Calling East Coast and West Coast orthodontists

NESO takes over Times Square in New York from Oct. 7 to 9

By Sierra Rendon, Managing Editor

The Northeastern Society of Orthodontists will host its annual meeting, “NESO NYC 2016,” from Oct. 7–9 at the Times Square Marriott Marquis.

NESO states that this is a premier professional development and networking event for orthodontists in the northeastern United States and Canada.

For three days, orthodontists can take part in lectures and workshops and check out the exhibit hall, featuring industry-leading partners and sponsors.

Here is a sampling of the sessions and speakers you will find available this year:

• See NESO, page 3

PCSO annual session heads to Seattle Oct. 13 to 16

By Sierra Rendon, Managing Editor

The Pacific Coast Society of Orthodontists will host its 80th annual session from Oct. 13–16 in Seattle at the Washington State Convention Center.

The PCSO states that its goal for this year’s event is to provide a stellar list of speakers, an up-to-date center conducive to learning and networking, a sold-out exhibit hall full of the latest technology and products, and social events that will offer attendees and guests plenty of opportunity to relax, enjoy and experience the best Seattle has to offer.

Each day, there are sessions aimed at doctors, clinical staff and administrative staff. Do not hesitate to bring your whole team, as everyone is bound to find a session that is appropriate!

Here is just a sampling of the sessions you can take part in:

• “Surgically Facilitated Orthodontic Therapy (SFOT): The Direction is Clear” with Dr. Rick Roblee
• “The Secret to Success in Today’s Orthodontic Practice” with Dr. Aaron Molen
• “Aligners = Braces: Are We There Yet?” with Dr. Sean Holliday
• “CBCT Do’s and Don’ts” with Sarah Pompa
• “Moving Beyond Sleep Dentistry: Interdisciplinary Resolution Strategies for Our Airway Patients” with Dr. Jeff Rouse
• “How to Use TADs Efficiently to Treat Open Bite: Cases and Clinical Tips” with Dr. Tae Woo Kim
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For dentists, the era of advanced degrees: Part I

By Dennis I. Tartakow, DMD, MED, EdD, PhD, Editor in Chief

T
donday, it is more common than ever before for den-
tists to go back to school for advanced degrees. Why? Until the 1990s, most doc-
tors were content to have only one advanced degree and never step foot in a school again. So why are so many individuals going back to school for advanced degrees, and is advanced education really worth the effort? Many doctors viewed the idea of con-
tinued learning more as a need, rather than a desire, to become more educated as clinicians, educators and/or leaders. This obviously has become a reality. Then with the coming of state-required mandatory C.E. credits for licensure, inter-

et courses began springing up, and schools and private institutions viewed this as a new way of increasing revenue. In 2002, 22 dental schools offered dual-degree programs. Dental schools in the United States and Canada were not encouraging potential dental scien-
tists to follow career paths that dental education desperately needed, some dental students view dentistry only as a technical discipline, while others who are interested in teaching and research careers might pursue research degrees (PhD). Today in 2016, almost all postgradu-
ate orthodontic programs range from two to four years in duration; some of-
fer certificates in orthodontics, and oth-
ers confer MS and/or PhD degrees. With the progressive emphasis on evidence-
based dentistry and the ongoing short-
age of dental faculty, dental schools be-

come instrumental in training future dental faculty. Some dental schools offer clinical and graduate training concomitantly, but there are far more institutions where research training is not a priority or an easily accessible option. A concept of “dental scientist” has been described for individuals who have completed funda-
mental dentistry as well as rigorous for-
mal research education leading to the PhD degree.

Adult education popularity has defi-
nitely become a reality. The need for con-
tinued education with regard to adults in general, but especially working pro-
fessional adults, is going to become even more pervasive in the future, it is more than just an intellectual exercise. With the demand for education for adults, it is important for adminis-
trators to know how to plan for, market and accommodate this population stud-
a. A key challenge for program planners will be to match organizational goals, delivery methods and institutional poli-
cies with the actual educational needs of adult students.

Thus, aecta est, the die has been cast for dentists to earn multiple gradu-
ate degrees but how, when and why?

Editor’s Note: Look for Part II in the next issue of Ortho Tribune!

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**Corrections**

Ortho Tribune strives to maintain the utmost accuracy in its news and clinical reports. If you find a factual error or content that requires clarification, please report the details to Managing Editor Sierra Rendon at s.rendon@dental-tribune.com.

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**Next issue of Ortho Tribune!**

[See the full issue for more articles and information.]

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**Editor’s Note:**

Do you have general comments or criticism you would like to share? Is there a particular topic you would like to see articles about in Ortho Tribune? Let us know by emailing Ortho@ dental-tribune.com. We look forward to hearing from you!
The American Association of Orthodontists (AAO) has announced it is expanding its Donated Orthodontic Services (DOS) program nationwide to provide opportunities for low-income children across the country to receive pro bono orthodontic treatment. The program previously operated in nine states.

“Every child should have the opportunity to have a healthy, beautiful smile that will have a positive impact throughout their lives,” said Morris N. Poole, DDS, past president of the AAO. “Thanks to the generosity of AAO member orthodontists who donate their time and talents to the program, more young patients will have the opportunity to achieve a functional bite, an attractive smile and good oral health.”

The DOS program is designed to provide orthodontic treatment to economically disadvantaged children who lack insurance coverage or who do not qualify for other dental health assistance where they live.

DOS is administered by the Dental Life Line Network (DLN), an organization that helps match patients who need care with doctors who can provide it. Applications are available at www.mylifemysmile.org/dos. Qualifying criteria include a low-income threshold and an examination by a general dentist to assess overall oral health.

Applicants must be patients of record of a general or pediatric dentist or a dental clinic. Poole notes that many accepted patients come into the program as a result of a referral from their family dentist.

“We are working hard to make the program as inclusive as possible,” Poole said. “A $200 program administration fee is required at the time of application. While it’s a relatively low fee, we appreciate that it may be a stretch for some families. To that end, provisions are in place to provide assistance, which is reviewed on a case-by-case basis.”

DOS typically advises that patients who have special needs seek orthodontic care through medical insurance or state-funded programs such as Medicaid.

As the DOS program builds its network of volunteer orthodontists nationwide, it expects to offer free treatment to 250 young patients in the coming year. Since 2009, nearly 500 patients have been treated in Illinois, Indiana, Kansas, New Jersey, North Carolina, Rhode Island, Tennessee, Michigan and Virginia.

Mindful of children who do not live near a volunteer orthodontist, the DLN will attempt to identify a nearby orthodontist who is willing to offer them pro bono treatment.

In states with two or more pro bono programs, Poole recommends that families apply for only one program at a time, leaving the option open to apply for alternative programs in the future if an application is declined.

Dental industry partners supporting Donated Orthodontic Services include DENTSPLY GAC International and Align Technologies.

(Source: American Association of Orthodontists)
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Skip the roughening and the sandblasting with Assure Plus

By Reliance Staff

Four years ago, Reliance released a revolutionary product, Assure® Plus. On top of bonding to every artificial surface found in the mouth, one of the most attractive features of Plus, according to the company, is the ability to eliminate the intrarosal use of hydrofluoric acid to etch ceramic crowns.

To the naked eye, all “ceramic” substrates look similar intraorally. The unfortunate fact is a “ceramic” surface can potentially be fabricated from lithium disilicate, porcelain, layered zirconia, monolithic zirconia and so on. In previous years, bond strength values were very poor if porcelain conditioner was applied to a zirconia surface; thus the clinician had to be confident the substrate was porcelain.

According to Reliance, there is news on the ever-developing situation of bonding to ceramic crowns. Extensive tests have shown that roughening or even sandblasting are no longer needed when using Reliance Porcelain Conditioner and Assure Plus. Furthermore, the task of differentiating zirconia from porcelain is unnecessary.

When confronted with bonding to a crown (porcelain or zirconia), the steps are as follows:

1. Prophy, rinse and dry
2. Apply one coat of Reliance Porcelain Conditioner, wait 60 seconds and air dry
3. Apply one coat of Assure Plus, air dry and light cure
4. Apply bracket with paste and light cure

Far too often we take for granted the benefit of a thorough prophylaxis. If adopting the above bonding modality, a thorough prophy is absolutely imperative to an acceptable bond strength. The drying of the active ingredient in Reliance Porcelain Conditioner now allows the clinician to skip the substrate identification. If the substrate is porcelain, the silane will bond to the glass filler. If the surface is zirconia, the drying and 60-second wait time allow the silane to go unutilized without interfering with Assure Plus.

When using Reliance Porcelain Conditioner and Assure Plus, roughening or even sandblasting might no longer be needed, according to Reliance.

Photo/Provided by Reliance
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Introducing TitanMoly Titanium Molybdenum arch wires

By G&H Orthodontics Staff

G&H Orthodontics, which says it is recognized as one of the world’s best manufacturers of premium archwires, introduces TitanMoly™ Titanium Molybdenum arch wires. According to the company, TitanMoly’s greatest advantage for orthodontists is the easier and faster archwire sequencing, which can reduce treatment times and patient discomfort.

“Orthodontists recognize our smooth-er wire,” Brandon Bernacchi, vice president of manufacturing, said. “The state-of-the-art diamond drawing process we use when combined with our proprietary mechanical polishing technology ensures a smoother surface for improved sliding mechanics and a more attractive finish. It’s important to note that independent laboratory tests have validated this comparison for G&H.”

Orthodontist Kristine S. West, DDS, MS, said that, “TitanMoly is the most effective titanium molybdenum archwire I have found. It is easily adaptable without breakage and enhances my treatment plans.”

According to the company, TitanMoly is the perfect bendable, nickel-free wire. It has enough recovery force and bendability without breaking. It is the preferred wire over stainless steel for a wide range of cases. Using TitanMoly means clinicians will have nearly twice the working range of stainless-steel wires, with 45 percent less deflection recovery force than stainless steel.

TitanMoly is a great wire for nickel sensitive patients because it contains no nickel, the company states.

To learn more about the features and benefits of TitanMoly, please visit GHOrthodontics.com/TitanMoly.

“The clinical advantages of titanium molybdenum archwires have been well documented,” said Howard A. Fine, DMD. “TitanMoly wires offer all the advantages plus reduced friction.”

About G&H Orthodontics
G&H Orthodontics is a leading provider of clinical solutions for the orthodontic community, serving customers for more than 41 years in more than 90 countries. G&H manufacturers a full line made in the United States, including brackets, bands, tubes, wires, springs, elastomerics and other orthodontic supplies. G&H Orthodontics is a privately held company headquartered in Franklin, Ind.

To learn more about G&H Orthodontics breadth of products, visit GHOrthodontics.com.

...using Assure or Assure Plus. On top of all the artificial surface bonding capabilities above, the variable reducing properties on enamel are the reason offices with the lowest bond failure rates utilize Assure Plus as a full-time, everyday primer, according to Reliance.

There are only two cases where any etching step is necessary: amalgam or composite restorations. Clinicians need to eliminate the idea that phosphoric acid will simply “clean” the work surface. The reasons are two-fold: chairside efficiency and primer interference.

If there is no enamel present, etching is a waste of time and money. Furthermore, etching can be detrimental to the bonding process when bonding to zirconia. If phosphoric acid is applied to a zirconia crown to “clean the surface,” the phosphate ions will attach to the substrate and subsequently repel the primers.
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Screening for a new revenue source that sets you apart

By Dr. Chris Farrell, BDS, CEO and founder of Myofunctional Research Co. (MRC)

Most dental professionals, by now, should be well aware of the rapid changes altering the dental playing field. The market-driven changes altering the corporatization of the industry and oversupply of new dental graduates, have been well highlighted in professional publications, and are now evident in the frequency of dental caries, particularly in young children, after decades of decreasing incidence, the dental profession, unlike its medical counterpart, relies on the ability to treat just a handful of diseases.

In previous articles, I wrote about the opportunities to widen our income base beyond the traditional that this changing dental landscape offers and explained how these opportunities are available now. Sleep Disordered Breathing (SDB) — and the serious effect it can have on a patient’s health and well-being — has recently gained attention and emerged as a new special interest. The disorder is recognized as being a result of the same upper airway and neuromuscular dysfunction causing malocclusion. For dental practitioners willing to grasp new opportunities, the ability to treat SDB/TMJ disorder represents a new revenue source.

The first step toward tapping into this new revenue source is to realize that each day more business walks out of your practice than is actually treated there. Virtually all growing children have a developing malocclusion, and early treatment or, where possible, prevention is sought after by parents.

Additionally, 35 percent of adults experience chronic pain as a result of TMJ disorder, and treatment is rarely offered. Furthermore, there is a high incidence of SDB among both children and adults, which is 80 percent undiagnosed. The potential increase in practice capacity is significant if these patients could be recognized and offered treatment. Therefore, the second step is developing the knowledge and ability to screen for these issues, which can be as simple as asking some questions. This can be achieved by setting aside one day each week to focus on consultations to identify these issues, which other dental practitioners may have never evaluated.

For kids: Myofunctional orthodontic evaluation (MOE), 5-15 years

Malocclusion is evident in children from the time the primary dentition is present and into the mixed dentition. Rather than genetics, the causes of the malocclusion are incorrect growth and development. The MOE identifies the causative factors of malocclusion, which, as is the case with mouth breathing, can lead to chronic health issues later in life.

Therefore, it is the duty of care of the dental profession to help identify these developmental issues in children and offer treatment options to their parents when available. Even in a practice that predominate treats adult patients, if those adults are parents, they will naturally take an interest in any health issues concerning their children.

For adults: TMJ disorder screening procedure

TMJ disorder is one area of the dental profession where tertiary education is lacking, with many academics considering it too complex an issue. Additionally, in order to avoid acknowledging the detrimental effects mandibular advancement devices (MADs) have on the occlusion and TMJ, many sleep dentistry practitioners make no mention of the TMJ during diagnosis.

Screening for TMJ disorder is made easy when the patients use a visual index to pinpoint to the practitioner what symptoms they are experiencing. This has the potential to identify a vast number of patients who have TMJ disorder, and because it is easily treatable in adults, and more severe issues can be avoided by treating early in childhood, existing patients can be offered solutions for issues that were previously unidentified.

In addition to opening a potential new source of income, identifying these patients and developing an effective, evidence-based treatment plan provides a great service. For many dentists today, it is easy to be mean a lack of patients while taking little action, except spending hard-earned income on advertising while offering the same service as colleagues. However, for practitioners who are focused on succeeding, the ability to effectively screen existing as well as new patients for SDB or TMJ disorder provides a means of differentiating from competitors.

Furthermore, by packaging habit correction, arch expansion, airway correction and dental alignment into cohesive treatments, Myobrace® and myOSA® systems, available from Myofunctional Research Co (MRC), are able to address the aetiological factors interfering with craniofacial growth and causing malocclusion as well as SDB and TMJ.

These systems, which were developed during the past 25 years and use a structured approach that integrates patient consultation, evaluation, diagnosis, treatment, education, clinical management and health goals, can enable dental professionals to treat more children earlier than previously possible. Increase patient flow, diversify treatment by offering solutions for SDB and improve practice efficiency.

In addition to providing financial benefit by enabling the practitioner to deliver high-quality biologically based treatments at a low cost, MRC’s systems provide a means of meeting an increasing demand for early orthodontic treatment.

Once potential patients have been identified through the screening methods outlined above, MRC’s myofunctional treatment systems are easily implemented into the practice. The treatment process begins with evaluation, education and treatment planning, which is completed via a series of optimized stages.

Implementing the Myobrace and myOSA systems in your practice

• Parent/patient education: The first consultation with parent/patient begins with MRC’s intuitively guided patient education presentation. This explains the causes of upper airway and neuromuscular dysfunction leading to SDB, malocclusion and TMJ disorder in children as well as adults.

• The presentation outlines to the parent/patient how myofunctional treatment is not just another means of straightening teeth or habit correction, rather, it is a complete treatment modality aimed at improving the patient’s overall health and development.

• Evaluation: As part of the first consultation with the parent/patient, a Myofunctional Orthodontic Evaluation (MOE) identifies areas that require focus (i.e., breathing dysfunction, incorrect myofunctional habits or nutrition). The patient’s myofunctional habits should be analyzed to provide context for the evaluation of the malocclusion, SDB and TMJ disorder.

• Record taking: In preparation of the case presentation and treatment plan, intra- and extra-oral photographic records are then taken along with impressions for study models. Additional videos of the patient’s function can be taken using a video camera or tablet. Patients are referred for an OPG and cephal X-rays as required, ensuring parent consent is recorded in the case notes.

• Case presentation: Through the use of visual aids the parent/patient is provided with a clear understanding of the issue as well as the proposed corrective action. The patient’s photographic records should be displayed on a monitor, utilizing the patient education presentation as a support tool to help explain treatment parameters. Treatment options and referrals are also discussed and in some cases, a referral to another health specialist may be required, which offers the opportunity for collaboration with other health professionals.

• The treatment plan: This makes up part of the case presentation and confirms in writing, the patient’s evaluation, established health goals, proposed treatment, including approximate timing and fee structure.

Once the parent or patient has accepted the treatment plan, an appointment is scheduled and treatment using the Myobrace or myOSA system can begin. Treatment involves the use of a series of intra-oral myofunctional appliances, specifically designed to re-train the oral musculature, develop the arch-form and align the teeth. In combination with the appliances, the fully automated patient education and activity program, the Myobrace Activities™ app, is an integral part of the treatment system.

A changing professional landscape as well as a new focus on evidence-based biologically focused treatment means that, for practitioners still reliant on the mechanical excellence of the past, profitability is diminishing. However, the good news for forward-thinking dental professionals focused on 21st-century, evidence-based dental and health care, is the opportunity to improve their patient’s health and well-being as well as operate a profitable practice is available.

To learn more about MRC’s patient education programs and to begin implementing the Myobrace and myOSA treatment systems, visit the courses section at myoresearch.com.
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