Koelbl appointed dean of College of Dental Medicine at University of New England

University of New England (UNE) President Danielle N. Ripich, PhD, has announced the appointment of new Dean of the College of Dental Medicine James J. Koelbl, DDS, MS, MI, of Claremont, Calif. Koelbl is the founding dean of the College of Dental Medicine at Western University of Health Sciences, Pomona, Calif., and will join UNE in April.

The college must be accredited by the Commission on Dental Accreditation (CODA) prior to opening, and a dean must be in place for the accreditation process. UNE’s publicly stated intent is to open the college in the fall of 2012, and an aggressive fundraising campaign is under way.

To date, $6.8 million has been raised with a lead gift of $2.3 million from Unum Life Insurance Company of America, New York, N.Y. In November 2008, the UNE board of trustees approved the $5 million bond allocates $3.5 million to establish a dental school’s competitive bid process and as part of its effort to raise money for the UNE College of Dental Medicine.

Prior to his current position at Western University, Koelbl served as the dean of the School of Dentistry at West Virginia University from 1999–2007; he held several senior positions at the American Dental Association from 1994–1999, including the position of associate executive director, served as associate dean for clinical affairs and professor at the University of Louisville School of Dentistry from 1992–1994, and held several administrative and faculty positions at the Loyola University School of Dentistry from 1977–1992, including: director, general practice residency; chair, operative dentistry; assistant dean for admissions and student affairs; and associate dean for academic affairs.

Koelbl was an instructor at the University of Illinois College of Dental Medicine from 1975 to 1977, has received numerous awards and honors and the critical shortage of dentists in Maine and Northern New England. The $5 million bond allocates $5.5 million to establish a dental school’s community-based teaching clinic, which UNE will apply for through a competitive bid process and as part of its effort to raise money for the UNE College of Dental Medicine.

Do you use a dental microscope? If not, read along as Dr. Craig S. Kohler illustrates its effectiveness for general dentistry and you might just be inspired to get one for yourself.

The dental microscope for GPs

Dental school takes aim at neck and back pain

In response to a high prevalence of neck and back pain among working dentists and dental hygienists, the dean of the University of Maryland Dental School, Christian S. Stohler, DMD, DrMedDent, has launched an initiative to bring renewed attention to ergonomics into dental education.

Starting with the current semester, every incoming student must take the school’s course “Ergonomics in Dentistry,” before he or she can practice simulations or live-patient dental work. The school wants to be the place where dentists and dental hygienists learn to practice ergonomically correct practices, says Stohler.

“Three out of every five dentists live with the pain,” due to years of practicing with poor posture and other unwise positioning, guest lecturer Lance Rucker, DDS, director of clinic...
has written multiple publications and articles during his career. Koelbl received his DDS from the University of Illinois College of Dentistry, his MS in oral biology from Loyola University School of Law and of Illinois College of Dentistry, and articles during his career. Koelbl has written multiple publications.

I am very pleased that Dr. Koelbl is joining us at the University of New England,” said Bigoch. “UNE will benefit greatly from his extensive experience in dental medicine and as the dean of two dental schools. I am confident Dr. Koelbl will enable UNE to expedite the accreditation of the College of Dental Medicine and will also greatly assist in our fundraising efforts for the college.”

“I am honored to be selected as the founding dean for the UNE College of Dental Medicine, and appreciate all of the hard work that has been accomplished to date,” Koelbl said. “We have the opportunity to create a unique and technologically advanced dental education program at UNE where a rich environment for collaboration exists, both internally and external.

“I appreciate the support that has already been provided by the dental community, and look forward to meeting and getting to know the dentists throughout the New England area.”

Koelbl noted that while many details are yet to be developed, the UNE dental program will focus on a strong foundation in science and research, realistic simulation, early and extensive clinical experiences, interprofessional education and significant community-based education.

“We recognize our strong obligation for the college and its graduates to help improve the health of individuals, families and communities in New England and beyond,” Koelbl added.

Named one of the best regionals universities in America by U.S. News & World Report, UNE is a leader in health sciences education, biomedical research and the liberal arts.

It offers student-centered, interdisciplinary programs in the College of Osteopathic Medicine, the Westbrook College of Health Professions, the College of Arts and Sciences, the College of Pharmacy and the College of Graduate Studies and the College of Arts and Sciences.

“Many dentists eventually need years of physical therapy, go to a chiropractor or even have surgery, but seldom do you hear about the need for preventive solutions, the etiology of the problem.”

Norman Bartenr, DDS, clinical assistant professor, leads a new ergonomics course at the University of Maryland Dental School. (Photo: Steve Berberich, UMD News Bureau)

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Top 10 suggestions for 2011

By Sally McKenzie, CEO

The best thing about a new year is the host of new opportunities it offers. It presents the chance to create a new mindset and the occasion to renew your commitment to making the most of your career, your relationships, your strengths, your team and your practice.

There is no better time to ask yourself, what are you going to do to make 2011 a perfect 10? I have a few suggestions to making this your most successful year in dentistry yet.

No. 1: If you can see it, you can create it

It’s called creating your vision and goals. In terms of the growth and success of your practice, where do you want to be one year from today?

Write this with your entire staff and involve them directly in spelling out the plan to ensure that everyone is aiming for the same target, namely certain success. Over the coming weeks and months, you and your team should work through various aspects, including:

• Improving communication skills and establishing dialogue
• Providing a non-threatening forum for the team to evaluate strengths and weaknesses
• Clearly defining jobs and responsibilities of every staff member
• Assessing individual roles in the group and understanding how each contributes to the practice’s objectives
• Developing specific team processes, such as decision-making and conflict management
• Improving problem-solving strategies
• Creating a culture of accountability

In addition, schedule a two-hour team meeting for every month this year to identify the vision, goals and the strategy for advancing practice success in the coming year.

No. 2: Set the example for your team

Dealing with the problem performers on your team. These are the people that you and your star performers have been carrying for far too long and at far too great an expense.

There are few things more demoralizing to top-flight employees than a boss who looks the other way when one or more members of the team consistently disregard policies, bring poor attitudes to work, generate conflict, make excuse after excuse for why they were late, why they were sick and why they simply cannot get their jobs done.

Yet, the deadwood workers that everyone is stepping over and is forced to just “deal with” get the same pay raises, same vacation time and the same perks as top performers on your team. Understandably, your capable staff will only tolerate this for so long.

As Vince Lombardi once said, “There is nothing more unequal than the equal treatment of unequals.” You want a team of people that can help you and your practice reach the pinnacle this year, not derail your efforts.

Next, take a close look at practice numbers, starting with establishing a realistic financial goal for your practice.

Let’s say you want to achieve $700,000 in clinical production. This calculates to $14,583 per week (taking four weeks out for vacation).

Working 40 hours per week means you’ll need to produce about $364 per hour. If you want to work fewer hours, obviously per hour production will need to be higher. Follow the steps below to get there.

No. 3: Monitor and measure the individual areas as a team and study practice reports

For your review key reports including the accounts receivables and outstanding insurance claims reports to monitor exactly how much money is owed to your practice.

In addition to recommending treatment according to both patient needs and wants, continue to educate patients. Emphasizing the importance of oral health and its impact on overall health has never been more important.

No. 4: The patient needs what the patient needs, regardless of his/her circumstances

Continue to diagnose patients’ needs and wants according to your practice philosophy, not on what you perceive they can afford. Present treatment plans that convey to patients that you are presenting options to address immediate needs, long-term needs and patient desires.

In addition to recommending treatment according to both patient needs and wants, continue to educate patients. Emphasizing the importance of oral health and its impact on overall health has never been more important.

No. 5: Create a clear plan of action for production

Establish daily production goals and schedule to meet those goals. Make certain that your scheduling coordinator understands exactly how much time is needed for each procedure.

You would be stunned how many business employees simply have to guess the number of units that should be allocated for procedures.

Prescribe a treatment plan for patients that includes everything that needs to be done: appointments necessary, the cost of treatment, an estimated length of treatment time and any treatment options. Designate a treatment coordinator who is responsible for presenting treatment plans to patients and is expected to secure at least 85 percent case acceptance.

• Implement an interpretive periodontal therapy program
• Provide superior customer service that will encourage patients to refer friends and family.

Each month run the year-to-date practice analysis report and compare it to the same period last year.

Now consider what needs to happen in the treatment room, which brings us to tip No. 4.

No. 6: Cut the deadwood and enjoy smooth sailing

Deal with the problem performers on your team. These are the people that you and your star performers have been carrying for far too long and at far too great an expense.

There are few things more demoralizing to top-flight employees than a boss who looks the other way when one or more members of the team consistently disregard policies, bring poor attitudes to work, generate conflict, make excuse after excuse for why they were late, why they were sick and why they simply cannot get their jobs done.

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Prescribe a treatment plan for patients that includes everything
The dental microscope for general dentistry

By Craig S. Kohler, DDS, MBA, MAGD

The dental microscope is an outstanding tool. Every general dentist should consider incorporating the ability to have multiple magnifications in his or her office. The following case studies illustrate their effectiveness.

I use the microscope every time I touch a tooth with a burr. The photos shown here are snapshots of procedures that have been videotaped.

The videos have been edited and can be found on www.YouTube.com under the case name. Go to www.YouTube.com and search for “craigs kohler” and the name of the case.

Case No. 1: Removal of amalgam stain and micro crack discovery

Summary of original treatment expectations:

Patient needs a simple two-surface silver amalgam filling, #3 MO replaced. The patient would like to have a tooth-colored restoration.

The silver amalgam is removed and carious tooth structure is found as well as extensive staining from the old silver filling (Fig. 1a). An intraoral sandblaster (Danville Engineering MicroEtcher IIA) was used to remove the stain and decay.

The stain at the gingival margin was more difficult to remove and a second application of the sandblaster removed it (Fig. 1b). Upon close inspection of the preparation, there was a small crack found in the enamel at the gingival margin and another crack under the mesial buccal cusp (Figs. 1c, 1d).

The dentist can evaluate and discuss the options that the patient has regarding the restoration of the tooth. If the patient can see the situation, he or she can make a more informed decision.

Possible future problems can be traced back to the original stress fractures in the tooth if the patient elects to have a simple filling placed.

This patient decided to have the simple filling and was willing to risk possible tooth fracture and sensitivity. In my office, a full crown is considered over treatment, but a conservative ceramic onlay with proper occlusal guidance may be the best enduring restoration (Figs. 1e, 1f).

A gold onlay has the clinical history to last the longest, but it would not satisfy the esthetic demands of most patients in my demographic area.

Case No. 2: Removal of an old tooth colored filling that had severe decay

Summary of original treatment expectations:

A 14-year-old female with a history of bad dental experiences at her pediatric dentist has decay on her lower right molar (#30).

The tooth has a silver amalgam with decalcification on the margins, and there is a large occlusal composite that appears intact visually. She is apprehensive about treatment (Fig. 2a).

The silver filling is removed and there is extensive decay (Fig. 2b). The tooth-colored composite is difficult to distinguish from dentin. The dental microscope enlarges the area so that all of the old composite and decay can be removed.

As more dentists are using composite that blends with the dentin, the removal of the entire old filling is getting more difficult to discern. In this case, there was decay behind most of the composite filling. A sandblaster and a slow-speed round burr removed the composite. Decay detector identified the active caries and illustrated to the patient and her mother the seriousness of the situation (Fig. 2c).

The final filling was a temporary measure and the patient can expect endodontic therapy someday in her future (Fig. 2d).

The necessity of vigilant recalls is...
understood and the patient returns to the office for three other similar problems on her other first molars. This case is an example of a patient who was a difficult management problem; however, she learned to appreciate the value of a dentist and patient working together to get a good result.

The dental microscope enlarged the field of view for treatment and documented the experience so the patient could take ownership of her dental problems.

Case No. 3: Crown buildup and preparation for a gold crown

Summary of original treatment expectations: The upper left molar, #15, had the palatal margin of a gold onlay breakdown (Fig. 3a). There was extensive decay. The onlay was removed and a core buildup placed. Then the tooth was prepared for a future gold crown, which was seated.

The extensive decay under a filling led to the need for a core build up. The dental microscope was used to refine the margins of the preparations. Notice the magnification (10x to 12x) that allowed the buildup tooth margin to be refined. The white buildup material could clearly be seen, which allowed the margin of the buildup to be placed above the crown margin (Fig. 3b).

The preparation was also adjusted at similar high magnification and two slots were placed in the buildup to increase retention for the crown. The impression was sent to the dental laboratory, Opus One Laboratories in Agoura Hills, Calif.

At the delivery appointment, the temporary was removed and the residual temporary cement was sandblasted away. The crown was checked for fit and occlusion and was cemented with Relyx Unicem cement by 3M ESPE. The delivery appointment took about 15 to 20 minutes.

In my office, a tooth that needs an extensive buildup typically takes 30 minutes. The preparation and impression appointment time is 45 to 60 minutes. My initial learning curve took about two months to feel comfortable in using the microscope for most dental procedures.
Craig S. Kohler, DDS, MBA, MAGD, has a full-time private practice in Wilmette, Ill., which is a suburb of Chicago. He has used surgical dental microscopes for 15 years.

He owns a five-stage Seiler Instrument & Manufacturing Company, a dental surgical microscope and a motorized zoom OPMI PROergo manufactured by Carl Zeiss Meditec.

He has been an instructor at NorthShore University Healthcare System General Hospital Residency program for 10 years, where he has taught dentists how to use the dental surgical microscope. In addition, Kohler has been a visiting faculty member for the Spear Institute in Scottsdale, Ariz., where he mentors dentists in occlusion and cosmetic dentistry with the aid of dental surgical microscopes.

Kohler will be teaching a one-day hands-on microscope course April 8 and 9 in Kansas City. Please contact him at craigskohler@comcast.net for more information.

Case No. 3: Crown buildup and preparation for a gold crown

Case No. 4: #31, severely cracked tooth with no pain

Summary of problem: A patient had an ordinary Class I filling on the lower right second molar, #51. There was a stress fracture line on the distal marginal ridge, and there was no pain. The initial filling can be seen on www.YouTube.com under the title for this case.

Upon removal of the silver amalgam, there was a stress fracture that could be seen under high magnification, 10x to 12x (Fig. 4). This fracture line originated on the distal marginal ridge, but continued on the floor of the dentin until 1/3 of the tooth was involved.

The patient understood the need to restore the tooth with a crown. There was a discussion about other occlusal issues that may have led to the creation of the crack in the first place.

The patient understood the possibility of tooth loss or need for endodontic therapy even with a crown. He was fully informed and understood that the crack could get worse with a simple filling, which could lead to tooth loss.

A final word

The dental microscope was introduced to dentistry in the late 1970s.

The cost, ergonomics and the perception of a steep learning curve has kept this useful tool from being implemented by the general dentist.

The four simple cases presented here illustrate how using multiple magnifications allows the general dentist to exceed his or her ability to see beyond one’s eyesight or loop magnification.

(All photos were provided by Dr. Kohler)
A 23-year-old male patient consulted in the department of oral pathology for the treatment of the tongue and lower lip swelling that has lasted for 20 years, and lead to difficulty in oral function.

The patient gave a history of temporary regression of the lesion following prolonged bleeding due to trauma from the teeth. Movement of the tongue provoked pain in the swelling region. Enlargement was diffuse, fleshy and erythematous in appearance with foci of ulceration, involving almost two-thirds of the tongue anteriorly with a deviation toward the left side. Similar swelling involved the lip on the right side.

1) What is your diagnosis?
   a) Lymphangioma
   b) Hereditary macroGLOSSIA
   c) Hemangioma
   d) Amyloidosis
   d) Squamous cell carcinoma

Part I
Let’s go step by step from the patient’s detail and assemble all the clues together.

Clue No. 1: Age, site and duration: 23-year old, tongue (majorly right side) and lower lip swelling for approximately the last 20 years, leading to difficulty in the functions associated.

Conclusion: Doesn’t appear to be squamous cell carcinoma as it started at around 2 to 3 years of age.

Clue No. 2: History — Patient gave a history of temporary regression of the lesion following prolonged bleeding due to trauma from the teeth. Movement of the tongue provoked pain in the swelling region.

Conclusion: Apparently a soft and vascular lesion with phases of regression with bleeding. This again rules out squamous cell carcinoma, hereditary macroGLOSSIA and amyloidosis because these are supposedly firm lesions.

(Note: These can also have superficial ulcerations and supra-infections to look erythematous with ulcerations.)

Clue No. 3: Appearance — Enlargement was diffuse, fleshy and erythematous in appearance with foci of ulceration, involving almost two-thirds of the tongue anteriorly with a deviation toward the left side. Similar swelling involved the lip.

Conclusion: This can help us rule out hereditary macroGLOSSIA; the reason being it’s a muscular hypertrophy, most often bilateral, doesn’t show fluctuations and generally not erythematous and doesn’t bleed often.
Narrowing down the diagnosis

a) Lymphangioma
b) Hemangioma
c) Amyloidosis

d) All of the above

Which of the following is a recommended form of treatment?

a) Generally regresses on its own, especially the superficial one; so no treatment required.
b) In some cases, a surgical treatment or lasers may be used to remove the small vessels.
c) Cavernous hemangiomas are generally treated with steroid injections or laser treatments or combination treatment.
d) All of the above are correct.

(Answers are below.)

The tongue generally becomes smooth or may possess a variety of polypoid appendages that form as the tongue grows against gaps in the teeth.

In addition to its large size, the tongue becomes adynamic, firm and friable and may cause problems with deglutition, speech and breathing.

The tongue tissue may break down and haemorrhage due to the size.

There are two types of amyloidosis:

• Organ-limited amyloidosis rarely shows up in oral soft tissues.
• Systemic amyloidosis show various other systemic signs and symptoms.

Thus, complete systemic examination and probably a biopsy is required before making a diagnosis of amyloidosis.

Ruling out lymphangioma

When seen in the denser tissue such as the tongue, lymphangioma is confined and histologically it presents as a microcystic lesion unlike a macrocystic lesion in the looser tissues.

The tongue presents superficially as “pebbly” with a vesicle-like feature and a so-called “frog-egg” or “tapioca-pudding” appearance. If located deeper, lymphangioma may present as a submucosal mass.

About 50 percent of the lesions are noted at birth and around 90 percent develop by 2 years of age.

Other causes of macroglossia:

a) Cretinism
b) Downs Syndrome
c) Mucopolysaccharidoses
d) Neurofibromatosis
e) Edentulous patients
f) Myxedema
g) Acromegaly
h) Angioedema
i) Carcinoma and other tumors

Part II: Hemangiomas

2) Check your knowledge of hemangiomas by marking true or false next to each of the following.

a) A hemangioma is a benign, self-involuting tumor of endothelial cells (the cells that line blood vessels) leading to an abnormal proliferation of blood vessels that may occur in any vascularized tissue.
b) Hemangiomas are one of the most common birthmarks in newborns.

c) The appearance depends on location. Superficials appear reddish; however, if they are just under the skin they present as a bluish swelling.
d) Some are formed during gestation while others (the most common) are not present at birth but appear during the first few weeks of life.

e) Histologically, subclassified as capillary or cavernous depending on the size of the vascular channels.
f) Show giant cell inflammatory reaction.

The development cycle of hemangiomas includes three stages of development and decay.

• In the proliferation stage, a hemangioma grows very quickly. This stage can last up to 12 months.
• In the rest stage, there is very little change in a hemangioma’s appearance. This usually lasts until the infant is 1 to 2 years old.
• In the involution phase, a hemangioma finally begins to diminish in size. Fifty percent of lesions will have disappeared by 5 years of age and the vast majority will have disappeared by 10 years of age.

3) Which of the following complications can a hemangioma show?

a) Bleeding
b) Breathing and eating difficulties
c) Secondary infections
d) Vision problems

e) All of the above

4) Which of the following is a recommended form of treatment?

a) Generally regresses on its own, especially the superficial one; so no treatment required.
b) In some cases, a surgical treatment or lasers may be used to remove the small vessels.
c) Cavernous hemangiomas are generally treated with steroid injections or laser treatments or combination treatment.
d) All of the above are correct.

(Answers are below.)

Dr. Monica Malhotra is an assistant professor at the Sudha Rustagi Dental College in India and also maintains a private practice.

In 2008 she was presented with a national award for the best scientific study presentation by the Indian Association of Oral and Maxillofacial Pathology.

Malhotra completed her master’s in oral pathology at the Manipal Institute, India, in 2009. You may contact her at drmonicamalhotra@yahoo.com.
Coming into its second year, the Dental Tribune Study Club (DTSC) at www.DTStudyClub.com celebrates its members and its accomplishments and looks forward to the future. Organizers have planned events both online and offline across the globe.

DTSC is an educational-based online community that inspires new possibilities while creating higher expectations in online learning. A participant of a recent live webinar summed it up by offering:

“The live and interactive webinar enabled me to ask the speaker questions and share with colleagues around the world. The international faculty exposes me to global opinion leaders, who aren’t really accessible to experience live. Plus, I did this in my pajamas!” (M.R., Ontario, Canada)

Yet, learning from the convenience of your own home or practice isn’t the only benefit of DTSC. Another past participant commented:

“Having the opportunity to learn with my assistants and entire team gave us an opportunity to learn together, which we never had. We are discovering useful tools and I am confident all of our procedures will run much smoother as a result.” (Dr. G.F., Colorado)

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In the “Getting started in …” lecture series, leading specialists provide a general overview of a selected field of dentistry for those who are interested in “getting started in” that area.

Each “Getting started in…” program includes a number of lectures that provide a thorough introduction to the techniques, products and practice management impact in that field of dentistry.

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Cannot make it to the event? Not to worry — the symposia are also recorded and offered online as individual C.E.-accredited webinars.

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Registering as a study club member is free and easy. You can also become a fan on Facebook to ensure you receive all the latest updates. For additional details, please contact Julia Wehkamp at j.wehkamp@dtstudyclub.com or (416) 907-9836.
Inventor of the original Piezon method unveils two new standalone tabletop units

“No pain for the patient.” This is what EMS Electro Medical Systems had in mind when the company developed the new Piezon® Master 700.

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The Piezon Power Pack comes with a sterilizable LED handpiece, three EMS Swiss Instruments each in CombiTorque® in their Steribox, two bottles and a two-step foot switch.

For more information about Piezon Master 700 and miniMaster, please visit www.ems-company.com.

G-ænial Universal Flo, G-ænial Flo & G-ænial Bond

GC America has launched a three-product family for restorative dentistry. The use of flowable composites in the past required the dental professional to make sacrifices in strength and esthetics in order to get the easy handling they loved. That is no longer the case.

G-ænial Universal Flo is a nano-hybrid light-cured composite that has the easy handling of a low-flow (high viscosity) flowable. Advancements in filler technology led to a new silanation process resulting in a product that is 69 percent (by weight) filled with 200 nm homogeneously dispersed particles. Tests have shown G-ænial Universal Flo is stronger, and has better wear resistance than leading flowable and conventional composites. It also has thixotropic attributes that allow the material to have easy handling and placement.

This flowable also finishes beautifully and maintains its gloss better than both flowables and conventional composites as well. Suitable for use in Class I, II, III, IV and V restorations, it is available in 15 shades. G-ænial Universal Flo will change the way the dental world looks at flowables.

G-ænial Flo is a low-viscosity version of G-ænial Universal Flo. It has many of the same great characteristics (high flexural strength, high gloss), in a more highly flowable version.

G-ænial Bond is a seventh generation, one-step self-etching bonding agent that builds upon the history of bonding materials from GC America. This product was designed specifically for the “selective etching” technique, meaning that bond strengths will be enhanced no matter which technique (self-etch on dentin or etch-and-rinse on enamel) the professional uses. With improved shear bond strength to both dentin and enamel, this is an excellent choice for all of your bonding needs, according to the company.

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Clinical indications for a composite metal PFM restorative

By Barry McArdle, DMD

Although “metal-free” has become a mantra in some dental circles, even when it comes to indirect restorations, all-ceramics have their limitations. When parafunctional habits, wear of the existing dentition, the need for subgingival margin placement, masking of discolored tooth structure or the necessity of conventional cementability contraindicate the use of these newer dental materials, the traditional porcelain-fused-to-metal restoration is called for.

It has, however, fallen out of favor with many practitioners primarily because of its cosmetic shortcomings in the esthetic zone. There is an alternative to conventional PFM, which has proven itself as a prime option under these circumstances both functionally and cosmetically. Captek (Precious Chemicals Company, Altamonte Springs, Fla.) is a composite metal, not an alloy, whose optical properties accurately mimic those of enamel’s underlying hard and soft tissues.¹

In the hands of master ceramists, such as the Elite porcelain team at Arrowhead Dental Laboratory (Sandy, Utah), ultimate vitality can be obtained by using this system (Figs. 1, 2) and the shade matches attained with this material is remarkable (Fig. 3). In addition, Captek has demonstrated micromechanical interlocking as its primary mechanism of porcelain adherence², which...

Dental students attend AACD scientific session for free

The American Academy of Cosmetic Dentistry is offering several scholarships to dental students so they can attend the AACD’s annual scientific session in May at no charge — a $1,045 value.

The AACD will host the session May 18–21 in Boston. The event, themed “The Rise of Collaboration,” will offer lectures, workshops and networking opportunities for cosmetic dental professionals.

The AACD APEX Student Scholarship includes:
- Registration fees to the annual scientific session ($125 undergraduate)
- Round-trip coach-class airfare (up to a $500 value)
- Four nights hotel accommodations (May 17–21) for the annual scientific session ($1,000 value)
- One year of AACD membership ($20 undergraduate)
- Undergraduate dental students are eligible to apply for the scholarships and will be judged on academic achievement, and their understanding of and commitment to the future of cosmetic dentistry. The deadline for applications is March 1.

To apply, students must submit:
- Completed scholarship application (available at www.aacd.com/students).
- Official dental school transcript (must be sent by a student’s school)
- Two letters of recommendation
- Essay (500–1,000 words) on the social or scientific value of cosmetic dentistry

Applications will be accepted and reviewed by an AACD assigned review committee for consideration.

For more information, visit www.aacd.com/students.

About the AACD
The AACD is the world’s largest non-profit member organization dedicated to advancing excellence in comprehensive oral care that combines art and science to optimally improve dental health, esthetics and function.

Composed of more than 6,500 cosmetic dental professionals in 70 countries worldwide, the AACD fulfills its mission by offering superior educational opportunities, promoting and supporting a respected accreditation credential, serving as a user-friendly and inviting forum for the creative exchange of knowledge and ideas, and providing accurate and useful information to the public and the profession.

¹ See page 3C
New study open for cosmetic dentists

A new cosmetic research study is open for dentist participation in the United States and internationally. The purpose of the cosmetic dental study, conducted by Dental Ideal Lab, Smile-Vision Dental Laboratory and Big Case Marketing, is to determine the behavioral impact of pre-treatment cosmetic simulations on patient case acceptance rates, measure time efficiency of the “template technique,” which improves esthetics and fit for E-max (Ivoclar), and measure time efficiency of the simulations on patient case acceptance rates, improving delivery of cosmetic units, and to track three years of clinical data related to fracture, debonding, color stability, esthetics and fit for Emax (bofcar), pressed glass and porcelain to zirconia restorations.

As a side effect of study participation, qualified cosmetic dentists can expect significant numbers of fee-for-service patients inquiring to their practice for cosmetic dental treatment.

General dentists and prosthodontists who have completed advanced cosmetic continuums or who have cosmetic academy credentials are eligible to apply for selection as a designated participating practice for the research study.

Participating dentists must be members of at least one of the following: the American Academy of Cosmetic Dentistry, the American Academy of Esthetic Dentistry, the European Academy of Esthetic Dentistry, the International Academy of Dental Facial Esthetics, the Academy of Comprehensive Esthetics or the International Association of Cosmetic Dentistry.

Qualified dentists accepted as research study sites will receive marketing ads and specific instructions on how to locate study participants in their geographic area who are interested in cosmetic dentistry.

While participating dentists will offer treatment at a discount for patients who opt to participate in the study, cosmetic services are not free. The number of practices in a geographic area allowed to participate is also limited.

“Gathering data-related success factors with these newer porcelain systems, using a very innovative technique that increases esthetic reliability and improves delivery speed of dentistry, and lastly measuring at least one key behavioral factor we know affects case acceptance rates makes this study the most unique of its kind in cosmetic dentistry,” said Dr. James McAnally, Miami dentist and director of the Cosmetic Research Study Program.

“We’re very pleased to be able to look at this on a global basis, to work with some of the best cosmetic clinicians in the world, and of course see far more patients worldwide benefit from cosmetic dentistry as a result,” McAnally said.

Dentists can use their local lab, and any local lab can become certified in the template technique required under the study guidelines. Patients participating in the study must need four or more units of cosmetic dentistry.

Dentists or labs wishing to apply as a participating site can go to www.CosmeticDentistryStudy.com or call (206) 601-6754.

(Source: PRWEB)

Cosmetic dentist restores leukemia-ravaged teeth

Leukemia took his health, made him deaf and ravaged his teeth, but Andre Fredricks has a new smile, thanks to San Antonio cosmetic dentist Dr. John Moore, DDS, and the Donated Dental Services program of the Texas Dental Association’s Smiles Foundation.

Fredricks, a 70-year-old San Antonio grandfather, was this year’s recipient of major dental restoration work by Moore, of Cosmetic Dental Associates of San Antonio. Moore has been a volunteer dentist for the Donated Dental Services program since 2001 and has contributed more than $21,000 to the cause.

Fredricks is in remission from leukemia, a disease that brought him to the brink of death, according to his wife and translator, Ms. Fredericks. “We lost him several times,” she said. “We thought he was a goner.”

At its worst, the disease took down his immune system, bringing the infection that took away his hearing, brought organ failures, and otherills. He wasted away to 92 pounds.

The disease and wasting took their toll on his mouth, where teeth and bridgework began loosening and falling out. By the time Fredricks saw Moore, he had just a few teeth left.

The financially strapped couple didn’t have the resources to correct the dental damage left by leukemia. Then a neighbor who had been the recipient of donated dental services herself suggested that they apply for the Smiles Foundation’s program.

The Texas Donated Dental Services program is open to patients who are at least 55 years or older, or have a permanent disability, and have no other way to get dental care. Patients submit their cases to the website, and register online or in person to become a candidate for these services.

Once the patients meet their requirements, their cases are then submitted to the clinic. The clinicians review each case they are given, and choose the patient that is financially and medically unable to receive the treatment otherwise.

In Fredricks’ case, the treatment started in July and continued several months into the autumn. Mrs. Fredricks said it was a godsend.

“We were blessed,” she said. “Dr. Moore did an awesome job with my husband’s teeth. We had a great time, and the whole staff [of Cosmetic Dental Associates] was friendly, nice and smiling.”

Moore said: “Over all the years I lived in the community and what the community has done for me, I feel it is fun to give back and help other.

Whether I help elderly people, children, my staff or animals I find it fun. Thank God I can not only help myself and my family, but I am in a position to help those that are not as fortunate as I. It is a blessing to be able to do that!”

Moore has been a San Antonio dentist for more than 25 years, and his credits include serving as an assistant professor of dentistry at the University of Texas Health Science Center in San Antonio. He is a prolific lecturer and published writer, and has won numerous awards, including being voted into America’s Top Dentists in Cosmetic Dentistry and honored as San Antonio’s Top Dentist in Cosmetic Dentistry. He is also a top San Antonio orthodontist, and has been honored for his groundbreaking treatments in correcting major alignment problems with a “no braces” method without jaw surgery.

(Source: PRWEB)
in my experience has resulted in the superior strength and fracture resistance that is often required in specific clinical situations.

Even though the Captek coping is not cast, its extensively documented marginal integrity and antibacterial qualities make it an ideal restorative where subgingival margins are necessary, and I have found in many cases that these properties may afford the clinician more leeway in relation to the biologic width.

Uses
It is often the case that the location of previous restorations or new carious lesions will mandate the placement of subgingival margins. Due to the moisture inherent in situations such as these, a cementable restoration is essential, and of the new generation in metal-free products, only zirconia will fit that bill.

However, zirconia is among the least esthetic of the ceramics where Captek is clearly superior, both intrinsically and for its influence on gingival appearance.

Captek has been found to outperform any other material in terms of its performance with regard to gingival color. Its aforementioned bacteriostatic properties contribute greatly to gingival health where other materials, even including semi-precious metal copings, can be problematic (Figs. 4, 5). Thus, Captek has become my material of choice for indirect restorations in the esthetic zone that demand subgingival margins.

As any dentist knows, endodontically treated teeth often discolor significantly after such procedures. It is also true that there are some implant cases where it is preferable to use a metal abutment, and in these instances, the effect on gingival color can be decidedly negative.

The translucency of most metal-free restoratives will not allow for the full masking of this tooth discoloration or metal reflection, and cosmetic outcomes will be adversely affected when those materials are used under these circumstances.

As a PFM restoration, Captek affords ultimate masking qualities, and its excellent esthetic results make it the prime choice in situations where masking abutment discoloration is of prime importance.

The longevity of large restorative cases is of major consequence to the treating dentist. Remakes due to functional failure are costly to the clinician not only economically, but in terms of his or her reputation as well.

The greater strength of PFM restorations over their metal-free counterparts, even including zirconia units, is well documented in the literature.4,5

In cases where occlusal or parafunctional matters are of a principal concern, ceramo-metal crowns will be the longest lasting. Considering Captek’s advanced cosmetic capabilities, there is no disadvantage to going with PFM restorations in a smile design case that has wear issues that could lead to potential failures if all-ceramics are used.

It is on this last point that I am met with the most skepticism during my lectures around the country. There are many practitioners who simply will not believe that a PFM restorative can match the vitality of an all-ceramic product.

I have found it true in my practical experience that all other things being equal (skill of the laboratory technician involved, quality of the clinical records provided, etc.), it is easier to fabricate a really life-like restoration from a metal-free material, but in the hands of a master ceramist, Captek restorations can achieve an organic realism that is virtually indistinguishable from nature.

In fact, complex restorative cases blending Captek, and all-ceramic units have been documented to realize a harmonious result.7

Conclusion
Although all-ceramic restorations have been en vogue when in comes to transformational restorative cases in the esthetic zone for some time, even being taught as state of the art in dental schools,8 they are not the be all or end all when it comes to these situations.

The placement of all-ceramic restorations is much more technique sensitive than its ceramo-metal counterpart, and their long-term function, especially when all occlusal considerations have not been carefully accounted for, is questionable at best in comparison.9

There is a porcelain-fused-to-metal alternative that is stronger than the all-ceramic choices available, kinder to gingival tissues, more esthetic when seen through those tissues, and every bit as natural looking when fabricated by a talented ceramist. These attributes come from the design of Captek’s unique composite metal coping, whose properties set it apart from all other PFMs.

If there are cases for which you hesitate to use a metal-free restorative due to occlusal questions or where periodontal and gingival factors are paramount, consider Captek.

It will perform flawlessly under all these conditions while delivering cosmetic results that are unsurpassed by any other material when in the hands of a gifted laboratory technician. What more could you ask for? 8

The author would like to thank the Elite porcelain team at Arrowhead Dental Laboratory for its expertise in fabricating the Captek restorations shown in this article.

A complete list of references is available from the publisher.

Fig. 3: Shade matching with Captek and accurate clinical records is virtually perfect. The crown in this picture is on tooth #13.

Fig. 4: The gingivae at these premolars restored with porcelain-fused-to-semi-precious-metal copings are severely inflamed and have receded substantially after only 14 months.

Fig. 5: The same teeth, 10 months after having been restored with Captek crowns, show no sign of gingival irritation whatsoever.

About the author
Dr. Barry F. McArdle graduated from Tufts in 1985 and maintains a private practice in Portsmouth, N.H.

An expert reviewer for JADA, he has authored numerous articles in the peer-reviewed literature. McArdle is also an alumnus of The Pankey Institute. He co-founded the Seacoast Esthetic Dentistry Association in 2000 and his lecture series, Seacoast Dental Seminars, in 2005.
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What’s new in CAMBRA?

By Shirley Gutkowski, RDH, BSDH, FACE

As you may know, CAMBRA stands for Caries Management By Risk Assessment. It doesn’t sound new or innovative for most clinicians because we believe we practice this way. Clinicians believe that they practice this protocol by looking into the mouth, seeing debris (the risk) and telling patients that they need to brush or floss to remove the soft deposits that have accumulated on the teeth (caries management).

This strategy worked for a long time. We can see it work by the declining edentulous rate. Somehow, over time, the focus of treating caries has shifted to repairing caries lesions—the ones caused by the bacterial infection. This is akin to treating diabetes complications by amputating gangrenous appendages and calling it treatment. Prevention is not really hitting all the high points, and this is partly because of confusing dental language.

Bacteria cause holes in the teeth, and CAMBRA impresses this idea on students by reducing quotas for drilling and filling and increasing the requirements for managing the disease. The requirement for saliva testing, bacterial testing and treatments that center on cariology receive more emphasis. Even today, some schools do not teach cariology as a separate class, but introduce bits and parts of cariology into other classes.

The CAMBRA dental students of today elevate the patients’ risk profile into a diagnostic tool to help launch a treatment plan that doesn’t center on surgically altering teeth and placing prosthetics in an effort to reestablish the biological dimensions of the tooth.

It’s a difficult undertaking. The dentists employed to manage the student clinic are of the surgical mindset, filling the holes in the teeth. When the new CAMBRA graduates are released into the public, they are often at odds with their employers.

The traditional dentist removes the infected part of the tooth, never really dealing with the cause of the damage. The current thought is that there’s no money in risk management.

The national board exams also do not reflect the CAMBRA focus on caries control protocols.

The Western CAMBRA meeting this past year focused on continually refining the language of dentistry and finding ways to reflect this educational model in the board exams. Dr. M. Fontana led a committee in the Cariology Special Interest Group (now a Section) on terminology at the American Dental Educators Association (ADEA). Together with other interested parties, the group created a “standardization of dental terms” to be used in dental programs. The glossary is published in Dental Clinics of North America, August 2010 (Dent Clin N Am 54 (2010) 423–440).

Over the past five years or so, these issues — of clinical instructor’s focus and standardizing dental language — are being ironed out at the schools. The liaison between CAMBRA and the dental examining boards has been working too. Requirements for drilling still far outweigh the requirements for including caries management recommendations, or even considering caries risk when establishing recall intervals.

While the idea of CAMBRA is working its way into the stream of traditional dentistry, the CAMBRA team is working on getting on top of the cause to educate dental and dental hygiene students about the management of caries and going beyond damage control. Language drives clarity and change.

What’s interesting about the language change is the list of words to be retired. Words such as “watch.” Watch has never been a technical term. The word “watch” in the context of caries management has traditionally been used to monitor an area. Without further treatment, “watch” really described passivity on the part of the practitioner to wait until the area had progressed to the point of cavitation and needing a restoration of some kind.

In the recent past (Dec. 2010), the FDA again addressed the safety of amalgam as a restorative for diseased enamel. The salient point that was never addressed, the elephant

First ‘Pros in the Profession’ winner is announced

Crest Oral-B announces Ann Benson, RDH, as first of five recipients

Crest® Oral-B announces Ann Benson, RDH, as the first recipient of the new Pros in the Profession award program for registered dental hygienists who go above and beyond the call of duty. Benson was selected from an overwhelming pool of qualified candidates for her initiative in starting Mobile Dentistry of Arizona, a practice that brings comprehensive dental care to those with limited transportation.

Providing excellent oral care for all is a passion for Benson, who works tirelessly to combat tooth decay and gum disease in her surrounding community, in and around the Phoenix metro area.

“I am so honored to be recognized by Crest Oral-B as the first of five Pros in the Profession,” said Benson, who graduated from University of Iowa and now resides in Mesa, Ariz. “I truly love what I do and could not imagine doing anything else; I so appreciate Crest Oral-B supporting me through and through.”

High-quality dental care with a personal touch is not just an aspiration for Benson, it is her way of life. Together with a staff of three dentists, three assistants and one other hygienist, she visits skilled nursing, long-term care and other age-qualified communities and assisted living homes to provide dental care to residents. Since starting Mobile Dentistry of Arizona in June 2009, Benson has noticed a growing demand for its services, especially for patients with Alzheimer’s and dementia.

These patients ask specifically for Benson, whose caring nature and keen skills, acquired through more than 15 years as an RDH, enable her to rise above challenging situations. For Benson, successful treatment of these patients is the ultimate reward.

“I have been working with Ann Benson for years to ensure her patients have the proper tools to improve their oral care, and couldn’t be more proud of her for winning this award,” said Terri Pipes, Crest Oral-B account manager.

“As evident through her intense dedication and everlasting passion for providing proper oral care for her patients, many of which would not have the care without her, she is truly deserving of being recognized by Crest Oral-B as a Pro in the Profession.”

To learn more about Pros in the Profession, including how to nominate a pro for consideration and for rules and regulations, please visit www.dentalcare.com/prosintheprofession.
A new year, a chance to reflect

As the calendar turned to 2011, many made resolutions about what they will or will not do in the new year. Things such as improving health, managing time better or spending more time with family likely appeared on many people’s lists. While many partake in this tradition, very few actually follow through with their plan for the entire year. This happens for a number of reasons. The most likely reason is that resolutions are personal, I challenge readers to make a professional resolution.

Reflect on your professional life from 2010. If your position is a clinical hygienist, assess your productivity. If your position is a clinical assistant, assess your productivity. If your position is a practice manager, assess your productivity. From 2010, it is important, how the goal will be achieved, decide what you will do next and repeat this process. Every successfully completed resolution that you cross off your list will make it easier to complete the next one.

Who knows, perhaps by this summer, you may have achieved each of your new year resolutions and you will need to make a new list! **

Best Regards,

Angie Stone, RDH, BS

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Pulpdent trains dental assistants at Greater N.Y. Dental Meeting

Pulpdent was invited to train 40 dental assistants on the subject of “New Technology Resins for Provisional Restoration” during the Greater N.Y. Dental Meeting on Nov. 29.

The educational program was sponsored by the American Dental Assistant Association Foundation (ADAAF), which provides continuing education and valuable demonstrations by selected manufacturers to further the knowledge and skills of the member dental assistants.

Larry Clark, director of clinical affairs for Pulpdent, presented a scientific program on the three provisional technology groups: acrylics (PUMA), bis-acryl and rubberized-urethane.

The strengths, weaknesses and clinical techniques for the three different chemistries were reviewed in detail. The scientific session was followed by a hands-on workshop and demonstration using Tuff-Temp, the new rubberized-urethane provisional material from Pulpdent.

Tuff-Temp’s rubberized-urethane is strong, impact resistant and fits tightly on the teeth. Breakage and debondings are minimized or eliminated. The material has the convenience and handling of a modern automix system, but does not shrink, stretch, break, debond or lose its margins like bis-acryl. It has the strength of powder and liquid acrylics, but eliminates the mixing, odor, shrinkage, heat generation, loose fit and recementations.

Tuff-Temp grinds and powders, producing crisp and accurate margins that do not soften or distort. Finishing instruments do not gum up or clog. Tuff-Temp is dual cure. It both self-cures and has a fast light cure option that is also ideal for use with a clear vinyl polysiloxane template.

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Pulpdent trains dental assistants at Greater N.Y. Dental Meeting

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in the room, was that rebalancing the oral pH and providing the missing components of saliva, thus for- feiting the reasons for the amalgam in the first place, could treat many of these lesions.

Following are some of the impor- tant glossary terms from Dental Clinics of North America. These definitions are quoted from the entry: Defining Dental Caries for 2010 and Beyond. References for the definitions can be found in the source for the following summary.

Caries process
The caries process is the dynamic sequence of biofilm-tooth interac- tion that can occur over time on and within a tooth surface.

This process involves a shift in the balance between protective factors (that aid in remineralization) and destructive factors (that aid in demineralization) in favor of demineralization of the tooth struc- ture over time. The process can be arrested at any time.

Demineralization
Demineralization is the loss of cal- cified material from the structure of the tooth. This chemical process can be biofilm mediated (i.e., car- ies) or chemically mediated (i.e., enamel erosion from endogenous or en- dogenous sources of acid (e.g., from the diet, environment or stomach).

Caries lesion/incipient lesion
A caries/incipient lesion is a detect- able change in the tooth structure that results from the biofilm-tooth interaction occurring due to the dynamic caries process. People have dental caries, teeth have caries lesions.”

Although attempts have been made in the literature to separate the term “caries lesion” from “cari- ous lesion” (and in some cases to delineate the term “carious”) — in some instances the latter is being used to refer to an “active” lesion — we find that applying those distinc- tions to everyday practice can be confusing, and thus we suggest that both terms can continue to be used interchangeably.

Caries lesion severity
This is the stage of lesion pro- gression along the spectrum of net mineral loss, from the initial loss at a molecular level to total tissue destruction.

This involves elements of both the extent of the lesion in a pulpalc direction (i.e., proximity to the den- to-enamel junction and pulp) and the mineral loss in volume terms. Not all cavitated and cavitated lesions are, for example, two specific stag- es of lesion severity.

Noncavitated lesion (a.k.a. incipi- ent lesion, initial lesion, an early lesion or white-spot lesion)
A noncavitated lesion is a car- ies/incipient lesion whose surface appears macroscopically intact. In other words, it is a caries lesion without visual evidence of cavitation.

This lesion is still potentially reversible by chemical means or ar- restable by chemical or mechani- cal means.

White-spot lesion
This is a noncavitated caries/cari- ous lesion that has reached the stage where the net subsurface mineral loss has produced changes in the optical properties of enamel, such that these are visibly detect- able as a loss of translucency, resulting in a white appearance of the enamel surface.

However, it must be noted that although initial lesions appear as a white, opaque change to the naked eye, not all white-spot lesions are either initial (beginning lesions) or incipient, as they may be present for many years and may involve enamel and/or dentin.

Brown-spot lesion
A brown-spot lesion is a noncavi- tated caries/carious lesion that has reached the stage where the net subsurface mineral loss — in conjunction with the acquisition of intrinsic or exogenous pigments — has produced changes in the optical properties of enamel, such that these are visibly detectable as a loss of translucency and a brown discoloration, resulting in a brown appearance of the enamel surface.

Microcavity/microcarviation
This is a caries/incipient lesion with a surface that has lost its original contour/integrity, without visually distinct cavity formation. This may take the form of localized “widening” of the enamel fissure mor- phology beyond its original features within an initial enamel lesion, and/or a very small cavity with no detectable dentine at the base.

Caries lesion activity (net progression toward demineralization)
The summation of the dynamics of the caries process resulting in the net loss of mineral over time from a caries lesion (i.e., there is active lesion progression).

Active caries lesion
A caries lesion from which, over a specified period of time, there is net mineral loss, that is, the lesion is progressing. Criteria include visu- al appearance, tactile feeling and potential for plaque accumulation.

Lesion is likely active when sur- face of enamel is whitish/yellowish opaque and chalky (with loss of luster); feels rough when the tip of the probe is moved gently across the surface.

Lesion is in a plaque stagnation area, that is, pits and fissures, near the gingival and approximal sur- face below the contact point.

In dentin, lesion is likely active when the dentin is soft or heath- ily on gently probing. The term active caries should be avoided and replaced by active caries lesion.

Arrested or inactive caries lesion
A lesion that is not undergoing net mineral loss, that is, the enamel loss in a specific lesion is no longer progressing. It is a scar of past dis- ease activity.

Clinical observations to be taken into consideration for assessing caries lesion activity include visu- al appearance, tactile feeling and potential for plaque accumulation.

Lesion is likely inactive when sur- face of enamel is whitish, evidence of lesion arrest but also one or more of other definite changes, includ- ing increased mineral concentra- tion (remineralization), increased radiodensity, decreased size of white-spot lesions, increased hard- ness of the surface and increased surface sheen compared with a pre- vious matte surface texture.

For the day-to-day clinician some of this sounds like an academic exercise. Attention to the details in terminology for even a week can make very positive changes in the practice and healthier patients will emerge.
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A DIASTEMA CLOSURE – LIVE PATIENT DEMONSTRATION TO INSURE MAXIMUM ESTHETIC RESULTS
This live patient procedure is designed to provide you with information and tips that will help you quickly select products and develop the techniques required to restore a diastema that esthetically meets today’s patient’s demand.

GARY BEY, D.D.S.
GET TO THE APEX MORE SAFELY AND EASILY – LIVE PATIENT PROCEDURE
This live demonstration is designed for the practitioner who is seeking new ways to practice endodontics safely, predictably and more frequently.

LARRY ROSENTHAL, D.D.S.
& MICHAEL APA, D.D.S.
IN-OFFICE CAD/CAM – A LIVE PATIENT DEMONSTRATION
A live patient step-by-step demonstration of a posterior onlay restoration is performed using the latest chairside CAD/CAM technology.

BRUCE J. LISH, D.D.S.
MINI DENTAL IMPLANTS TO RETAIN LOWER DENTURES – LIVE PATIENT PROCEDURE
The use of mini dental implants to help retain and stabilize a complete lower denture has helped improve the quality of life for many patients.

JACK RINGER, D.D.S.
DESIGNING AND CREATING BEAUTIFUL PORCELAIN LAMINATES PREDICTABLY – LIVE PATIENT DEMONSTRATION
This live patient program is designed to demonstrate the most predictable, efficient and successful protocol available today in creating porcelain laminates from initial consultation with the patient to completion.

THE BEAUTIFUL SIMPLICITY OF COMPOSITE RESIN BONDING: A LIVE DEMONSTRATION
Composite resin restorations offer a conservative and viable alternative to porcelain. Restorations that were once thought to be impossible or “heroic” at best, can now be achieved easily, reliably, and consistently with composite resin.

MICHAEL H. MORGAN, D.D.S., M.S.
REAL-TIME COMPUTER NAVIGATION TO OPTIMIZE IMPLANT PLACEMENT USING THE IGI – IMAGE GUIDED IMPLANT DENTISTRY SYSTEM – LIVE PATIENT DEMONSTRATION
Live demonstration utilizing the state of the art IGI – Image Guided Implant Dentistry System by Image Navigation Ltd. for the planning and placement of dental implants is shown.

FRANK J. MILNAR, D.D.S.
PREDICTABLE TECHNIQUES TO CREATE A POST AND CORE AND LIFE-LIKE PROVISIONAL- LIVE PATIENT DEMONSTRATION
This live patient demonstration teaches the attendees how to create esthetic transitional restorations and use minimally invasive concepts when preparing and restoring a post and core.

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