Help invent the future of informatics in dental care and research

By Titus Schleyer, DMD, PhD

Dentistry is going digital. Computer-based patient records, digital impressions, 3-D models, CAD/CAM, personal dental records, online scheduling and teledentistry are some of the technologies that only recently have seen the light of day. But have you ever wondered how these innovations are created? Where are the people who have these ideas and make them real? How are they trained?

You’d be surprised to hear that innovators are found nearly everywhere in dentistry — in the corporate R&D departments of industry, public and private research institutes, universities and dental practices. Engineers, computer scientists, cognitive and quantitative psychologists, information technology specialists and computer-savvy dentists all contribute to the technological revolution of dentistry. Should you be one of them?

Some of us are quite happy observing the steady stream of new technologies, and picking and choosing what appears useful and usable to us. Others take a more conservative approach and adopt few or none of the newfangled gadgets and technologies. Still others are not happy with just watching the revolution occur — they want to shape it.

It is for these individuals this column is written. We want you! Through our training program in dental informatics (see di.dental.pitt.edu/postgrad.php), we educate tomorrow’s leaders of the technological revolution in dental care and research. The program is targeted at people with bright ideas who want to change the practice of dentistry.

Gaining the expertise and knowledge to help lead the technological revolution in dentistry requires some work. Our program offers a master’s or PhD degree in biomedical informatics with a concentration in dental informatics; a postgraduate program is available (see Table, Page 6). Degree programs are composed of a rigorous didactic component and in-depth research training, beginning in the first semester. Trainees are expected to fully immerse themselves into the science of biomedical informatics, and to present and publish their work frequently.

The University of Pittsburgh Bio-medical Informatics Training Program provides a unique setting — medicine, dentistry, nursing, psychology, computer science, informatics, and environment for future dental informatics researchers. More than 25 core faculty interact with and teach the approximately 35 trainees enrolled at any one time. Trainees are expected to fully immerse themselves into the science of biomedical informatics, and to present and publish their work frequently.

See HELP, Page 6

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

By Joy L. Moeller, RDH, BS, COM

Types of therapy programs offered

I have been practicing orofacial myofunctional therapy for 50 years and have treated thousands of patients. My son had this problem when he was 7 years old and I witnessed the positive change in his teeth, headache pain, and attention deficit disorder (ADD) and temporal mandibular dysfunction (TMD) issues. The dramatic results motivated me to study everything available in OMT. I began a private practice in OMT in addition to my dental hygiene practice in 1978. I love the challenge of helping improve the quality of my patients’ lives. I have five different programs I offer to my patients:

◗ Habit Elimination Therapy
◗ Mini-Myo Program for the young

See CRITICAL, Page 4
Trade news

5 Mo. in Minnesota increased third quarter sales of oral care products 15 percent.

GlaxoSmithKline in the UK agreed to pay $170 million to purchase Biotene for the treatment of dry mouth syndrome oral cancer lesions in California.

Zimmer Holdings in Indiana increased third quarter sales in its dental implant business 5 percent to $52 million.

According to a P&G survey, a third of people in the United States believe that a little gum bleeding is normal when they brush their teeth.

American Dental Supply in Pennsylvania agreed to acquire Leach & Dillon Products in Rhode Island for an undisclosed sum.

Dale Dental in Texas introduced an online case entry Web site for dental labs that automatically prints air bills to ship cases and prints unique PanTrax™ to aid in production planning.

Two investment firms acquired Dental One Inc., a privately owned practice management firm in Texas. Dental One generated annual revenues of $55 million from its approximately 60 dental offices in the south-western United States.

The state of Arkansas is considering opening a new dental school at the University of Arkansas. If approved, this would be the only dental school in the state.

Great Expressions Dental Centers in Michigan purchased Consolident Inc., a dental chain with 41 affiliated practices in Florida and Michigan.

Kettenbach in Germany is launching its line of impression materials in the United States, through its newly formed California subsidiary. The firm will market these products directly to dentists.

Zila Inc. in Arizona engaged the investment-banking firm William Blair & Company in Chicago to shore up the company’s capital structure and further evaluate opportunities for growth.

Researchers at the UCLA School of Dentistry are developing a test to detect oral cancer by measuring protein levels in saliva.

3D4 Technologies Inc. in Texas announced that its E4D Dental system can now make restorations with Ivoclar Vivadent’s high-strength IPS e.max CAD LT material.

Infinity Medical Group Inc. in Canada contracted with Kerry Associates to develop a franchise strategy for its dental implant and cosmetic medical laser clinics.

Nobel Biocare North America in California announced that it is offering dentists who purchase a minimum of 15 dental implants a free Web site with one year of free hosting.

Dr. Jane Grover, vice president of the American Dental Association, testified before the United States Congress urging members to get more dentists to participate in Medicaid for low-income children.

CMP Industries in Alhany, N. Y. reported that its Nobelium/Ticonium division opened a new distribution center in central Florida to serve the southeastern United States.

Internet Dental Alliance in Tibuso, Calif. is now providing its Nine Truths dental office marketing program online.

Turnkey Opportunities Inc. in Exton, Pa. is now marketing the TKO™ Dental Assisting School Program, which allows dentists to use their existing facilities to train assistants and generate significant new revenue.

Dental, medical and other bio-medical sites created more than 1.5 billion pounds [0.68 billion kg] of biomedical waste in 2006.

5 Mo. ESPE donated $45,000 to Oral Health America’s Smiles Across America program.


Bright Now! Dental in California reported that all of its offices in Oregon and Washington state are now offering Luminere veneers at $1,200 per tooth.

Turku University’s Institute for Dentistry in Finland developed a baby pacifier that releases xylitol and probiotics to boost children’s immune systems.

Henry Schein Inc. sponsored its 11th annual Back to School program that provided more than 1,500 children with back to school clothing and supplies.

National Dentex Inc. purchased Dental Art Laboratories in Michigan. This adds more than $7.2 million in additional revenues.

Philips Oral Care launched the Philips Sonicare HealthWhite power toothbrush that can whiten teeth two shades after two weeks of use.

Sales of mouthwash products in the United States increased 4.7 percent last year to $3.54 billion.

BPA WORLDWIDE BUSINESS

Dental Tribune America, LLC
213 West 55th Street, Suite 801
New York, NY 10001
Tel.: (212) 244-7181
Fax: (212) 244-7185

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Dental Tribune is a biweekly publication for dentists. The content includes news, commentary, clinical reports and continuing education. Dental Tribune is distributed to 42 affiliated practices in Florida and Michigan.

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Habit elimination therapy

My program for habit elimination treatment is three to five visits. I work with thumb and finger sucking, nail biting, hair chewing, tongue and lip sucking and/or chewing, and many other oral habits with a 95 percent success rate.

Rosemarie A. Van Norman, an expert in the field of thumb sucking, has determined:

- 60 percent of malocclusion is caused by prolonged digit sucking;
- 10 percent of 6-11 year olds suck their digits;
- 85 percent of digit suckers exhibit an open bite;
- many times, open bites lead to TMD due to lateral movements of the jaw in order to chew food;
- 49.9 percent of orthognathic surgery patients with open bite relapse;
- 50 percent of digit suckers experience atypical root resorption;
- 40 percent of digit suckers have learning and behavior problems in school.

Infants are born with only a sucking skill, which enables them to survive. Usually, at 9 months to 5.5 years, the child starts drinking from a cup and eating more solid foods and transitions from sucking to sucking, which is supposed to be wrong for them. As a dental hygienist, I have learned that the value of pro-active therapy is to minimize behavior modification and positive reinforcement. The patient feels so proud to have ceased the habit once and for all. The success of this program will empower patients to control many choices in their lives that feel good, but that they know is wrong for them. As a dental hygienist, I have learned that the value of pro-active therapy is to minimize or eliminate problems by treating early.

The Mini-Myo Program for the young child

Many times young children can benefit from doing exercises to develop positive growth factors and eliminate negative growth pressures. The young child program has to be fun and fast in order to achieve success. Because the bones are soft, the changes can be remarkably fast. I use a variety of rewards and behavior modification techniques. Parental support at home is essential. The young child program lasts from three to six months and can make a major life enhancing change.

The goals of the Mini-Myo Program include:

- encourage nasal breathing;
- develop a lip seal;
- implement a palatal tongue rest posture;
- encourage bilateral chewing;
- work on proper sleep posture as well as eating posture;
- introduce the “bite, sip, and swallow back” motion;
- keep hands and objects away from the face.

Orofacial Myofunctional Therapy

This is my standard program for those ages 7 to 97. It consists of a yearlong program of therapy exercises for creating proper patterning of the tongue and facial muscles and includes:

a) noxious habit elimination;

b) many different therapy exercises to stretch, tone and develop proper neuromuscular proprioception of the facial muscles;

c) introducing the proper chewing and swallowing patterns;

d) development of proper head and neck posture;

e) habituation of the new patterns.

The first eight weeks of treatment is the intensive period, followed by habituation of the new pattern.

Special needs patients

These patients need an individual program based on their physical limitations, pain factors and ability to cooperate. The treatment plan always needs to be individualized for the best result possible. The goals would be the same as the other programs, but the methods are customized to meet the needs of the patients. The patients really appreciate this help that no other specialty has been able to provide.

Some patients with special needs afflicted with incorrect muscle patterns would present:

- TMD
- Autism
- Cerebral palsy
- Down syndrome
- Attention deficit disorder
- Bells’ palsy
- Orthognathic surgery
- Trauma-induced muscle abnormalities
- Sturge Weber syndrome

Cosmetic muscle toning for facial fitness

With age, orofacial posture changes. There are about 40 facial muscles that work in group function. This allows for facial expression. If the patient presents with chronic non-nutritive facial muscle habit patterns, inadequate orofacial postural patterns, orofacial muscle function patterns or orofacial muscle integration patterns, then the overall cosmetic appearance will be compromised in spite of cosmetic surgery or orthodontics.

Plastic surgery patients are tired of having their face cut, burned, injected, creamed and acid etched only to have gravity pull the muscles down again. The more effective way to achieve desired results would be to develop tone and fitness in the facial muscles by changing muscle patterns, habits and postures by a trained orofacial myofunctional therapist and work with the surgeon and orthodontist both before and after surgery. A personal trainer will tell you that you have to stretch, lift weights and do cardio three to four times a week in order to be fit. Why not exercise your face as well? I feel that this type of treatment will be the way of the future for orofacial myofunctional therapists.

In Brazil, plastic surgeons would not think of doing surgery without having a trained orofacial myofunctional therapist to work with them. The field of cosmetic orthodontics is growing. It is only natural that cosmetic orofacial myofunctional therapy will follow.

Orofacial myofunctional courses and certification

For speech and language pathologists, dental hygienists, physical therapists, registered nurses, and other allied health care profession-
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 IAOM 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.

After taking an approved IAOM course and becoming a member of the IAOM, one can apply to take a written exam and an on-site practical evaluation. The courses are usually five intensive days with a recommendation to follow up with an internship and other courses of study in the field. For more information, check out the IAOM Web site, www.IAOM.com.

Practicing OMT guides patients toward making major life enhancing changes that affect their entire body. After 50 years of practicing and teaching courses in OMT, I view the profession of OMT as a specialty of its own, working parallel with orthodontic treatment, and one that is the critical missing element to complete care.

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.

Joy Moeller will teach a seven-day IAOM-approved course on orofacial myofunctional therapy (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@tongue thrust.com or call (805) 985-6779.

Figs. 3a, b: This 61-year-old female exhibits low muscle tone, digestive disorders, short lingual frenum and anterior tongue thrust. After two months of therapy, patient feels better and her friends are commenting on how much younger she looks. She is now ready to pursue orthodontic and restorative treatment.
Research projects are chosen from a broad range of topics. Most of our research involves clinical informatics and thus is focused on the application of computers in patient care. PhD student Jeannie Irwin is currently working on a grant-funded project to develop a natural language interface to electronic dental records, which will make it possible for dentists to record findings and planned treatment without using complex computer commands. Dr. Humberto Torres-Urquidy is working on reference terminology for dental findings and diagnoses, while Dr. Amit Acharya is developing an information model for patient records in general dentistry.

Other research projects include the design of an electronic dental record centered on the cognitive requirements of clinicians, 3-D visualizations, the development of a virtual community for people interested in dental informatics, and systems to help biomedical researchers find the most appropriate and qualified collaborators.

The program prepares individuals primarily for research and teaching careers in dental informatics; other career options include positions within larger dental care delivery organizations, such as group practices and independent practice associations to support the application of computer technology. Dental software developers, such as dental practice management system vendors, also require the expertise offered by dental informatics specialists.

Trainees come from a wide variety of backgrounds. While some are dentists, that is not a precondition for admission. The mix of individuals from different backgrounds ensures that many different ideas and viewpoints come to bear on solving scientific problems.

For U.S. citizens and permanent residents, financial support from the National Institute of Dental and Craniofacial Research (NIDCR) is available. The NIDCR funds provide a stipend, tuition, fees and health insurance support, travel subsidies, and a state-of-the-art computer. These positions are highly sought after and admission is very competitive. The program also offers a limited number of positions for self-funded trainees. Typically, we have approximately three to five dental informatics trainees in the program at any one time.

We do not know how you decide whether this program is for you? If you like to innovate, be in control of technology (rather than being controlled by it), and would like to contribute to improving dentistry and dental care using technology, this program is for you. You should have good analytical and qualitative abilities. A background in programming and/or information technology is a plus because although informatics is not just about computers, we use them a lot in our day-to-day work. Additional information about the program is available at dti.dental.pitt.edu/postgrad.php. We are currently looking to fill several trainee positions. For any questions, please contact the program director, Dr. Titus Schleyer, at titus@pitt.edu.

The Dental Tribune Symposia at the Greater New York Dental Meeting offer an inspiring schedule of continuing education lectures in various dental disciplines. Each scientific lecture will provide an overview of important advances in a specific area of dental practice.

We have developed a course schedule that is both diverse and engaging, and which also offers you the opportunity to earn C.E. credits. The symposia sessions are FREE for registered Greater N.Y. Dental Meeting attendees, but pre-registration is recommended.

**Schedule**

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<th>Mon., Dec. 1</th>
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<td>10–11 a.m. CEREC CAD/CAM: The Power of Technology in Clinical Restorative Dentistry by Dr. Eugene Antenucci and brought to you by CEREC – Sirona</td>
<td>10:30 a.m.–11:30 a.m. Using 3-D X-ray Imaging and Planning to Increase Patient Treatment Acceptance by Dr. Neal Patel and brought to you by Gallileo – Sirona</td>
<td>10:30 a.m.–11:30 a.m. Details to follow shortly</td>
</tr>
<tr>
<td>1:00–3:00 p.m. Endodontic Irrigation via EndoVac: Safety, Efficacy and Clinical Techniques by Dr. John Schoeffel and brought to you by Discus Dental – Smart Endodontics</td>
<td>1:30–2:30 p.m. Tissue Care in the Maxillary Anterior: Ancylus – A New Paradigm by Dr. David Dijkstra and brought to you by Ankylos – A New Paradigm</td>
<td>1:30–2:30 p.m. Details to follow shortly and brought to you by D4D Technologies</td>
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<td>3–4:00 p.m.</td>
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<td>High resolution Cone Beam with PlanX by Dr. Daniel McClellan and brought to you by PlanX</td>
<td>Minimally Invasive Dentistry in Rapid-Fluor Fashion by Dr. James Jesse and brought to you by Tulsa Dental Specialties</td>
<td>Bone Preservation: One of the Keys to Esthetic Success in Immediate Implant Therapy by Dr. Barry Levin and brought to you by Titan Instruments</td>
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**Program details for Weds., Dec. 3 to follow shortly.**

**Attendee Registration**

Dental Tribune International

Free for registered GNYDM attendees, but pre-registration is recommended. For additional information and registration, please contact: Julia Wehkamp, E-mail: j.wehkamp@dtamerica.com, Tel.: (416) 907-9836.

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**Contact info**

Titus Schleyer, DMD, PhD
Associate Professor & Director Center for Dental Informatics School of Dental Medicine University of Pittsburgh 5501 Terrace Street Pittsburgh, PA 15261

Tel.: (412) 648-8886
Fax: (412) 648-9960
E-mail: titus@pitt.edu
Web site: www.dental.pitt.edu
Certainly, when it comes to the family, the ties that bind can also fray. What is supposed to be a source of strength is often the cause of stress and anxiety. And maintaining family harmony in the face of workplace challenges can be no small undertaking for any business, particularly dental practices. Although everyone may be related, clearly everyone is not alike. Families, as we know, are composed of varying personalities, opinions, styles, problems and issues, all of which may need to be taken into account when trying to simply get along, let alone work together.

The family has a profound impact in shaping our decisions, our values and our culture. It also has a huge effect on the economy at large. In fact, family businesses encompass 80-90 percent of all businesses in North America. In the United States alone, family businesses account for 50 percent of U.S. gross domestic product and 60 percent of all new job creation according to the University of Southern Maine’s Institute for Family-Owned Business. Certainly, the family business is an economic powerhouse, but for those working in the trenches of the “blood-born” unit, it’s the emotional toll that packs the bigger punch.

Family businesses can be very complex, to say the least. And navigating through the potential minefields is no small challenge for many. After all, when it comes to working with family there is a lot to gain — and a lot to lose. In dentistry, family-run practices are common with fathers and sons, husbands and wives, mothers and daughters, sisters and brothers, aunts, uncles, etc. working under the same roof.

Some function very effectively together and, typically, those are the most successful are able to deal with business issues as partners, instead of as husband-wife, father-son, mother-daughter, etc. However, without clearly defined roles and responsibilities and family “issues” can quickly take over.

Family communication and trust are essential. Clearly defined management systems and accountability are absolutely critical. Maybe the practitioner’s spouse has been doing things “that way” since 1999, but asking prospective patients whether they have insurance immediately after arriving indicates that she or he would like to schedule an appointment simply isn’t good for the office — no matter how long she’s been doing it that way.” Perhaps brother Joe, the financial coordinator, is allowing his friends and neighbors to carry balances indefinitely, sending accounts receivables over the top. And Aunt Carol is habitually late. Joe, Carol and yes, even the practitioner’s spouse, must be educated and held accountable for their actions and their results.

The bottom line is: Just because you are the spouse, the sister, the brother, the owner or their brother or their sister, it can be far worse. Too often family members won’t question one another’s decisions or actions. They won’t address problems. They refuse to buck the status quo and push for necessary change because they are afraid to start an argument within the family. Families that attempt to dodge conflict open the door for much bigger problems because the issues only grow and fester. And if family members won’t confront family members, where does that leave the rest of the staff? Most likely searching for employment elsewhere.

Then there’s the issue of control. Countless dentists or their spouses are running dental offices but don’t understand what it takes to manage the business side of a practice. They are incapable of reading and understanding practice reports and business statements. They don’t comprehend the impact of overhead or how something so seemingly innocuous as a little pay raise can cause salaries to spiral off the charts. Yet because they “own the practice” they make decisions based on what they think is right that affect their own long-term financial health as well as the fiscal health of the practice.

For the lucky ones, the family members settle into their roles and are able to understand and compensate for each other’s strengths and weaknesses. You may have one family member who is more technology oriented and handles those aspects of the practice. Another may be the human resources “guru” and still another who is the recognized “financial expert.” If the individuals take responsibility for their jobs and the rest of the family can let them do their jobs, these informal arrangements become formal without the practice ever having to spell them out. What typically makes these situations work, however, is that the family members all have the same philosophy of care and business. However, the success of such informal arrangements can be rare.

Structural guidelines

Most successful business arrangements require a more formal organization. Dental practices are no different. There needs to be a clear designation of exactly who is responsible for what and what the family wants to get out of the practice.

Do you want it to grow? Do you want to keep it where it is? What’s more important to you, giving up some control and growing or keeping control and staying where you are? What’s your vision of the practice? What if it’s different than your spouse’s or your brother’s or your dad’s? Whose vision gets priority? What steps will the practice take to achieve that vision and those goals? Who will be responsible for which areas? How will the practice measure its success? It’s those issues — where you want to take the practice — that require open and honest communication, but can cause significant friction. Yet all players in the family practice must be on the same page. If not, it’s grounds for a family meeting, probably several.

Ultimately, there may be those on the “family” team that would rather strike out on their own. In some cases, that is the best alternative. Maybe Chuck the dad and Brian the son work well together in their general practice, but Dave the brother and periodontist, wants his own office, separate and away from dad and his brother. Although it may be hard to reject the family, doing so early on will be much easier for

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everyone, and Dave will be far less likely to feel that he sacrificed his own vision and goals for the sake of “the family practice.”

In other cases, family members are in the wrong jobs and would be much more effective in another position. For example, Ellen the wife is working as the office manager but would make a much better financial coordinator. The dentist must have the courage to make the change and Ellen must have the courage to accept it, a tall order for both. And oftentimes, it’s necessary to bring in outside help to navigate the players through the process of developing job descriptions and identifying who will work best in which positions. The fact is that family members are simply too close to the issue — literally.

**Things to consider**

Certainly, there are those families that sincerely enjoy working together and are successful in doing so. But it’s not for everyone. Before you decide to partner with your spouse, sister, brother, mother, father, uncle, cousin or whomever, evaluate the decision carefully. We all have family members whose company we enjoy, but we wouldn’t necessarily want to spend 40 hours a week with them. We’ve all made excuses for that eccentric relative who made a poor financial or professional decision here or there, but we wouldn’t want to have to do it on a regular basis, no matter how good hearted he is or hard working she is. Consider whether this arrangement is consistent with your personal practice philosophy of care and business management approach. Carefully evaluate whether you will have the opportunity to grow as a professional and fulfill your personal goals. Is this the career move you’ve dreamed of or dreaded? Will you be given the opportunity to use your strengths in making a contribution or pigeonholed into a particular role? If you believe you can contribute your expertise, abilities and know-how to the practice, your chances of success increase exponentially. They decrease significantly, however, if you make the move because of family pressure or a sense of entitlement.

Realistically consider if you can work with your family. Being honest with yourself from the beginning will potentially save you years of frustration and discontent. Remember, a “good son,” “good daughter,” or “supportive spouse” is far different from being an effective business partner. It will take courage to raise issues that may put you at odds with your family. And serious problems can arise if communication is weak or if the relationships in general tend to be strained. Be sure that you are emotionally and economically prepared to leave if frustrations become too great.

Certainly, for some, working with your spouse, mom, dad, brother, sister, etc. can feel more like a life sentence than the opportunity of a lifetime. However, for many who choose this road it can and does work if the systems are in place, the roles are clearly defined and communication is open. And if, most importantly, everyone understands that when it comes to the family practice, it’s business first and family second.

**About the author**

Sally McKenzie, certified management consultant, is a nationally known lecturer and author. She is CEO of McKenzie Management, which provides highly successful and proven management services to dentistry, and has since 1980. McKenzie Management offers a full line of educational and management products, which are available on its Web site, www.mckenziemgmt.com. In addition, the company offers a vast array of Practice Enrichment Programs and team training. McKenzie is the editor of the e-Management newsletter and The Dentist’s Network newsletter sent complimentary to practices nationwide. To subscribe visit www.mckenziemgmt.com and www.thedentistsnetwork.net. McKenzie welcomes specific practice questions and can be reached toll free at (877) 777-6151 or at sallymck@mckenziemgmt.com.

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Cone beam computed tomography (CBCT) offers a whole new paradigm to dental radiography. From what were conventional 2-D images, dentists now have the ability to look at the maxillofacial region in any direction, and at any thickness, as well as in 3-D. With the introduction of CBCT the specialist and general dentist alike can now afford to own and enjoy the benefits of this fantastic diagnostic tool. This symposium will cover the basics of CBCT, field of view (FOV), focal spot, flat panel types, processing time and gray scale, and how these affect resolution and image quality. PreXion 3-D high resolution images will be discussed and time spent with real scans showing how these images can be used in planning periodontal treatment, implants, oral surgery, complex endodontic diagnosis, and treatment planning for the general dentist.


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CEREC CAD/CAM: The power of technology in clinical restorative dentistry

Join your colleagues for Dr. Antenucci’s lecture at the Dental Tribune Symposia during the Greater N.Y. Dental Meeting at 10 a.m.–1 p.m. on Nov. 30.

CAD/CAM technology has revolutionized the practice of dentistry with enormous implications for the delivery of patient care that is timely, comfortable, long lasting, beautiful and economical. This presentation is designed to provide not only an overview of the role of CAD/CAM and CEREC in clinical dentistry today, but also provide attendees with practical clinical information on how CEREC 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 CAD/CAM technology in achieving outstanding results.

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

Catch Dr. DiGalloreno’s lecture at the Dental Tribune Symposia during the Greater N.Y. Dental Meeting at 1:30–2:30 p.m. on Dec. 1.

This lecture will provide a systemic, biologic and evidence-based approach to ensure success in the class 1 to class 4 case utilizing the “Tissue Care Concept by Ankylos,” PRGF, lasers and piezo surgery. Learn about:

- Diagnosis of patient biotypes and its affect on treatment decisions.
- Immediate or staged?
- Surgical management: incisions, atraumatic extraction, periodontal plastics, bone grafting (PRGF), overcorrection, site preparation, and 3-D implant placement.
- Prosthetic management: abutment selection, provisionalization, restorative materials and methods.

Endodontic irrigation via EndoVac: safety, efficacy and clinical techniques

Don’t miss Dr. Schoeffel’s lecture at the Dental Tribune Symposia during the Greater N.Y. Dental Meeting at 1:30–2:30 p.m. on Nov. 30.

Although seemingly simple, 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:

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

For more information and registration, please contact Julia Wehkamp: j.wehkamp@dtamerica.com.
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The information on many of the forms in a dental office is best collected using pen and paper: new patient forms in a dental office is best collected Xpaper PDF is a must! Safe, secure and easily retrieved, then sure the information in your charts is "chartless" or you just want to be practice. If your goal is to become and documents within your dental technology will increase your efficiency in handling a wide variety of forms record. Xpaper PDF and “digital pen”

Magnified Video Dentistry partners with Swiss Optics manufacturer

M magnified Video Dentistry, Inc., the manufacturer of the MagnaVu PS2, the leading dental procedure scope in the nation, announced that it has formed an international cooperative partnership with Swiss Medical Technologies GmbH (SMT), a Swiss-based optics design and manufacturing company. SMT is widely regarded as a world leader in advanced imaging optics and 3-D processing technology and solutions.

The original MagnaVu Dental Procedure Scope started a revolution in dentistry. Dentists and magnification back in 2004. The latest, fourth-generation PS2 (procedure scope 2) was designed to make your job easier by enhancing the way you currently do dentistry, and not changing it. Through increased magnification (up to 24x) and bright white LED lighting, you are able to see and perform better dentistry, and feel better by reducing strain and fatigue. By providing the same image and orientation that you currently view, the MagnaVu PS2 is extremely easy to use and transition into.

The MagnaVu is also easy to incorporate and available through most major dental dealers. They simply remove your current operatory light and install the MagnaVu in the place of your exam light. The PS2 features a built-in video freeze-frame for patient communication and has multiple video outputs for various video displays, computers or DVD recorders. It eliminates the need for most dental cameras, scopes, loupes and exam lights.

The joint cooperation between MVD and SMT allows both companies to increase funding for research and development, and create a strong global presence by jointly sharing the many U.S. and international patents already filed. For additional information, please call (877) 556-6587 or visit www.magnaVu.com.

Supporting Comments for the New Extraction Forceps

I have never looked forward to doing extractions in my practice. It can take just a few minutes or more than half an hour if I hear that dreaded ‘cracking’ sound indicating I have broken a crown or a root. Since using the Physics Forceps that sound is a thing of the past. These new forceps don’t rely on brute force, but rather, use the simple concept of leverage. Instead of grasping, pushing, twisting and pulling the clinical crown, this technique employs a slow, steady rotational force that literally rolls the tooth free from the PDL. Selecting new innovations come along that truly revolutionize the way a dentist approaches a service – this is one!

Faster, easier and better - these are the three magic attributes that I look for whenever I evaluate new products. The GoldenMisch Physics Forceps are by far one of the greatest advancements I have seen in exodontia in my 28 year career. Using these unique instruments greatly reduces buccal bone loss during the extraction, making implant support and esthetic success much more predictable. The amount of time, effort and frustration saved is incredible, especially with challenging teeth. The Physics Forceps are an absolute must for every dental practice and I highly recommend them in my lectures.
Nobody cares for your money like you and RG Capital

Robert Graham, founder and owner of RG Capital, had a vision: to create an atmosphere where businesses and individuals would be able to prosper in the financial arena. To date, the company has distinguished itself as one that also specializes in working with dentists and dental specialists. As such, the company has worked with practice management firms for four and a half years and been an official Levin Group Alliance Partner for the last two and a half years.

Founded in May 2004 in Scottsdale, Ariz., RG Capital has a team of 10 advisors. These advisors, Graham included, provide wealth management services with the goal of focusing not only on the process of wealth accumulation, but also informing and educating clients about every step used to reach that goal.

This relatively young company now boasts a management portfolio of more than $450 million and numbers some 1,800 clients spread throughout 50 states. Graham attributes RG Capital’s most recent success to its growing client base within the dental industry. Although it specializes in advising dental professionals, its clients range across a broad spectrum — from professional athletes, such as star defense Adrian Wilson of the Arizona Cardinals, to large corporations and middle-income individuals and families.

RG Capital’s clients benefit from working with a company that maintains the variety of resources one would generally expect from a very large institution. The first step in the company’s personalized service entails identifying a client’s visions and goals. Once the RG Capital advisor understands the client’s visions and goals, the advisor will implement the best strategies, tactics and tools to help accomplish the best possible outcome.

Dental clients experience the RG Capital SmartPlan approach. The RG SmartPlan centers on tax avoidance strategies, practice tax savings, income tax savings, efficient investing, investment cost efficiency, accumulation strategies, estate planning and asset protection. This holistic approach has given rise to RG Capital’s rapid growth within dentistry. RG Capital was ranked No. 5 within the Top Ten Fastest Growing Advisory Firms.

Probably the most important factor that ensured the company’s strong success is that from the outset it attracted a highly experienced group of financial professionals who decided to leave much larger companies due to various mergers and acquisitions. In addition, these advisors shoulder all the responsibility for their individual clients. The advisors’ complete responsibility means that there is no “investment big brother” looking over their shoulders and demanding that they push proprietary products that are in the best interests of the company, but not necessarily so for the client.

RG Capital’s independent and open architectural structure allows its advisors to take a client-centered, process-driven approach. The client-centered approach centers on what the client defines as the “best possible outcome.”

“Our investment strategy is based on the values, vision and client’s personal goals; it is what drives our actions. This is in contrast to the cookie-cutter investment approach taught today that categorizes clients’ investment approach based solely on their age,” said President and CEO Robert Graham. Whether one has vast sums to work with or a more modest amount, the key to wealth management is to differentiate between what you want and what you need.

When seeking out a financial advisor to help you down that path, you want one that places accountability and a willingness to educate you about the options offered. Graham values strong customer relationships so highly that he was dissatisfied with the customer relationship management systems on the market. So he created his own that now forms the backbone of iNation, a company for which Graham is recognized as the founder.

The atmosphere RG Capital creates for its clients is one of simplification, accountability and reliability. The company’s personalized service includes well thought out timelines for goal achievement and regular reviews to assess progress and make any adjustments in goals.

Whether you own your practice or not, planning your wealth management strategy can be a daunting task. RG Capital has the unique experience and insight you can rely on to help guide you down the path of wealth management that allows you to achieve your short-term and long-term goals.

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Financial advice geared toward dentists at the Greater New York Dental Meeting!

Join RG Capital at the Dental Tribune America Symposium from 1:30–3:30 p.m. on Dec. 5. Robert Graham will discuss efficient investing, investment cost efficiency, accumulation strategies, estate planning and asset protection, and many more topics of specific interest to dentists today.

The lecture is free to all CNYDM visitors, but pre-registration is recommended for guaranteed seating. For more information and registration please contact Julia Wehkamp at j.wehkamp@dtamerica.com.

Tell us what you think!

Do you have general comments or criticism you would like to share? Is there a particular topic you would like to see more articles about? Let us know by e-mailing us at feedback@dtamerica.com. If you would like to make any change to your subscription (name, address or to opt out) please send us an e-mail at database@dtamerica.com and be sure to include which publication you are referring to. Also, please note that subscription changes can take up to 6 weeks to process.
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For years dental offices have sent patients seeking higher dollar procedures to third-party companies for financing. While this solution provides an option for patients that could otherwise not afford treatment, it presents several challenges.

Challenges presented when using third-party financing

▷ Third-party finance companies charge as much as 10 percent to the practice. These high fees result in lower profit margins and have left many dentists unwilling to accept anything other than cash up-front for treatment.

If it sounds too good to be true, it probably is! Third-party finance companies offer attractive “same as cash” or “no interest” options to patients. While these sound like great deals, one late payment will result in retroactive interest charges as high as 24.99 percent. This scenario can leave patients with ill feelings toward the practice. A national business magazine recently featured a dental practice in its cover-story article on patient financing and its negative impact on patients.

▷ A growing number of patients may not qualify for third-party financing. Historically, when our nation enters a downturn in its economy, lenders tighten credit criteria resulting in more credit declinations. Dental practices will likely feel the crunch in the form of lower case acceptance as patients struggle to come up with cash before treatment. Answering this challenge requires a solution that will help the patient pay over time while minimizing the potential risk to the practice and increasing profit margins.

It’s time for a paradigm shift

Dental practices have avoided office payment plans for two reasons:

▷ Fear of non-payment.
▷ A lack of staff resources for billing and payment collection.

Resolving these two objections allows a practice to have an office payment plan that answers patients’ needs and provides a new revenue stream to the practice.

Let’s first answer the problem of credit risk. Many consumers cannot afford to pay treatment costs up front, but can comfortably afford payments over time. The trick is to separate which patients can afford and maintain monthly payments from those who are potential collection problems. A practice can solve this quandary by using a credit report with a scoring model to separate patients by risk level.

When exploring avenues for purchasing credit reports, be sure to ask for help deciphering scores or, better yet, a system that will automatically separate the candidates into risk categories. You will also need to assess the cost to the practice by asking if there are annual fees or monthly minimum charges. Once a practice has a good credit evaluation mechanism in place, an office payment plan will not seem so daunting.

Now let’s explore options for an office payment plan. By offering patients the ability to pay over time, a practice opens up new opportunities for case acceptance. Based on credit levels, an office may choose to stretch payment plans over six, 12 or even 24 months to offer a solution that makes costly treatment affordable to a greater number of people. But how much extra work will this create for the staff and how does a doctor know that the staff will stay on top of the collection process?

Many companies are now using automatic drafting to insure payments are received on time every month. These auto-debits can be set up through various software packages or can be outsourced to a payment drafting or payment management company. These options require varying degrees of hands-on staff time. The goal should be to find a solution that requires minimal employee time so they are not burdened with the payment process.

Increase case acceptance and profitability!

With a little research and a shift in thinking, a practice can become much more profitable by putting more patients on the books without losing up to 10 percent of the treatment fee to third-party finance companies. Since the nation’s credit crisis has made it more difficult for consumers to receive financing, this could be the solution to maintaining or growing the level of business for the practice during a time that many businesses are suffering. By assessing risk and keeping management costs low, a practice can offer an office payment plan that is a win-win solution for the patient and the dentist.

Marla Merritt is the director of sales and marketing of DentalBanc, a payment management solutions provider. She can be contacted at (888) 738-0584, ext. 8304 or by e-mail at mmerritt@orthobanc.com.
Crosstex®, the leading global manufacturer of infection control and preventative products, is proud to help support the fight against women’s cancers with its new ‘Pink with a Purpose’ program that launched in August. Now, when dental professionals purchase Crosstex Pink products, a portion of the proceeds will go toward funding breast and reproductive cancer research at Memorial Sloan-Kettering Cancer Center.

“Crosstex has always been interested in helping advance breast and reproductive cancer research, raise awareness and build hope for future generations. This year we’ve decided to be more aggressive and add our voice to help strengthen the cause. This has meant mobilizing every facet of our company, from manufacturing to sales and distribution, and engaging the support of thousands of dental professionals who use our products,” states Andrew Whitehead, VP of sales and marketing for Crosstex.

In creating this program, Crosstex has produced dozens of its products in pink — offering a broad selection while heightening breast and reproductive cancer awareness. Clinicians can select from face masks, skin care lotions, Premium® Saliva Ejectors and Patient’s Choice® products such as GumNumb™ Topical Anesthetic, Sparkle™ Prophy Pastes and Zap® Fluorides, to name just a few — all proudly displayed in pink. Several new products were specifically designed for this effort including the Pink with a Purpose Sterilization Pouch and the Pink with a Purpose Econoback® Towel.

“The Pink with a Purpose program transforms ordinary dental products into statements about compassion and support,” states Whitehead. He continues, “Seeing these pink products also makes patients aware that their dental office supports the cause.” Crosstex will also offer promotional incentives to reward dental offices purchasing specified quantities of pink items.

For more information on the Crosstex “Pink with a Purpose” program and other Crosstex products, please call Crosstex International at (888) 276-7785 (toll free), (631) 582-6777 or visit www.crosstex.com.

Crosstex launches ‘Pink with a Purpose’ to help support women’s cancer initiatives

Patients: quality or quantity?

By Heather Victorn

If you agree that the key to attracting new patients comes from combining targeted marketing, professional referrals and services that appeal to your patient-base, you already know that a successful practice needs a balance of both quality and quantity.

Think about it. You could see 10 people for single amalgams or one for a full-mouth restoration. For your practice to succeed, you need

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FREE OFFER!

See PATIENTS, Page 16

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Improving the number of high-value patients can greatly benefit the productivity and profitability of your office. Dentists offering oral sedation dentistry are attracting more of these types of people each day — those who require extensive crown, bridge, cosmetic and implant work.

Oral sedation dentistry has become one of the most effective and appealing treatment options for bringing in new high-value patients, such as the 50 percent of the U.S. population that is too afraid of the dentist to otherwise seek care and the 15 percent of the population that suffers from belonephobia — a fear of needles. These people have often avoided the dentist for years, sometimes even decades, and need comprehensive care. Sedation is also an attractive option for those with time constraints who need to have more dentistry performed in a single visit.

Sedation practitioner Steve Smith, DDS, who received his training from the Dental Organization for Conscious Sedation (DOCS), recently stated that sedation has been the key to his practice success.

"Sedation has given me incredible satisfaction in helping others go to the dentist who ordinarily could not sit through a visit. Sedation has set my practice apart."

DOCS Fellow David Penwell, DDS, agrees. "I enjoy sedation because I can sit down and restore patients in one or two longer, more complex appointments rather than a bunch of little ones."

Sedation patients who have positive experiences regularly refer friends, family and colleagues, helping sustain the flow of quality and quantity to your practice. They regularly pay the cost of their care in advance and are more willing to complete full treatment plans. It is a win-win for both you and them.

To learn more about oral sedation dentistry or DOCS, visit DOCSeduca
tion.org or call (877) 323-3627.

PATIENTS
From Page 15

a mixture of both.

In less than four years, Town & Country Dental Studios has restored more than 9,500 Atlantis CAD/CAM abutments using its “SIMPL,” Simplified Implant Restoration Protocol®. With SIMPL®, practitioners are able to restore more implant cases with a predictable, clinically superior result and a success rate of more than 99 percent.

Town & Country Dental Studios created SIMPL to answer practitioners’ requests for a simplified process for restoring implants. SIMPL utilizes Atlantis CAD/CAM abutments for greater accuracy and a better result. SIMPL also eliminates the need for implant parts, makes cases easy to estimate, and provides the ability to restore cases in as little as two 15-minute restorative appointments.

With SIMPL, practitioners report saving money over gold custom-cast implant abutments, and saving time over modified stock abutments. This protocol works with most implant fixtures, comes with a full warranty, and practitioners say they now have the confidence to restore any implant case.

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Mention the “kit and caboodle ad” when you order for some extra kit!
Esthetic inlays and onlays: the coming of age

By Ronald D. Jackson, DDS, FAGD, FAACD

There are many prominent teaching clinicians who feel that inlays and onlays (of whatever color) are a grossly underutilized restoration, and that crowns are an overutilized one. I think it is worthwhile to examine some of the possible reasons for this unfortunate situation (for our patients’ sake) and see if the reasons for dentists’ reluctance to incorporate these restorations into their routine services are really valid today.

Reason No. 1: Large amalgam fillings are easier and more affordable than inlays and onlays.

Both terms — easier, affordable — are relative. Whether something is easy or not in dentistry depends on your training and how often you’ve done it. Our first amalgam filling or crown in dental school wasn’t easy either. As for affordable, isn’t that for the patient to decide? People generally buy what they want or what they perceive is in their best interest.

Reason No. 2: It’s just easier to do a crown than an onlay.

Same response as above. However, I will agree that when doing a crown, the clinician isn’t faced with the decision of which cusps to keep and which to remove — you just unthinkingly remove them all. But as practitioners, we have to ask, are we deserving of patients’ trust and their money by only recommending that which we perceive (possibly because of lack of training or practice) as expedient?

Reason No. 3: Inlays and onlays are expensive.

Not anymore than crowns or root canals! We have no trouble recommending these services when they are indicated. Maybe it would be easier for dentists to accept and recommend these restorations if an onlay (gold or tooth colored) was referred to, and thought of, as a partial crown and carried the same fee as a crown.

Reason No. 4: Crows last longer and are more predictable.

Although longevity is important and ingrained in the dental psyche, it is not the only criteria of value. In the age of adhesive dentistry, respecting remaining tooth structure and esthetics have become components of value as well. Keeping in mind that patients are living longer and want and expect to keep their teeth for a lifetime (something we tell them can be done) means, in most instances, it is best to recommend a crown only when it’s truly indicated.

The name of the game in dentistry today is “bank the tooth structure” for future use. Regarding durability, esthetic inlays and onlays are not new anymore. They have a track record, and it is good.** With today’s materials, longevity is mainly a matter of diagnosis, correct treatment planning and proper execution of technique (Figs. 1–4).

Although not esthetic, well-done gold inlays and onlays are considered to have a proven durability and longevity similar to crowns. If esthetics is not an issue, gold is still the standard and what I always recommend for second molars when a conservative indirect restoration is indicated. However, it’s interesting to note the number of people and the types of people who still desire tooth-colored or non-metal restorations even in these teeth.

Reason No. 5: Posterior direct resin restorations are less costly to the patient and can be completed in one appointment.

It is a fact that more and more patients today are selecting tooth-colored restorations for their posterior teeth,† and there is no question that well-placed Class I and Class II direct resin restorations are proving to be viable alternatives to amalgam.‡ However, the indications for these restorations do have limits.

Generally, when the cavity is large or the tooth is under excessive functional demand (heavy bruxer or clencher), indirect restorations (resin or ceramic) are indicated. Certainly, when a cusp is missing, many clinicians feel the standard of care is best satisfied by an indirect restoration (Figs. 5–10). After all, there is no question that a laboratory technician working with mounted models at the bench is going to provide a more accurate occlusal morphology, contact and overall contour as well as properly located functional stops of the right intensity than we can by grinding all the blue spots in the mouth. It’s also very difficult to achieve quality contacts in large restorations with poor tooth alignment or spacing.

No matter how good the direct resin materials get, the above situations will usually be better served by indirect restorations in the same way that gold inlays/onlays are considered superior to large amalgams, especially those that replace cusps.

Reason No. 6: Many third-party payment plans don’t pay benefits for esthetic inlays and onlays, but most pay a benefit toward porcelain-fused-to-metal crowns.

In a health care profession, it shouldn’t be necessary to even respond to such a statement, but I will. If a properly informed patient See ESTHETIC, Page 2
would rather sacrifice healthy tooth structure to save a few dollars or for a perceived greater longevity, well, that’s his or her choice. It may be what that patient feels is best for himself or herself at that time. The operative words, however, are “properly informed” (pros vs. cons) and “his or her choice.” We shouldn’t make the choice for a patient based on an assumption that all patients want the cheapest option or what their insurance will partially pay for.

In conclusion, for many dental practices, offering only low-cost (at least initially), large fillings or expeditious crowns where they may not be the best our profession has to offer, is questionable and shortsighted. The bottom line in dentistry today, as it always has been, is to recommend treatment, which according to the clinician’s professional judgment, is in the patients’ best interest. This is usually what the clinician would select if he or she were the patient. The patients may not always want that particular service and decline to have it done, but they always deserve the choice.

The trend in dentistry is clearly toward more aesthetic and less invasive. Indirect resin and ceramic inlays and onlays are not only compatible with this trend, but fulfill very nicely the restorative void between fillings and crowns.

**Literature**


**Fig. 7:** Molars with failing restorations and recurrent decay.

**Fig. 8:** Both distal cusp of the first molar was onlayed due to a horizontal crack in the middle of the pulp floor that stopped halfway across. The distal buccal cusp of the second molar was onlayed due to a crack in the pulp floor at the base of the cusp.

**Fig. 9:** This 44-year-old patient was pleased that crowns could be avoided and no sound healthy tooth structure was unnecessarily removed.

**Fig. 10:** Indirect resin composite onlays at four years. Note contacts and marginal integrity at gingival margin as seen on the radiograph.

**About the author**

Dr. Ron Jackson has published many articles on aesthetic and adhesive dentistry and has lectured extensively across the United States and abroad. He has presented at all the major U.S. scientific conferences. Jackson is a fellow in the American Academy of Cosmetic Dentistry, a fellow in the Academy of General Dentistry and is director of the Advanced Adhesive Aesthetic Dentistry and Anterior Direct Resin programs at the Las Vegas Institute for Advanced Dental Studies. Jackson maintains a private practice in Middleburg, Va. emphasizing comprehensive restorative and cosmetic dentistry.
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A reason to smile: New immigrants respond best to oral hygiene campaign

Tobacco cessation intervention: pharmacotherapy

By Carol Southard, RN, MSN

An updated clinical practice guideline released by the United States Public Health Service on May 7, 2008, identified new medication treatments that are effective for helping people to quit smoking. No matter the level of addiction, anyone attempting to quit should consider trying at least one or more of the effective pharmacotherapies.

The goal of cessation pharmacotherapy is to alleviate or diminish the symptoms of withdrawal. The more physically comfortable the smoker is, the more likely he or she will make a serious quit attempt and succeed in permanently quitting.

Assessing pharmacotherapy’s application

Tobacco use is a complex behavior involving the interplay of physiological, psychological and habitual factors that continuously reinforce one another to promote dependence. One way to determine if pharmacotherapy would be helpful is to determine the level of physical addiction. Two hallmarks of dependency include smoking within 30 minutes of arising from sleep and experiencing withdrawal symptoms if a regular pattern of use is disrupted.

The cardinal withdrawal symptoms include a craving for nicotine, irritability, anxiety, fatigue, difficulty concentrating and restlessness.

Approved medications

Currently, the FDA-approved, first-line agents for smoking cessation include five nicotine replacement therapy (NRT) products and two non-nicotine medications. All of these medications were found to be effective first-line medications in the guideline’s meta-analyses. There is no question that the odds of a smoker quitting are increased by using a pharmacological treatment.

In addition, multiple combinations of medications were shown to be effective. For the first time, the 2008 clinical practice guideline update assessed the relative effectiveness of cessation medications. These comparisons showed that two forms of pharmacotherapy, varenicline (Chantix) used alone and the combination of a long-term nicotine patch plus ad lib (i.e., as needed) nicotine nasal spray or gum, produced significantly higher long-term quit rates than did the patch by itself.

This is “off label” use but now it is definitely medically sanctioned. (I have been encouraging my own clients to use multiple NRT products for years!)

Several quitlines distribute over-the-counter nicotine replacement therapy to callers. The use of accepted cessation pharmacotherapy at least doubles the odds of quitting. Adding psychosocial therapy increases quit rates. However, unlike with other drug dependencies, concomitant psychosocial therapy is not mandatory for cessation medication use.

There are five nicotine replacement therapy (NRT) products on the market in the United States. The nicotine gum first appeared in 1984 and the nicotine patch was made available in 1997.

Several prescriptions, in addition to their over-the-counter counterparts, are available primarily through quitlines. Several nicotine replacement therapies include nicotine gum, nicotine nasal spray, nicotine inhaler, nicotine patch, and nicotine lozenge.

The authors hope that their research will encourage smokers to use pharmacotherapy to help them quit.

A reason to smile: New immigrants respond best to oral hygiene campaign

Several factors that continuously reinforce one another to promote dependence. One way to determine if pharmacotherapy would be helpful is to determine the level of physical addiction. Two hallmarks of dependency include smoking within 30 minutes of arising from sleep and experiencing withdrawal symptoms if a regular pattern of use is disrupted.

The cardinal withdrawal symptoms include a craving for nicotine, irritability, anxiety, fatigue, difficulty concentrating and restlessness.

Approved medications

Currently, the FDA-approved, first-line agents for smoking cessation include five nicotine replacement therapy (NRT) products and two non-nicotine medications. All of these medications were found to be effective first-line medications in the guideline’s meta-analyses. There is no question that the odds of a smoker quitting are increased by using a pharmacological treatment.

In addition, multiple combinations of medications were shown to be effective. For the first time, the 2008 clinical practice guideline update assessed the relative effectiveness of cessation medications. These comparisons showed that two forms of pharmacotherapy, varenicline (Chantix) used alone and the combination of a long-term nicotine patch plus ad lib (i.e., as needed) nicotine nasal spray or gum, produced significantly higher long-term quit rates than did the patch by itself.

This is “off label” use but now it is definitely medically sanctioned. (I have been encouraging my own clients to use multiple NRT products for years!)

Several quitlines distribute over-the-counter nicotine replacement therapy to callers. The use of accepted cessation pharmacotherapy at least doubles the odds of quitting. Adding psychosocial therapy increases quit rates. However, unlike with other drug dependencies, concomitant psychosocial therapy is not mandatory for cessation medication use.

There are five nicotine replacement therapy (NRT) products on the market in the United States. The nicotine gum first appeared in 1984 and the nicotine patch was made available in 1997.

Several prescriptions, in addition to their over-the-counter counterparts, are available primarily through quitlines. Several nicotine replacement therapies include nicotine gum, nicotine nasal spray, nicotine inhaler, nicotine patch, and nicotine lozenge.

The authors hope that their research will encourage smokers to use pharmacotherapy to help them quit.

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Dear Readers,

Ever time we turn around these days we can’t help but hear about the state of the economy. It is affecting most everything currently, including dentistry. While people are trying to spend less money on things they don’t think are necessary, dental needs may be put off. Some patients view dental care as a luxury and not as an essential piece necessary to complete the puzzle of overall health. This train of thought leads to cancelled appointments and lost revenue for the dental office. So short of dragging patients in off the streets, what can the dental team do to help patients realize that preventive dentistry is necessary? Education is paramount!

At each professional cleaning and dental check-up appointment, clinicians need to be reiterating the connections between oral health and overall health. Patients need to be taught that bleeding gums are not healthy and may be a sign of much larger problems. Co-diagnosis needs to be taking place with each patient that sits in the dental chair.

Patients understand what they are being told much better if they can see the issue. Who is able to believe there isn’t a problem if they see the issue with their own eyes? If patients understand why they need to return to the office, they are more likely to place the visit on the necessary list than the luxury list.

It is time to pull out all the stops so dental offices remain productive through these shaky times. Educate, educate, educate! This is no time to be chatting and polishing.

If you have any comments or suggestions on this topic, please feel free to let us know!

Best Regards,

Angie Stone, RDH, BS
Editor in Chief

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**UPCOMING EVENT**

‘Train the Trainer’ workshop on infection control

The United States Air Force (USAF) and the Organization for Safety & Asepsis Procedures (OSAP) will hold their 2009 Federal Dental Services Infection Control Training Course from Jan. 12–15, 2009 at the Crowne Plaza Atlanta-Bavinia Hotel in Atlanta. This four-day “Train the Trainer” course is recommended for everyone responsible for their dental facility’s infection control and safety program.

The Federal Dental Services Infection Control Training Course offers a way for dental professionals to verify competency in dental infection control and safety principles. The program will provide the latest information on the implementation and management of effective infection control and occupational health and safety programs for dental settings, emphasizing the infectious diseases and occupational risks associated with dentistry.

The program is geared to federal services dentists, hygienists, dental assistants and laboratory technicians who have been assigned responsibilities in infection control and occupational health/safety, but is also applicable to large civilian dental practices, health maintenance organizations, dental insurers, dental manufacturer sales/marketing staff, dental infection control consultants, faculty of dental schools, dental hygiene and dental assisting programs, and infection control nurses who work closely with dentists.

Attendees can receive up to 27 C.E. hours. OSAP and the USAF are American Dental Association (ADA) CERP recognized providers. These credits are also accepted by the Academy of General Dentistry.

For more information, visit the www.OSAP.org Web site. There are also opportunities for companies to exhibit products and services at the product vendor fair. For more information, call (800) 298-OSAP (6727).

OSAP is the Organization for Safety & Asepsis Procedures. Founded in 1984, the non-profit association is dentistry’s premier resource for infection control and safety information. Through its publications, courses, Web site and worldwide collaborations, OSAP and the tax-exempt OSAP Foundation support education, research, service and policy development to promote safety and the control of infectious diseases in dental health care settings worldwide.

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TOBACCO
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able in 1994. Between 1995 and 1996 both became available without a prescription. This resulted in the largest increase in smoking cessation since the 1964 surgeon general's report on smoking. Two NRT products are attainable only through prescription: the Nicotrol Nasal Spray, which appeared in 1996, and the Nicotrol Inhaler that appeared in 1998. The final NRT product to materialize, obtainable without a prescription, is the nicotine lozenge, which has been on the market since 2002.

Research and labeling
Almost all researchers agree that nicotine is not a carcinogen and there is growing consensus that nicotine derived from medications does not promote cardiovascular disease. All of the NRT formulations are associated with slower onset and much lower nicotine levels than are cigarettes and, of course, they do not produce carbon monoxide, toxins and carcinogens. The safety and abuse records of NRT have been excellent. The choice of NRT should be individualized — based on preference, past experience, smoking dependence and habits.

The labeling on NRT products still instructs tobacco users to consult their clinician if there is a history of heart disease, ulcers, hypertension or if the patient is pregnant or breastfeeding. However, the only medical contraindications in the guideline are:

- immediate myocardial infarction (less than 2 weeks)
- serious or worsening angina pectoris
- accelerated hypertension

There is a documented lack of an association between NRT and acute cardiovascular events in persons who continue to smoke while on the patch as well as in those who have had past cardiac events! The guideline recommends the use of NRT in pregnancy if other therapies have failed. Clearly, the fetus is exposed to significantly less nicotine with NRT than with smoking and, most importantly, is not exposed to carbon monoxide, carcinogens and toxins from cigarettes.

Light smokers

Light smoking has become more common, perhaps due to smoking restrictions and increases in the price and taxation of tobacco products. Many light smokers have a strong dependence even though they smoke relatively few cigarettes. They are less likely to receive treatment than are heavier smokers, but anecdotal evidence shows an increase in success rates for light smokers with the use of NRT. At the other end of the spectrum, higher than recommended doses may be indicated in tobacco users with severe addiction. Failure to respond to NRT products may reflect inadequate dosage, incorrect usage or both.

Other options

Bupropion There are two non-nicotine medications available to tobacco users as well. Bupropion (Zyban), an atypical antidepressant, has been shown to double quit rates. It blocks the reuptake of dopamine and norepinephrine in the central nervous system, which modulates the dopamine reward pathway and reduces cravings for nicotine and symptoms of withdrawal. It is effective in those who or not the symptoms are current or past depressives. Combining bupropion with NRT often increases success rates over bupropion used alone.

Varenicline The most recent non-nicotine medication is varenicline (Chantix), a partial agonist selective for a specific nicotine receptor subtype, and it was approved in 2006. The drug’s efficacy is believed to be the result of a sustained, low-level agonist activity at the receptor site, combined with competitive blockade of nicotine binding. The partial agonist activity modestly stimulates receptors, leading to increased dopamine levels that reduce nicotine withdrawal symptoms. By blocking the binding of nicotine to receptors in the central nervous system, varenicline inhibits the surge of dopamine release that occurs immediately (seven to 10 seconds) following each inhalation of tobacco smoke. This effect may help prevent relapse by reducing or even eliminating the pleasure linked with smoking. Evidence suggests that using varenicline can increase successful quitting three times more when compared to placebo.

About the author
Carol Southard, RN, MSN, an American Lung Association certified Tobacco Treatment Specialist 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 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.

Carol Southard, RN, MSN
Tobacco Treatment Specialist
Northwestern Memorial Physicians Group
Wellness Institute
150 East Huron, Ste. 1100
Chicago, IL 60611
Tel.: (312) 926-2069
Fax: (312) 926-5444

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