Inside this week

DT America Symposia
Join us at the Greater New York Dental Meeting for our “Getting started...” Symposia. The four days of this event will feature all you need to get started in the areas of endodontics, implants, cosmetic dentistry and digital dentistry.

Cosmetic Tribune: case study
Join Dr. Berland and Dr. Kong as they share their reasoning behind a particular case study where an optimal aesthetic result was achieved that also allowed the patient to keep her original restorations without damaging them.

Hygiene Tribune: smoking cessation
Dental hygienists are in an ideal position for patient interventions in regards to smoking cessation. By investing as few as three minutes per patient, you could be the impetus that helps patients to quit smoking.

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 AADC meeting 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!

The critical missing element to complete care: where dentistry and orofacial myofunctional therapy meet (Part 1 of 2)

By Joy L. Moeller, RDH, BS, COM

I. Problems that can be addressed

- Does your patient complain about chronic headaches?
- Does your patient have an open-mouth rest posture?
- Have your patient’s teeth moved after orthodontic treatment?
- Does your patient exhibit an open bite?
- Does your patient complain of temporal mandibular joint dysfunction (TMD) or neck pain?
- Is the patient’s tongue always “in the way” when you are drilling, scaling or examining the teeth?
- Does your patient exhibit a scalloped tongue from pressing against the teeth?
- Have you noticed oral habits such as thumb or finger sucking, nail biting, lip licking or hair twirling or chewing?
- Does your patient lisp when saying the “s” sounds?
- Do you see the tongue come forward against the teeth when swallowing?
- Is your patient a mouth breather contributing to anterior gingivitis or open-mouth rest posture?

See Complete care, Page 3
NCOHF and ADHA urge all dental hygienists to become tooth fairies

The National Children’s Oral Health Foundation (NCOHF) and the American Dental Hygienists’ Association (ADHA) urge all dental hygienists to participate in the Dental Hygienist Toothfairy Campaign to help eliminate pediatric dental disease. The national program invites all hygienists to “earn your wings” and with a minimum contribution of $25, they can also enter a raffle to win up to 12 pairs of Sybron Orascoptic Loupes, (valued at $1,425 each).

“NCOHF and ADHA are moving aggressively to raise awareness of the widespread nature of pediatric dental disease and most importantly, provide practical solutions,” said Margaret Lappan Green, RDH, MS, past president of the ADHA, and founding chair, Dental Hygienist Toothfairy Campaign. “I hope all dental hygienists and students enthusiastically support the Dental Hygienist Toothfairy Campaign, a fabulous initiative that will bring health and well being to millions of our nation’s at-risk children.”

Pediatric dental disease is the No. 1 chronic illness among our nation’s children and is completely preventable. The potential health-related, societal and economic-side effects are alarming. The U.S. Surgeon General calls it a “silent epidemic” because most Americans have no idea that it is so widespread.

“As most hygienists know, millions of children experience sleepless nights, have trouble eating, and are unable to concentrate and learn in school due to mouth pain,” states Fern K. Ingber, NCOHF’s president and CEO. “We are so grateful to the ADHA for helping to mobilize hygienists who are on the frontline of defense – where care begins.”

For more information on how to be part of the solution, call (704) 350-1600 or visit www.ncohf.org/ADHIToothfairy.php or www.adha.org.
Complete care
From Page 1

- Does your patient grind or clench his/her teeth?
- Does your patient have chronic stomachaches, burping, drooling, hiccup or acid reflux?
- Does your patient have a forward head posture?
- Does your patient have a short lingual frenum or a tight labial frenum?
- When you check for oral cancer on the sides of the tongue, have you found lesions from tongue thrusting causing chronic irritation?

These are all signs and symptoms of an orofacial muscle asymmetry that can be addressed by an orofacial myofunctional therapist.

History of orofacial myofunctional therapy (OMT)

OMT is an area of specialization arising out of orthodontics. The field of OMT is unique because the therapist helps the patient to make major life-enhancing changes, which affect the entire body.

Many dentists during the 1800s and early 1900s recognized that tongue rest posture, mouth breathing and oral habits influenced occlusion. Edward H. Angle — justly termed by some as the grandfather of orthodontics — wrote “Malocclusion of the Teeth,” appearing in Dental Cosmos in 1907, in which he recognized the influence of the facial muscles on dental occlusion. In his research he concluded that mouth breathing was the chief etiological factor in malocclusion.

The first formal program of OMT began in 1918 with an article written by an orthodontist, Dr. Alfred P. Rogers, titled “Living Orthodontic Appliances.” He was one of the first doctors in the United States who suggested that corrective exercises would develop tonicity and proper muscle function and thereby influence proper occlusion.

In the 1970s and ’80s there were two different organizations representing therapists. Daniel Garliner and Dr. Roy Langer founded the Myofunctional Therapy Association, and Dr. Marvin Hanson, Richard Barrett, William Zickfesosse, and Galen Peachey founded the International Association of Orofacial Myology (IAOM). Currently the IAOM is the main professional organization in the world promoting and developing orofacial myofunctional therapy.

The team approach

Today the field is expanding to include many professions. Through a team approach the patient can experience the best of all worlds and achieve remarkable results. The interdisciplinary approach to patient wellness includes but is not limited to:

- orthodontics
- general dentistry
- speech-language pathology
- dental hygiene
- periodontics
- oral surgery
- ear, nose and throat specialty
- cranial osteopathy
- allergyology
- pediatric dentistry
- pediatrics
- physical therapy
- chiropractics
- gastroenterology
- plastic surgery

Failure to help many patients

Through 50 years of practicing orofacial myofunctional therapy, some questions patients or their parents asked me include:
- Why didn’t someone tell me about this earlier?
- I knew I had a tongue thrust, I didn’t know there was a special person to help me.
- Why didn’t someone tell me my habit of tongue thrusting, thumb sucking or nail biting could be easily eliminated in therapy?
- I have tried multiple splints, functional appliances, medications and occlusal adjustments for my TMD problem. I was even referred to a psychologist for counseling because they told me it was stress related. Why didn’t someone recognize my facial muscle dysfunction and refer me for orofacial muscle therapy sooner?
- This is the third time my orthognathic surgical result has relapsed. Why wasn’t referred to an orofacial myofunctional therapist immediately following the expander being removed?
- I was told I was tongue-tied and needed a lingual frenectomy. After surgery, my tongue reattached.

Why hasn’t anyone referred me to a therapist who specialized in treating this disorder with exercises?

My child wore a palatal expander for a high narrow palate. After the expander was removed, the palate collapsed because the tongue was resting down. Why wasn’t I referred to an orofacial myofunctional therapist immediately following the expander being removed?

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Why didn’t someone refer me to an orofacial myofunctional therapist immediately following the expander being removed?

My child was traumatized by wearing a “rake” in his mouth to stop his tongue thrust. His speech has gotten worse and he has withdrawn. After the rake was removed, the tongue thrust returned. Why wasn’t I given the option of seeing a therapist who specialized in treating this disorder with exercises?

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scar tissue formed and was worse than before we started! Why wasn’t I told to see a therapist immediately following surgery to prevent re-attachment? Patients can learn to develop healthy muscle patterns. Healthy muscle patterns, when permanently habituated, can be proactive in preventing or treating:

- orthodontic relapses,
- articulation disorders,
- breathing disorders due to allergies or mouth breathing habits,
- TMD when it is a muscle or habit-related issue,
- digestive disorders from not chewing properly or swallowing air,
- postural problems,
- faster normalization of the facial muscles and neuro-muscular facilitation post orthognathic surgery.

How can orofacial myofunctional therapy help the general dentist?

Orofacial myologists can assist the dentist in many aspects of his or her practice to:

- Re-educate muscle patterns that promote a stable orthodontic result.
- Reduce the time spent in fixed appliances.
- Normalize the inter-dental arch vertical rest posture dimension, the freeway space, also called the oral volume.
- Identify and eliminate orofacial noxious habits that interfere with stable occlusal results.
- Teach nasal breathing and remodel the airway through nasal cleansing and behavior modification.
- Reinforce compliance with wearing rubber bands, functional appliances and retainers.
- Develop a healthy muscle matrix and eliminate habits that contribute to TMD.
- Correct head and neck posture problems.
- Stabilize the periodontal condition by reducing tongue thrusting pressures and mouth breathing habits.

Since most of our patients are in need of orthodontic treatment or treatment by a functional dentist, if the patient was referred by a source outside of dentistry, we are certainly a great potential referral

Study OMT!

Joy Moeller will teach a five-day IOM-approved course on orofacial myofunctional therapy Oct. 19–23, 2008, and a seven-day course (which includes two days of internship) on February 11–17 and June 24–30, 2009 in Los Angeles with Barbara J. Greene, COM, and Licia Cocceani-Paskay, MS, CCC-SLP, COM. For more information contact Greene at bgreene@tonguehurt.com or call (805) 985-6779.
source for dentists.

The best time for the dentist to refer the patient to an orofacial myofunctional therapist is before intervention by appliance therapy. It is always best to do the least invasive treatment first and eliminate habits that are interfering with treatment. This will ensure that the muscles are working with the forces of the appliances. Also, another good time to refer would be before the braces come off, depending on the patient’s facial structure and motivation. We can work together to help the motivated patient achieve amazing results.

To elaborate on the importance of the working relationship between OMTs and the dental community, I have reached out to some of my esteemed colleagues for commentary.

According to Dr. John Kishibay, an orthodontist from Santa Monica, Calif., who is a professor at USC School of Dentistry, “Orofacial myofunctional therapy must be part of the treatment plan from the beginning. This way the patient understands from day one that the muscle adaptation is important for long term stability. Especially important would be the orthognathic patient.

Dr. William Hang, an orthodontist practicing in Westlake Village, Calif., believes that OMT problems are one cause of poor facial development. He says, “Stability will continue to be an elusive, unachievable goal with poor facial balance frequently being the norm of the post orthodontic result. Myofunctional therapy must become the first line of defense in the quest for proper facial development rather than the rescue squad when the orthodontic result is going up in flames. When orthodontists embrace myofunctional therapy, they stop treating symptoms and begin to focus on treating the cause of poor facial development [altered oral rest posture].”

Dr. Jerry Zimring, a practicing orthodontist for 44 years in Los Angeles, believes that attaining proper occlusion is a state of balance between the teeth, the muscles and the bones. He states, “Both my daughter and my grandson were treated with myofunctional therapy with excellent results that would not have been possible without this valuable treatment. I feel strongly that myofunctional therapy should be part of every orthodontic practice.”

Dr. Richard L. Jacobson, a Diplomate of the American Board of Orthodontics who has been in the exclusive practice of orthodontics in Pacific Palisades, Calif., for the past 28 years, stated, “We know that form follows function and function can follow form. Therefore, it is vital to identify those patients that need myofunctional therapy. In these patients myofunctional therapy by a specialist is essential. Treatment is effective and orthodontic stability is enhanced.”

The author would like to thank Karen Macedonio, a Certified Life Coach (and patient), Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM for their assistance with writing this article. A complete list of references is available from the publisher.

To find a therapist near you, go to www.iaom.com and look at the directory.
Webinar schedule

Cone Beams: a new dimension of dentistry, by Dr. Daniel McEowen
October 21 — 7:00 pm E.S.T. — Free

PreXion 3-D Dental Scanners are addressing the rapid shift in dentistry from analog-based 2-D film radiography to digital 2-D and 3-D volumetric rendering. This Webinar will introduce attendees to cone beam technology in general and make comparisons between all currently available CBCT units. It will include a live scan, from scanning to processing, until images are available to work with. The objective is to learn to use the PreXion 3-D for general dentistry, endodontics, implantology, oral surgery, oral-maxillofacial surgery and periodontics, and show the ease of use of this unit.

Register at www.dtiinstitute.com/webinar/cone-beam

Increase net revenue, foster employee confidence: the five keys to effective employment relations for the dental office, by Juris Doctor Michael Garth Moore
November 11 — 7:00 pm E.S.T. — $95 fee

Gain familiarity with legal concepts underlying employee claims; learn the processes and practices that reduce turnover of good employees; learn how to reduce anxiety in dealing with employee relations issues; learn the documentation that reduces the risk of unemployment compensation and wrongful termination claims.

Register at www.dtiinstitute.com/webinar/hr

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- More than 4 times a month

How well do Dental Tribune publications meet your needs for dental news and information?
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- Very well
- To some extent
- Not at all
- Not sure

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- Very well
- To some extent
- Not at all
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- To some extent
- Not at all
- Not sure

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- Rarely
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Compared to other journals, Dental Tribune publications are:
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- Too much to read

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- Always
- Often
- Sometimes
- Rarely
- Never

Please select all the dental publications that you read or refer to:
- Dental Tribunes
- Compendium
- Dental Practice Report
- Dental Town
- Inside Dentistry
- JADA
- PPAD
- ADA News
- Dental Economics
- Dental Products Report
- Dentistry Today
- Other (please note):

Please fax to 212-244-7185 for a $100 AMEX gift card drawing!

Be THE exceptional practice!, by Dr. Ron Schefdore
October 30 — 7:00 pm E.S.T. — $95 fee

Learn how to improve patients’ oral and overall health; grow a quality practice; why, when and how to screen periodontal patients for diabetes; obtain a professional blood lab report to use as a cross referral tool with physicians; remove the liability of blood screening from your office; treat periodontal disease from a bacterial, nutritional and underlying medical point of view for long-term periodontal health, overall wellness, and increased profits establish the ideal practice.

Register at www.dtiinstitute.com/webinar/das betes

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Ortho Tribune

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For a free online subscription to the newspaper of your choice, please provide a valid e-mail address. Subscribers will occasionally receive e-mail newsletters filled with info about events, products, technology and general news.
CAD/CAM technology has revolutionized the practice of dentistry with enormous implications for the delivery of patient care that is time-saving, comfortable, long-lasting, beautiful and economical. This presentation is designed to provide not only an overview of the role of CAD/CAM and CEREC 3D in clinical dentistry today, but also provide attendees with practical clinical information on how CEREC 3-D literally transforms the practice of restorative dentistry. Numerous clinical cases will be provided along with a thorough discussion of case selection, fabrication and design, delivery and finish. Attendees will leave with a thorough understanding of the clinical application and use of CEREC 3D CAD CAM technology in achieving outstanding results.

Endodontic irrigation via EndoVac: safety, efficacy and clinical techniques

Endodontic irrigation is a highly complex problem that begins with patient safety and ends with clinically efficient and effective results. However, as complex as the problem is, the answer is equally simple. Attendees will learn the answer, while becoming familiar with:

1. Identifying flaws in current endodontic irrigation studies.
2. Listing the principles and ancillary benefits of apical negative pressure.
3. Describing the critical importance of safely using full-strength sodium hypochlorite during endodontic irrigation.

Earn C.E. credits! Attendance is free for all GNYDM visitors!

For more info and registration, please contact Julia Wehkamp: j.wehkamp@dtamerica.com.

Successful treatment strategies for anterior total tooth replacement in the thin scalloped periodontal architecture: the ankylos tissue care concept for long-term success

Don’t miss Dr. Schoeffel’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting on November 30, 10:00 a.m.–1:00 p.m.

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Mention the “kit and caboodle ad” when you order for some extra kit.
Zenith Dental makes an impression at University of Washington

Zenith Dental, the exclusive distributor of DMG-manufactured products, recently supplied the University of Washington (UW) School of Dentistry and athletics program with its MixStar-eMotion multifunctional materials mixer and hundreds of StatusBlue® automix cartridges. The donation provided over 130 mouth guard fittings for UW’s student athletes.

The University of Washington School of Dentistry and the UW Athletic Department held the mouth guard event in July at the university’s dental clinic. Over 130 student athletes visited the clinic to be fitted for the mouth guards. Sixty dental students took impressions of the athletes’ teeth, as faculty members and staff supervised the process and offered tips on the best fit.

For more information on the University of Washington’s mouthguard event, please visit www.uwnews.org.

For more information on Zenith Dental’s full line of products, including StatusBlue and MixStar-eMotion, log onto www.zenithdental.com or call (800) 662-6383.

(Source: Zenith Dental)

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Tooth augmentation

By Sarah Kong and Lorin Berland

**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 incisors (Fig. 2a) as well (Figs. 5a, 5b). We knew that her low lip line was on our side, as even her fullest smile did not show her gum line. This was an ideal case for 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 re-doing these restorations, we 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 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.

Contact info

Mayor Fred Costello
City of Ormond Beach
22 S. Beach St.
Ormond Beach, FL. 52175-0277
City Tel.: (561) 677-5204
City Fax: (561) 677-5330
Work Tel.: (561) 675-1511
Home Tel.: (561) 677-8702
E-mail: costello@ormondbeach.org
www.ormondbeach.org

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 gets you re-elected or real — 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 us 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 touch balance to prove you are capable without morphing into self-promotion. 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 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
Letter from the Editor in Chief

Dear Cosmetic Dentists,

Welcome to the second edition of Cosmetic Tribune. Our first edition was dedicated to the annual AADC 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.

Tooth

From Page 1
to the undercuts in the old crowns and cantilever bridge. Also, we had more flexibility finishing the facial contours with resin as opposed to porcelain, especially since we had to over-contour in certain areas to account for blocked out undercuts. In this particular situation, these areas could be adjusted and polished in the mouth far better than porcelain.

Invaluable to the case was the Smile Style Guide, a comprehensive library for smile design (Fig. 4). She has round canines, and since we did not want to change her canines, we looked at the possibilities with round cuspids. She instinctively chose R-2, square centrals, square-round laterals, and round canines. For the length she selected L-3, the laterals significantly shorter than the centrals and cuspids (Figs. 5a, 5b).

As with most cases, we were able to show our patient side-by-side images of her smile before and with a mock-up using Dexis software. With this technology, the capability to e-mail radiographs and photographs with a few clicks gave us an almost instant response from our periodontist. Instant response from our periodontist was involved with each case. We want 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 (drberland@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
tist regarding our implant concerns before starting her case (Fig. 6).

To begin, we placed Expasyl (Kerr) on the facial gingiva to retract her tissues and liquid dam on the lingual interproximals, 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 such as Take 1 Advanced (Kerr) or Virtual ( Ivoclar Vivadent) were taken along with SuperDent Bite Registration (CAMLOG USA) and Axis Qwik Strip interproximally (Fig. 13).

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. We chose flowable composite rather than veneer cement to fill in any undercuts due to the no 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 Ghetro periodontal knife along the gingival margins (Fig. 12) and Axis Qwik Strip interproximally (Fig. 13).

The patient’s 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, transitionals, 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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A meeting of change
ADHA unveils new format at 85th Annual Session

By Kristine Colker
Managing Editor, Ortho Tribune

Change was in the air this past June, as hygienists, students and others gathered for the revamped American Dental Hygienists’ Association’s Center for Life-long Learning at the 85th Annual Session in Albuquerque, N.M. The newly formatted meeting featured a variety of continuing education career tracks on the front end and the ADHA business meetings on the back end.

Gone were the days when the ADHA was focused strictly on policy, said ADHA past president Jean Connor. Instead the organization is repositioned to provide tobacco cessation services. The more intensive the intervention, the higher the quit rates, but even minimal tobacco interventions — less than 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 support. The efficacy to patient’s use of tobacco and progressive hygiene visit provides a unique opportunity to enhance their experiences.

Worldwide, 5 million people die each year from tobacco use. That number has been 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 30 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 by 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 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.

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 — less than three minutes — increase the proportion of tobacco users who quit and have a considerable public health impact.

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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, blindness, and stroke. Smoking has been linked to more than 300 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 by 25 times that of a non-smoker.

Hygiene Tribune
The World’s Dental Hygiene Newspaper • U.S. Edition
Vol. 1, No. 2
www.dental-tribune.com

September 2008
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 r.goodman@dtamerica.com!

Sincerely,

Robin Goodman
Group Editor

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**Contact info**

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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**Tobacco From Page 1**

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, 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 particularly high 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 illnesses such as distant gums and bone loss. Use of chewing 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.

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 periodontal disease. 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 habit 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**
- **Bad breath**
- **Stained teeth**
- **Tooth loss**
- **Bone loss**
- **Loss of taste**
- **Less success with periodontal treatment**
- **Less success with dental implants**
- **Gum recession**
- **Mouth sores**
- **Facial wrinkling**
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