Are you a ‘cutting edge dentist’?

By Robin Goodman
Group Editor

Dear Martha Cortes, current president of the American Academy of Cosmetic Dentistry New York Chapter and former co-chair of dentistry with the American Society for Laser Medicine and Surgery, took some time to talk about lasers with Dental Tribune.

What is the state of lasers in dentistry today?

Dental lasers are state-of-the-art technologies. Every dentist should own one and use it as an integral part of his or her practice, especially as they are much more affordable than they were 15 years ago when I got my first laser; I had the the Duopulse by Excel Quantronix, which has two separate lasers in one unit: a holmium and neodymium laser. I still have this unit in my office and use it as a backup laser to my newer ones. Lasers can be used by themselves or as an adjunct tool as they are versatile and precise. A simple diode laser can be used to disinfect tooth structure, in crown lengthening, frenectomy, biopsy, periodontal disease and gingival sculpting, etc.

There are lasers like the Peri-lase MVP-7, which are specifically built around a patented soft-tissue technique for periodontitis — laser assisted new attachment procedure [LANAP]. There are hard-tissue (modifies lasers) as well as soft-tissue (modifies lasers) and there are lasers available today that combine both a soft and hard tissue laser in one unit. It all depends on the practice one has, or the one that you want to develop. Bottom line is that you cannot consider yourself a dentist on the cutting edge if you do not have and use a laser as part of your daily regimen regardless of what type of dentistry you practice.

How about lasers and soft tissue such as gum and pulp?

I have developed a direct pulp capping technique involving a laser and the immediate placement of a porcelain restoration [CEREC], which has a great success rate as the laser can reach places that antiseptics and antimicrobials cannot reach because of their shallow penetration into bacterial colonies [biofilms]. Lasers can be used on the delicate tissue of the pulp without causing necrosis by using the correct settings and the right lasers.

Nd:YAG’s and diodes are great for sculpting the gingival tissue in crown lengthening, smile makeovers and gingivectomy. Both can be used in treating gum disease, although the diode is not as ideal as the Nd:YAG laser, as it is hotter, can cut deeper and has a potential greater zone of thermal damage in the wrong hands; it should not be used on pockets deeper than 4 mm. The Nd:YAG can contribute to anterior gingivitis or open-mouth rest posture?

Does your patient grind or clench his/her teeth?

Does your patient have chronic stomachaches, burping, drooling, hiccupcs or acid reflex?

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

Inside this week

Going to the Greater New York Dental Meeting?

If you are, you won’t want to miss our “Getting started ...” Symposia, which are free for all attendees. If you’ve thought about getting started in endo, implants, cosmetic dentistry or digital dentistry then please join us!

Cosmetic Tribune: gingival health

As dentists, we can directly affect the esthetics of the teeth and gingiva. However, we can also indirectly affect the lips and face by how we design teeth to sit in the oral cavity.

Hygiene Tribune: smoking cessation, part 2

About 50 percent of patients in any given practice are current smokers. Although 70 percent of smokers say they are “interested” in quitting, only 10 percent to 20 percent plan to quit in the next month.

Are you a ‘cutting edge dentist’?

By Robin Goodman
Group Editor

I. Problems that can be addressed

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 an open bite?

Does your patient grind or clench his/her teeth?

Does your patient have chronic headaches?

Does your patient have chronic stomachaches, burping, drooling, hiccups 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
be used to pocket depths above 12 mm. Those interested in the Nd:YAG laser for gum disease should really look at the Periolase MVP-7 by Millennium Dental Technologies as the laser is sold with instruction/training in the LANAP technique.

And for lasers and hard tissue such as tooth and bone?

Erbium lasers are great for disinfection of teeth and for osseous surgery as they are specifically made for disinfecting and cutting hard tissue. They are also ideal for preparing class I and class V restorations in hard tissue.

Metals and porcelains must first be removed using the drill; however, once they are removed the laser can be used directly to remove any underlying caries. If the caries are very deep, the erbium laser can be used in a direct/indirect pulp-capping technique with the immediate placement of a CEREC 3-D porcelain restoration. An erbium laser like the Waterlase MD by Biolase can also be used in the direct treatment of root canals as it has laser endodontic tips that are used post instrumentation for cleaning and disinfecting the canal.

What are your thoughts on a connection between heart disease and periodontal disease?

I love it when patients tell me that they are fit and in good shape except, of course, for the severe gum disease they have. Unfortunately, we have grown up with faulty medical/dental health models that describe the body as distinct and disconnected units, and this shows up in how we view disease and the body. Severe infection in the body is dangerous as it can spread, especially to vulnerable organs.

Oral health should not be considered in isolation. Periodontitis is a bi-directional manifestation of disease. It can be seen as a manifestation of systemic disease such as diabetes, cutaneous disease, joint disease and osteoporosis. It can also be seen separately from systemic ones as its own complete disease with the great potential of releasing bacterial emboli into the blood system that can travel to the heart, lungs and other major organs. It has been linked to cardiovascular disease since the late 1990s and right- ly, so, as oral bacteria are not contained but spread and are particularly dangerous for heart patients who are vulnerable to endocarditis, especially before open-heart surgery.

An Nd:YAG laser can reduce microbial colonies that inhabit periodontal pockets by 97 to 100 percent, as the laser is precise, site specific and does not rely on secondary or tertiary effects to kill microbes. It destroys microbes and their colonies on contact without any side effects.

Editor's Note: Please see Cosmetic Tribune in this edition for a clinical article by Dr. Cortes and her contact information.

Failure to help many patients

Through 50 years of practicing orofacial myofunctional therapy, some questions patients or their par ents 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 stopped his tongue thrust. His speech has gotten worse and he has with-

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drawn. 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?

- 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 surgery to prevent re-attachment?

- I was told I was tongue-tied and needed a lingual frenectomy. After surgery, my tongue reattached and scar tissue formed and was worse than before we started! Why wasn’t I referred to an orofacial myofunctional 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.

Because 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 source for dentists.

The best time for the dentist to refer the patient to an orofacial myofunctional therapist is before inter-
Joy Moeller, BS, RDH, COM, is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in the exclusive private practice of OMT 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.

**Study OMT!**
Joy Moeller will teach a five-day IAOI-approved course on orofacial myofunctional therapy Oct. 19–23 and a seven-day course which includes two days of internship on Feb. 11–17 and June 24–30, 2009 in Los Angeles with Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM. For more information contact Greene at bgreene@tonguethrust.com or call (805) 985-6779.

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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. The patient must learn to use the new space in an ergonomic manner, in both a functional patterning and habit elimination awareness.”

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, unachieviable 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.”

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Joy Moeller, BS, RDH, COM, is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in the exclusive private practice of OMT in Pacific Palisades and Beverly Hills, Calif. She is currently an elected member of the Board of Directors of the IAOI and is the hygiene liaison. Joy is also a former associate professor at Indiana University School of Dentistry and an on-going guest lecturer at USC and UCLA to ortho, perio and pedo dental residents, and at Cerritos College to hygiene students.

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What is the key to managing stress?

By Roger P. Levin

What’s the leading cause of stress? Is it even possible to pinpoint one cause when so many variables operate in busy dental practices? It’s safe to say that every dental office experiences too much stress at one time or other. Some practices accept it as a fact of life, while others want something better. For them, total success includes having a low-stress practice.

Levin Group consultants have observed that stress usually results from a combination of factors. The most common problems are a lack of well-defined business systems, ineffective leadership skills and teams that are not as committed as they should be. All of these issues can be solved. The final result is a low-stress practice, which is the goal of every dentist who has ever gone into practice.

The Levin Group Method for Total Practice Success™ includes five steps doctors can take to have an immediate and positive impact on stress:

1) Empower the team
2) Hold morning meetings
3) Revise the schedule
4) Improve communication
5) Become a better leader

Empower the team

The doctor’s best resource for reducing inefficiency and lowering stress is the dental team. Involve as many team members as possible in examining your systems. Everyone on the team will have valuable insights to contribute. Special staff meetings can be held to review the major systems such as scheduling, case presentation, hygiene, practice financial management and patient finance. Some strategies include:

◗ Ask team members to bring a list of 10 possible improvements to the next staff meeting.
◗ Organize an off-site, all-day retreat to focus on current issues and strategic planning for the practice. This approach creates an opportunity to bring people together, forge a team spirit and identify problem areas and solutions.
◗ Send your office manager to regularly scheduled continuing education courses to gain new perspectives and ideas on dental management.

Task the office manager with the project of creating a written operations manual for every major business system in the practice. These manuals must include a step-by-step analysis of each system so that a person not trained in dentistry can quickly learn how the office operates by following the manuals.

Hold morning meetings

Once the team has been empowered, it is a valuable asset to a daily morning meeting. Conducting morning meetings before patients arrive is a surefire method of proactively organizing the day and minimizing stress. During these meetings, the doctor and the team must identify times during the day when:

◗ Emergencies can be seen
◗ Time crunches are likely to occur
◗ New patients will need extra attention from the dentist
◗ Any special situations may affect the day.

Making preparations for what’s ahead on a given day will greatly reduce stress in the practice.

Revise the schedule

The backbone of the practice is the schedule, and it affects nearly every aspect of practice operations. Poorly constructed schedules can have chaotic results — frustrated patients, cancelled appointments, lost production and a stressful work environment for the staff. When this situation is left uncorrected, the practice risks losing good team members, thus creating even more stress for the remaining staff.

Examine how your practice schedule is constructed. For example, are there too many holes in the schedule? That’s a sign that appointments are spaced too far apart. This scenario increases stress for the dentist and the team. Levin Group recommends to its clients Power Cell Scheduling™, a high-performance scheduling system using 10-minute units to accurately schedule appointments and allow more scheduling flexibility. Fifteen-minute units would result in under- or over-scheduling patients. For example, if a procedure takes 20 minutes, the practice using 15-minute units would have to schedule this as a 15-minute or a 30-minute appointment.

From one day to the next, the schedule’s format should be very similar. Mornings should be reserved for longer, higher-revenue procedures that make up most of the day’s production goal. Afternoons can then be scheduled with simpler procedures. Within this framework the dentist and dental team are less stressed. This type of schedule keeps}

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Improve communication

Look at any successful practice
and you will see an office that com-
municates extremely well. Commu-
nication affects every aspect of the
patient experience, ranging from
scheduling an appointment to case
acceptance. For the dentist, the first
step in improving communication is
cultivating clear, positive and well-
understood interactions with team
members.

Throughout the day, the dentist
has opportunities to coach team
members, respond to questions and
concerns, and motivate the team.
Dentists should be providing positive
feedback to team members through-
out the day. Don’t wait to recognize
good performance until a staff meet-
ing. When team members perform
well, tell them that day.

Clear communication and sup-
portive coaching become more criti-
cal as the practice grows. The dentist
needs to inspire team members, indi-
vidually and collectively, to achieve
the highest levels of success.

Become a better leader

A mismanaged practice is a stress-
ful place to work. Efficiency, pro-
ductivity and communication are all
reflections of your leadership skills.
Therefore, dentists who work to
improve their leadership skills can
measurably reduce the stress in their
practices.

Good leaders have learned to work
through their teams — not around
them. The most successful dentists
have figured out how to delegate
responsibilities to team members.
Delegating responsibility accom-
plishes two things: dentists reduce
their stress and team members gain
a sense of empowerment. Staff mem-
bers want to feel they play an impor-
tant part in practice success.

Leading by example is another
facet of leadership. Team members
learn how to act by watching the
leader’s behavior. A dentist who is
positive and motivational inspires
team members to act in the same
way. Lead the way and your team
will be sure to follow!

Conclusion

Chronic stress indicates that some
vital elements of leadership are
underdeveloped on the doctor’s part.
Dentists can remedy this situation
by taking more proactive measures
as leaders of their practices. Team
members are relying on the doctor
to set the tone, solve problems and
identify strategies to get control of
problem areas that are sources of
stress.

Yet paradoxically, dentists who
are working to become good lead-
ers learn to empower their teams as
much as possible. Dentists become
better leaders by tapping into team
member’s insights, abilities and
skills. These five steps can help den-
tists become better leaders, build
better teams and achieve total suc-
cess.

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What is

From Page 5


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About the author

Dr. Roger P. Levin is found-
er and chief executive officer of
Levin Group, Inc., a leading dental
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firm that provides a comprehe-
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To learn more about Bien-Air products or for a free in-office demo, call (800) 455-2456. You can also visit us online at www.bien-air.com.
‘Those troublesome occlusal shots’

By Martin B. Goldstein DMD

The following e-mail is typical of the trials and tribulations that doctors and staff encounter when attempting to add digital occlusal shots to their new patient examination protocols.

“My staff and I are still having problems with getting decent occlusal pictures. We even bought the newer occlusal mirror with an attached handle and the lip lifter. We already had mirrors, both large and small, without handles. It seems to be a problem with getting a good clear picture back to the second molars, and of course, the lower is even harder than the upper. We blow air on the mirror to clear the fog. Perhaps the problem is that the patient is not reclined back in the chair enough, or is not opening wide enough. Should we be taking the picture from in front of the patient, or from behind? We take it from the front. Gagging is a problem all the time. I need some advice.

Occlusal images may indeed be tough to get. Assuming your camera is properly set up, the following tips might help regardless of whether you are using auto or manual focus to take your occlusal shots. (Note: manual focus might be more predictable with respect to magnification and illumination, but auto-focus will certainly speed up the process).

It’s important to retract the cheeks when taking occlusal shots. Wire retractors may aid the cause as mirrors can slide through them rather than bump into them as they do with the solid plastic retractors.

It helps to pull the retractors up and out when shooting the maxilla and down and out when shooting the mandible. This 45 degree tug will expose the second molars.

The patient is usually reclined to about 30 degrees with the photographer shooting from the front of the patient. (If you are shooting with manual focus, use 1:5 magnification.)

We often ask the patient to move his or her tongue behind the mirror when taking the occlusal shots. This often helps to clear the field.

Air is essential to defog the mirror and a bit of indirect lighting from the overhead light will help the camera to lock in focus.

Sounds crazy, but the wide end of the occlusal mirror goes in first, not the small end. (You’d be surprised at what I see at my hands-on seminars.)

Attempt to get the image as close to a perpendicular to the occlusal plane as possible; the bigger the mouth, the easier it is.

If I can’t get a good occlusal shot, I’ll take quadrant shots to make up for this using a smaller mirror.

Finally, realize that mirrored shots taken like this will need to be “mirror-flipped” vertically with image editing software to properly orient the arch prior to presentation.

I hope these tips are helpful. Practice makes perfect.

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Instant Gratification for Denture Patients

About the author

Dr. Martin Goldstein, a member of the International Academy of Dento-Facial Esthetics, practices general dentistry in Wolcott, Conn. Noted as a Dentistry Today C.E. Leader for the last five years, he lectures and writes extensively concerning cosmetics and the integration of digital photography into the general practice. A regular contributing editor for Dentistry Today, he has also authored numerous articles for multiple dental periodicals both in the United States and abroad. He can be contacted at marty924@cox.net. His current speaking schedule can be found at www.drgoldstein speaks.com.
The importance of gingival health in a functional cosmetic case

By Martha Cortes

Complete dentistry is the esthetic and occlusal harmonization of the teeth with the gingiva, lips and face. As dentists, we can directly affect the esthetics of the teeth and gingiva. However, we can also indirectly affect the lips and face by how we design teeth to sit in the oral cavity.

Laser Assisted New Attachment Procedure (LANAP) is the standard of care for periodontal laser therapy and beyond that of conventional treatment, which amputates, leading to roughs that can be less than desirable. LANAP is a patented soft-tissue technique specifically utilizing the Periolase® MVP-7 Nd:YAG (1064 nm wavelength) laser (Millennium Dental Technologies, Inc.) with the aim of regeneration rather than traditional resection of the gum tissue, which is done solely for pocket maintenance.

The patient, a woman in her early 60s, came to my office because she was having problems with a bridge (lower left) that had recently been replaced; she was unable to chew well. During the discussion she revealed that she was also having problems on the lower right, indicating that the problem was not local but one that involved the bite.

On further examination, it was revealed that she not only had occlusal problems, but she also had moderate periodontitis throughout with bone loss especially impacting the lower anterior. The patient had worn away her teeth and, as a result, suffered from severe malocclusion.

She had large diastemas between the upper and lower centrals with little occlusal guidance. Her temporal mandibular joints demonstrated hypermobility while opening and closing. The patient also had ill-fitting porcelain fused to metal crowns on teeth #5–5 and #1, #30, #12, #21 with metal exposure and a new zirconium bridge with flat occlusion on teeth #18–20. All prosthesis had poor color matching and flat occlusion.

The periodontitis and bone loss were partially due to traumatic bite that improperly distributed the occlusal forces laterally rather than perpendicularly so that the loading forces were forcing the lower anterior riors to splay.

In order to inhibit the mechanical progression of the periodontitis and bone loss, and prevent the teeth from splaying further, it was decided to completely restore the teeth to a fully functional platform. The patient was at first intimidated by the idea of a complete smile makeover, and yet she was at the same time ready for this life-changing event. The patient understood that the esthetics would be built functionally so that the occlusion, teeth, arches and periodontium would support each other and thereby help keep the entire oral cavity healthy.

Having a functionally beautiful smile not only affects a patient’s self-esteem, it also has an effect on the health of the head, neck, and body as the patient tends to have better posture and better body integration, because aligned jaws might proprioceptively affect the body in space. Although the patient’s main concern was dental health, the added benefit of gorgeous esthetics appealed to her greatly.

Due to her severe malocclusion, the patient’s habitual centric bite could not be used as the guide for her smile-makeover. The proper functional height for the patient’s teeth needed to be found and established. The patient had ground down her posterior teeth, and many of the forces of mastication were pathologically loading on the lower anteriors, causing them to splay and repetitively injuring the gingiva.

LANAP’s uniqueness allows for the prepping and placing of restorations without having to wait an inordinate amount of time for the gums to heal as the gingiva is not cut and sutured; therefore, healing is quicker and less traumatic and esthetically more pleasing.

The patient was neurromuscularly tested using the K7 Evaluation System (Myotronics) in order to determine where the bite ought to be before restoring. The patient received a fixed orthotic/occlusal device that was worn for approximately six months in order to relax the pathologic forces, arrive at the correct vertical dimension for the patient and gradually retrain the neuromuscular defects. The splint would also help to abate any negative forces affecting the gingiva.

The patient would be restored with an eye toward the correct Shim-bashi measurement and with golden proportion principles in mind. A myocentric position is derived from the orthotic, and the use of a transcusaneous electrical nerve stimulator (TENS) that erases the habitual bite and helps to create healthy neuromuscular conditions, which inhibits its occlusal breakdown.

She was tested again a few months later with the K7 to evaluate the temporal mandibular/neuromuscular complex with the occlusal device determining the health of the new vertical on the entire system. At approximately four months after the mandibular trajectory was found, the upper teeth were ideally leveled with the provisional to correct the maxillary cant by proportioning the anterior canines and canines and harmonizing them with the posterior curve of Wilson.

The patient received LANAP on all quadrants using the Periolase MVP-7 laser for pockets that were between 4–7 mm, approximately three weeks before the orthotic was fixed to the lower arch. Had this been done conventionally, the patient would have needed to wait at least three months or more for the tissue to heal. Dental lasers are site specific, biostimulating, allow for excellent hemostasis.
and are intrinsically antiseptic and bactericidal on contact. The patient received 28 units made of a pressible ceramic (IPS Empress® Esthetic Ivoclar Vivadent). The zirconium bridge was not removed as it was new, in good condition and the occlusion and stability could be added directly on to it by building it up. The patient's vertical dimension was permanently raised with the prosthetics throughout, to compensate for the collapsed occlusion. This altered the facial structure and smile by enhancing how the teeth, lips gums and face work together as a whole. Also, the patient benefited from a healthier oral cavity. Two years later, there is bone regeneration in the lower anteriors (a benefit of LANAP), the pockets have dissapeared and the patient is enjoying occlusal health with esthetic accompaniment.

Dr. Martha Cortes is a graduate from the University of New York at Buffalo School of Dental Medicine. She is the current president of the American Academy of Cosmetic Dentistry New York Chapter, as well as a past president (1994–1996) and past international chair serving consecutive terms, and an accredited member since 1992. An international lecturer and published author, Dr. Cortes has served two consecutive years as co-chair of dentistry with the American Society for Laser Medicine and Surgery and is a recognized member of the American Society of Dental Aesthetics, as well as a diplomat of the American Board of Aesthetic Dentistry and the International Dental Facial Esthetic Society and an LVI fellow. Dr. Cortes is a qualified laser educator and former examiner for laser qualifications for the Academy of Laser Dentistry, and has a mastership in laser technology through the Academy of Laser Dentistry. You may e-mail Dr. Cortes at lazersmile@aol.com.

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COMING SOON FROM DENTSPLY CAULK
Bleeding gums linked to heart disease

By Coral Southard, RDH, MSN

I

t is a testament to the power of tobacco addiction that 20.8 per cent of U.S. adults (about 45 million) are current smokers. In that time, an estimated 42 percent of the American population smoked. However, the current prevalence has not significantly decreased since 2004, demonstrating a stall in the previous seven-year decline.

Unfortunately, the incidence is also higher in powerless populations. Those living below the poverty line are 40 percent more likely to smoke than those living above the poverty line. The most powerless populations — the young, indigent, depressed, uninsured, less educated, blue-collar and minorities — have the highest percentages of smokers in the United States.

Tragically, tobacco use must be considered a pediatric disease with more than 2,000 children and adolescents becoming regular users of tobacco each day in the United States alone. Half of all smokers start prior to the age of 14 and 90 percent begin by age 19. Only 10 percent of smokers initiate the habit as adults.

About 30 percent of patients in any given practice are current smokers. About 70 percent of patients who say they are “interested” in quitting, only 10 percent to 20 percent plan to quit in the next month. About 45 percent of smokers will try to quit in a given year. The majority of smokers try to quit on their own. For most, relapse occurs quickly. Only half succeed for two days and only a third last one week. Relapse often occurs in the first few months.

Overall, “self-quoters” have a success rate of 4 to 6 percent. Most smokers make three to eight quit attempts before finally succeeding. The good news is that half of all smokers eventually quit. There are now as many former smokers as current smokers in the United States.

How the hygienist can help

An important implication of the above statistics is that dental hygienists need to understand the importance of helping the tobacco user.

See Tobacco, Page 3

The RDH’s vital role!

By Coral Southard, RDH, MSN

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See Tobacco, Page 3

Tobacco cessation intervention: The RDH’s vital role!

B

ad teeth, bleeding gums and poor dental hygiene can end up causing heart disease, scientists heard at the Society for General Microbiology’s Autumn meeting held in September at Trinity College in Dublin, Ireland. People with poor dental hygiene and those who don’t brush their teeth regularly end up with bleeding gums, which provide an entry to the bloodstream for up to 700 different types of bacteria found in our mouths. This increases the risk of having a heart attack, according to microbiologists from the University of Bristol and the Royal College of Surgeons in Ireland.

“The mouth is probably the dirtiest place in the human body,” said Dr. Steve Kerrigan from the Royal College of Surgeons in Dublin, Ireland. “If you have an open blood vessel from bleeding gums, bacteria will gain entry to your bloodstream. When bacteria get into the bloodstream, they encounter tiny fragments called platelets that clot blood when you get a cut. By sticking to the platelets, bacteria cause them to clot inside the blood vessel, partially blocking it. This prevents the blood flow back to the heart and we run the risk of suffering a heart attack.”

The only treatment for this type of disease is aggressive antibiotic therapy, but with the increasing problem of multiple drug resistant bacteria, this option is becoming short lived.

 Cardiovascular disease is currently the biggest killer in the western world. Oral bacteria such as Streptococcus gordonii and Streptococcus sanguinis are common infecting agents, and we now recognise that bacterial infections are an independent risk factor for heart diseases,” said Professor Howard Jenkinson from the University of Bristol. “In other words it doesn’t matter how fit, slim or healthy you are, you’re adding to your chances of getting heart disease by having bad teeth.”

Researchers at Bristol have been investigating the ways in which the bacteria interact with platelets in order to develop new and improved therapies.

“Most of the studies that have looked at how bacteria interact with platelets were carried out under conditions that do not resemble those in the human circulatory system. We mimicked the pressure inside the blood vessels and in the heart”, Professor Jenkinson said. “Using this technique we demonstrated that bacteria use different mechanisms to cause platelets to clump together, allowing them to completely encase the bacteria. This shields the bacteria from the cells of our immune systems, which would normally kill bacteria, and most importantly also protects them from antibiotics.”

These findings suggest why antibiotics do not always work in the treatment of infectious heart disease and also highlight the need to develop new drugs to treat this disease. “We are currently in the process of identifying the exact site at which the bacteria stick to the platelets,” said Professor Jenkinson. “Once this is identified, we will design a new drug to prevent this interaction.”

“We also identified several proteins on the bacteria that lead to platelet clumping,” Dr. Kerrigan said. “Genetic deletion of these proteins from the bacteria prevented the platelets from clumping which shows that these proteins play an essential role and may be candidate proteins for new drug development or producing vaccines.”

(Source: Society for General Microbiology)
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.”

During the years I have spent in the dental profession, I have been exposed to a world of endless possibilities. Yet, another opportunity has presented itself. Through the pages of Hygiene Tribune, I am being afforded the ability to touch the minds and hopefully the souls of my dental and dental hygiene colleagues.

I have witnessed time and time again when working with dental teams that dentistry is dentistry and dental hygiene is dental hygiene. Seldom is there a cohesive flow between the two entities. If, however the team is going to deliver the highest quality comprehensive dental care possible, it is imperative the whole team understands and appreciates the contributions of each team player. Once this goal is achieved, then and only then, will the team recognize the endless possibilities they have as a team.

Dental Tribune America has recognized this need and is addressing it by incorporating Hygiene Tribune into their Dental Tribune publications. By combining these publications, the entire dental team will benefit from two publications that are distributed simultaneously for the first time. The hope is that the sharing of this newspaper will open the lines of communication between dentistry and dental hygiene.

As Editor in Chief, I will strive to see that you receive pertinent and credible information from the pages of Hygiene Tribune. I welcome your feedback and will make every effort to address your concerns. It is my hope that operating on this premise will allow all of Hygiene Tribune and Dental Tribune readers to realize the endless possibilities that lie in front of them.

Best Regards,

Angie Stone, RDH, BS
Editor in Chief
through not just one quit attempt, but rather through several attempts! Another implication is that dental hygienists need to prompt and re-prompt tobacco users to make efforts to quit. Offering consistent treatment intervention will not only help smokers who want to quit, but can also motivate ambivalent smokers to at least try to stop.

The Clinical Practice Guideline for Treating Tobacco Use and Dependence published by the United States Department of Health and Human Services is considered the benchmark for cessation techniques and treatment delivery strategies. The updated 2008 guideline reflects the scientific cessation literature published from 1975 to 2007. As the first 1996 publication recommended, the "5 A's" — Ask, Advise, Assess, Assist and Arrange — are still considered key components of comprehensive tobacco cessation counseling.

The American Dental Hygienists’ Association (ADHA) has developed a condensed “user-friendly” model for the dental hygienist who does not have the time, inclination or expertise to provide the more comprehensive tobacco cessation counseling as recommended by the guideline. The “Ask, Advise, Refer.” (AAR) is the ADHA’s national Smoking Cessation Initiative (SCI) designed to promote cessation intervention by dental hygienists. The “Ask, Advise, Refer.” approach integrates the “5 A’s” into an abbreviated intervention that remains consistent with recommended guidelines.

As part of the “Ask, Advise, Refer.” campaign, dental hygienists refer their patients who use tobacco to Quitlines as well as to Web-based and local cessation programs. Dental hygienists can utilize a variety of resources to help their patients quit smoking. The “Ask, Advise, Refer.” program is designed as a program that dental hygienists can easily integrate into their tobacco cessation efforts. See www.askadviserefer.org.

By referring their patients to a Quitline, dental hygienists are incorporating all “5 A’s” (Ask, Advise, Assess, Assist, Arrange) of the Smoking Cessation Clinical Practice Guidelines. Quitlines have proven to be one of the more effective methods of promoting smoking cessation. The United States Department of Health and Human Services has recognized the overwhelming success of Quitlines and is dedicated to providing every citizen in every state with this important tool.

Quitlines are easy to access and free to use. Additionally, tobacco users have had to overcome various barriers in accessing cessation services, including:

- Sporadic availability of programs, both geographically and over time.
- Transportation difficulties.
- Childcare responsibilities.
- Financial cost of participating.

Quitlines reduce these barriers by allowing tobacco users to access service from their own homes at a time that is convenient for them and at no cost. Quitline services have the potential to reach large numbers of tobacco users, including low income, rural, elderly, uninsured and racial/ethnic populations who may not otherwise have access to cessation programs. The main reason Quitlines have proliferated is that there is strong evidence of their efficacy. Dental hygienists are natural partners for Quitlines and can play a major role in increasing their utilization. Dental hygienists who ask all patients whether they use tobacco, advise quitting and refer to Quitlines for comprehensive cessation counseling can have a profound and lasting impact on patient health.

Contact info

Carol Southard, RN, MSN, an American Lung Association certified instructor with more than 20 years of 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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