Be careful whom you kiss!

Is kissing harmful to your health? With just one kiss couples can share more than 500 different types of disease-causing germs and viruses, warns the Academy of General Dentistry (AGD).

“Not knowing who you are kissing could be as dangerous to your health as having multiple sexual partners,” says AGD spokesperson Connie White, DDS, FAGD.

Before you puck up again, White dishes on the most common diseases and viruses that you and your sweetie can transmit to each other while smooching.

Cold sores
Cold sores are caused by the herpes virus. They appear as tiny, clear, fluid-filled blisters that form around the mouth and lips. The sores are highly contagious, especially if they are leaking fluid. However, even sores that have scabbed over can be contagious.

“A wound near the lips is most often herpes,” says White. “A good rule of thumb is that if a person has any visible sores near his or her lips, avoid intimate contact!”

Know whom you are kissing, says the AGD. (Photo/Dreamstime.com)

Colds
If you feel a cold or flu virus coming on, White suggests avoiding a make-out session. Common cold and flu viruses can be transmitted very easily through contact with the saliva or nasal secretions of a sick person (Yuck!).

Mononucleosis
Mononucleosis, also known as the “kissing disease,” is easily communicated to others through kissing, as well as sharing food, a cup, a toothbrush or cups and utensils. The virus is spread through saliva, and is highly contagious.

Know whom you are kissing, says the AGD. (Photo/Dreamstime.com)

Dentists at risk for hearing loss

Everyone knows there are certain jobs that carry a risk for loss of hearing. Rock musicians come immediately to mind. So do construction workers who use jackhammers. And don’t forget the people who use those yellow flashlights to direct planes at airports. According to a recent study, dentists can also consider themselves among those at risk for ear trouble.

Most individuals would not consider a dental office to be a place where noise is a problem, but the federal Occupational Safety and Health Administration (OSHA) warns that any workers exposed to noise levels in excess of 85 decibels are at risk.

The exposure to continuous high frequencies from a dental drill can degrade one’s hearing. According to the experts, dental professionals should use protective hearing equipment.
Smiles Change Lives

“I love to smile now. It’s just automatic,” exudes Carrie, a recent Smiles Change Lives (SCL) program alumna. Now a beaming 16-year-old living in the Kansas City area, Carrie attributes her newfound confidence to a program that connects caring orthodontists with children in need.

“It was almost too good to be true. Finally, we found a program that helps working families try to make ends meet,” shares Shelby, Carrie’s mother. “We applied to the program, found out that Carrie met the Smiles Change Lives guidelines, and got Carrie assigned to a wonderful orthodontist near us for a very reasonable price.”

With more than 900 immediate openings nationwide, SCL is a national nonprofit organization that connects caring orthodontists with children in need. With nearly 400 orthodontic providers and more joining each day, SCL is seeking applicants who meet the following criteria:

- Ages 11–18 with good oral health
- Family income at or below 200 percent of federal poverty level
- Crooked teeth and/or misaligned jaws

“We’re not a family that takes these tips to get fresh breath:

- Chew sugar-free gum after meals to wash away food particles and cavity-causing bacteria. It also protects teeth from acids.
- utensils or straws.
- White says that college students are more prone to developing mononucleosis, due to lowered resistance and living in close quarters with other students.
- “People can look as healthy as can be, but you have no idea what kind of diseases they are carrying,” says White. “To protect yourself, know the person you are kissing.”
- If you’re still in the mood — and you and your partner are healthy — stealing some smooches may benefit your oral health by increasing saliva production.
- Saliva helps to wash away food particles and cavity-causing bacteria. It also protects teeth from decay by neutralizing harmful acids.

Another important consideration when it comes to kissing is how to keep your breath in minty-fresh condition. White shares these tips to get fresh breath:

- Avoid spicy foods, such as onions and garlic, and coffee. These foods and drinks can be detected on a person’s breath for up to 72 hours after digestion.
- Brush and floss your teeth at least twice a day. Remember to brush the tongue, cheeks and the roof of the mouth.
- Chew sugar-free gum after meals to wash away food particles that get stuck between teeth and cause bad odors.

“If these methods don’t alleviate bad breath, members of the public should make an appointment with a general dentist to determine its source,” says White.

“Your dentist believes that the problem is caused internally, such as an infection, the dentist may refer to a family physician or a specialist to help remedy the cause of the problem.”

The AGD has made these and many other oral health tips available on its website, located at www.KnowYourTeeth. com. This site is the AGD’s source of consumer information on dental care and oral health.

Its goal is to provide reliable information in a format that is easy to use and navigate, and to provide tools that will help consumers of all ages to care for their teeth and other aspects of oral care.

The site answers important dental health questions, offers the latest information on current dental treatments and tips for first-rate oral hygiene and can help visitors find qualified dentists near where they live or work.

(Source: Academy of General Dentistry)

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An invitation to Vancouver for the Pacific Dental Congress

Visit the 2011 Pacific Dental Conference (PDC) at the Vancouver Convention Centre, in beautiful Vancouver, British Columbia, Canada. This is the second year at this venue and the new home of the PDC has brought the conference to a new level. Last year’s attendance exceeded 12,000.

The PDC is fast becoming the most recognized dental conference in Canada by attendees, exhibitors and speakers and the organizers are pleased to offer participants a wide selection of quality continuing education programming.

This year, with 138 speakers presenting and a selection of 205 sessions to choose from, you will find more than enough variety for every member of the dental team. During the three-day conference, you can refine your clinical and practice excellence, participate in personal development courses and, of course, meet with your colleagues in a relaxed environment at one of the social events.

The roster of speakers from Canada, the United States and outside North America will be presenting topics ranging from clinical dentistry to team building and other important facets of dental practice. Speakers include Gordon J. Christensen, Joe Blaes, Anthony Cardoza, Ray Padilla, Michael Koeja, Robert Edwab and Mariano Rocabado to name a few.

Increasing the Saturday programming has been a main focus for organizers of the PDC. This year they have planned a full day of sessions and are kick-starting the day with some good old Canadian entertainment as Corner Gas star and creator Brent Butt takes the stage at 8:30 a.m. for the inaugural Saturday morning breakfast session.

Due to popular demand, organizers have brought back the “So You Think You Can Speak? Series,” be sure to include one or two of these sessions in your Saturday schedule in support of these new budding speakers.

Once again, the exhibit hall continues to grow and 2011 will be the largest ever. With more than 267 exhibitors occupying 540 booths, you will be sure to find the latest and best range of products and services for your practice.

The exhibit hall provides an excellent opportunity for you to compare products and services from the leading companies in the dental industry.

Please be sure to stop by the Live Dentistry stage while you are visiting the exhibit hall and check out the live demonstrations by Clayton A. Chan, Elliot Mechanic and Dwayne Karateew on both Thursday and Friday.

Be sure to take some time to visit Vancouver’s arts, culture, fine dining, sights and a wide range of attractions, including spring skiing at world famous Whistler Mountain.

Visit www.pdconf.com for registration, hotel and conference program information. The organizers of the PDC look forward to seeing you in Vancouver.
Dental malpractice prevention

Some simple guidelines to help you reduce the risk to you and your practice

By Stuart Oberman, Esq.

Dental malpractice litigation is on the rise. Now more than ever, dentists need to practice risk management in order to avoid malpractice actions. Accurate records should be kept, patients should be completely informed and patients should be actively involved in their treatment process.

Following these easy guidelines will greatly reduce the risk of a dental malpractice claim.

Legal terminology
Dentists must have a basic understanding of certain legal terminology in order to reduce the likelihood of a malpractice action brought against them.

Negligence is a common claim brought against a dentist in a malpractice action. In order to prove negligence against a dentist, the patient must allege and prove four components.

First, the patient must prove that the dentist owed a duty of care to the patient.

Once that is established, in the second component the patient must prove that the dentist breached that duty of care.

Third, there must be an injury to the patient.

Finally, the injury must be proximately caused by the breach of the dentist’s duty of care.

Most dentists are aware that they have a duty to comply with the “standard of care.” Many lawsuits simply allege that a dentist has not met the applicable standard of care.

The standard of care for a dentist is the level of care that is expected of a reasonably competent dentist acting in similar circumstances.

It is important to note that the standard of care is based on that of the average dentist, not on specialists or on the top percentage of dentists nationally. The standard of care is based on the level at which an ordinary, prudent dentist with the same training and experience would practice in similar circumstances.

The last-clear-chance doctrine provides that if the dentist has information from another health care provider that the dentist knows, or should know, is incorrect, the dentist is liable if he/she relies on that incorrect information and the patient is harmed, as the dentist had the last chance to save the patient from harm.

Most dentists are familiar with informed consent. Informed consent is required to give consent to a proposed treatment. However, patients can still fall back on the lack of informed consent and start a legal action against the dentist.

In order to give consent to a proposed treatment, the patient must be completely informed. Patient relations will be improved through informed consent, as the patient will realistically know what to expect from a given procedure.

Practicing risk management
It is well known that dentists should keep accurate and complete records on every patient as well as documentation of each patient’s consent and understanding of a proposed treatment.

Once a malpractice action is commenced, dentists will have a better legal defense if these steps are followed. However, dentists need to do more in the office to prevent these malpractice claims from arising.

Patients want to make their own decisions regarding their health. Dentists who include patients in the
through involving their patients in the treatment planning process. Patients are much less likely to sue a dentist whom they know and trust.

It is also important for dentists to understand the needs of their patients. The patients’ best interests should be kept in mind at all times. Patients may have special health needs or may be concerned about financing. The dentist may suggest providing dental care in phases in order to best serve the patients’ needs or to make payments more affordable. This, in turn, will allow the dentist to gain the patients’ trust.

It is important to market your services to patients; however, “puffery” should always be avoided. Puffery is a promotional statement that expresses subjective rather than objective viewpoints. Typically, puffery is a statement that no reasonable person would take literally.

When discussing the expected outcome of a dental procedure, statements such as, “this root canal will be easy,” “this treatment will be relatively pain free” or “your teeth will be beautiful after this procedure” should be avoided.

This may cause the patient to build up high (maybe even unreasonable) expectations that may lead to disappointment and, potentially, to a lawsuit.

In addition, after performing an invasive procedure on a patient, it is a good idea for a dentist to follow up with the patient through a phone call. This not only builds trust and improves the quality of care the dentist provides, but also alerts the dentist if the patient is experiencing unexpected problems that the dentist may be able to remedy.

If the problems are left unaddressed, however, the potential for a lawsuit becomes much greater.

With a more thorough understanding of malpractice actions and by following these simple tips for handling patient relations in the dental office, dentists will be more likely to avoid costly malpractice actions.

In addition, by involving patients in decisions regarding their dental care, the dentist will gain each patient’s trust. This, in turn, will also reduce the risk of malpractice actions — protecting both you and your practice.

About the author

Stuart J. Oberman, Esq., has extensive experience in representing dentists during dental partnership agreements, partnership buy-ins, dental MSOs, commercial leasing, entity formation (professional corporations, limited liability companies), real estate transactions, employment law, dental board defense, estate planning, and other business transactions that a dentist will face during his or her career.

For questions or comments regarding this article, visit www.gadentalattorney.com.

Stuart J. Oberman, Esq., has been invited to lecture at Boston University Henry M. Goldman School of Dental Medicine. Oberman will be one of the featured speakers at a continuing education course titled “How to Prevent Fraud in the Dental Office” on June 27.

For more information on Stuart J. Oberman, please visit www.GaDentalAttorney.com, or go to the corporate website at www.ObermanLaw.com.

Prevent fraud in the dental office
Clinical

Maxillofacial prosthesis: it can happen to anyone

By Dov M. Almog, DMD, Stephen F. Bergen, DDS, and Giselle Yap, DMD

Craniofacial reconstruction has been recorded throughout recorded history. Human beings have found the need to reconstruct missing or defective maxillofacial parts — such as eyes, ears, noses, maxilla, mandible and teeth — with artificial substitutes. These maxillofacial deformities may be due to congenital defects such as cleft palates, acquired disfigurements of the face from accidents, war trauma, cancer or other diseases. Evidence of the making of such prostheses has been found in archeological digs dating back to the Egyptian Dynasty (pre-2500 B.C.).

Maxillofacial defects can cause not only functional difficulties, but also some serious psychological struggles that could cause the individual to avoid social contact at all together.

In view of the significance placed upon facial appearance, especially in today’s society, accolades should be given to those creative professionals involved in the development and improvement of various facial and ocular prosthetic restorations, materials and treatment modalities. There are several synthetic polymeric materials, such as rubber, silicone or acrylic, that are currently used for facial prostheses. These require color and texture blending and matching with that of the patient to achieve a realistic and seamless appearance.

Long-term success of these facial prostheses depends mainly on their material stability, strength and facial retention. For many years, retention of the synthetic polymeric craniofacial prosthetic restoration was obtained by inferior mechanical factors, such as tissue undercuts or skin adhesives. The retentive abilities were somewhat proven to be unpredictable, with the potential of prompting some very delicate psychological circumstances. It was only after the introduction of extraoral osseointegrated implants, with retention bars, clips, magnets and other attachment mechanisms for anchoring the prostheses, that the area of maxillofacial reconstruction gained the needed support, security and the anchorage that patients required for confidence in the treatment of their complex reconstructive prostheses.

One exception to this was patients who have received radiation therapy. Those should be selected cautiously because overall success rates in this category were found to be low.

Case report

In 1930, Dr. V. Eskenazi, the subject of this case report — a general dentist who served his mandatory term in the Israeli Defense Force (IDF) — sustained a shattering facial injury. In addition, the location of the injury involved a facial birthmark that was compounded by basal cell carcinoma. As a result, for the following 10 years, he ended up having numerous surgical and radiation procedures. Interestingly enough, Eskenazi originally practiced dentistry in Bucharest, the largest city and capital of Romania. Shortly after he was discharged from the IDF, he re-established a dental office and resumed his career as a dentist. Unfortunately, the basal cell carcinoma turned out to be a "rodent ulcer" type, a persistent basal cell carcinoma condition. As a result, the affected site increased in size following each surgical excision. Ultimately, about 10 years after his injury, his right eye and surrounding socket were removed as well.

His medical records defined this procedure as an "orbital exenteration and radical maxillary resection." The defect encompassed the right orbit, midface and right maxilla. It...
was closed with a skin graft, taken primarily from his thighs and shoulders regions. Each surgical procedure also left permanent scars at the donor sites.

In 1975, he was diagnosed again with clinical evidence of recurrence of basal cell carcinoma in the deep portion of the facial defect. According to his medical records, this recurrence infiltrated his sinuses near the margins of the existing skin grafts. At this point, the Organization of Disabled IDF Veterans decided to seek international expertise, and sent him to the head and neck service at Memorial Sloan-Kettering Cancer Center in New York City.

In July 1975, Eskenazi was operated on at Memorial Sloan-Kettering. According to his medical records, the disease was indeed evident bilaterally in the posterior sphenoid sinuses. While most of the diseased tissue was removed, there were no satisfactory margins that were completely clean of the disease.

Surgeons further extended the resection to include the midface and the entire maxilla. The surgical site extended from above his right eyebrow onto his forehead, crossed the midline and included a large segment of the nose and a total maxilectomy, thus significantly increasing the size of the defect (Fig. 1a).

Craniofacial prosthesis incident
Before returning to Israel, Eskenazi was referred to the Burn Institute in Galveston, Texas, where a special maxillofacial prosthesis was fabricated.

Composed of a silicone rubber, a facemask with one glass eye, eyebrow, cheek and nose was designed for him by a medical sculptor. This was in addition to a maxillary obturator prosthesis restoring the roof of his mouth.

Once the maxillofacial prosthesis was shaped, hand painted and dyed to visually match his face shape and skin color, it was given to him and he returned to Israel. Shortly after, despite his somewhat unusual looking face and slurred speech, he regained his strength and returned to the practice dentistry.

Although his silicone maxillofacial prosthesis was custom made, it had limited retention. As mentioned earlier, back in the ’70s the success of the majority of these large facial prostheses depended on retention primarily derived from mechanical undercuts and medical grade skin adhesives.

Due to the size, extent and weight of his prosthesis, these forms of retention were insufficient.

After wearing the extraoral prosthesis for some time, Eskenazi finally refused to wear the prosthesis. Apparently, one day while working in his dental office, due to the combination of the weight, size and high temperature, the prosthesis dislodged. Surprised and horrified at the sight, his patient jumped out of the dental chair while pointing at his face.

As a result, from that time forward and most likely due to insecurity, Eskenazi no longer wore his maxillofacial prosthesis. Instead, he carefully packed the defect in his face with gauze pads and then covered it externally with a large piece of gauze, a ritual, he repeated each morning.

Fig. 1: a) Following radical head and facial surgeries in 1975 and 1977, Dr. Eskenazi ended up with a large gaping defect in his face. His tongue and throat could be seen through the defect. b) To his satisfaction, the surgeons left a sliver of his upper right side of his lip and mustache, concealing somewhat the bottom section of the defect below the gauze. (Photos/Provided by Dr. Almog)
before he went to work (Fig. 1b). In 1977, following another recurrence of his disease coupled with spontaneous bleeding and aggravation in his speech impairment, the IDF decided to once again send him back to Memorial Sloan-Kettering in New York City, where he was operated on for a second time.

This time they had to remove additional surrounding bone and tissue, resulting in an even greater disfigurement. In 1979, Eskenazi succumbed to his devastating condition.

Phantom sensations
According to medical literature, there is an illusion of connectivity between our physical body parts and our brain. Following an amputation of a body part, an individual continues to feel the missing part and experience sensations such as body touch, pain, pressure and temperature.9

These sensations are called "phantom limb sensations" and Eskenazi experienced them on a regular basis.

According to family records, family members were curious to see him scratch the area that used to be his right eye. When he was asked why he was scratching the gauze on his face, he replied that he “got an itch in his eye.” When his family members tried to argue that he lost his eye, he tried to explain that it felt like he had sand in his eye, and shrugged his shoulders.

Conclusion
Injuries to the head and face seem to fascinate the public more than other injuries. Over the years, we have learned about many cases similar to Eskenazi’s where someone “lost his or her face.” While some are related to devastating illnesses,10 others are war-, accident- or birth-related.

Facial appearance affects a person’s ability to communicate and clearly embodies one’s self-esteem and character. Just think about having to look at oneself in the mirror daily. Loss of facial appearance brings with it difficult psychological effects, which makes re-entering life both at work and home very difficult.11

References
Children’s Oral Health Month:
GC America’s MI Paste appears on ‘The Balancing Act’

GC America announced that its MI Paste will be one of the featured products on the Lifetime Network’s daily morning show, “The Balancing Act.”

A special segment was produced in anticipation of Children’s Oral Health Month in February called “Protecting Your Children’s Teeth: The Importance of Good Oral Care for Your Kids.”

The show aired Feb. 16 and will air again on March 2.

Dr. Brian Nový, assistant professor of restorative dentistry and recipient of the ADA’s award for his preventive practice, spoke with one of the show’s host, Danielle Knox, on the many benefits of MI Paste and MI Paste Plus.

MI Paste Plus™ is a water-based topical tooth cream containing RECALDENT™, with incorporated fluoride (CPP-ACP: casein phosphopeptide-amorphous calcium phosphate fluoride).

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GC America has a designated website for MI Paste and MI Paste Plus at www.mipaste.com.

For more information on GC America and its complete product line, please visit the company’s website at www.gcamerica.com.

“The Balancing Act” airs on Lifetime Television at 7 a.m. (ET/PT) and is America’s premier morning show that is about women, for women and trusted by women. For more information, visit www.thebalancingact.com.


Fight oral cancer!

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerselfexam.com. This website was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations.

Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?

Emerging science shows the strong connection between oral health and our overall quality of life. This slate of speakers presents innovations and modern techniques to help you lead your patients to good health through exceptional dental care.

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Ms. Renee’ C. Graham
Ms. Shirley Gutkowski
Dr. Randy F. Huffines
Dr. Gregory M. Lutke
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EMS launches new Piezon

Inventor of the original Piezon method unveils 2 new stand-alone 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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With its modern three-touch panel, the Piezon Master 700 sets new standards for ease of operation and hygiene, according to the company.

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According to the company, the acclaimed benefits of the original Piezon method remain unchanged: absolutely linear oscillations, ultrafine surfaces of EMS Swiss Instruments and continuous feedback control for top performance.

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

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Limited Seating!
Please register early to avoid disappointment.
Caries removal and esthetic direct composite restorations

By Ian Shuman, DDS, MAGD

When treating a carious lesion, it is critical to identify and remove only infected tooth structure, avoiding the needless removal of healthy tissue. Past techniques were unreliable for the sole removal of diseased tissue; however, current advances have improved both the recognition of what is considered active caries and those methods for its elimination.

Research conducted at Temple University has verified that a new instrument made from a unique polymer resin technology is able to remove decay, and unlike carbides and other burs, is the only rotary cutting instrument that is incapable of cutting healthy tissue. The Smartburs II works because it is harder than decay, but not as hard as healthy dentin.

Mode of operation

The Smartburs II uses an extraordinary concept in blade configuration and material structure, allowing it to remove carious dentin only, and rendering it incapable of cutting healthy dentinal tissue. By eliminating contact with the dentinal tubules, pain is virtually eliminated.

During the removal process, patients have reported only a feeling of pressure, thereby eliminating the need for anesthesia.

This improvement in clinical efficiency translates into savings of both time and cost and an increase in patient referrals.

In cases where the lesion is deep and anesthesia is required, pulp exposure can be greatly reduced, providing safer, more comfortable and effective treatment; making the Smartburs II the only, and rendering it incapable of cutting healthy tissue.

BEFORE

Fig. 1a: Patient reported with the chief complaint of having cavities in his upper front teeth.

AFTER

Fig. 1b: Tissue appearance after one week.

28 earn Aacd accreditation: largest class in history

The American Academy of Cosmetic Dentistry (AACD) announced that 28 dental professionals have recently been awarded accreditation status—the largest group to be awarded the coveted AACD credential to date.

There are only 531 dental professionals worldwide who have achieved this prestigious honor, having reached this achievement after completing a rigorous credentialing process including a written examination, oral examination and the submission of clinical cases for peer-reviewed evaluation.

These professionals practice internationally and in the United States. The newly accredited AACD members are shown in the box at right.

The accreditation process, which was developed by the AACD and is the world’s most recognized advanced credentialing program, encourages further education, interaction with like-minded colleagues and the opportunity for professional growth. Accreditation requires dedication to continuing education and responsible patient care.

“We are honored to welcome these professionals to the ranks of AACD accredited members,” said Dr. Nils Olson, chairperson for AACD Accreditation.

“Accredited dentists and laboratory technicians are the most passionate and committed dental professionals. Those who have achieved accreditation have improved their skills, acquired new techniques and can provide their patients with better care and services.”

“They understand that a smile is more than just an anatomical part, it’s an expression of who their patients are,” Olson added.

The 28 newly accredited dental professionals will receive their recognition and award at a special ceremony during the 27th Annual AACD Scientific Session, to be held May 18–21 in Boston. For more information about AACD accreditation, visit www.AACD.com/accreditation.

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.
Removing decayed dentin with Smartburs II

**Step 1:** In order to use the Smartburs II properly, an operating range of 5,000–10,000 rpm in a standard slow speed is ideal and increases the longevity of the bur. In addition, a light brushstroke is used during operation, essentially teasing out the carious tissue.

This is a significant departure from previous techniques using traditional carbide and diamond burs.

**Step 2:** When treating a carious lesion, it is critical that sharp and ragged enamel edges be removed with an appropriate high-speed bur before introducing the Smartburs II to avoid dulling the instrument.

The Smartburs II is then introduced into the center of the lesion.

This helps to avoid unnecessary initial contact with healthy enamel and dentin that could prematurely dull the bur.

**Step 3:** Starting in the center of the lesion, the most superficial, softest decay is removed using the largest size Smartburs II. The next smaller size Smartburs II is then worked laterally, removing layer by layer throughout the lesion, finally cleaning the entire cavity floor.

The removal of caries to the cavity floor in one area only will prematurely dull the instrument and make caries removal in adjacent areas more difficult.

It is important to emphasize that contact of Smartburs II with hard enamel, healthy dentin or restorative materials will result in dulling and premature failure of Smartburs II.

**Step 4:** The last action with the Smartburs II is to clean the cavity floor with more forceful strokes. Here you will have increased tactile sense when encountering decay versus using standard carbide burs.

This enables the conservation of healthy tissue when the self-limiting action of the Smartburs II instrument is experienced. After using the Smartburs II instrument, a careful examination of the area is required to confirm complete decay removal.

**Case report**

A patient reported with the chief complaint of having cavities in his upper front teeth (Fig. 1a). He reported no discomfort, but was self-conscious about his appearance.

Upon examination, the maxillary anterior teeth were diagnosed with both Class V and Class III carious lesions.

A treatment plan was formed that would include the restoration of these teeth using a direct composite resin technique with the possibility of root canal therapy where required.

Following the administration of local anesthesia, the cavity preparation for the maxillary right cen-
New option for missing teeth

For many years, people with chronic dental problems or missing teeth had limited options. They could continue with the endless cycle and expense of root canals, crowns and other restorations; live with the chewing, speaking and comfort problems often associated with dentures; or pay the extremely high costs of dental implants.

Now Drs. Andrew Spector and Michael Migdal, practitioners in Havurth, N.J., who have long been at the forefront of dental implant technology, are one of a relative handful of dentists throughout the country (and the only ones in the New York metropolitan area) to offer patients the benefits of “permanent teeth” at about half to one-third the cost of implants, and in a fraction of the time.

Hybridge™ — a hybrid bridge system — is a mix between a conventional fixed bridge and a denture. Unlike a conventional bridge made of metal and porcelain, the system uses a resin and titanium bridge restoration that replaces up to 12 teeth and is supported on five or six dental implants. It is not intended for people requiring single tooth implants, but rather sectional or complete mouth restoration.

The teeth look, feel and function just like healthy, natural teeth and last a lifetime.

As with conventional implants and unlike dentures, they sit on implants rather than the gum line for greater comfort, allow people to eat and chew as they would with their own teeth, and stimulate the jawbone (thereby preventing the “caved in” look found in people with years of denture wearing).

While a fixed bridge or removable dentures works for cosmetic reasons, and allows the individual to enhance retention, decrease micro-leakage and improve esthetics. To maximize the amount of light diffraction and the final esthetic outcome, a wavy striation pattern was created.

Following total acid etching and the application of a primer/bonding agent (Optibond, Kerr), composite resin was applied. A thin layer of flowable composite resin in shade A3.5 was placed along the cervical margin and light cured.

The gingival margins demonstrated significant improvement owing to the corrected emergence profiles (Fig. 10).

Meanwhile, removable dentures can slip, cause embarrassing clicking sounds and lead to bone loss around teeth they are hooked onto.

“In the efficiency and precision of the fabrication with the Hybridge system allows us to keep the fee far lower than traditional implant treatment for those patients who need to replace an entire upper or lower archway,” said Spector, who has been at the forefront of dental implants for many years and taught implantology at NYU Dental School.

“While dental implants remain the ‘gold standard’ for patients replacing single teeth, the cost makes them prohibitive for many who require full mouth or arch restoration, as many older people do.”

Patients for the Hybridge system tend to be older, according to the American Association of Oral and Maxillofacial Surgeons, and by age 74 more than one in four American adults have lost all their permanent teeth.

Yet, Spector said that he has also recommended Hybridge for patients who have lost their teeth as a result of early periodontal disease, traumatic injuries and eating disorders, such as bulimia, which cause tooth decay.

The remaining Class V and Class III carious lesions were prepared (Fig. 8) and restored (Fig. 9). At the next appointment one week later, the patient was seen for continued treatment.

The gingival margins demonstrated significant improvement owing to the corrected emergence profiles (Fig. 10).
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Sequence matters ...

By Cathie Stark, RDH, Orofacial Myologist

The sequence of appointments is critical to achieve the goal of care for the periodontally involved patient. Proper professional care is important when addressing this disease.

We are challenged to treat it with compassion while promoting health by ridding the destruction to our patient’s mouth and ultimately creating optimal overall health.

When assessing a patient, the hygienist plays an important role by aiding the dentist in proper diagnosis of disease. The hygienist gathers all information from the patient, including medical history, proper dental radiographs, a thorough intra- and extra-oral examination as well as periodontal charting.

Proper charting includes multiple factors. A straight probe is important, as is one without burs. Proper angulation of the probe gives the clinician the best idea of the amount of bone loss in a particular location. Finally, the appropriate pressure the clinician uses on the probe, 15 grams, is necessary if bleeding on probing is used as a disease indicator.

The Florida Probe is a “go-to” tool to assess and educate. It provides a computer voice verbalizing the readings of the periodontal probe. The patient’s attention is grabbed when “danger” is mentioned in pockets 4 mm and greater during an exam.

It’s important to get this third party endorsement of the disease process as patients become more cognitively aware. For clinicians hesitant to bring up a person’s periodontal condition, this uninvolved voice from the computer takes away that hesitation as well.

The Florida Probe sums up all the data professionally. The patient sees as well as hears the status of his or her condition. Keep in mind that today’s insurance world requires that today’s insurance world requires charting of periodontal recordings before treatment.

Periodontal charting and dental radiographs help provide the utmost care in treating disease. Radiographs should be current, based on the diagnostic needs of the patient and permit proper interpretation of the status of the periodontium. Intra-oral camera photos before and after any procedure show the patient a before-and-after perspective. A picture is truly worth a thousand words.

If the oral condition is such that a diagnosis cannot be made due to calculus getting in the way, a debridement, using code (D4555), is necessary. This code is only used if calculus blocks visualization of hard and soft tissue.

To complete the periodontal diagnosis, the patient must return for a comprehensive exam (D0150) after the debridement.

This exam must be comprehensive and involve charting existing restorations and their condition, soft-tissue condition and areas of dental decay. The periodontal condition is also part of this comprehensive examination.

Once fully assessed, the patient’s treatment is developed according to the oral condition and his or her periodontal diagnosis.

If the patient does have a periodontal infection and non-surgical therapy is the recommended treatment, the treatment plan can be broken down into full-mouth treatment or quadrants/sextants of periodontal therapy.

Because periodontal disease is a biofilm disease, it may be isolated to certain teeth or parts of teeth.

For people with less than four teeth involved in the disease, the new code for one to three teeth, D4542, may be used. Full quadrant of four or more teeth involved may be coded using D4541.

Each of these appointments should take approximately one hour and should be adjusted to an appropriate amount of time depending on the case.

At the appointment time, before scaling or any other invasive treatment, pre-procedural rinsing with an acceptable antimicrobial mouth rinse is imperative to protect the clinician and the patient.

Patient comfort is critical to a good healthy outcome. There are different types of anesthetic given by

Crest Oral-B introduces patient-based solutions

Clinical Pro-Health System for Gingivitis

Crest® Oral-B® recently introduced the Clinical Pro-Health™ System for Gingivitis, clinically tested to virtually eliminate gingivitis.1

With routine dental check-ups and regular use, patients with mild to moderate, persistent gingivitis can reduce inflammation and bleeding and significantly improve their gum health.

“It’s our mission to offer solutions to meet every patient’s oral care needs and be a resource and partner to dental health professionals,” said Ann Hochman, marketing director for Crest Oral-B.

“Our patient-based approach helps us develop targeted, innovative solutions for varying patient types, and include distinct, complete regimens in the plaque, whitening, orthodontics, pediatric and, most recently, gingivitis categories.”

The inspiration behind Crest Oral-B’s latest patient-based solution stems from the fact that one out of two American adults continues to suffer from gingivitis.

In fact, 55 percent of Americans believe that having “a little bleed-
Get with the ‘probe-gram’

Dentistry in 2011 is very different than it was in the 1950s. Most of us have seen images of dental operato-
ries from the mid 1900s. If we think about those images, we can probably remember seeing belt-
driven handpieces have no place in the hygiene operatory, just as belt-
generation probes really have no place in the invention, but in the year 2011, first generation probes really have no place to allow measuring to take place.

The Williams Periodontal Probe was invented in 1936 by periodontist Charles H. M. Williams and remains the prototype, or benchmark, for all periodontal probes.

In 1956 this probe was a wonderful invention, but in the year 2011, first generation probes really have no place in the operatory, just as belt-driven handpieces have no place in the operatory.

First generation probes are readily available, inexpensive and relatively easy to learn how to use, however, there are disadvantages. These probes do not provide constancy between cli-

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Disclosure: Angie Stone is an avid user of Florida Probe in her clinical practice. She trains office staff to use Florida Probe after purchase the device and occasionally lectures on the topic of periodontal disease and the use of Florida Probe, both of which is compensated for by the makers of Florida Probe.

Best Regards,
Angie Stone, RDH, BS

Baby’s first steps to a healthy mouth

February is National Children’s Dental Health Month

Parents are a child’s first teach-
ers in life and they play a sig-
nificant role in maintaining their child’s overall health. In obser-
vance of National Children’s Den-
tal Health Month, the Academy of General Dentistry’s (AGD) encour-
ages parents to introduce good oral health habits to their children during infancy.

According to the U. S. Centers for Disease Control and Preven-
tion, tooth decay affects children in the United States more than any other chronic infectious disease, highlighting the need for thorough oral care and regular dental visits.

The ideal time for a child to visit the dentist is six months after the child’s first teeth erupt. During this initial visit, a dentist will be able to examine the development of the child’s mouth.

“Parents are surprised when I tell them that their infants can develop tooth decay and cavities soon after their teeth first appear,” says AGD spokesperson Steven A. Ghareeb, DDS, FAGD.

“We usually call this baby-hot-
tooth decay, which is caused by the long-term exposure such as teething irritations, gum disease and pro-
longed thumb or pacifier sucking, often start early. The sooner the child visits a dentist, the better.

There are many things that parents can do with their child at home to maintain good oral health:

• Clean the infant’s gums with a clean, damp cloth twice a day.
• Ask a dentist how to take care of your baby’s teeth. Parents may begin to rub a tiny dab of tooth-
paste on the child’s gums. Doing so will help the child become accustomed to the flavor of tooth-
paste.
• As soon as the teeth first come in, begin brushing them with a small, soft-bristled toothbrush and a pea-sized dab of fluoride toothpaste.
• Help a young child brush at night, which is the most impor-
tant time to brush, due to lower saliva flow during sleep and higher susceptibility to cavities and plaque.
• By approximately age 5, a child can learn to brush his or her teeth with proper parental instruction and supervision.

“The best way to teach a child how to brush is to lead by your good example,” says Ghareeb.

“Allowing your child to watch you brush your teeth teaches the importance of good oral hygiene.”

Children, like adults, should see the dentist every six months. Some dentists may schedule interim vis-
its for every three months when the child is very young, to build the child’s comfort and confidence

levels or for treatment needs.

For more tips to ensure a child has good oral health, visit www.knowyourearth.com.

About www.knowyourearth.com

www.knowyourearth.com is the Academy of General Dentistry’s (AGD) source of consumer infor-
mation on dental care and oral health.

It’s goal is to provide reliable information in a format that is easy to use and navigate, and to provide the tools that will help consumers of all ages to care for their teeth and other aspects of oral care.

Tell us what you think!

Do you have general comments or criti-
cism you would like to share? Is there a particular topic you would like to see addressed in Hygiene Tribune? Let us know by e-mailing feedback@dental-tribune.com. We look forward to hearing from you!

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For more tips to ensure a child has good oral health, visit www.knowyourearth.com.

About www.knowyourearth.com
Children, like adults, should see the dentist every six months.

The Clinical Pro-Health System for Gingivitis is an oral care regimen that offers the highest level of protection to help eliminate gingivitis altogether.1,2

With this system for gingivitis, we have found in a clinical study an extraordinary 95 percent reduction in the number of bleeding sites after six weeks of treatment when compared to a control group that used regular manual toothbrush after a dental prophylaxis at baseline.1

“To break the cycle of this all too prevalent disease, Crest Oral-B is introducing a regimen specially designed for patients with recurring gingivitis.”

The Clinical Pro-Health System for Gingivitis helps break the cycle of gingival inflammation and gingival bleeding for improved oral health in patients with mild to moderate, persistent gingivitis.

Post scaling and the placement of a locally delivered antibiotic such as Atridox or Arestin.

Personalized oral hygiene instruction is demonstrated to the patient before or after each treatment is completed. The patient’s daily removal of food and plaque greatly affects the management of this disease. The periodontal re- care appointments in three-month intervals have been found to be effective in maintaining the established gingival health.2

To break the cycle of this all too prevalent disease, Crest Oral-B provides the most adequate removal of hard deposits and toxins from the tooth structure.

The care for the periodontal patient may include irrigation with a chlorhexidine or povidone iodine solution during brushing and flossing.2

In laboratory tests.

To learn more about the system, visit www.dentalcare.com/clinical.1

References

1. Stark has been a big advocate for screening for oral cancer and educating the public about dental care by volunteering at local schools and health fairs that educate children and their parents.

She is a CareerFusion alumni and faculty member and seeks to bridge the gap between dental and medical care.

You may contact her at catherine.stark.321@gmail.com.
5 extraordinary dental hygienists will receive:

- A feature in an upcoming dental trade publication
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- VIP all-expense-paid trip to ADHA’s 88th Annual Session, Nashville
- Recognition at major conferences throughout the year
- Pampering spa experience
- Exclusive trip to P&G headquarters!

Ann B exceeded expectations as a Registered Dental Hygienist when she helped to create Mobile Dentistry of Arizona, a practice that brings comprehensive dental care to the residents — and staff members — of assisted living homes, skilled nursing, long term care communities, and other age qualified communities.

“I am so honored to be recognized by Crest Oral-B as their first of five Pros in the Profession. I truly love what I do and could not imagine doing anything else; so I appreciate Crest Oral-B supporting me through and through.”

In Trudy M’s more than 30 years as a Registered Dental Hygienist, she has continually gone above & beyond the call of duty. She currently works with students & faculty at the University of Nebraska Medical Center, College of Dentistry, and has been published in a number of scholarly journals.

“Educating patients and working with periodontal residents on proper oral health for their patients has always been my focus and I thought that was reward enough, but to be a Pro in the Profession is such a great opportunity!”

Log onto www.dentalcare.com/prosintheprofession or stop by the Crest Oral-B booth at upcoming dental meetings to nominate your Pro. From now until April 2011, Crest Oral-B will be accepting nominations.