How to get what you want: an implant success story

By Roger P. Levin, DDS

Dr. Sherman Smock knew how much potential his periodontal practice had, but he wasn’t sure how to realise it. ‘I felt comfortable with my practice philosophy,’ he says, ‘but my office was still underperforming. I was working hard, but not achieving progress.’

He had made some effort to improve his business by developing better customer service models and writing out his vision and sharing it with his employees. The trouble was, neither he nor his staff was following through.

Dr. Smock needed to do something. He sought out the services of Levin Group’s Total Implant Success™ Management and Referral Marketing program. After a detailed practice assessment, Dr. Smock and his consultant identified three major areas on which to work: leadership, practice systems and communication. Dr. Smock has since been happy to see his production increase by 22 per cent and his referrals by 18 per cent.

Leadership
‘I was not in control of my practice,’ Dr. Smock admits. He had developed a practice vision previously but, as he says, ‘I didn’t have the time or the skills to make it a reality.’

‘One of my greatest challenges,’ he says, ‘was coming to terms with the fact that any change for the better would have to come through my actions.’

With the help and guidance of his Levin Group consultant, Dr. Smock began taking charge of his team, initiating marketing and customer service systems, leading by example the way to a brighter future.

Practice systems
At first, Dr. Smock wasn’t sure whether leadership or practice systems should take a priority in his practice overhaul. His Levin Group consultant helped him realise the practice could work on both issues at the same time, that they are really two sides of the same coin. The office began making changes to the practice marketing plan and the way the office communicated with referring offices, to the practice’s customer service models and to the way the practice handles competition with the area’s other periodontal office.

Referral marketing
Dr. Smock’s office had been providing up-to-date periodontal treatments in areas such as bone and soft-tissue grafts. The office had also started offering continuing education classes for referring doctors to promote implant referrals. However, marketing was not a priority, and relationships with referring offices were left mostly as is, with no concerted efforts to strengthen them.

‘Stress levels were high,’ Dr. Smock says, ‘because we weren’t following basic business requirements. We were making no consistent marketing effort.’

This began to change as Dr. Smock and his team followed the Levin Group referral-based marketing program — a consistent and ongoing set of 15 to 30 strategies customised for each type of referring office.

Customer service
‘In the past, when we’ve performed patient satisfaction surveys, we received good marks in clinical services,’ Dr. Smock says. ‘But now I see superior marks in all areas of the practice, as well as in clinical services.’

By following their practice plan, the business office has become more effective in handling insurance issues and has improved collections. Efforts by the professional relations coordinator have enhanced the practice’s image in the eyes of referring offices. In addition, current patients, thanks to internal marketing and strong customer service, are happy to refer friends and family to the practice on a more consistent basis.

Conclusion

The changes Dr. Smock and his staff have made over a two-year period are remarkable. Production has skyrocketed 22 per cent, and referrals are up by 18 per cent. This should serve as an inspiration to any practice leader who recognises the possibility of greater success and professional satisfaction, but hasn’t yet figured out how to make it happen.

With the assistance of the Levin Group Method™, Dr. Smock has been able to focus on the integral areas of practice systems, communication skills and leadership, and the practice has grown.

As Dr. Smock knows, help is available, and hope is possible. In his own words, ‘We’ve gone from burnout to dreaming; survival to growth; aimlessness to direction; drudgery to joy; from a group of individuals to a team.’

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Key to this process is keeping staff on target with the practice systems. After a transition period, the staff now works as a cohesive unit, as directed by Dr. Smock’s vision for the future.

Looking to the future
As Dr. Smock acknowledges, there remains much that he and his staff can do to improve their practice. Quality of life for the team has improved greatly, but Dr. Smock knows that things can, and will, get better. As he says, ‘There is a clear sense of commitment on the part of those who have gone through this program and have seen the benefits of the Levin Group Method.’

Dr. Roger P. Levin

is founder and chief executive officer of Levin Group, Inc., the leading implant practice management firm. Levin Group provides Total Implant Success™, the premier comprehensive consulting solution for lifetime success to implant doctors in the United States and around the world. For more than two decades, Dr. Levin and Levin Group have been dedicated to improving the lives of implant doctors.

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We all see extensive advertised dental implants in the dental press and patients continue to ask their dentists about the possibilites of dental implant restoration. As dentists, we all have to constantly update our knowledge and skill base in this field. The General Dental Council has been working for some time with interested bodies, including The Association of Dental Implantology, to clarify satisfactory training pathways for dental surgeons undertaking dental implantology. The ADI has been instrumental in helping to formulate these guidelines. Which are available online at www.fgdp.org.uk

Essential components of dental implant training, which have been designed by the ADI are the online dedicated implant audit programme, ADIA, which is available live now as a free benefit for members. This fulfils the GDC guidelines regarding the necessity for audit of dental implant work. Additionally, an online postgraduate education programme will be available leading education via a web-based learning programme.

Offering support

One of the main areas highlighted by the GDC and heavily emphasised, is the need to be monitored to ensure a dentist in training is guided appropriately. This has long been part of the dental education process, indeed as students our basic dental education was monitored carefully to ensure we progressed.

There are a number of postgraduate training courses widely advertised by the Universities, dental specialist practitioners, the dental implant companies and via The ADI. But the practicable day-to-day assistance in case assessment, planning and indeed surgical placement are difficult to arrange for the busy practitioner in a format that is suitable for the busy practice environment.

The Association of Dental Implantology has been aware of this and has been working towards providing for its members a selection of mentors who would be able to help in this phase of their dental implantology training. These are ADI members with experience in various systems and experience in a wide variety of dental implant procedures. The database is available via the ADI website. The mentors have been assessed and have all carried out a specific training programme in mentoring dental implantology training.

The database is offered to ADI members at no charge, another benefit of ADI membership. The mentors can be selected by geographic position, implant system or indeed an ADI member could seek out a mentor to help with a specific area of implantology or specific procedure. Once contacted the mentor will guide and advise the training of their colleague. The arrangement of how much or little is required, how and when the two should meet and what appropriate fees would be charged would all be arranged between the two individuals, mentor and trainee.

This is another phase in the development of dental implant training, at which the ADI is at the forefront. Visit the website at www.adi.org.uk.

ADi launches dental implant mentoring database

Adrian Binney, the Welsh representative of the Association of Dental Implantology discusses the benefits of a new mentoring system for dental surgeons
Maxillary denture retention – anatomical considerations

Achieving a well fitting upper denture can be quite straightforward and most of us achieve an acceptable result using our standard, tried and tested, technique.

Occasionally however the retention we, and the patient, are seeking is not achieved. This is the depressing moment when after fitting the denture you take your hand away and the denture fails to resist gravity, dropping gently to meet the lower arch.

This article addresses what we are actually trying to achieve when fabricating a well fitting denture base, potential warning signs and how problems may be resolved.

For a denture to fit optimally the following criteria are essential:
1. The denture base must extend properly over the maximum area possible without interference with the surrounding structures.
2. The occlusal plane must be at the correct height.
3. The teeth must be placed within the ‘neutral zone’ between the tongue and the cheeks.

Even if you achieve optimal denture base extension, there are still factors, which can compromise your retention:

1. CLOSE FIT
To be effective the denture base also needs to have a close fit to the underlying mucosa to maximise interfacial surface tension.

2. COHESIVE PROPERTIES

A direct result of your impression between the denture base and the mucosa to maximise interfacial surface tension will be enough fit to the underlying mucosa to carry out the cohesive properties.

3. RESIDUAL RIDGE

The quantity and viscosity of the saliva affects its adhesive and cohesive properties.

4. BLOOD SUPPLY

The quantity and viscosity of the saliva affects its adhesive and cohesive properties and is a direct result of your impression technique and material used.

5. BORDER SEAL

An effective ‘seal’ around the entire denture border, is essential as this creates retention due to ‘atmospheric pressure’ and the easily recognised ‘suction’ which is the resistance to dislodgement that we use to test retention of our dentures.

Hard palate – the basic support for the upper denture is the two maxillae and palatine bone. The keratinised mucosa over the midline is of varying thickness and critically is at its thinnest in the midline. In this area it is non-resilient and may need to be re-epithelialised to avoid trauma. This is the reason for the recently fitted upper denture patient to present with an ulcer in the midline under the post dam. The hard palate is resistant to resorption and is, therefore, the primary denture bearing area.

Residual ridge – the ridge left after the teeth are removed is of varying shape and being liable to vary with time and can present with a centre ridge, two maxillary and two palatine, or two maxillary and one palatine, or even two palatine alone.

Anatomical considerations for upper denture base extension.

Fig 1 – Upper arch denture landmarks.
1. hard palate, 2. residual ridge, 3. incisive papilla, 4. maxillary tuberosity, 5. labial vestibule, 6. labial frenum, 7. buccal vestibule, 8. buccal frenum, 9. hamular notch, 10. vestibulolingual frenum area, 11. corusso process.

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resorption changes with time, and the pressure placed on it. For this reason the ridge is secondary in support to the hard palate. This can explain why dentures are liable to fracture in the mid-line, and why regular review and relining is so important.

Incisive foramen – Beneath the incisive papillae, this does not resorb and, as it is always positioned just behind the central incisors, gives an indication of the extent of resorption that has occurred.

Maxillary tuberosity – if the maxillary posterior teeth had been allowed to over-erupt prior to their loss there is a good chance of having a large tuberosity. It is not generally necessary to surgically alter these as they can provide significant resistance to rotational or tipping forces. It is, however, important to ensure that the occlusal plane is not compromised.

Lahial vestibule – these are either side of the anterior lalhial frenum and running as far as the buccal frenum. It is often assumed that the form, and shape, of the lip is directly controlled by the shape of the lalhial flange, this is not the case. It is the position of the necks of the teeth which should have most influence on the lip support, with the flange at its extremity being as thin as possible. Sufficient space needs to be made for the flange to navigate the lalhial frenum (by manipulation of the lip during impression taking) as painful ulcers can quickly develop.

Buccal Vestibule – this is the area lying next to the tuberosity and extending from the buccal frenum to the hamular notch. Unlike the lalhial vestibule the width of the buccal vestibule is critical. Correct recording of the buccal vestibule is often overlooked, it is however essential in creating the border seal. Problems are associated with recording the buccal vestibule because it changes size, in the same patient, depending on the contraction of the masstes and buccinator muscles and the position of the mandible. The distal portion of the buccal vestibule must be adjusted to accommodate the muscles, the ramus, and coronoïd process during the impression. At rest the distal vestibule is at its widest and this is when it should be examined. When the mandible is moved forward or to the opposite side it reduces significantly through influence of the ramus and coronoïd process. When the masstes contracts it is similarly affected.

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From a practical perspective it is essential to take a border moulded impression where both the initial impression compound, or heavier putty material and secondary wash material are allowed to set following careful movement of the mandible from side to side.

Done correctly the shape of the coronoid process and mandible can be seen on the outer surface of the impression. If incorrectly done the results will be; too much space buccal to the flange and a loss of seal, or (if made too thick) painful bruising of the ramus.

Occasionally with large tuberosities there may be little or no space for the acrylic denture base material and a metal base is required, together with instruction on reducing excessive eccentric jaw movement.

Once successfully recorded, whoever casts and trims the model must know to box out this area and not to over trim the model, but to leave the width and height of the sulcus. This is only necessary in this area, the reflection of the sulcus being sufficient for the rest of the model.

Hamular Notch - This is behind the tuberosity and between it and the hamulus of the medial pterygoid plate. The tissue in the hamular notch needs to be displaced by the denture to create the seal. If over extended, pressure will be exerted on the pterygomandibular raphe which extends from the hamulus to the retromolar pad (and which is pulled forward when the jaw opens). This can be extremely painful, with patients being unable to open their mouths or even swallow.

Vibrating line – this is classically taught as the imaginary line across the palate that marks the beginning of movement of the soft palate when the patient says ‘Ah!’ The suggestion has always been that the post dam should be placed 2-3mm distal to this. Our experience is that the vibrating line is rarely visible. Instead we opt to palpate the join between the hard and soft palate and to hand draw our preferred post dam position on the impression for transfer to the working cast. A second ‘minor’ post dam can also be utilised, esp. if there are concerns over the patient’s tolerance to the distal palatal extension.

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