their enthusiasm for our profession was truly empowering. I left UOR feeling challenged and motivated again. This was honestly a blessing for me. Thanks so much!”

All entries for the sweepstakes were received by May 30. Winners were selected in a random drawing on June 2, and were announced on the Zenith Web site and contacted via telephone and e-mail.

“Zenith was pleased to offer an easy and convenient way for hygienists who may not have been able to attend the event a chance to participate in one of the most popular and important gatherings for their profession,” remarked President of Zenith Dental George Wolfe. “The event was a three-day extravaganza of workshops, exhibits, and networking that introduced attendees to new products, techniques, and people that they may not otherwise have the chance to experience in their everyday workplace.”

About RDH Under One Roof

RDH Under One Roof is an action-packed event that offers quality dental hygiene continuing education. The dental hygienist experiences dental hygiene continuing education courses with some of the leading speakers in the industry. The RDH exhibitors feature new dental hygiene products, dental products and dental equipment. The next RDH Under One Roof Summer Conference will take place July 29-31, 2009, at Rio All Suites Hotel & Casino in Las Vegas.

About Zenith Dental

Since 1982, Zenith Dental has been the visionary company responsible for introducing some of the most widely used and clinically successful dental restorative products to North America. Zenith selects and partners with leading global dental manufacturers to provide American and Canadian dentists with a comprehensive range of exceptional restorative materials.

Zenith’s premier partner is DMG, recognized for 40 years as a global leader in the research, development and production of innovative dental materials. Zenith Dental has the distinction of being the exclusive distributor of DMG products in the U.S. and Canada. Together with DMG, Zenith Dental has become known as the “automix specialist.” Its leading role in automix products began over a decade ago with the release of Luxatemp®, the first automix provisional restorative material. Zenith went on to introduce a wide range of advanced materials, which have become market leaders thanks to their clinical efficacy and ease of use.

For more information and a complete list of Zenith Dental product offerings, please visit www.zenith-dental.com, or call (800) 662-0383.

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 Hygiene Tribune? Let us know by e-mailing feedback@dtamerica.com. We look forward to hearing from you!
tions, infertility and fire-related injury or death. There is no doubt that the risk for smoking-related disease increases with the amount a person smokes. However, smoking one to four cigarettes per day is associated with a significantly higher risk of premature death. The bottom line is that smoking any amount harms nearly every organ of the body, damaging a smoker’s overall health even when it does not cause a specific illness.

Other forms of tobacco use are not safe alternatives to smoking cigarettes. Smokeless tobacco products have been linked to cancers of the mouth and pancreas, as well as to many oral cavity ills such as recessed gums and bone loss. Use of spit tobacco causes a number of serious oral health problems including cancer of the mouth and gum, periodontitis and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung and emphysema and heart disease.

Carol Southard, RN, MSN, an American Lung Association certified instructor with more than 20 years experience and proven success, is a pioneer in the field of smoking cessation. Southard is a Tobacco Cessation Consultant for Chicago area hospitals and has published articles and presented numerous workshops and seminars for health professionals as well as for community groups on smoking cessation throughout the nation. Southard served as the Project Consultant of the Smoking Cessation Initiative, a national program under the auspices of the American Dental Hygienists’ Association. Recently, Southard joined the staff of the University of Chicago Medical Center as a Study Therapist for the Clinical Addictions Research Laboratory. In addition, Southard was instrumental in launching the Chicago Second Wind: A Chicagoland Smoking Cessation Initiative.

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Bidis (small, often flavored, hand-rolled cigarettes) increase the risk of coronary heart disease and cancer of the mouth, pharynx and larynx, lung, esophagus, stomach and liver. Smoking a hookah (a kind of tobacco water pipe) results in the same carbon monoxide level as smoking a pack of cigarettes a day. All tobacco products emit more than 4,000 chemicals, 45 of which have been identified as carcinogens.

All oral health care professionals should be concerned with their patients’ use of tobacco products. Smoking may be responsible for more than half of the cases of periodontal disease among adults in this country. Tobacco use is therefore one of the most significant risk factors in the development, progression and successful treatment of periodontitis. Current smokers are about four times more likely than people who have never smoked to have advanced periodontal disease. Even in adult smokers with generally high oral hygiene standards and regular dental care habits, smoking accelerates periodontal disease.

Tobacco use has been directly implicated in numerous oral morbidities, including oral cancer, stomatitis, oral leukoplakia, gingival recession and soft tissue changes. Tobacco use causes an increase in dental staining and delays in wound or oral surgery healing. Smoking is associated with increased levels of prevalence as well as the severity of vertical bone loss. Smoking exerts a strong, chronic, and dose dependent suppressive effect on gingival bleeding on probing.

Cigarette smoking may be a cofactor in the relationship between periodontal disease and chronic obstructive pulmonary disease, and in the relationship between periodontal disease and coronary heart disease. Smoking extends a favorable habitat for bacteria and in this way can promote early development of periodontal lesions.

Other oral problems
Researchers also have found that the following problems occur more often in people who use tobacco products:

- Oral cancer
- Gum recession
- Bad breath
- Stained teeth
- Tooth loss
- Bone loss
- Loss of taste
- Less success with periodontal treatment
- Less success with dental implants

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