Midlevel providers: Risky business or access-to-care cure?

ADA-sponsored reports prompt more discussion

By Robert Selleck, Managing Editor

A focus on midlevel dental providers as a core response to dental care access challenges might be better directed elsewhere because the business models in play aren’t sustainable. That’s what the American Dental Association is saying based on a consulting company’s examination of three midlevel workforce models under consideration in five states.

But at least two dental organizations responding to the report’s conclusions show there are plenty of other opinions about the viability of a midlevel-provider workforce and the benefits such professionals can provide to underserved populations.

The American Association of Public Health Dentistry (AAPHD) and the American Dental Hygienists’ Association (ADHA) issued statements that question the ADA’s conclusions. Both organizations ask why dental-school-graduate numbers are expected to increase, workforce expansion is the wrong strategy to use to address shortage of dentists in the aggregate, and the ADA consistently fought the midlevel provider concept, arguing that it is not in the best interest of patients to perform irreversible dental procedures, such as tooth extractions and major restorative work, to be performed by non-dentists. It also has argued that because there is no formal education and training for midlevel providers, it is not in the best interest of patients to perform these procedures.

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The ADA-commissioned report examines proposed midlevel workforce models in Connecticut, Kansas, New Hampshire, Vermont and Washington. It items detailed financial projections for various business models for Dental Health Aide Therapists (DHAT), Dental Therapists (DT) and Advanced Dental Hygiene Practitioners (ADHP). Revenue and expense projections are based on different combinations of public and private payment-for-services scenarios. The midlevel provider’s education debt also is factored into the analysis. The ADA has consistently fought the midlevel provider concept, arguing that it is not in the best interest of patients to perform irreversible dental procedures, such as tooth extractions and major restorative work, to be performed by non-dentists. It also has argued that because there is no formal education and training for midlevel providers, it is not in the best interest of patients to perform these procedures.

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‘Turn off that phone!’

How do managers deal with cell phone usage in the office?

By Heather Collicchio and Teresa Duncan, MS, FAADOM

The membership of the American Association of Dental Office Managers (AADOM) is composed of individuals who have first-hand experience dealing with situations that would make many people cringe. Some of the most common questions that emerge on our AADOM member forum deal with the rise of text messaging and personal calls in the office. We love text messaging and phone calls, but not so much among our staff.

We asked several of our AADOM members to answer this hot potato question:

How do you handle your team when excessive texting and phone calls are an issue? Is there an example you’d like to share?

Melanie Duncan: To text, or not to text—is that the question? I love technology, but sometimes it can be a detriment to your team. Believe me I have seen it all! There is the hygienist who is texting while a patient watches a CAESY video or the team members have to keep their phones on them in case of an emergency. Really? Are they trying to say that the front office team cannot handle passing on a message? The answers are simple:

1) Make sure there is a policy in your employee manual that is clear and to the point.
2) Have the employee sign an agreement to leave his or her phone in the break room.
3) Expect 100 percent compliance! A 50 percent success rate is not acceptable.

There will be a list of excuses, but long as you are consistent with your actions, technology will once again be your friend.

Lisa Spradley: Our office allows cell phones and text messaging as long as it does not interfere with your patient flow. However, when cell phones were first brought into the practice there were problems with rampant usage. We would have employees coming into the office with the cellphone to their ear and clocking in, and they would stay on the phone until they were ready to seat the patient. This was unacceptable.

After a discussion with the doctor, we decided that while we did not want to completely ban cell phones, we did need some basic guidelines. When employees come into the office and click in, they should not be on their phones. Also—while texting in between patients is OK—it must not delay patients being seated or rooms being cleaned. No one is allowed to be on their cell phone or texting if they have a patient in the room. These guidelines helped to keep our patients as the No. 1 focus.

Deanna Alexander: Simply put, it is stated in our office manual. No cell phones are allowed in our work area. Each staff member has his or her own personal cubby space in the staff lounge area, this is where the cell phones belong. Everyone respects this policy.

Lisa M. Spradley

Melanie Duncan, FAADOM

Provided by AADOM

PRACTICE MATTERS
Tina Brown: Excessive phone calls and texting can be quite a problem. With new employ-ees, we are very upfront with poli-cies and guidelines. They tend to follow them for a while until the “newness” wears off. Our more seasoned team members, on occasion, can get caught up as well but gentle re-minders in the very beginning of the oc-currence with any team member usually helps.

Upon the second time I remind them again and let them know they are dis-rupting the flow of the day. I also ask if there is anything I can help them with so they can stay on task and suggest they save their calls and texts for their lunch hour or break.

If a third occurrence dares to hap-pen they relinquish their phone for the rest of the day. It’s sad that sometimes it comes to that but I didn’t come up with the idea, they did!

When it became apparent there was an issue, I rallied the troops together and asked them to come up with a fair and reasonable penance.

They decided to give up their phones in lieu of documentation going into their employee file.

Julie McKee: Team morale is my top priority when im-plementing new policies and procedures. I do not enforce a policy that I have not researched and thought long and hard about. That being said, I have addressed this policy in a group/open-forum type set-ting so that I could share the reasoning behind the policy, and give them time to share how they feel as well. I maintain an open-door policy all the time and I want to know if and why they do not sup-port a decision. This way I may be able to help them to understand the reasoning instead of having a ‘just do it’ attitude.

That’s no fun.

Our policy — in a condensed version — states that any type of mobile device is not to be on your person in the clini-cal and business area. You may have your mobile in the break area or in your lock-er. The ringer must be set to vibrate if not turned off. All personal phone calls are not to be made during work hours, only on breaks and lunchtimes, unless of course it is an emergency. The staff is re-sponsible for creating awareness of this policy to friends and family members.

I make sure the team knows that they are respected and this in no way implies that they would abuse company time, this is simply to prevent distractions for themselves and other co-workers, as well as to prevent the possible misconception that could arise from another person or patient viewing a team member on their cellphone for any reason. Why? The patients don’t know it’s your son telling you he will be going to his friend’s house after school, or that maybe a friend just told you a quick joke at which you giggle. In the minds of patients (or even co-workers), all they know is “She is not giving my time and care the attention and respect I deserve, how do I trust her in my mouth?” or, “Is she laughing at me?”

Conclusion
As you can see, our members all have different techniques but are equally ef-fective. It all boils down to a policy issue that must be stated above of time and communicated effectively to the team. Take a look around your office and if you see someone texting or wasting time on the phone, begin to draw up your policy and plan its implementation. Re-member — the patient’s perception is your reality!

MELANIE DUNCAN, FAADOM, is owner/president of Results Unlimited Dental Consulting and director of clinics for Heritage Creek Dental. The AADOM 2008 Office Manager of the Year and a subject-matter expert for the Dale Foundation, she has been in practice management more than 22 years. Her affiliation with AADOM has given her many opportunities to seek guidance and give from her own experience to others. She is dedicated to making dental care accessible and affordable for everyone. Contact her at melanie@duncan@resultsunlimitedconsulting.com.

LISA M. SPRADLEY has been in the dental field for more than 15 years. She is an office manager for a general dentist and has her own dental consulting business, TCB Dental Consulting. She helps train front-office staff in effective time management techniques. She is an active, lifetime member with AADOM and plans to receive her Fellowship this fall. She can be reached at lisamary@tcbdentalconsulting.com.

DEANNA ALEXANDER, FAADOM, has been in dentistry for more than 30 years. She attends many continuing educa-tion courses to keep up with the fast pace of the ever-changing dental world. She loves the everyday variety of her responsibilities and being in touch with the patients.

TINA BROWN, FAADOM, has more than 30 years of experience in the dental field and is the president of Applied Dental Practice Enhancement—a training, consulting and speaking firm. She attended San Diego State University and Pacific College of Dental Assistants in San Diego. She is a retired RDA and has spent the last 20 years as an ad-ministrator. She is a lifetime member of AADOM and writes articles for the administrative team.

JULIE MCKEE, dental director at Gordon Dental, considers the practice and its patients a huge part of her family. She thrives on the camaraderie and pride of working in a state-of-the-art dental practice. She uses the AADOM network to share resources and ideas to keep the practice on the leading edge of patient satisfaction. She considers herself a lifelong learner and encourages those around her to be in a constant state of study, growth and action.

HEATHER COUCHIO is the president and founder of the American Association of Dental Office Managers.

TERESA DUNCAN is its educational content adviser. For more information please visit www.dentalmanagers.com.
Unique maxillary frenectomy with a diode laser

By David L. Hoexter, DMD, FICD, FACD
Editor in Chief

There are many opinions, both in favor of and against, the utilization of lasers in periodontal therapy. There are also many reports of the different surgical techniques utilizing sharp metallic instruments for exacting predictable and desired results. The use of a laser to achieve these results does not mean that there are not other efficient, “classical” procedures that would accomplish the goal. Yet, a laser might be a more direct and efficacious path to achieve the same goal, with easier healing and less side effects.

This case presentation allows me to demonstrate the utilization of a diode laser to allow ease of technique, avoid unnecessary bleeding, avoid the use of sutures (and their removal), and provide a comfortable transition for the patient without swelling or need for a periodontal dressing after the surgery.

In this presentation, a young female patient presented in my office, complaining about her frenum in the maxillary anterior. She related that it hurt whenever she bit into a firm substance, such as corn on the cob. Her tongue constantly reached to this uncomfortable area, affecting her speech, and she felt pain in her lip when she tried to smile.

A few years prior, she had a lot of dentistry done in her maxillary anterior for esthetic purposes. She had been aware of and bothered by a natural, large diastema between her maxillary centrals. The previous dentist had closed the diastema space between the crowns by overbonding the area, leaving overhanging margins on the mesial of both centrals (Fig 1). The area now appeared clinically closed, but the constant irritation and bleeding in the area, especially due to the frenum pull, made this teenage patient feel very uncomfortable.

X-rays taken by my office revealed an obvious space, seen as a large radiolucent dark-appearing space between the centrals’ roots. Note the large restorations’ mesial overhanging margins. (Fig 2). The area, affected by the large void pointed out in Figure 2 that is obvious, huge, dark-appearing void. Because this was a surgery that involved only soft tissue, our choice of lasers is the CO2, Nd:YAG and diode lasers. Other lasers may be used for both soft and hard tissue. I chose to utilize just a tissue laser, and chose a diode laser. This AMD diode laser also offered the use of a disposable tip containing a thin fiber that would transmit the therapeutic treatment. The tip, being disposable, will aid in the consistency of maintenance and hygienic cleansing in and during our treatment.

A standard frenectomy, where we might remove the frenum with a sharp stainless steel instrument, might lead to further complications by exposing the large void pointed out in Figure 2 that is covered by tissue. If the frenum is just incised and removed, the area will have an obvious, huge, dark-appearing void. Yet the frenum should be removed. The obvious restorative necessities and options were discussed first. This young patient wished to do a little at a time, starting with the frenum removal.

After local anesthesia with xilocaine, the frenum was infiltrated, incised from the attachment of the tissue and lip-side of tissue first, rather than incising in the center of the frenum or separating and detaching the tissue from the side attached to the alveolus. Using the AMD diode laser, the tissue was incised, keeping the field of vision intact and accessible.

Continuing movement of the laser tip toward the alveolar-covered tissue allows the trough to be made wider until the desired length is acquired. All of this is accomplished painlessly, without a pool of blood blocking the view. This laser automatically enhances a clot, allowing not only a view but also a comfortable working environment for the operator as well as a painless one for the patient.

The assistant retracts the lip, with the laser allowing complete vision and aiding in curtailing the bleeding. After the tissue is dissected to the desired level, the remaining loose tissue of the frenum is removed using the diode laser, as well. These results leave a slight charring when we wish to control bleeding (Figs 4, 5).

Healing proceeds uneventfully until it is completed and is maintainable (Fig 6). Once the frenum is removed and healed, the patient is no longer uncomfortable when eating. Nor is her lip restricted when she desires to smile.

The healed area allows the patient to keep the area clean. She is able to reach and floss the mesial aspects, which she couldn’t do previously. After completion, she is reminded of the need to correct the restorations of her maxillary anterior teeth and get rid of the obvious overhanging margins. This particular patient desired a little correction at a time, but, in the meantime, the positive results of the laser treatment made her positive about correcting and improving the esthetics of her anterior maxillary teeth in the near future.

With the use of this AMD diode laser, we are able to remove the frenum attachment from the lip side initially, allowing a predictable approach that helps avoid exposing a large hole in the very front and center of her smile. This laser treatment and its positive results for her, allowed her to consider future restorative corrections with a positive attitude. In this case, use of the AMD diode laser allowed her smile to be corrected, and changed her discomfort into a comfortable glow.
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Attendees enthusiastic about IACA 2012 annual meeting

More than 800 dental professionals from around the world attended the International Association of Comprehensive Dentistry (IACA) annual meeting. The event was July 26–28 at the Westin Diplomat Resort and Spa in Hollywood, Fla. Most of the attendees were returning members, and many reported that this was the best meeting yet in the IACA’s eight-year history.

One first-time attendee said, “As my first IACA, the whole atmosphere and caliber of people was much more than I anticipated. [while] I’d heard a lot from people who have attended nearly all, if not all of them, I still didn’t expect it to be as good as it was. I got so much good and benefited from not only the lecture series, but from talking to other people who shared a little piece of themselves, which helped me change the way I do things. I just had the best time. It was well run and [included] lots of fun. This was the best dental meeting in the world!”

Next year’s meeting is in Calgary, Alberta, Aug. 1–3. For more information, visit www.theiaca.com, or call (866) NOW-IACA.

(Source: International Association of Comprehensive Aesthetics)

Courses fill quickly at dental office managers conference

Many courses have already hit their maximum-registration limits for the American Association of Dental Office Managers (AADOM) annual conference in Scottsdale, Ariz., Sept. 6–8 (Thursday through Saturday).

Held at the Westin Kierland Resort, the conference has a lineup offering up to nine continuing education hours toward AADOM’s Fellowship Program.

The conference is for dental office managers, practice administrators and anyone involved in the business end of the practice. Attendees can choose from a variety of courses and sessions specific to the efficient and successful management of a dental practice. Topics include marketing, communication, technology and insurance coding updates. Special focus will also be given to leadership and

*See AADOM page A7

The annual IACA conferences present a variety of lectures and hands-on workshops by world-renowned professionals. The 2012 meeting pictured here, in Hollywood, Fla., earns high praise from first-time and returning attendees alike. Photos/Provided by IACA

Host site for the American Association of Dental Office Managers conference is the Westin Kierland Resort in Scottsdale, Ariz. Photo/Provided by AADOM
Try microscopic dentistry

Whether you’re a microscope user or not, the Academy of Microscope Enhanced Dentistry 11th Annual Meeting and Scientific Session promises to open your eyes to new possibilities. Early-bird registration at www.microscopedentistry.com ends Sept. 15.

Non-members and those who haven’t worked with a microscope are encouraged to attend to learn why microscopic dentistry is gaining so many advocates. "Micro Vision: On the Cusp of Science & Precision," is Friday and Saturday, Nov. 16–17, at the Hotel Del Coronado in San Diego. This year’s meeting represents a return to a live, onsite format, following the academy’s virtual-only meeting last year. However, the virtual option continues, too, with live online streaming video available as an alternative strategy to access the meeting. Some of the sessions will air live online from California. And sessions will be recorded for archived availability online. This enables onsite attendees to view or review sessions later. Access to the recorded sessions is included in as part of registration. Copyright law restricts some of the sessions from be available online.

The scientific session features general sessions, vignettes, panel discussions/Q&As and hands-on courses with top clinicians and leaders sharing the latest science and techniques. All major sectors of dentistry are represented: restorative, endodontics, periodontics and implants.

The hands-on courses give attendees the opportunity to test-drive different microscopes while learning new procedures. Among the hands-on offerings: "Microsurgery I: The Principles of Suturing," with David Cross, DDS; "Implant Microsurgery II: Sinus Elevation," with Adriana McGregor, DDS; "Micro-Aesthetics II: The Art of Micro-laminates — How to Master Ideal Prepara- tion," with Claudia Cia Worschech, DDS, PhD; and "Auxiliary Course: Maximizing the use of Magnification for All Assistants & Hygienist," with Arvie Malik, RDIH, and Karen Nester, DA.

Contact AMED at (260) 249-1028 (ET) or at admin@microscopedentistry.com. You can register for the meeting or get more details at www.microscopedentistry.com.

(Source: AMED)
Register now: Greater New York Dental Meeting

Scientific Meeting: Nov. 23–28; Exhibit Floor: Nov. 25–28

Registration is open for the 2012 Greater New York Dental Meeting (GNYDM), the largest dental congress and health-care meeting in the United States, with 53,789 attendees from all 50 states and 127 countries in 2011.

A significantly expanded international program accommodated 6,656 international visitors in 2011, with sessions in French, Spanish, Portuguese, Italian and Russian.

The 2012 meeting runs Friday through Wednesday, Nov. 23–28.

The high-energy event, which never has a pre-registration fee, draws top dental professionals with an expansive exhibit hall and more than 300 educational courses, including full-day and half-day seminars, essays, hands-on workshops and a live, 430-seat, high-tech patient demonstration area.

New York City is full of cultural enclaves that give attendees the opportunity to experience foods, festivals, arts and more from all over the globe. Few cities offer a wider variety of iconic attractions, historic buildings and cultural sites.

Three major international airports, Newark Liberty (EWR), Kennedy (JFK) and La Guardia (LGA) and discounted hotel rates for registrants, make it easy for any dental professional to visit New York City and attend the meeting.

The GNYDM staff encourages you to see all New York City has to offer during one of its most beautiful times of year.

(Source: Greater New York Dental Meeting)

Yankee Dental Congress 2013

Jan. 30–Feb. 3 in Boston

Connect with some of the brightest minds in dentistry, and discover the latest trends, techniques, products and services at the 38th Yankee Dental Congress. You’ll find 450-plus exhibitors and a 300-plus speaker lineup that includes crowd favorites Gordon Christensen, the Madow Brothers, Loretta LaRoche, Laney Kay and Roger Levin. Other highlights include:

Dentaltown: Discover new and exciting ways to implement technology in your office from your fellow dental professionals.

RDH @ YDC: For the first time, the experts at RDH Magazine and RDH Under One Roof bring their quality continuing education and action-packed events to Yankee.

Essentials of Management: A “Mini-MBA” for dentists is offered by Bentley University.

Dentist as the CEO: Learn the tools to improve the business side of your practice, such as controlling expenses, setting goals and hiring effectively.

Healthy Living Pavilion: Have lunch with a registered dietitian and learn how to eat healthfully — while earning C.E. credit; plus there are many other valuable courses.

Dental Management of Sleep Apnea Fast Track: In one-hour sessions throughout the day, learn to work with sleep apnea patients.

Yankee Boardwalk: Kick back with your favorite beverage, light fare, and upbeat music at a free, family-friendly event open to everyone, Thursday, Jan. 31.

Friday Night Laughs: Share some giggles with colleagues, friends, and family when Kathleen Madigan takes the stage Feb. 1.


(Source: Yankee Dental Congress)
The American Academy of Implant Prosthodontics (AAIP) joined with its affiliates, Atlantic Dental Implant Seminars (ADIS) and the Linkow Implant Institute, to present a five-day comprehensive implant training course in Ocho Rios, Jamaica, in early July.

The course included lectures, hands-on participation, surgical and prosthodontic demonstrations, diagnosis and treatment planning of implant cases, construction of surgical templates, diagnostic wax-ups, insertion of two to six implants by each participant and sinus lifts under supervision of course faculty.

The nine participating dentists inserted 56 implants, performed three sinus lifts and restored seven implants placed in a previous course. Patients were provided by the Ministry of Health and the University of Technology, School of Dental Sciences, Jamaica. Course participants were from Arizona, Illinois, New Jersey, New York, Jamaica and St. Kitts.

Upon completion of the one-week comprehensive implant-training program, participating clinicians are able to accomplish the following tasks: identify cases suitable for dental implants; diagnose and treatment plan for preservation and restoration of edentulous and partially edentulous arches; demonstrate competency in the placement of single-tooth implants, soft-tissue management and bone augmentation; obtain an ideal implant occlusion; work as part of an implant team with other professionals; and incorporate implant treatment into private practice with quality results, cost effectiveness and profitability.

A dental degree was required for all participants. The course was tax deductible and 35 hours of dental continuing education credits were awarded on course completion. Patient treatment was provided in a Jamaican dental school, with personalized training in small-group settings. The course is a cooperative effort of the Jamaican Ministry of Health, the University of Technology, School of Dental Sciences, Jamaica, and the American Academy of Implant Prosthodontics.

Dr. Mike Shulman is course coordinator; Dr. Leonard I. Linkow is course director; and Dr. Sheldon Winkler is course advisor. Course faculty, in addition to Shulman, Linkow and Winkler, included Drs. Robert Braun, Ira L. Eisenstein, E. Richard Hughes, Charles S. Mandell, Harold F. Morris, Peter A. Neff, Robert Russo and Robert E. Weiner. Shulman and Winkler taught the July seminar.

Implants and components for AAIP/ADIS implant seminars were provided by HIOSEN Dental Implants. Dental laboratory support was provided by: DCA Laboratory, Citrus Heights, Calif.; Dani Dental Studio, Tempe, Ariz.; and Dutton Dental Concepts Inc., Bolivar, Ohio.

The objective of the Academy of Implant Prosthodontics — founded by Dr. Maurice J. Fagan Jr. in 1982 at the School of Dentistry, Medical College of Georgia — is to support and foster the practice of implant prosthodontics as an integral component of dentistry.

The academy supports component and affiliate implant associations around the world, including organizations in Egypt, France, Italy, Israel, Jamaica, Jordan, Kazakhstan, Paraguay and Thailand.


American Academy of Implant Prosthodontics is an approved PACE program provider by the Academy of General Dentistry. The formal continuing education programs of this program provider are accepted by AGD for fellowship, mastership and membership maintenance credit. The current term of approval extends from Jan. 1, 2010 to Dec. 31, 2013.

Complete information on the AAIP/ADIS Jamaica implant continuing education programs, including tuition, faculty lectures, transportation and hotel accommodations, can be obtained through www.adiseminars.com or by calling (550) 653-1909. AAIP membership information can be obtained from the AAIP headquarters at 8672 E. Eagle Claw Drive, Scottsdale, Ariz., 85266-1058; telephone (480) 588-8062, fax (480) 588-8296, or via e-mail at swinkdent@cox.net. The AAIP website is www.aaipusa.com.

Participants at AAIP/ADIS implant seminar, Ocho Rios, Jamaica, July 3–7. Dr. Sheldon Winkler is center left and Dr. Mike Shulman is center right. Photo/Provided by AAIP & ADIS.

5 days of training, 9 dentists, 56 implants

Comprehensive, hands-on implant-training course in Jamaica graduates latest class

(Sources: AAIP and ADIS)
Implant impression techniques: comparative review: Transfer impression versus direct abutment level

By Zvi Fudim, DDS

The inaccuracy in dental implant impression is a vast and unsolved problem. It is so serious that the high rate of osteointegration of the majority of implants is absolutely meaningless. Knowing that traditional transfer impression techniques seldom deliver a passive fit of a framework means that most bridges will end up with a failure (Fig. 1).

Different studies show that transfer technique is almost four times worse than the official requirement. Therefore, besides the mechanical issue, it is also a patient’s right to know that transfer impression transfer method is extremely inaccurate, and requires at least a warning and a legal consent. Patients are often misled by widely accepted sources that state:

The success rates of dental implants vary depending on where in the jaw the implants are placed but, in general, dental implants have a success rate of up to 98 percent. With proper care (see below), implants can last a lifetime (WebMD.com).

Numerous in-vitro studies have examined implant restoration accuracy. There is no doubt about the fact that the transfer impression is to blame for the misfit of the framework, but what exactly causes the distortion has not yet been pointed out.

What is wrong in the transfer impression?
The first problem is that the transfer, which is mechanically caught in the impression material (such as PVS), does not become an integral part of the impression. In fact, it can be easily moved. However, due to the friction between the surfaces of the transfer and the impression material, it does not return back to its original position (Figs. 2a, 2b, 2c). That displacement cannot be avoided when the technician engages analogs into the impression. In other words, forces in high torque or pressure dislocate and mobilize irreversibly the imbedded implant parts.

Fastening in the screw into the analog should be done avoiding any contact with the tray, however, that cannot be always guaranteed. The shift of the transfer can take place even due to the gravity forces of the impression tray, especially in the molar areas. A tray that weighs 100 grams generates in the molar area a torque of 8 Ncm by only its own weight; that’s enough to rotate the transfer. The polymer impression materials are characterized by a serious amount of expansion, making the transfers lose and mobile in the impression (Figs. 3a, 3b, 3c). The implant manufacturers should indicate that polymer impression materials are not suitable for the techniques using impression transfers.

Splitting transfers with acrylic resins may lead to displacement of the transfers due to the shrinkage of the acrylic materials. Even a splinted complex of impression transfers does not become an integral part of the impression. The second problem is due to the uneven amount of the stone around the analog. The expansion of the dental stone during its setting causes a severe inclination of the abutment from its original position. The third problem is also related to the dental stone expansion. Unlike the stone, the analog does not have any expansion. The analog becomes lose and mobile. Gripping firmly a one-piece analog with a hemostat, one can see with a naked eye how it rotates in the model around its own axis (Fig. 4a, 4b).

Almost always, sectioning of an implant stone model is very difficult to perform because of the presence of the hard steel analogs in the body of the model. Additionally, a small amount of the dental stone around the analogs often leads to breakage of the die and doubt about whether there is a root of the dental model or working on an unsectioned model. These difficult working conditions prevent precise fabrication of the restoration.

Implant manufacturers have invested a lot of resources in the implant improvement but very little in the improvement of the impression accuracy. Many dentists become so frustrated by the results of the implant restoration that they stop restoring implants and refer the clients to prosthodontists.

Finally, more and more dentists today have come to the conclusion that a simple direct impression of the abutment is much better than the traditional transfer impression. The accuracy of the PVS material is very high; it has high volumetric stability and a good resistance for tearing. Additionally, the PVS by its slight rate of shrinkage can partially compensate the expansion of the dental stone and with aid of a rigid impression tray provides fabrication of accurate restoration. The main concern with the direct impression is the abutment’s subgingival area registration. In 2008 JADA Dr. Vincent Bennani published a review called Gingival retraction techniques for implants versus teeth. Bennani covered most gingival retraction means for natural teeth and discussed the possibility of applying them in the impression of the implant restoration. His conclusion was that there is no existing device or method for gingival retraction that practically can be used for direct impression of the implant abutment. Aluminum Chloride Exaplay™ was recently tested for use with the titanium endosseous implants and was found as a harmful material for the polished surfaces of the implant and implant parts. Bicon implants™ uses oversized healing abutments or custom oversized temporary abutments to expand the surrounding tissue. This method has little predictability because the rebound of the tissue varies from patient to patient.

Recently, a Canadian company, Stomato-tech, came up with a simple idea to retract the gingival tissue using a disposable plastic collar that is inserted on the apical end of the abutment before the abutment is engaged into the implant (Fig. 5).

Following the abutment’s engagement to the implant, the plastic collar is found between the apical part of the abutment and the gingival soft tissue (Fig. 6). Shortly after the removal of the impression from the mouth, the plastic collar is pulled out and removed permanently. The plastic collar creates a perfect gingival retraction with a valve factor preventing the liquids from contaminating the area of the finish line of the abutment.

It is undeniable that the plastic collar eliminates the need of the impression transfer and the analog. However, the main advantage of that device is the fact that it does not impact the accuracy of the final restoration (Fig. 7).

- See IMPRESSION page A13.
WE SPEAK ACCURACY
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xpAPce and XPsquared launched

Dentists create 24/7 online conference, tradeshow, C.E. forum

Dentistry is mired in a perfect storm that challenges the profession from all sides: weak economies in the Unites States and worldwide, dental trade show attendance declining every year, and dentists reluctant to close their offices or give up personal time (away from their friends and families) in order to take continuing education courses or spend time at trade shows like they did in the past.

On the vendor side, there are more than 150 trade shows in the Unites States and worldwide, each with tax vendor resources. While some meetings and shows are as strong as ever, many are in the decline. And when attendance drops at meetings, it is more difficult for vendors to realize a good ROI (return on investment). As a profession, we have come to expect vendor visibility (and often high visibility) at most major events. We ask vendors to support lunches and cocktail hours, supply tote bags and more, to the point that it is assumed they will always meet our needs. But are we meeting theirs? The way all of us learn and do business has changed forever.

Enter xpAPce and XPsquared. Formed by two dentists, Drs. Alan A. Winter and Frank Murphy (who combined have more than 75 years in education and clinical practice), xpAPce and XPsquared address the challenges facing both the dental profession and the vendors who supply that profession.

How? Let’s take xpAPce. Awkward as it appears, it is not a word to be spoken but an acronym for “eXPeriential Proven Continuing Education.” Focus on “eXPerience.” We have assembled 15 leading experts to serve as academic advisors who monitor the content and timeliness of our courses given by our world class scholars. XPsquared courses are procedural specific. They provide the tools that utilize current thinking and practices that enhance patient outcomes.

xpAPce and XPsquared form a unique tandem that brings 21st century dentistry to dental professionals and vendors around the world. The future is now! You can register (without charge) to join the XPsquared community at:

info@xpsquared.com

or call (212) 355-5535.

For more information, email info@xpapce.com or go straight to the online community at www.xpsquared.com.

Fifteen leading experts serve as academic advisors monitoring content and time lines of the xpAPce and XPsquared courses delivered online by world class scholars. Learn more at www.xpapce.com, www.xpsquared.com and www.2-virtualevents365.com.

xpAPce and XPsquared (Photo/Provided by www-2.virtualevents365.com)

D4D Technologies, manufacturer of the E4D Dentist™ system, has launched E4D Compare™ — an innovative adaptive learning technology tool for dental teaching institutions.

E4D Compare provides students with self-evaluation tools for precise measurement and feedback about the student’s sample preparations and restorations and how they compare to the institution’s standards. As students progress, they develop digital portfolios that demonstrate their accomplishments in tooth preparation, restoration design and occlusal articulation.

From the faculty perspective, E4D Compare provides evidence-based assessment tools that also document student progress. “The development of E4D Compare and its utilization in teaching institutions provide both students and faculty an innovative method of self-paced learning and a more consistent and objective evaluation of all parameters. This is another example of our commitment at D4D to making dentistry better at every level,” said Dr. Gary Severance of D4D Technologies.

“There is a crisis in dental education; many students believe that grading is subjective and inconsistent,” said Alan Winter DDS FACP.

Utilizing 3D Imaging: The New Standard of Care

Drs. Alan A. Winter and Frank Murphy (who combined have more than 75 years in education and clinical practice), xpAPce and XPsquared form a unique tandem that brings 21st century dentistry to dental professionals and vendors around the world. The future is now! You can register (without charge) to join the XPsquared community at:

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or call (212) 355-5535.

For more information, email info@xpapce.com or go straight to the online community at www.xpsquared.com.

xpAPce and XPsquared (Photo/Provided by www-2.virtualevents365.com)
Excel Studios is a full-service dental laboratory specializing in full-mouth and implant reconstructions. The state-of-the-art facility is equipped with the latest in CAD/CAM technology. Through its unique partnerships with leading implant manufacturers it is able to offer name-brand products with full manufacturer warranties for your peace of mind. Visit Excel Studios on the Web at www.weknowsmiles.com or contact a representative directly at (800) 981-9008, and let Excel Studios help you reach your ceramic goals.

(Source: Excel Studios)

High-tech laboratory uses latest CAD/CAM

Excel Studios is a full-service dental laboratory specializing in full-mouth and implant reconstructions. The state-of-the-art facility is equipped with the latest in CAD/CAM technology. Through its unique partnerships with leading implant manufacturers it is able to offer name-brand products with full manufacturer warranties for your peace of mind. Visit Excel Studios on the Web at www.weknowsmiles.com or contact a representative directly at (800) 981-9008, and let Excel Studios help you reach your ceramic goals.

(Source: Excel Studios)

A comparative study by J. B. Da Costa published in JOD, shows that there is no difference between direct oral scanning and indirect scanning of a stone model from PVS impression, which confirms the high accuracy of both methods.

Summary
The passive fit of the prosthetic framework is extremely important, especially for longevity of an implant. Every implant, even the cheapest one, can last many years in the patient’s mouth if only it is correctly loaded and properly restored. Lack of the passive fit usually leads to serious bone loss and implant failure.

Note: A complete list if references is available from the publisher.

The practitioners have to do everything possible to keep the restoration in the zone of 10 µm of the marginal fit. An implant, unlike a natural tooth, does not have periodontal mechanism that gives the natural tooth a resilience of 50-80 µm. Splinting as many crowns as possible divides evenly the load between the implants but can compromise the passivity due to the poor accuracy. To achieve 10 µm level of accuracy, every single negative cause should be eliminated from the impression procedure.

The only recipe for implant-supported restoration success is an accurate impression. Currently, the alternative to the transfer impression is the silicon or optical direct impression of the abutment with G-Cuff™ by Stomatotech or with an optical impression with an aid of scanable bodies. These two methods deliver a substantial passive fit that assures longevity of the implants and of the whole restoration.

Note: A complete list if references is available from the publisher.

Dr. Walter Renne, course director for CAD/CAM technologies and ceramics at the Medical University of South Carolina, College of Dental Medicine. “The E4D Compare software program enables students to learn by challenging themselves against the ‘master’ templates. E4D Compare has proven to be revolutionary in my classes. The students that have used this program have seen fast results and have been engaged from the beginning. The E4D Compare software provides new possibilities for enhancing the learning experience within the dental curriculum.”

E4D Compare is available through Henry Schein Dental and is compatible with E4D Dentist and E4D Labworks systems and PCs meeting certain processing and graphics requirements. For more information, go to www.e4d.com/compare.

About DaD Technologies
DaD Technologies is the creator of the E4D Dentist and E4D Labworks systems, which use high-speed laser scanning technology to produce digital 3-D impressions of teeth without the application of contrast agents. Intuitive DentalLogic™ software enables operators to customize restoration designs and send them wirelessly to the precision mill that uses the latest restorative materials to produce fine esthetic restorations. DaD also offers E4D Compass for restorative-driven implant solutions and E4D Compare adaptive learning technology for teaching institutions.

(Source: DaD Technologies)

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- Participants can bring their own cases for discussion and guidance
- After course follow-up for assistance in diagnosis and treatment planning for implant cases

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- Identify cases suitable for dental implants.
- Diagnose and establish a treatment plan for preservation and restoration of edentulous and partially edentulous arches.
- Demonstrate competence in the placement of single tooth implants, soft tissue management, and bone augmentation.
- Obtain an ideal implant occlusion.
- Work as part of an implant team with other professionals.
- Incorporate implant treatment into private practice with quality results, cost effectiveness and profitability.

“Wow a tremendous value this course is. Anyone who has taken implant courses but is still hesitant to start placing implants needs to sign up for this program. I enjoyed it so much I am considering returning to further progress my implant skills.” Steven Bloem, DDS, St. Petersburg, FL.

“Now I am having more confidence in implant dentistry. I diagnosed 2 cases for new patients this past week. They are maxillary premolar cases. Thank you for your instruction and guidance in implantology.” Alexander Jhang, DDS, Chico, CA.

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