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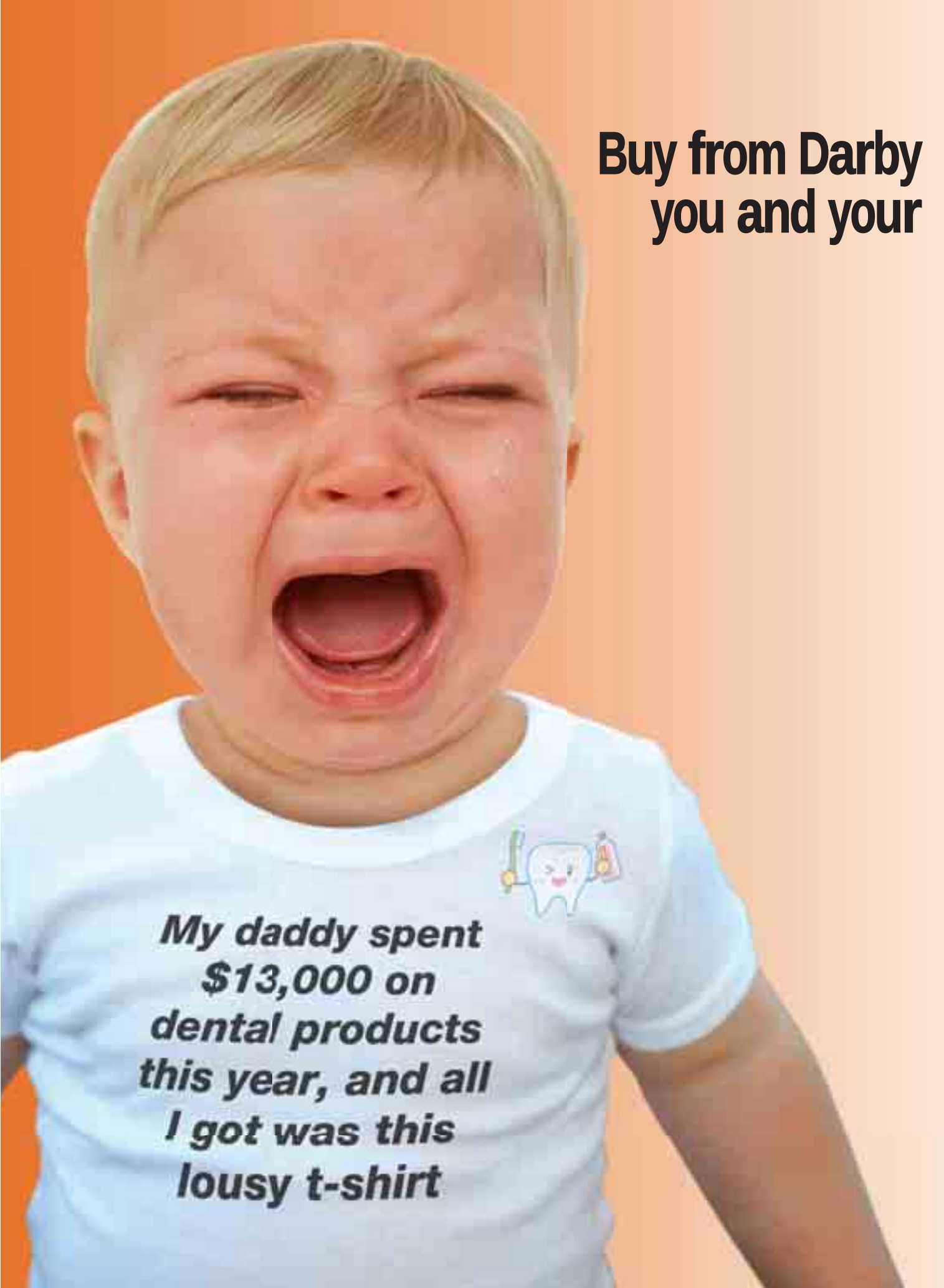
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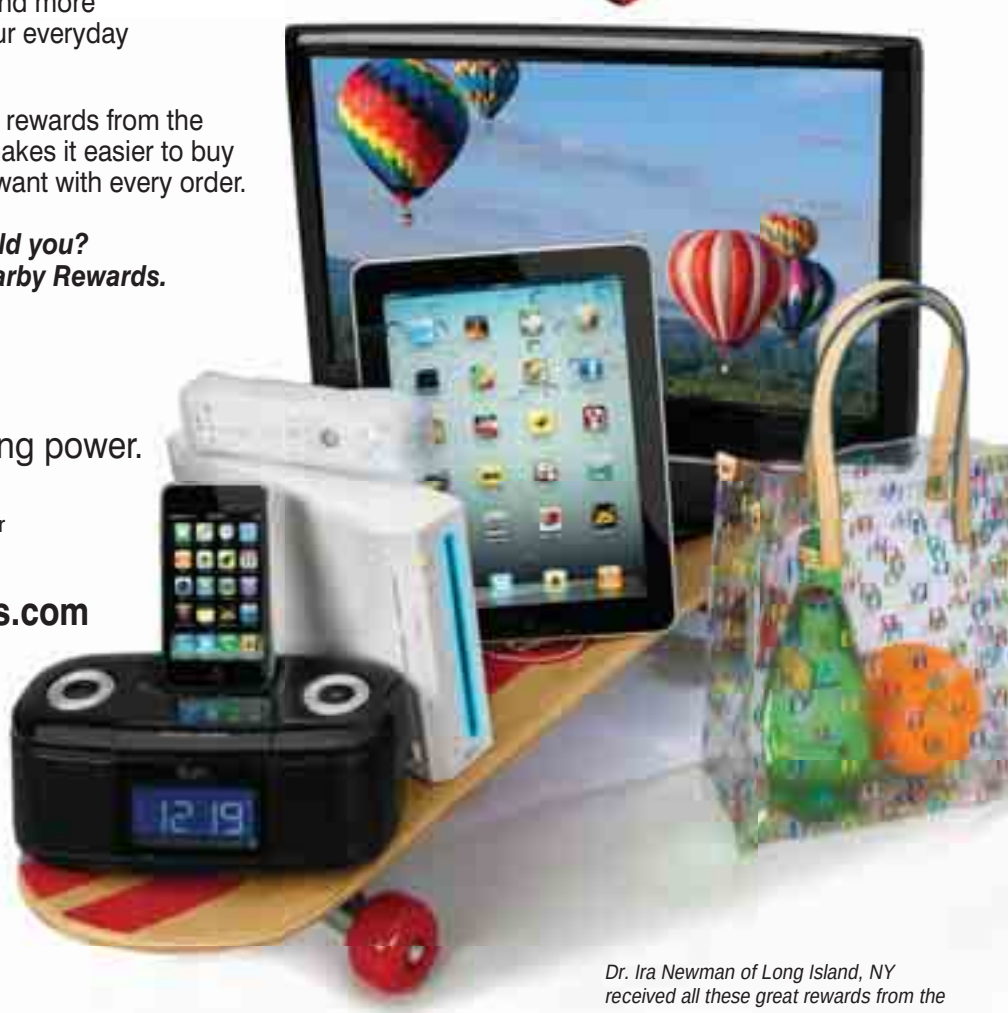

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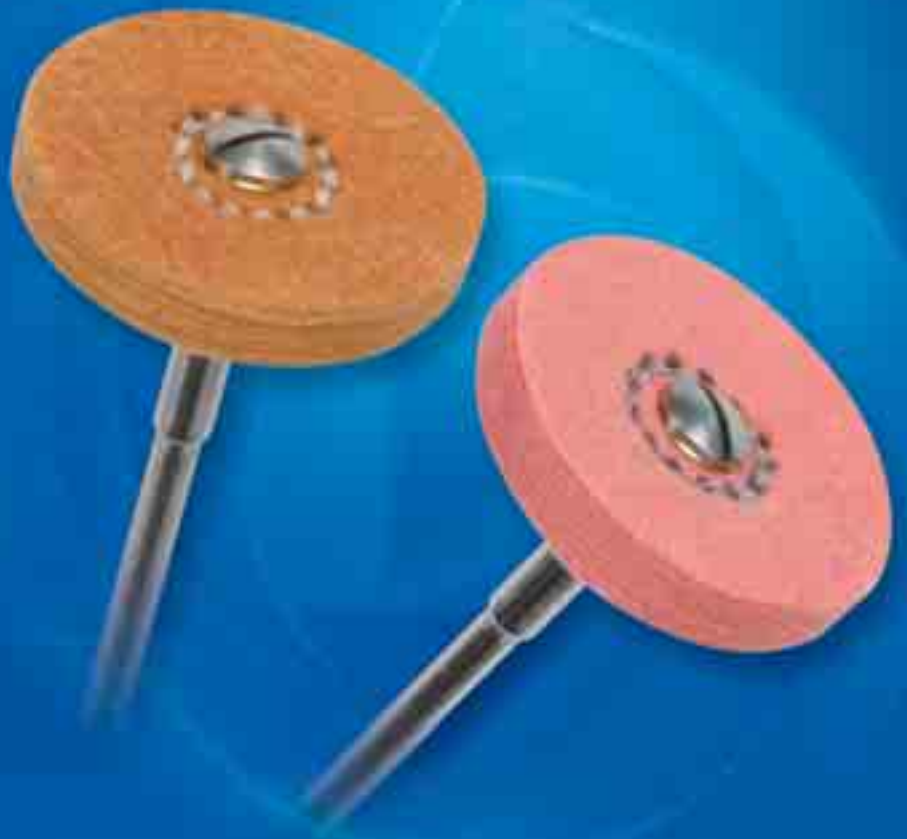

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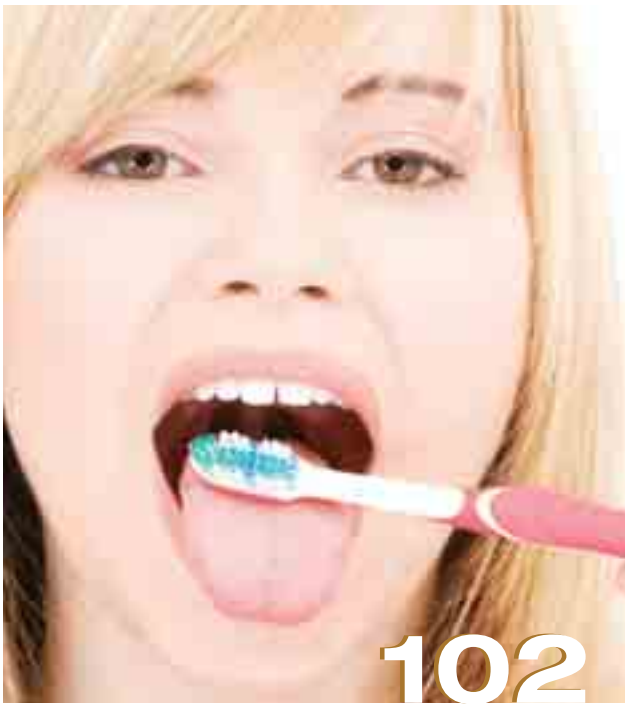

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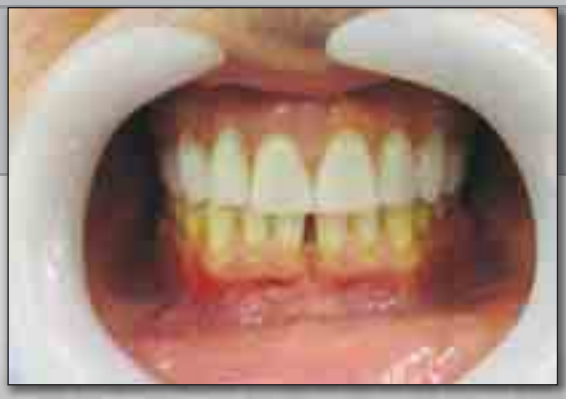

Another Veneer Case – Would Like Some Advice on Veneering Teeth with Receded Gums, Please

Everyone knows we cannot bond well to root surfaces, so what is the solution in this case?

Advice on Veneering Teeth Search

Message Boards

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Heroic and successful. This is a tough case, well documented.

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The benefits of a good surgical guide are often overlooked. Join the debate.

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Mary Randall presents five ways Easy Dental practice management system can make you money in a tough economy.

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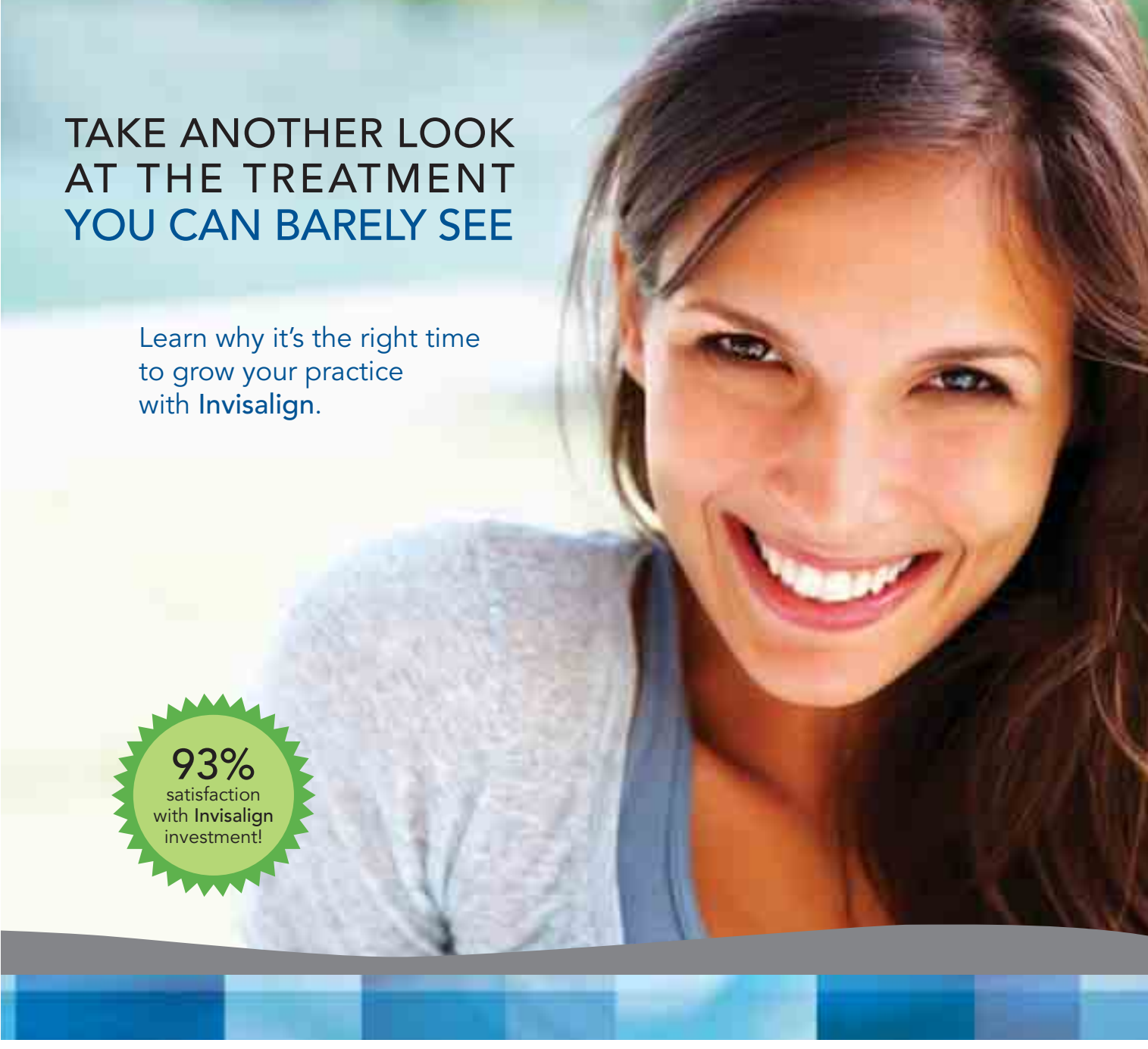

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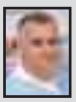
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The First Day of the Rest of Your Life

by Howard Farran, DDS, MAGD, MBA, Publisher, *Dentaltown Magazine*

"If only I could do it all over again…"

When I'm having a conversation with someone and he begins his next statement with the above phrase, I get frustrated because the sentence usually concludes with, "…I would have gotten my MBA," or "…I would have become a periodontist," or something else along those lines.

If you could do it all over again? I really don't understand that.

If you wanted to do it all over again would you really have to go all the way back to when you were in college to make a fresh start? What's so sacred about the ages between 18 and 22? This is the supposed sacrosanct four-year span of time where we're told everything we do will determine the outcome of the rest of our lives. You surely remember these years; your life was under a microscope and everyone took stock in your life. The pressure was on. You worked hard to get good grades. You would have fired yourself out of a cannon just to get ahead.

> *"If you say 'If only I could do it over again…,' you probably never had any intention of doing it in the first place. If you wanted to do it, you would do it today."*

But what about today? Here you are, bored (maybe), complacent (probably), burned out (hope not), with no drive except to cruise into the office, see a few patients, collect your paycheck so you can head home and stream 80s movies on Netflix (definitely). And you tell people, "If I could do it all over again…"

What happened?

There is *nothing* sacred about 18 to 22. I'm 48 years old, and if I were to meet the 23-year-old me, I'd be able to tell after only a short conversation that 23-year-old me knew just a little bit more than *nothing!* If I knew then what I know now, I could have made some better decisions along the way, but that's how humans learn. So why don't we take some of that knowledge we've learned since we were 23 and apply it to something that will make us happier today?

If you say "If only I could do it over again…," you probably never had any intention of doing it in the first place. If you wanted to do it, you would do it *today.* Today is the first day of the rest of your life. When people say, "If only…" they're just making excuses. Go back to school. Learn something new. It doesn't matter if you're 22 or 72, you can make a new start today!

Dentists – most of whom are in their 40s – tell me if they could do it over again they would have gone to endo school or they would have become an orthodontist. What are you waiting for? Why don't you go back to school right now? You were on student loans once, go on student loans again. Or maybe you've socked enough money away that you don't have to go on student loans this time around (wouldn't that be nice?).

Maybe you've been out of school for 10 or 20 years. Things have certainly changed since then. When I was in college, there were very few jobs in computers because nobody owned a computer. There weren't DVDs or cell phones. Microprocessors barely existed. I was still buying my music on vinyl and cassette tapes. There were thousands of Americans working in the vinyl album business. Then the compact disc came out in 1983 and changed how people bought their music. Now CDs are falling to the wayside as more and more of us just click a button and download the newest Foo Fighters album to our iPods. I graduated from dental school in 1987 and I can think

To hear more of Howard's thoughts on this topic, go to Dentaltown.com and search: DTV Howard Speaks

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of only a handful of things I learned then that I actually perform now. I was trained on lidocaine and I haven't used lidocaine in years!

From 1900 to 2000 the educational format was that you graduated from high school, moved on to college, learned a specific skill set for four years and then went out into the workforce for the next 45 years until you retired. That format is becoming extinct. Now the world is turned on its head every five years. Education isn't just what you learned in college anymore – it's what you learn every day of your life.

In dentistry, technology is ever-evolving and it means we have to stay on top of our games and continue to take in every shred of new information to stay current. If I was still practicing the same way I did when I first started my practice, my techniques would be archaic now. For example, when I got out of school I used to file all my root canals by hand; now we use 300rpm NiTi files that can clean out the canals 10 times better than a hand file, and it can be accomplished in a scant fraction of the time.

Also, when I first got out of school, orthodontics was extremely difficult – it took both an artist and a long period of time to get results. Now, orthodondics has become easier for orthodontists thanks to technology, and general practitioners can facilitate minor orthodontic work in a short period of time.

We now have BruxZir crowns, e.max crowns and all-porcelain crowns. When I got out of school we all had to answer to the aesthetic-health compromise. I could give a patient a white porcelain crown but it would only last half as long as a gold crown. We had to ask each of our patients which was more important to them: the looks or the long-term health of the tooth. Now BruxZir and e.max last as long as a gold crown.

CAD/CAM is another one of those technologies that I had to learn after I went through dental school. Instead of shipping all of my posterior crowns off to the dental lab, I can do them all in-house and on the same day. Patients love that!

Technology keeps changing the face of our profession, and we should all strive to learn how to implement each of these technologies into our practices. Technologies like CAD/CAM and lasers get me excited about my day. They re-energize me and they keep me and my practice at the forefront of dentistry. If you wish you would have gone to grad school to become an orthodontist 25 years ago, why don't you apply today? If you are a dentist and you wish you would have gone to law school to practice dental malpractice, apply to law school today! I went back and got my MBA 10 years after I had graduated from dental school.

It's never too late to change your life for the better. Take a look at Ray Kroc. The guy was in the malt shaker business, and every restaurant that ever bought a malt shaker from him only bought one per restaurant. That is until he sold 10 to the McDonald brothers for their 10 locations. They kept buying mixers from Kroc until they had 10 in each store. Kroc didn't believe it, so he flew to California to see these restaurants at work. Kroc was in his 50s, debt-free, and with his life savings he bought the restaurant chain from the McDonald brothers and the rest is history. He pioneered the franchise concept, put easy systems in place and by the time he died McDonald's had somewhere around 30,000 locations and Kroc owned the San Diego Padres. Heck, even Colonel Sanders didn't start Kentucky Fried Chicken until he was retired!

Bottom line: It doesn't matter how long you've been out of dental school or how old you are or even how successful you have become – keep pushing the envelope, keep learning, make yourself better and you'll never have to say, "If only…" ■

Howard Live

Howard Farran, DDS, MBA, MAGD, is an international speaker who has written dozens of published articles. To schedule Howard to speak to your next national, state or local dental meeting, e-mail colleen@farranmedia.com.

Dr. Farran's next speaking engagement is **June 24, 2011, at the Tunica Extravaganza Dental Meeting in Tunica, Mississippi.** For more information, please call Colleen at 480-445-9712.

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The Hunter Becomes the Hunted

by Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

In 1899 two travelling businessmen met when they shared a hotel room in Boscobel, Wisconsin. Their chance meeting led to the founding of Gideons International. This group has been distributing copies of the Bible in hotel rooms, hospitals, nursing homes and prisons since 1908. Their noble marketing efforts have distributed 1.7 billion Bibles in 94 languages and 194 countries.

Marketing is the science of creating awareness. Most often, the ultimate goal of that awareness is a commitment to purchase something, support a cause or join a group. The men of Madison Avenue, that are the subjects of *Mad Men,* portray the early days of modern marketing. The show is set in the 1960s and print advertising is a staple of their business, with TV making a rapid rise as a new medium.

Fast forward to 2011 and our marketing options have exploded: print, Web sites, Facebook, Google and many other examples too numerous to mention. We share a common goal to generate new patients in our practices or to motivate existing patients to accept elective treatments. Walking around your local shopping mall you might see the crowd as a mob of potential patients, each one with a treatment plan that will grow your business. You will go home and spend your hard earned dollars trying to get them to take action and call your office. Perhaps you send a direct mail piece knowing that one to two percent response rate is considered a success. As the marketer, you need these new patients to survive and grow. If your marketing message is a success, they will need you too.

How does your attitude change when you are the subject of the marketing? What is your response as the target audience?

I have always been fascinated by dentists who embrace marketing their practices in both subtle and not-so-subtle ways, but they reject all marketing directed toward them. If our patients had this attitude, we would be very lonely.

For example, trade shows exist in some form for every conceivable market. Some attendees will not visit the show floor because they dislike the aggressive tactics employed by some companies. Think of it this way: what if every dentist in your town had a booth in the local mall for one day per year, and that was your only chance to attract as many new patients as possible. Some of your colleagues might take an aggressive approach.

Certainly it is no secret that the magazine you are holding in your hands and our companion Web site, Dentaltown.com, are entirely supported by advertising dollars. Through these vehicles we provide dentists the ability to learn and interact with their colleagues around the world. Our advertisers support us for the opportunity to reach the most passionate dentists in our profession. I would encourage you to subscribe to our e-mail promotions and e-mail newsletter to be certain you do not miss an opportunity to grow your practice.

By now, you should have said to yourself: "What about word-of-mouth?" That is a great question. Many mature dental offices are successful solely through referrals by other patients. In my practice, that is our main driver of growth. Dentaltown.com provides the same environment for dental professionals to share their word-of-mouth stories on products and equipment that they use every day.

As you continue to read this magazine, visit our Web site, sort the mail at your office or attend trade shows, remember that you are both a marketer and the marketed. Give the marketing the same consideration you hope a perspective patient would give to your Web site or direct mail piece. When you have an opportunity to be face to face with a company, let them know what you need to make decisions about the products and services for your practice.

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I Brush My Teeth with Sugar!

by Chris Kammer, DDS

Second opinions are common in health care; whether a doctor is sorting out a difficult case or a patient is not sure what to do next. In the context of our magazine, the first opinion will always belong to the reader. This feature will allow fellow dental professionals to share their opinions on various topics, providing you with a "Second Opinion." Perhaps some of these observations will change your mind; while others will solidify your position. In the end, our goal is to create discussion and debate to enrich our profession. — Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

Yes, I really do brush my teeth with sugar! That might sound like the craziest thing you have ever heard. In much the same way that there are good fats like flax seed oil, and bad fats like trans fats, not all sugars are bad for your teeth. In fact the sugar that I brush my teeth with is a secret weapon to wipe out oral disease-causing bacteria. This sugar is xylitol and it is poised to replace fluoride as the greatest scientific discovery for healthier mouths. Furthermore, xylitol is safe and has been used by diabetics for decades. Xylitol has none of the controversy that surrounds fluoride and it comes in a variety of usable forms that make it very easy, delicious and economical to use.

There's a battle going on in our mouths and xylitol can help us all win and easily give us healthier mouths. While oral disease continues its rampage against teeth and gums, as a profession we should be doing much more on the front end of this problem to prevent it.

The "Miracle Drug" is Here Now

For many populations worldwide, the levels of dental caries have reached epidemic proportions. Even in the U.S., childhood tooth decay is on the rise. I have heard some patients of mine claim that they are victims to this disease that caused their mouthful of cavities because they were born with the misfortune of having "soft teeth." Many people believe that cavities and gum disease are inevitable. Sadly these people are probably waiting for a future miracle drug that will kill the bugs that are behind all of these problems. However the closest thing we have to a "miracle drug" is already here and it's not a drug – it's xylitol, a naturally occurring substance that is as sweet as candy and disarms the bad cavity-causing bacteria in your mouth. With consistent use of xylitol, the nasty oral bacteria are rendered virtually harmless. Studies have shown that five to 10 grams of xylitol a day can reduce the acid-producing bacteria by as much as 95 percent after six months. Pure xylitol looks and tastes like regular white table sugar and it is used to sweeten a variety of candies and chewing gum, in addition to toothpastes and mouth rinses.

We all know that sucrose (white table sugar) serves as food for the harmful bacteria in our mouths, resulting in acid production that destroys tooth structure. Xylitol is a different kind of sugar known as a polyol. It occurs naturally in many fruits and vegetables and is produced in the human body as well. Side by side in a sugar bowl you can't really tell them apart and they both taste deliciously sweet, however, xylitol has a much different effect on the bad bacteria in our mouths, preventing it from adhering to the tooth surfaces. Also, since the bacteria can't metabolize xylitol, they can't create the acid byproduct that is created when bacteria eats up regular sugar. The xylitol-fed bacteria starve and die off! Regular use of xylitol has been shown to not only reduce tooth decay but also facilitate the remineralization of teeth.

We Need Xylitol Now

Dental caries affects the populations in every country. The National Center for Health Statistics reports that in the U.S. by the time kids are age 17, almost 80 percent have experienced tooth decay. In Finland it is practically the opposite where 80 percent of high school graduates have no caries. What is the difference? Finland schools regularly distribute xylitol to the students. Need more proof? Dr. Peter Allen, head of the Ministry of Health in Belize, reports that in his country's landmark study, xylitol reduced caries by more than 50 percent with results continuing to show that same reduction even five years after the study (and xylitol usage) was completed. It appears that xylitol usage has a very long-lasting effect.

Knowing that a child's major oral infection source is his or her mother, studies in Finland showed that maternal

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Which Wax-up do you prefer

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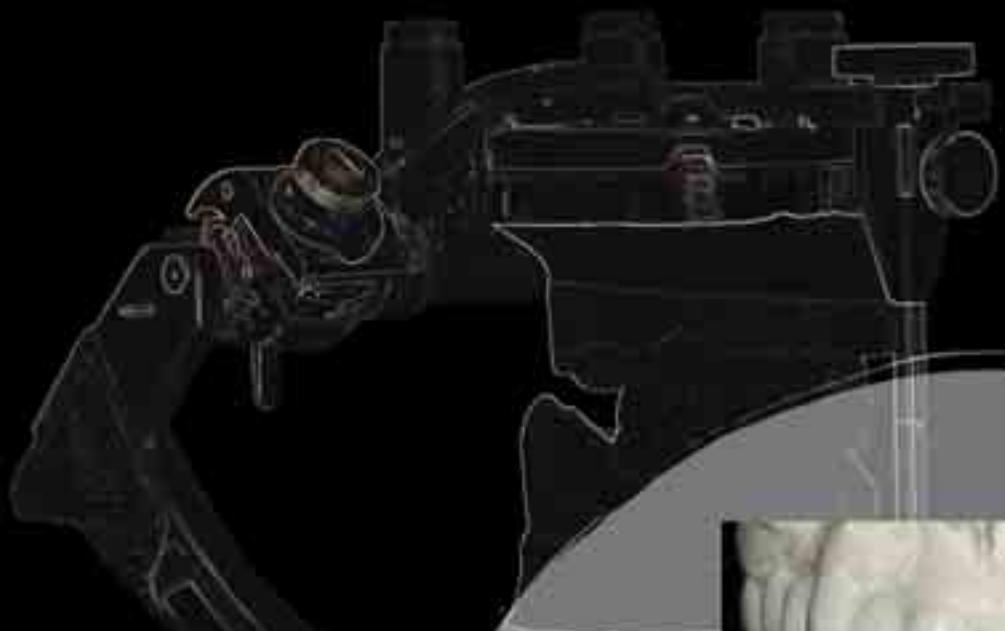
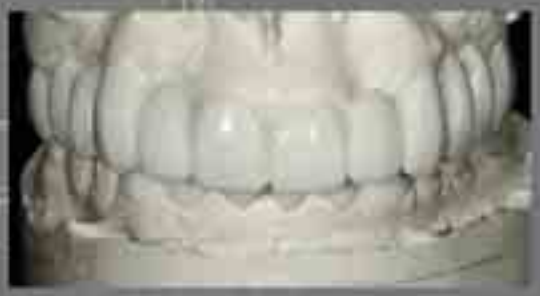
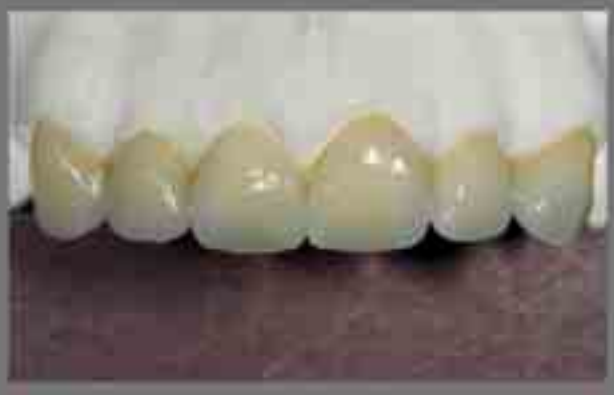




Other Lab's Wax-up



Case courtesy of Joseph L. Caruso, DDS, MS

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use of xylitol can prevent the colonization of the *Strep Mutans* in the dentition of the child. This leads to caries prevention in the child. Additionally, Professor Brian A. Burt, editor-in-chief of *Community Dentistry & Oral Epidemiology,* stated that "the evidence is strong enough to support the regular use of xylitol-sweetened gum as a way to prevent caries, and it can be promoted as a public-health preventive measure."

Dr. Catherine Hayes from the Harvard School of Dental Medicine Department of Oral Health Policy and Epidemiology published a review of the evidence in the *Journal of Dental Education* and she felt so strongly about the positive effects of xylitol's strong caries protective effect, she stated, "it would be unethical to deprive subjects of its potential benefits." Yet how many dental health professionals are educating their patients about the benefits of xylitol and delivering it to them in the office? Sadly very few.

A Candy Store

Your dental office's front counter should look like a candy store. Your office should display a variety of products that are sweetened with xylitol for all of your patients to see and purchase. This will also create great discussions between your patients and office team about the power of xylitol. You will be amazed at all of the delicious treats that are 100 percent sweetened with xylitol. You will find boxed chocolates, caramels, taffy, lollipops, hard candies, flavored mints and chewing gum. Have a plentiful supply of them on hand in your office and every patient will walk out the door with some. Don't let your patients be fooled by general marketplace products like Trident chewing gum for example, which proclaim on the package that it contains xylitol but actually contains only traces of the ingredient.

Go with products that clearly say how many grams of xylitol are in each serving. Products geared toward the serious "sweetened 100 percent with xylitol" user usually have a total of one gram of xylitol in two individual pieces of gum or mints. Here are three leading Web sites to learn about xylitol's benefits and where to buy products:

www.zellies.com is from Dr. Ellie Phillips. She wrote the book *Kiss Your Dentist Goodbye* about xylitol's benefits.

www.xlear.com is from the makers of Spry xylitol products. They are one of the larger distributors of xylitol products.

www.drjohns.com is a company founded by a dentist and his wife who is a hygienist. They have a huge variety of unique xylitol chocolates and candies.

All of the above companies will also sell you granular xylitol for around $8 per pound. That might be the most economical way to get your xylitol. A quarter teaspoon of granular xylitol is one gram. The healthy benefits of xylitol are maximized by getting one to two grams of xylitol during five separate exposures throughout the day. "Strive for five!" (exposures) is the xylitol battle cry. I keep a quarter teaspoon measure in the granular xylitol container, scoop it and place it directly in my mouth. The delicious sweetness has a cooling effect and it dissolves almost instantly and stimulates plenty of saliva. I swish it around for a minute or two and then brush my teeth before I spit it out. You don't have to swallow the xylitol, it just needs to be in your oral environment to be effective.

The Xylitol Buzz Is Beginning!

Why isn't xylitol being enthusiastically promoted by every dentist and hygienist? Could it be that we haven't noticed the xylitol message because we are so wrapped up in fixing the disease damage? Hard to imagine most people having teeth without decay, isn't it? A new mindset is springing up among progressively conservative dental professionals to mount a pre-emptive strike that includes using xylitol as a protective agent to seriously disarm the bacteria involved in the destruction of teeth and the disease in gums. These dentists have formed an organization called the American Academy for Oral Systemic Health (www.aaosh.com) and I am honored to be their president. In order for dentists, hygienists and other health professionals to be in this group they must demonstrate their knowledge of how the health of the mouth impacts the health of the body and they must know and understand the role of xylitol among many other important oral-systemic issues. These dentists are currently recommending a daily xylitol regimen to most of their patients. As changes like this begin to occur in our profession, we are on our way to a healthier nation. ■

Author's Bio

Chris Kammer, DDS, was profiled on ABC World News Tonight as its "Person of the Week" in October 2010 for promoting the Halloween Candy Buy Back to all dentists. He was also featured on this year's American Idol singing his song, "Get Out the Brush!" His "stop-at-nothing" passion for creating new ways to communicate the modern dental message has made him a favorite in the media and on the lecture circuit with his "Gums of Steel Hygiene Transformation" seminars. Contact Dr. Kammer personally at drchris@thesmileexperts.com.

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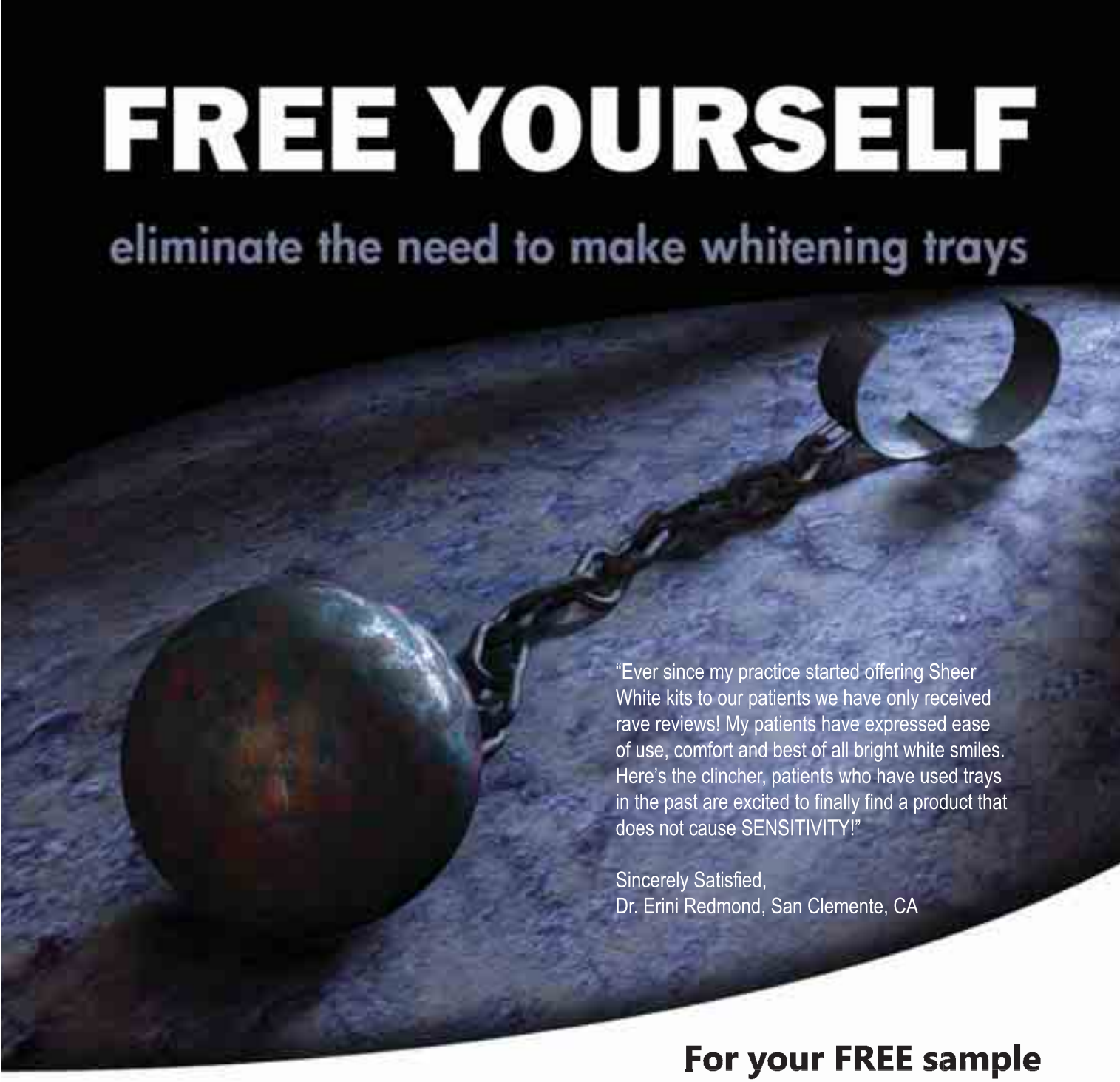

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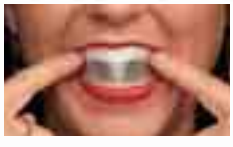

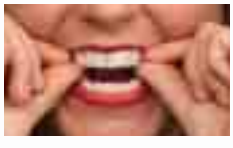

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Dental News in Brief

The Industry News section helps keep you informed and up-to-date about what's happening in the dental profession. If there is information you would like to share in this section, please e-mail your news releases to ben@dentaltown.com. All material is subject to editing and space availability.

New Dental Treatment Tools Available With i-CAT

The i-CAT Cone Beam 3D imaging system brings clinicians a collection of new clinical tools for implants, airway, TMD, orthodontics and surgical procedures through a unique, direct link with the latest version of Invivo5 (5.1) 3D imaging software. Dentists can combine high-quality, three-dimensional diagnostic information from the i-CAT with the latest in advanced 3D visualization and treatment tools to perform analysis, planning and treatment for patients. The full implementation of i-CAT and Invivo5 into the practice delivers fast and precise 3D workflow through quick scan, reconstruction and tools to effectively treat dental, skeletal, airway and sinus anatomy. For more information, visit www.i-cat.com.

DENTSPLY Authorizes 12 Million Share Increase in Stock Repurchase Program

DENTSPLY International Inc.'s board of directors has increased the company's authorization to repurchase shares under its stock repurchase program. Under this program, the company can repurchase shares of company stock on the open market or in negotiated transactions in an amount to maintain up to 34 million shares in Treasury, an increase in the repurchase authorization of 12 million shares. The company has repurchased more than two million shares thus far in 2011 and currently has 22 million shares of Treasury stock, completing its prior authorization level. The company has approximately 141 million shares of common stock outstanding. Visit www.dentsply.com for more information.

FireFly Facebook Campaign Raises Funds for Smile Train

Beginning April 12, 2011, the Dr. Fresh, Inc., maker of the FireFly children's light-up timer toothbrush will donate $1 to Smile Train, up to $2,500, for every new "Like" on FireFly's Facebook page. The organization provides life-changing surgery for poor children in developing countries suffering from cleft lip and palates, a common birth defect, as well as specialized training for medical professionals to make surgery more accessible. To "Like" FireFly and to join in the campaign to raise awareness and funds for Smile Train, visit www.facebook.com/fireflytoothbrush, and click the "Like" button.

BiteDownDeals Launches Web Site Catering to Dental Professionals

BiteDownDeals offers low pricing for the everyday products most dentists use and replenish on a monthly basis. Without overhead or inventory, BiteDownDeals is able to offer dentists prices 40 to 80 percent below competitors' prices. In addition, the site offers $5 flat rate shipping nationwide, regardless of what is purchased. Initially, subscribers will receive an e-mail each Tuesday morning showcasing the newest deal of the week. Each deal has its own defined expiration time and maximum quantity to purchase, ensuring that more people can enjoy the deal. Learn more at www.bitedowndeals.com.

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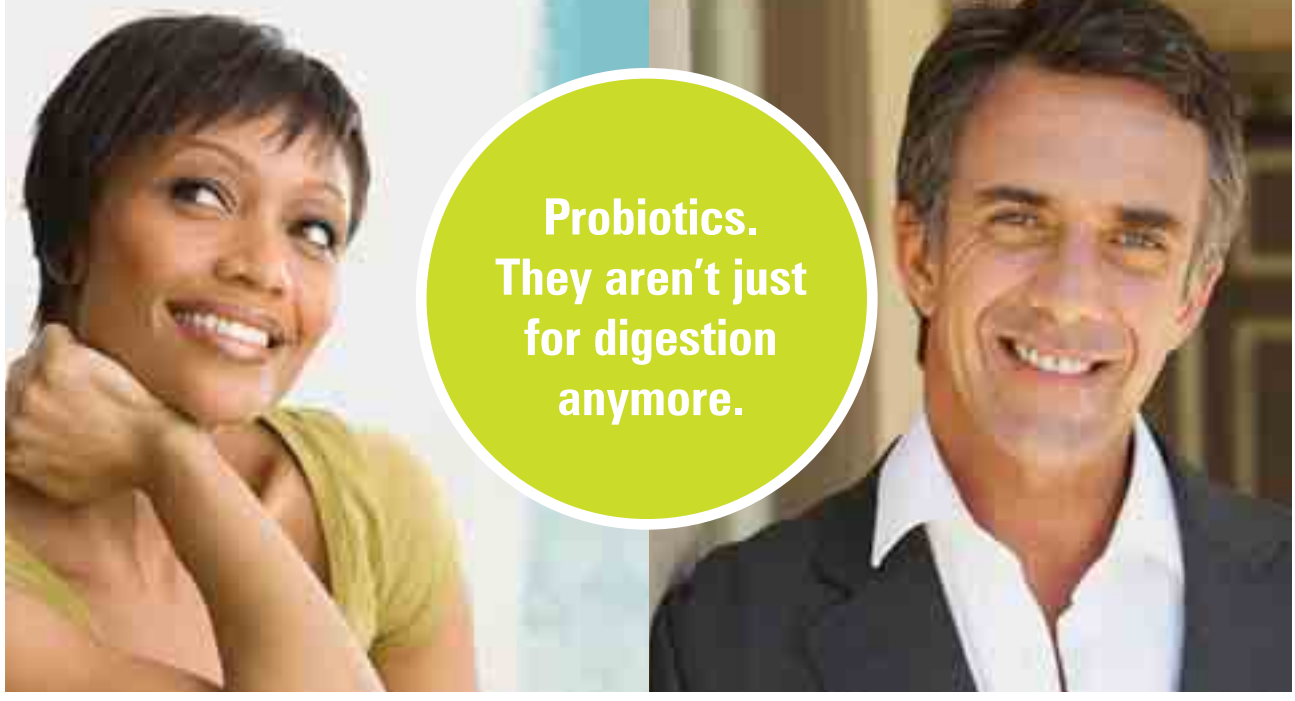

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The Eco-Dentistry Association 2.0: A State-of-the-Art Green Dentistry Web Site

The Eco-Dentistry Association (EDA) officially launched its recently redesigned Web site, www.ecodentistry.org. The new Web site has been revamped with a fresh look, robust new content, effortless navigation links, improved functionality, expanded educational offerings and a new online community for dental professionals and companies interested in being part of the green dentistry movement. The new Web site will regularly feature new content, and is intended to be a frequent destination for clinicians, consumers, patients, sponsors, business partners and journalists who are interested in the latest advancements in green dentistry.

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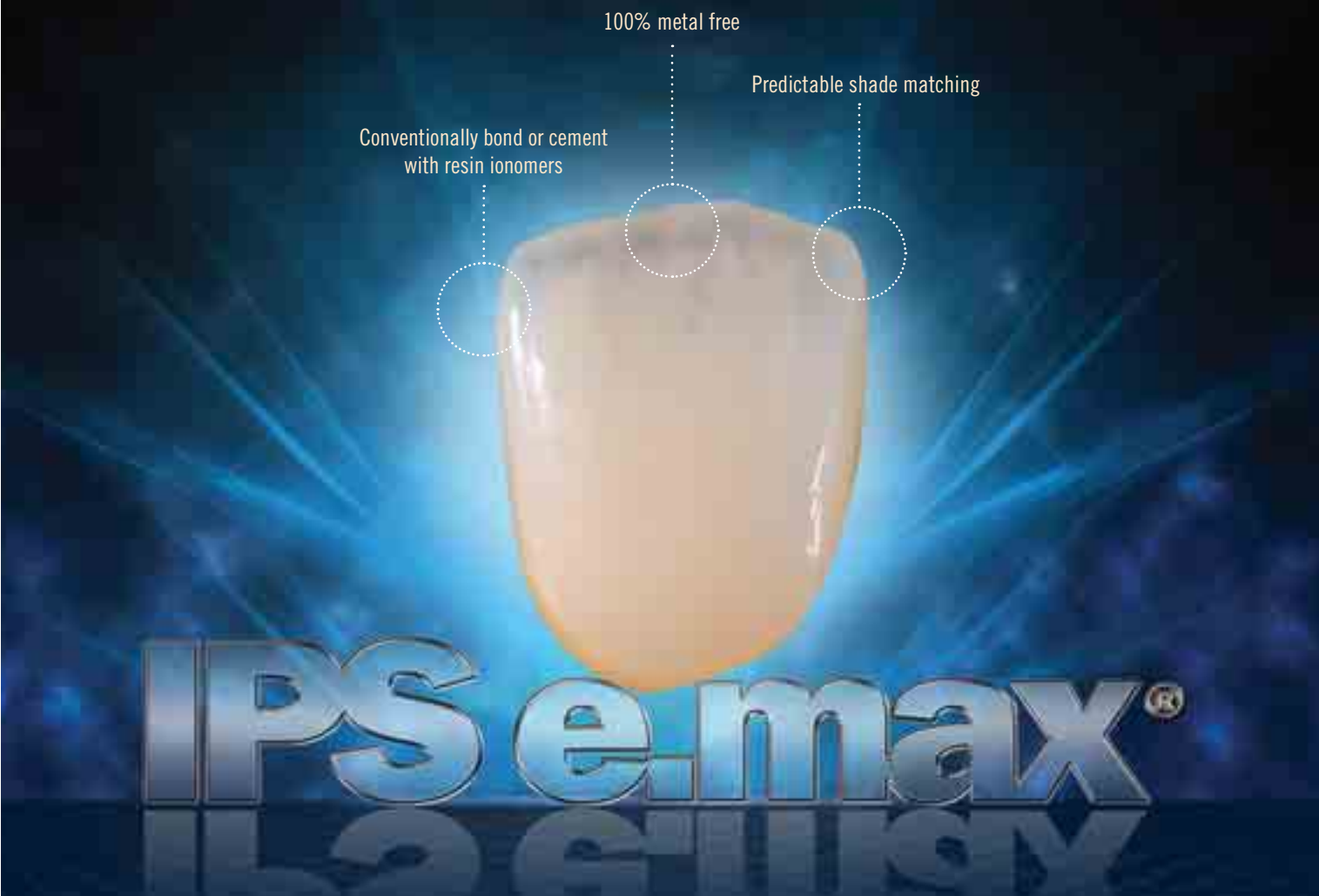

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Posted: 7/13/2010
Post: 1 of 51

So lately I have been getting a good amount of PMs (private messages) asking me how I insert a large case so I figured I would post some photos explaining what I do.

These photos are from two different cases that I put together to illustrate my insertion process.

Step 1: I place an OptraGate and try in each restoration individually to verify fit.

I then try them all in together to verify that the contacts are correct and that the margins are all still closed.

Depending on your ingot selection, you can now try in the restorations with try-in paste. I use either RelyX veneer cement or Variolink Veneer cement. Each has great try-in pastes. You can place a light try-in paste in one side (either +3 or B0.5 and -3 or A3) on the other side and see what it does to the restorations.

Step 2: Take out the OptraGate and let the patient approve his or her smile. During this time have the dental assistant treat the ceramics while you place the rubber dam.

Here is the big issue with the rubber dam. You get the huge opening in the center when you place a rubber dam over 12 teeth. So what I do is place Blu Mousse or some other VPS bite registration material to block this out.

I also have my assistant retract the dam under the buccal of both molar clamps and I inject Blu Mousse here as well. Instant retraction!

Step 3: Etch the preps with 35 percent phosphoric acid etch for 15 seconds. I utilize four-handed dentistry and work on one side, while my assistant does the other. If you cannot do this do the etch in segments.

Step 4: Rinse and place Systemp.desensitizer for 15 seconds. Blot this dry.

Step 5: Apply bonding agent of choice (I used 3M Single Bond). I use an A-dec warm air dryer to thin, and then cure for 10 seconds per tooth.

Step 6: Now seat all the restorations at once with light-cure-only cement; do not cure yet! I start with the centrals, then laterals, then canines, etc. This was 3M A1 RelyX veneer cement.

Like what you're reading? Check out these related message boards:

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continued on page 32

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continued from page 30

Having these treated and placed in a restoration box I feel is a key component. Tons of companies make these to hold the restorations loaded with cement and closed to keep light out.

Once in place I leave all the cement in place – I do not typically wipe off the cement at the margin. I did it here for a comparison as to how much is usually in excess.

Step 7: Now comes the "tac" of the tac and wave. I will place my finger on the incisal edge. My assistant is holding the base of the light and with my other hand I use the light as the push at the gingival margin. Some people teach to use two instruments with the light in between and I just feel it is too crowded for that. Either way works… whichever is best for you.

I say "go" and my assistant hits the light (I do not say "yes" or "okay" when ready because you will have a tendency to say okay or yes too often and get mistaken... there is no mistaking "go"). This is a quick one-second tac.

Step 8: After they are all tac-ed, you take off the tac light and put on the regular tip. Hold the light approximately one inch or so away and quickly wave over all the restorations for three to five seconds depending on the strength of your light.

Step 9: You should be left with the cement in the gel type state that FujiCEM gets to. If you waved too long – it is harder. This should clean off easily with an explorer or scaler. I get it all off. Floss, the whole nine yards.

Step 10: When it is all cleaned off I apply De-Ox and do my final cure.

There you have it – quick and easy tac and wave technique!

Let me know what I can help with! ■ John Nosti, DMD, FAGD, FACE

deserteagle
Posted: 7/13/2010
Post: 2 of 51

Thanks for posting, John. Beautiful case.

John, you use Scotchbond MP. Isn't it too thick if you cure it before placing the restorations? Is it better than Single Bond?

Regards. ■ Toni

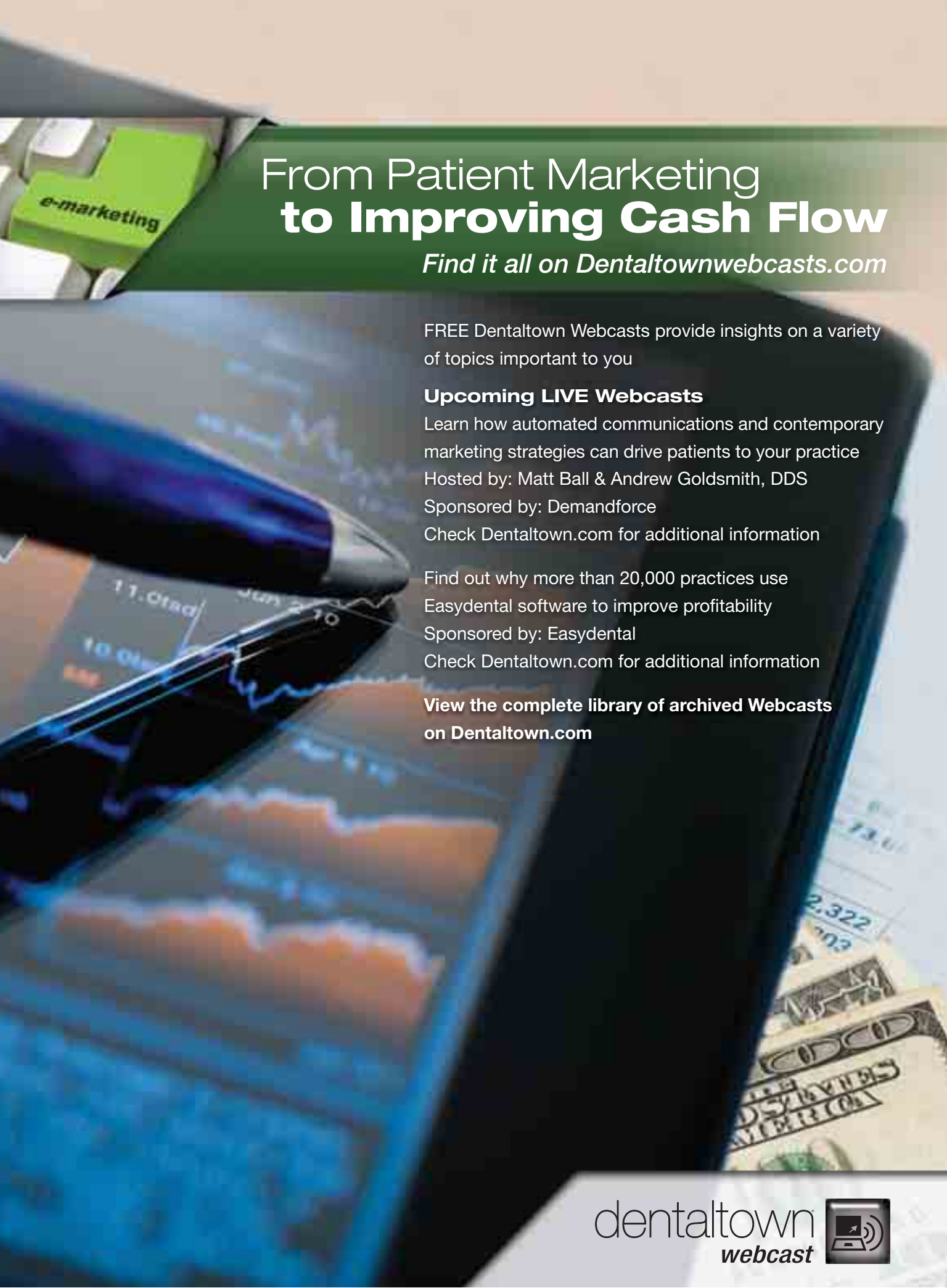
drnosti
Posted: 7/14/2010
Post: 3 of 51

Toni, thanks for pointing out my blunder! I do use Scotchbond Single Bond and thin it down with the A-dec warm air dryer. It is a really cool tool! Prevents any water/air mix or oil for that matter.

I know that the directions say not to cure the bonding agent ahead of time prior to insertion. I have to say that I believe the majority of research points to the fact you get decreased bond strength if you do this.

Saying that… have I ever not cured the bonding agent prior to cementation? Yes, I have not cured the bonding agent when my preps were completely in enamel, or if

continued on page 34



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continued from page 32

it was a no-prep situation. I have not done this for every conservative prepared case or every no-prep case, but I have done it. Those veneers are still holding up strong.

I would never not cure the bonding agent with a case like I posted that has more involved preps. I hope that helps! ■ John Nosti, DMD, FAGD, FACE

doctorq
Posted: 7/15/2010
Post: 5 of 51

Thanks for sharing this, John. Clarify, you cure the bond, even though, for example, the RelyX veneer says to place bond on the tooth and in the restoration, thin, but don't bond? What material are these?

I agree – if it's not been done much, a "provisional workshop" would be a good thread. ■ Matthew Quinlivan

drnosti
Posted: 7/15/2010
Post: 8 of 51

I do cure the bonding agent, especially with more involved preps. I believe all the sound literature points to the fact that bonding strength is decreased if you do not cure it prior to cementation. If you are asking what material of ceramic, it is Empress. If you are asking about the bonding agent, it is Scotchbond Single Bond and RelyX veneer cement.

If you have super conservative or no-prep veneers and are using a thick bonding agent like OptiBond Solo Plus, you might want to not cure the bonding agent prior to cementation. It is all in the try-in.

For example, if you cured the bonding agent like I suggested and then started inserting, but you notice one veneer or restoration isn't seating fully... what would you do? ■ John Nosti, DMD, FAGD, FACE

continued on page 36

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continued from page 34

Jonathan Abenaim DMD FICOI DICOI
Posted: 7/16/2010
Post: 13 of 51

Dude this is why you are cementing my veneers next week! Great job!

I know you are anal with your post-ops of peroxide and CHX. Why not post your instructions here! ■

drnosti
Posted: 7/16/2010
Post: 14 of 51

The peroxide and CHX is for temps... not after the permanents are cemented! That will be on the other thread! ■ John Nosti, DMD, FAGD, FACE

lancet
Posted: 7/17/2010
Post: 15 of 51

John, awesome case! Ceramics, tissue... all of it – great!

Why not isolate in a quadrant manner, i.e. punch a hole for every tooth? Yes, it takes longer... sometimes much longer, but you'll get a far superior isolation.

How do you make sure laminates fit well if you can't see the margin because of cement surplus? (and, on the side note, do you really need to use that much cement so it flows everywhere?) ■

drnosti
Posted: 7/17/2010
Post: 16 of 51

Great questions!

1) Let me address the ceramic fit. If you notice in the first picture the patient has an OptraGate in place. I try in each ceramic individually to ensure fit, color, prep influence on shade, etc. Next, I try them all in together to verify that each ceramic still closes the margins and that the proximal contacts are not too tight. I then try them in with try-in paste so that the patient can see his or her smile. This is also a preview of how the insert should go with the cement in place. Once you have verified things are perfect that is when you move to placing the rubber dam.

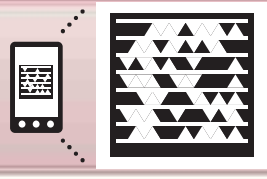
When you go to cement them with the cement in place it is easy to see if one doesn't fit right by the incisal edge of the tooth next to it... appearance, axial inclination. This might come with experience but it is easy to see (nor should it happen if the try-in went perfect, and your bonding is correct). I did not have to put that much cement in place... I did it so that you could see how easily the cement pulls away when the tac and wave is done properly. I would rather have too much than too little, in my opinion.

2) I think it would be extremely hard to isolate per tooth. It is not the same as placing a restoration where you have the gingival part of the tooth there to help hold the rubber dam... the tooth is prepped. Having the rubber dam go subgingival and potentially move and mis-seat the ceramic would be catastrophic. I don't think the isolation can get much better the way it is shown in the first couple of pictures. Blu Mousse seals off the palate very nicely and you can see all the way around and up the ridge.

Give your way a try next time you cement a case and give this one a try. Take pictures and keep us posted which you thought was easier and worked better! ■

Find it online at www.dentaltown.com

Inserting Maxillary 10



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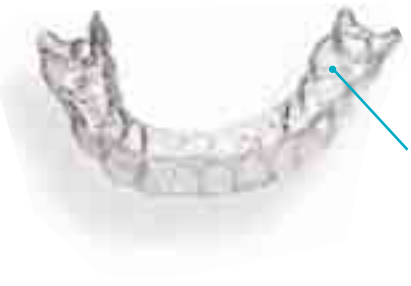

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I Like to Dabble with e.max Cases

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satchdds
Posted: 3/16/2011
Post: 1 of 32

Figs. 1-4: Patient was not happy with his 20-year-old crown.


Fig. 1


Fig. 2


Fig. 3


Fig. 4


Fig. 5


Fig. 6

Figs. 5-6: Temps from my quick wax-up. We waited a few months while patient bleached his other teeth. No problems with temps.


Fig. 7


Fig. 8


Fig. 9

Fig. 7: Impregum.
Fig. 8: e.max bonded with Surpass and Anchor.
Fig. 9: Slight difference in value.

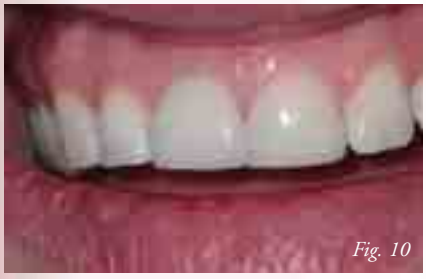
Fig. 10


Fig. 11


Fig. 12


Fig. 13

Fig. 10-13: Patient is thrilled. ■

Want to see more e.max cases? Then check out these message boards:

4 e.max CEREC Made All Myself
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continued on page 40

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DN0611

continued from page 38

rovster
Posted: 3/17/2011
Post: 3 of 32

Looks good. Very nice preps. The difference in value is just something you get with e.max. Been there, done that. Usually, the lab might use a higher opacity core and layer over top to compensate. When the HT (high-translucency) stuff is thick, it looks gray. Overall, I think it's a huge improvement. It's hard to nail a veneer and crown with that much difference in reduction bang on. Did the patient notice? I would guess no. Thanks for posting. ■

BBlairDDS
Posted: 3/17/2011
Post: 4 of 32

Looks great.

Agree with Rovster; I have had e.max turn a little gray too, and I think that they used a too-translucent ingot. We are working on that.

Thanks for sharing. Nice to see smaller, bread-and-butter cosmetic cases too. ■

blutzen
Posted: 3/17/2011
Post: 6 of 32

Next time you are trying to mix densities, avoid HT.

Technician managed to get HO (high-opacity) crown to mix with veneers in a ridiculously challenging case for him, because they were LT (low translucency).

MO (medium opacity) can also be used. They are less brilliant, but you won't get the difference. ■

rovster
Posted: 3/17/2011
Post: 7 of 32

Here's an e.max case that I did not long ago where the two centrals are different preps and way different colors. It's not perfect by any means, the gingival symmetry is off and you can see the core on the #8, but overall the value is very close despite the ultra-minimal thickness of 9 and the thick dark #8. 6-10 were restored.

Fig. 14: Pre-op.
Fig. 15: Post. ■

dandds
Posted: 3/17/2011
Post: 14 of 32

Nice job, Satch, I just seated a case with single veneer on 8 (e.max), e.max crowns on 9, 10. I'm still not happy with the graying of the crowns. The veneer was fine; 9, 10 were over endo treated teeth. I'm probably going to redo them and use Captek. He's a golfing buddy and every time I see them they just don't quite match the veneer. Patient doesn't really notice as much as I do, but I don't want to stare at them every time I see him. We actually made three different attempts at trying to mask out the darker stumps, using HO, MO, etc. Still gray. ■ Dan

Find it online at
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Dabble with emax
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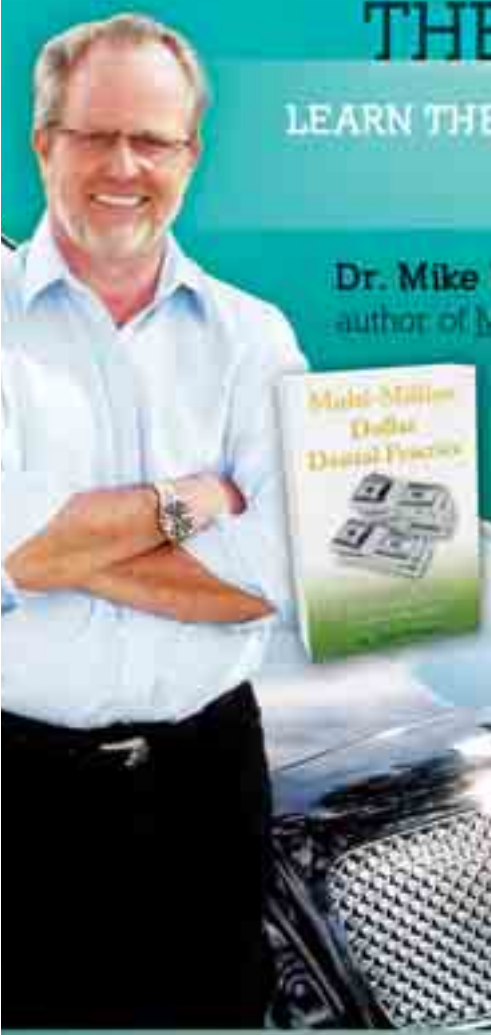

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Advertising on Facebook

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mikebarrdds
Posted: 8/24/2010
Post: 1 of 188

Got another Six Month Smiles patient via a Facebook (FB) ad today. Nice!

To be honest, I didn't expect FB ads to be productive, but I thought I'd experiment with it.

One thing I like about FB ads (over AdWords on Google) is that they can be very specifically targeted. Part of my FB ad strategy is to advertise a niche service like Six Month Smiles to a narrowly targeted group. This keeps my costs down and it only takes a few conversions (for a relatively high-ticket service) to make the return on investment quite good.

Thoughts? Other experiences? ■ Mike

Ryan McCall
Posted: 8/25/2010
Post: 4 of 188

I dropped all of my radio advertising and plan to increase my Facebook budget big time. I currently spend $25 a day, or a little more than $700 a month on Facebook. For you big swingers out there that is probably nothing, but I have a small practice and like to maximize my advertising money... it's more than I was spending on under-performing radio and the room for growth is staggering.

With a few basic ads I draw hits from Denver, Colorado Springs and Nebraska – two million people staring at their computer screens all day with a fractured filling that needs a crown, or a toothache that needs an implant. I have Northern Colorado and Southern Wyoming on denture lock-down.

Crazy, you say?

Think about this: do people spend more time on Facebook or driving past a billboard? How much are we all willing to (talk about and) pay for billboards? How often are you on Facebook? Too much.

I consistently get 30 to 50 unique visitors from Facebook every day. It refers more people to the Web site than Google by a large margin, and you guys know how enthusiastic I was about Google searches! ■

emcgee
Posted: 8/25/2010 ▪ Post: 5 of 188

I will admit I know absolutely nothing about advertising of FB. Could you (or anyone else, for that matter) tell me how it works? ■

drscoles
Posted: 8/25/2010
Post: 13 of 188

I haven't got anything from FB yet. I wonder if they accept a low bid for your placement, like it gets less priority (i.e., if I pay 10 cents a click, it doesn't get much air time versus the 70 cents per click one they wanted me to do.)

Yelp is the bomb. Hands down best online thing going for me. ■

emcgee
Posted: 8/25/2010
Post: 14 of 188

Yelp must be a West Coast thing – I get absolutely nothing from it.

Either that or I suck.

Radio on the other hand, works pretty well. ■

continued on page 44

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continued from page 42

drscoles
Posted: 8/25/2010
Post: 15 of 188

Here in the land of Microsoft, people are pretty into Yelp. They might not even listen to radio. Nice thing about Yelp, no shoppers. You get solid patients who want quality care. ■

AditiDoc
Posted: 8/26/2010
Post: 16 of 188

FB is not doing anything for us at all – maybe it has not been enough time yet but we have got zippo from FB.

I get clicks but no calls! Hoping some people can shed some light on how to get conversion. ■

mikebarrdds
Posted: 8/26/2010
Post: 17 of 188

Your Web site landing pages (presumably from your FB ads) are essentially coupons. So your USP (unique selling proposition) is that the patient might save some money if he or she chooses you. I submit that, especially when it comes to big ticket services like implants, ortho and cosmetic services, people aren't necessarily looking to save a buck – they are looking for "the best." Most people want the best for themselves. They are also looking for a solution to their unique problem. If you can identify and articulate the problem and the solution in your Web copy, you will have the visitor's attention. Just a coupon isn't going to do it in my opinion.

Or perhaps your USP can be a service that nobody else offers. But my impression of your landing pages is that you are offering a commoditized service at $XX off the regular fee. That's your "headline." My thought is that nobody cares and that's why they haven't called.

People interested in ortho, implants, smile makeovers, etc. are going to do their homework. They research dentists online trying to find the best one to help them solve their problem.

I think (again especially for big ticket services) that the goal is to show them why they should pick you. How are you the expert?

Now with that all said... I've been experimenting with FB ads. Contrary to my predictions... the darned things are working! It's still early in the race, but I'm well in the black on ROI. For bigger ticket services like Six Month Smiles, it only takes a few patients to make the campaign pay off. I don't offer any discounts, by the way. My draw (USP) is my expertise, my experience and proof of all that is in photos of my patients on my Web

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site. Good headlines and good copy are essential. Remember to sell benefits not features. What's in it for the patient?

I don't have any experience with Yelp or other review site services. I'll say I'm skeptical, but I was skeptical about FB ads, too. It seems Yelp is big on the West Coast. ■

Ryan McCall
Posted: 8/26/2010
Post: 20 of 188

How to work it.

1. Target specific demographics – engaged people want veneers and free whitening. People that "Like" Mountain Dew and Marlboro cigarettes want dentures. This is easy money, guys. Target the group you want to go after. I do a lot of age 40 and older with my denture ads and age 20 and older for tooth pain and flexible partials ads. Hammer ads all day long.
   I have 10 different ads. Some target people that "Like" Jarritos (Mexican soda). Hablo espanol. If you want pedo patients, target their parents. People that "Like" Babies R Us are going to be easy picking!
2. Keep it simple – don't overdo it. Facebook is cheap enough to have multiple ads running to different demographics at the same time. Hit hard, be quick and deliver on the other end. I prefer to spend $0.75 to $1 on my most effective denture ads and $1.75 on ads with my logo. No one is going to click on your logo, so you can afford to be ballsy and have it shown 200,000 times a day. Free branding to a huge audience.
3. Have fun – what would you want to see on Facebook? I practice in one of the most competitive states in America, so dentists are cut-throat. Facebook ads aren't going anywhere and people are still signing up for Facebook in droves. The time is now. I see a lot of dentists running ads for short-term ortho, but no one is going after neglected teeth. My most click-inspiring ad is an old lady holding dentures and making a kissing face. Headline, "Kiss Goo Goodbye!" People love it. My ads for flexible partials – in two days – are going ballistic.
4. I'm in my 20s so I'm not going to pay anyone for social media help. This stuff is easy; if you are older it might be worth looking into.
5. Commit to Facebook. When I was spending $3 a day I didn't get any new patients. Now that I spend $30 or more a day we have lines of people waiting for dentures!

Facebook is amazing. ■

greatdentalwebsites
Posted: 8/29/2010
Post: 26 of 188

This entire post is pure genius and it's so simple it's one of those things that make me say "I can't believe I didn't think of this." I am always one to take a good idea from someone else and run with it.

I've been trying out some ads based on Dr. McCall's Facebook method.

continued on page 46

continued from page 45

In the spirit of sharing our ideas (and hoping others do the same) here is our most effective one so far:

Targeting

- who live in the United States
- who live within 10 miles of <censored> or <censored>
- who are male
- who like Alexander Ovechkin, Calgary Flames, hockey, hockey night in Canada, ice hockey, Jeremy Roenick, leafs suck, NHL, roller hockey, slap shot, slapshot, Stanley Cup, street hockey, Team Canada, Toronto Maple Leafs, watching hockey or Wayne Gretzky
- who are interested in women

Click-through rate (CTR) is $.08.

The ad reads: "Hockey Teeth...[photo of guy with front teeth missing]

That look just isn't gonna cut it anymore. Of course, we could help with that."

One awesome thing about this is that Facebook ads have an application programming interface. Once we have an effective suite of ads set up, we can write a program that will custom tailor this for whatever city you're in and boom – setup is done. Excited about rolling this out to some GDW customers. ■

Want to read more about advertising online? Then check out these message boards:

I Just Committed $900 a Month to Yelp....
Search: ***Committed $900***

Google AdWords
Search: ***Google AdWords***

Steven Polevoy
Posted: 8/29/2010
Post: 30 of 188

Targeting is addictive, isn't it? I am up to 39 ads now.

I've got ads that target 80 users.

Now if I could just improve on the 87 percent bounce rate. ■

Negotiating a Lease?

Don't let the landlord take advantage of you.

"The benefits I received were well worth the investment."

- Dr. Po-Cheng Tsai
Meriden, CT

To level the playing field, simply call toll-free or visit **georgevaill.com/dt/**

GEORGEVAILL
DENTAL OFFICE LEASE NEGOTIATIONS
800-340-2701

winnsmiles
Posted: 8/30/2010
Post: 39 of 188

So my ad on sedation dentistry went live yesterday around noon. I've already had 35 clicks (CTR of about .04 percent) and an average cost-per-click of around $1.04. So we'll see if this generates to new patients. ■

drlentau
Posted: 8/30/2010
Post: 60 of 188

I thought I would throw in my two cents regarding Facebook. I ran ads last year when it was not as popular and had some success. Stopped until recently and just put a Six Month Smiles ad on this past Friday. When I got into the office I had messages from two people who are interested in the procedure. I was not expecting much, but two patients the first day! Got to love it! ■

skr RDH
Posted: 9/2/2010
Post: 72 of 188

Weird thing happened to me this past week. Up until a week ago I broadcast to everyone within a 10 kilometer radius on FB with no other restrictions. After a month, I noticed that more than 70 percent of the clicks I got were from folks 18 to 22 years old. Not a great demographic to spend all

the FB budget on, of course. So I changed the specs to 22 years and older only. For exactly five days after I changed the specs, the impressions dropped from over 100k to 1,400 a day and clicks dropped to zero. Then suddenly they resumed back at more than 100k and 20 clicks yesterday. Was FB just punishing me for the change and are just now begrudgingly allowing me to resume getting decent exposure? ■

AditiDoc
Posted: 9/2/2010
Post: 73 of 188

Yes, the same thing happens to me all the time. FB does not seem to like if you mess with an ad that is going strong. Once you do mess with it, it reduces the impressions down by 10 to 50 times for a day or two. I have even tried doubling the cost-per-click to no avail. They just take some time for your ad to get going again.

Another thing I noticed is that small changes to my ad have large swings in the recommended bid by Facebook! I have been unable to understand any rhyme or reason behind their method.

Sometimes it is cheaper to create a very wide ad that covers 50 to 100k people while at other times, the bid of a small 4,000 to 10,000 population is much lower than the wider ad. ■

mikebarrdds
Posted: 9/2/2010
Post: 74 of 188

Interesting. Just last week I tweaked a FB ad and the impressions and clicks fell off a cliff! I mean from 40,000 impressions to 500. From six clicks to zero. Very strange. All I did was change my bid (up a bit) and increased my daily budget. ■

KabooshDDS
Posted: 9/13/2010
Post: 86 of 188

The critical piece that isn't being discussed yet: is your Facebook page or Web site the landing pages for your FB ads? Mike touched on it a bit, but what is your target audience doing when they click on your FB ad? They're taken to either your Facebook page or a Web site. Unless you've got a killer FB page or a good call to action on your Web site, those clicks you get won't get converted to patient visits.

You need to have a good landing page for your FB ads that get the patients calling your office and scheduling. You can have a great ad getting a lot of clicks, but that won't translate to patients if the landing page doesn't get them to schedule or at least call you.

Ryan and Mike, what are your landing pages for your ads? If I click on your FB ad, does it take me right to an appointment request on your Web site? ■

mikebarrdds
Posted: 9/13/2010
Post: 87 of 188

Very good point. Yes... the ad is just the first step... similar to search engine optimization (SEO). I've said many times that there are three steps to successful marketing on the Web:

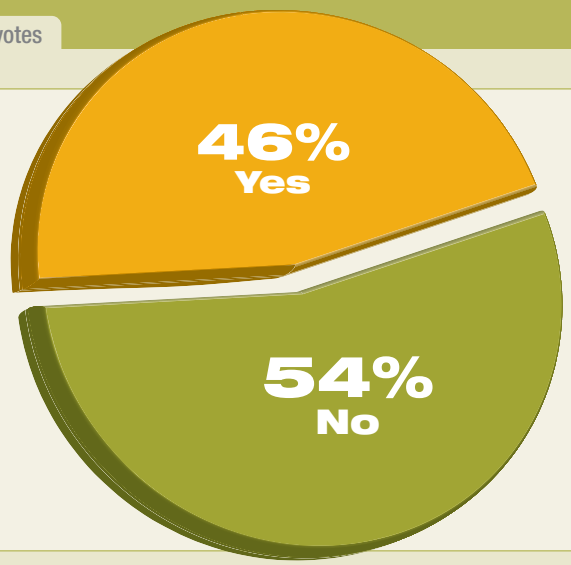
1. Get them to your Web site (SEO, SEM, social media).
2. Keep them on your Web site (good headline, good copy and good content).
3. Get them to take action (Usually to make an appointment; compelling content and a call to action). ■ Mike

Dentaltown Research: **Implants**

Dentaltown is digging a little deeper. Based on the monthly poll on Dentaltown.com we're determining explanations for each poll result. Included with the poll statistics are the most popular write-in answers as well as small fun facts and recaps of the Townie Choice Award winning categories that coincide with our research topic. Don't forget to participate in the poll on Dentaltown.com each month. The more opinions you can provide us, the more information and statistics we can supply to you. The following poll was conducted from April 4, 2011 to May 4, 2011 on Dentaltown.com.

Do you place implants in your practice?

535 total votes



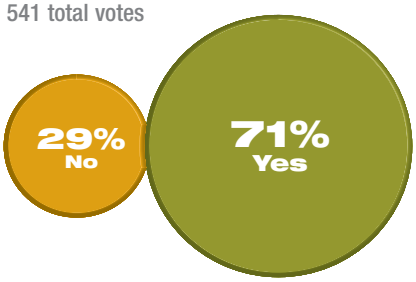
Have you fabricated an implant-retained removable prosthesis in the last 12 months?

59% Yes
41% No

557 total votes

If an implant fails, do you provide credit to the patient for the replacement restoration?

541 total votes



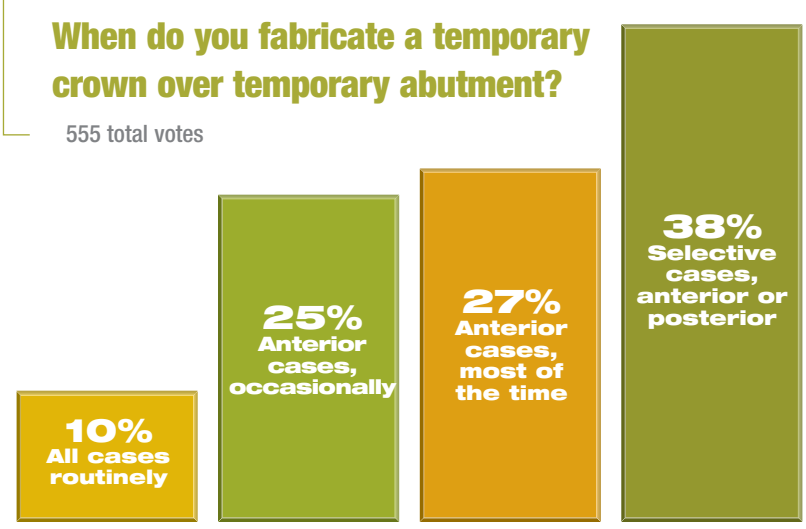
Which of the following statements best describes your opinion of the lab side of implant restorations?

3% The process takes too long
47% Lab fees are too high for implant crown vs. tooth-supported crown
26% Time and fees are reasonable, all things considered
24% There is some room for improvement

562 total votes

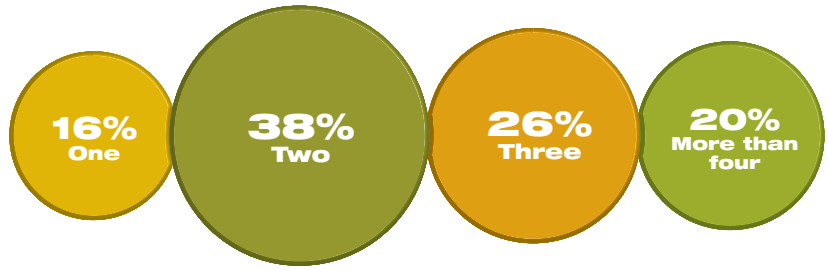
When do you fabricate a temporary crown over temporary abutment?

555 total votes



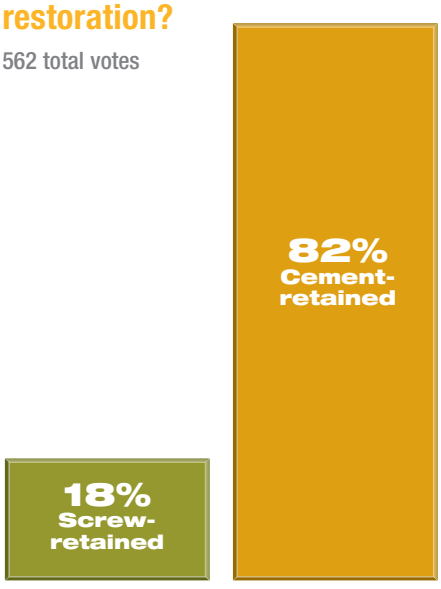
How many different implant systems do you restore in your practice?

558 total votes



Which do you prefer as final restoration?

562 total votes



What do you use to cement crowns over implants?

25% Temporary cement
22% Implant cement
53% Permanent cement

561 total votes

Approximately what percentage of your posterior cases are restored with a custom abutment?

48% 1-10 percent
11% 11-20 percent
9% 21-33 percent
32% More than 34 percent

558 total votes

Approximately what percentage of your anterior cases are restored with a custom abutment?

21% 1-10 percent
12% 11-20 percent
11% 21-33 percent
56% More than 34 percent

552 total votes

World Record

Margaret Brown of Canada was the oldest patient to receive dental implants. She was 94 years and 354 days old when Dr. Milan Somborac of Tenax Implant, Inc., in Collingwood, Ontario, Canada, placed two dental implants in her lower jaw on June 13, 2002.

Source:
www.guinnessworldrecords.com/search/Details/Oldest-patient---dental-implants/58609.htm

Dentaltown Implantology Forum Statistics

(As of May 9, 2011)

Total views: 1,543,114
Total number of topics: 6,670

Implants: 2010 Townie Choice Award Winners Recap

Implant Systems – Crown & Bridge:
Nobel Biocare

Implant Systems – Removable Prosthetics:
Zest Anchors, Inc.

Mini Implants:
IMTEC Corporation – 3M ESPE

Postgraduate Implant Institutes:
Nobel Biocare

As Good as Gold

by Benjamin Lund, Editor, *Dentaltown Magazine*

With a renowned reputation in the area of aesthetic restorations, Paul Lindsey and Rob Maatta, the principals of Gold Dust Dental Laboratory, are more anxious to celebrate their clients' successes, than to talk about their own. For the last 14 years these two have driven Gold Dust to become one of the most progressive medium-sized laboratories in the country. *Dentaltown Magazine* interviewed Lindsey and Maatta to learn more.

Tell me a little about Gold Dust's history.

Rob: Gold Dust was established in 1981 as a high-quality posterior crown-and-bridge laboratory. In 1997, both Paul and I, en route to dental school, did internships at the lab. We were inspired by the technical and artistic side of the business. Ultimately we made the decision to make this our career path in the dental profession. We purchased the lab in 2003 with the intent of making it something special.

Describe Gold Dust's current business philosophy.

Paul: Simply put, we believe the cornerstone of our business is the relationship we have with our clients and their teams. Our motto and the philosophy we live by is, "Do what you say you are going to do," which holds every one of our employees to a

level of integrity valued by our clients. While it's not a revolutionary concept, we find it's pretty rare.

What are the key products Gold Dust produces?

Rob: Gold Dust is a fixed restorative laboratory in all materials, but possesses a true expertise in all-ceramic restorations. Everyday products include Empress, e.max, Authentic, Lava zirconia, PFM, implants, composites and gold restorations. We use only branded, quality materials with the research and development to support excellent results. We've been involved as a beta lab and materials-testing partner for manufacturers to ensure Gold Dust stays ahead of the competition.

What sets you apart from other dental labs?

Paul: The relationships we have with our clients. Ultimately, if we contribute to their success, we know it will come back to us. We know them by name; we know their preferences; and we know what they want and what their patients expect. We don't have aspirations to be the biggest dental lab. We just want to be the one with a great reputation for taking care of people. We plan for the growth necessary to invest in emerging technologies and education, contribute to our team members and continue to grow with

Gold Dust Success Story: Dr. John Nosti

Dr. John Nosti practices full time in New Jersey with an emphasis on treating functional cosmetic cases, full-mouth rehabilitations and TMJ dysfunction. Completing more than 1,800 hours of advanced training, Dr. Nosti shares his expertise with dentists around the country in providing advanced procedures.

Nosti lists three things that have contributed to his success and made dentistry something that he loves. First, he notes advanced continuing education, which "fires you up and gives you confidence." Second, he lists Gold Dust who "understands what's on the line with my patients and delivers superb ceramics, making me a better dentist," and third, he says, "the lifelong friendships I've been privileged with along the way."

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Gold Dust Success Story: Drs. Jason and Colleen Olitsky

Drs. Jason and Colleen Olitsky operate a practice with a focus on cosmetics in Jacksonville, Florida. As one of the youngest dentists ever to achieve accreditation with the AACD, Dr. Jason Olitsky is passionate about the quality of dentistry and his patient results. His motivation for pursing accreditation? He says, "I knew the process would make me a better dentist and I had the full support of Gold Dust, which has been my lab partner since I finished my aesthetic training." His next goal is fellowship... which involves another 50 perfect cases, and the partnership of Gold Dust.

the needs of our clients. We do, however, want to stay small enough that we never lose sight of the importance of relationships with the clinicians who make Gold Dust what it is.

How do you sustain those relationships?

Rob: We constantly find ways to contribute to our clients – hosting continuing education and providing practice support such as found on our Web site. We customize the ways we connect to our clients based on what they need. The basis is to obviously provide high-quality restorations that meet the aesthetic demands of today's most discerning clinicians and patients.

How do you ensure the quality and aesthetic excellence Gold Dust is known for?

Paul: We recruit and retain the most talented ceramists in the country and ensure they are growing with our clients' needs, which means providing education and a constant, never-ending objective to improve their skill set.

Rob: In pursuits such as an aesthetic ceramic case, they require not only technically exceptional ceramists, but a special attention to the artistic element that brings a doctor's vision to life. This unique balance – artisan and craftsman – in one individual is not something you can train, only something you can nurture in someone who already has it.

What does Gold Dust do to stay closely involved with its dentists?

Paul: The collaborative process in every case is to ensure that the patients get what they want. In some cases, that means developing some additional ways to communicate and confirm a patient's desires. We support our clients by talking through concerns in aesthetics and function and oftentimes communicating these through a variety of tools to validate what a patient really wants.

Rob: For instance, a patient might indicate they want "Reese Witherspoon's smile." As a restorative team, we need to confirm what that means before final fabrication. Does she really want a reverse smile line with facial displaced squarer centrals and laterals or does she want a broad buccal corridor? By discussing our concerns through our experience with other cases, we enhance the doctor's ability to effectively communicate with the patient and achieve a patient's desires simply by our relationship. In fact, we guarantee patient satisfaction at try in, if they aren't happy, we will do whatever is necessary to make sure they are.

What is the most significant change in your clientele in the last ten years?

Rob: No doubt, the shift from a focus on cosmetics to function. As a lab partner, we have always been most concerned about how things are going to work or last while making a case look great. Our clients are really Functionally Aesthetic dentists.

There is a perception in dentistry that Gold Dust is a dental lab only for cosmetic dentists; how accurate is that perception?

Rob: We believe that everything we do is aesthetic in nature. While many clients only send their complex work, smile designs, full-mouth rehabilitations, implant restorations and the like, Gold Dust's foundation in single-unit posterior restorations continues to be what makes most restorative practices successful and recession-proof. We've developed a department that specifically supports this segment, called Gold Rush, which is primarily pressed and stained units as a value priced product line.

"We don't have aspirations to be the biggest dental lab. We just want to be the one with a great reputation for taking care of people."

Education is a large component of Gold Dust's repertoire. What sort of education is Gold Dust involved in?

Paul: We have been committed to postgraduate, live-patient, hands-on education for more than 14 years. As a participating laboratory and primary partner in Pac-Live, LVI, the Hornbrook Group and Clinical Mastery Series, Gold Dust has been privileged to support education by providing the restorations and working in tandem with doctors chairside. We host a series of occlusion, over-the-shoulder and live-patient programs. It has been congruent with our vision of creating relationships, as we have a special bond with participants when we go through that process together. We find that the doctors who are committed to improving their clinical skills are the doctors who value excellence and want the best for their patients. This ultimately is the type of doctor with whom we work most effectively.

How is CAD/CAM affecting your business? Do you use it in your lab?

Paul: CAD/CAM has been a significant part of our business for many years. With the inclusion of 3M Lava Milling operated as a subsidiary of Gold Dust called Core Design, we were a very early adopter of the technology.

Rob: We certainly are not the first to predict that the future of dentistry will be centered in CAD/CAM technology, however we find that milling is not the ideal solution for every restoration, nor can we achieve the aesthetic results equivalent to pressed restorations... yet.

We've recently invested in chairside imaging technology to test different systems and provide recommendations to clients based on their desires moving forward. The ability to file share in real-time with our clients prior to the patient leaving the office will be more and more common, along with everyone benefitting from the accuracy of digital impressions. We anticipate this being the fastest growing area in CAD/CAM and are excited to be part of it.

How does Gold Dust compete in terms of cost and quality?

Rob: As you can suspect, we are not a low-cost laboratory and neither are we the most expensive. Our fees are dictated by the level of talent we recruit to achieve the results that make Gold Dust what it is today. We manufacture everything we send to clients in our facility in Tempe, Arizona, and outsource nothing. Every restoration goes through a stringent quality assurance check. We believe in the talent of our team.

How do you address remakes?

Paul: Everyone suffers when a case needs to be remade, for whatever reason. We first address what we could have done, if anything, in order to avoid having it occur again. Ultimately, we have to stand behind the result and to that end we have created guidelines that guarantee all of our restorations against defects, while making sure the patient is happy.

What can a dentist expect when working with Gold Dust?

Paul: A passionate commitment to their patients' satisfaction. Period.

To learn more about Gold Dust Dental Laboratory, visit www.golddustdental.com or call 800-513-6131. n

Gold Dust Success Story: Drs. Valerie Warren and Amy Carrico

Drs. Valerie Warren and Amy Carrico of Kentucky have developed a unique practice strategy that is custom-tailored to their goals. Operating as independent practices and sharing space, they are able to raise young families (each have three young boys), which allows them to have the autonomy, flexibility and independence to pursue clinical excellence while creating a lucrative income and benefiting from the joys of motherhood.

Since both clinicians work part-time schedules, their need to be productive is paramount. "Gold Dust has allowed me to be extremely productive because of the predictable, high quality work with very few adjustments. Time is my biggest asset and Gold Dust gives me time," says Carrico.

Warren adds, "Gold Dust is so much more than just a lab to me. I feel it has allowed me to take my practice to the next level. Not only does it provide me with the highest quality restorations with unmatched predictability, but it also provides me with a vast array of resources to enhance my practice and ensure my success. Gold Dust has honestly become a synergistic part of my practice and the only lab I use."

New Products

You are invited to visit Dentaltown.com to ask questions or post comments about the following New Product Profiles.

EasyScan HD

EasyScan HD is a compact electronic device that scans dental X-ray film directly to the computer archive, patient's file, e-mail, etc. EasyScan HD provides on-touch scanning of standard 31x41mm (1.2"x1.6") dental X-ray film enabling it to be magnified and viewed on a display screen. At the same time, you can choose to save the image to a computer for archival, e-mail or other purposes. Visit www.dentcorp.com or call 800-454-9244 for more information.

EasyScan HD

Dimanto

Dimanto is a one-step, multi-use polishing system for pre-polishing and high-gloss finish of composites, including those of the latest generation with a particularly hard surface due to high filler rates. Dimanto achieves a faster high surface gloss without using polishing paste. The diamond-interspersed silicone polishers are manufactured to very high quality standards and are autoclavable. Dimanto polishers work in wet or dry applications and are available in five different shapes: lens, small and large tips, small and large cups. Visit www.vocoamerica.com for more information.

Dimanto

Brush'n Time Toothbrush Kit

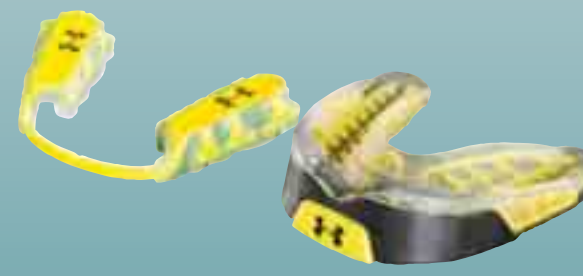
Practicon's Brush'n Time Toothbrush Kit includes a smiley-face toothbrush designed for children age three to eight, along with a three-minute brushing sand timer. The toothbrush has a soft, easy-grip handle and a suction cup base. Its head holds 22 tufts of end-rounded bristles. For more information, visit www.practicon.com or call 800-959-9505.

Brush'n Time Toothbrush Kit

Boil-n-Bite ArmourBite Mouthwear

ArmourBite Mouthguards and Mouthpieces are now available in a boil-n-bite version. The ArmourBite Technology in Under Armor Performance Mouthwear prevents teeth from clenching, relieving pressure on the temporomandibular joint. Previously, UA Performance Mouthwear products were designed specifically to be a custom-fit appliance and required a prescription. Now authorized dental providers can offer both the custom and the new boil-n-bite version. For more information, visit www.underarmour.com. To learn more about becoming an authorized provider, call 877-248-3832 or visit www.bitetech.com.

Boil-n-Bite ArmourBite Mouthwear



If you would like to submit a new product for consideration to appear in this section, please send your press releases to Assistant Editor Marie Leland at marie@farranmedia.com.

Prometey Soft Tissue Laser

The Prometey Soft Tissue Laser from Laser Dental Innovations can perform virtually all soft tissue surgical procedures as well as minimally invasive laser endo, perio and bleaching treatments. The three-watt laser uses flexible low-cost fibers or the Litesaber handpiece, which along with the cable can be autoclaved. The Prometey Laser is available in 980 and 810Nm wavelengths and includes certification training with eight CE credits for $2,650. For more information, call 877-753-5054 or go to www.lazerdental.net.

Prometey Soft Tissue Laser

miniMARK Miniature Dental Implant System

Developed by ACE Surgical Supply and Zest Anchors, the miniMARK system is available as a mini implant 2.3mm, a standard body 3.25mm or as a one-piece 2.3mm with a prepable head that can be used for mandibular anterior single tooth applications. The miniature implant system incorporates the Locator attachment by Zest Anchors. The miniMARK Dental Implant System is available exclusively through Henry Schein Dental. For more information, visit www.minimarkimplant.com.

miniMARK Miniature Implant System

Sonicare AirFloss

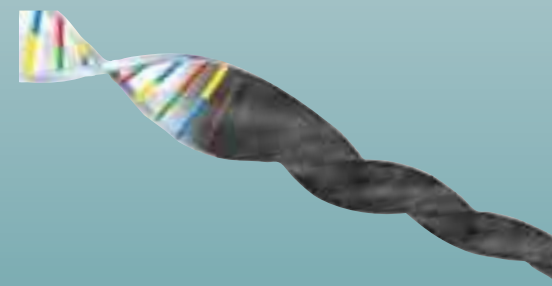
The Sonicare AirFloss is an interproximal device that uses MicroBurst technology to remove plaque from in between teeth with quick bursts of air and micro-water droplets. The cleaning action reaches deep between teeth, where food particles can get caught. It can clean in between all teeth in 60 seconds and produces less than one teaspoon of water. For additional information on the Sonicare AirFloss, visit www.sonicare.com.

Sonicare AirFloss

HyFlex CM Rotary Files

HyFlex CM Rotary Files have a "Controlled Memory" (CM) effect. The files are manufactured utilizing a unique process that controls the material's memory, making the files extremely flexible, without the shape memory of other NiTi files. The process allows the instrument to follow the canal without creating undesired lateral forces on the canal walls, making the files extremely flexible with no rebound, while reducing the risk of file separation, binding and complications such as ledging. Visit www.coltenewhaledent.com for additional information.

HyFlex CM Rotary Files



Cures for the Dental ZOMBIE

by Douglas Carlsen, DDS

Dr. Yanni can't seem to find any energy for his practice. "I just don't like work anymore," is his constant whine. "I went into dentistry to help people and have a comfortable income, yet I've become a dental zombie – with hunger only for the paycheck, 5 p.m. and extraction cases."

Meanwhile, Dr. Botch enjoys the energy of her patients and their satisfaction with her work, yet she can't stay on time, her assistant is constantly searching for instruments and the front desk people forget half the things she asks for. "I'm surrounded by zombies," is her complaint.

Where do these two doctors go for help? Dr. Botch might drop Egyptian obelisks on the heads of her staff and Dr. Yanni apparently needs a rare butterfly-blood infusion. There might be a more legal and compassionate solution: employing a business coach or consultant. These terms are often interchanged with each other – but are different.

According to Karyn Greenstreet, owner of Passion for Business, LLC, a business coach – now commonly called a business and life coach – brings out the best that's already inside you. The focus is on the "bigger picture" to create your business and your lifestyle. Moving forward with your dreams, goals and tasks is paramount. Honest insights of the "wisdom within" are evaluated. You create a plan for moving forward and the coach partners with you to support you in actualizing that plan in your business.

A consultant teaches specific skills and provides program management, like better time management, employee relations and marketing techniques. After careful discussion and analysis of what results you're looking to achieve, a plan of action to move forward on your projects is instituted.

The distinctions between these job descriptions are often blurred with coaches providing management consulting and consultants providing basic coaching. Let's look at real examples of a dental business and life coach and a dental consultant.

First, our coach, Dan Kingsbury, DDS, of the Dental Coaches Association:[1]

Dan provides CE and curriculum to dental schools internationally and works in tandem with Don Deems, DDS, and Alan Goldstein, DMD, to provide top-level business and life coaching. All are credentialed through programs associated with the International Coach Federation (ICF). ICF credentialing entails a stringent educational and examination process through which

1. Find Dr. Kingsbury's Web site at www.dentalcoachesassociation.org.

coaches must demonstrate their skills, proficiency and documented experience in application of coaching core competencies. Continuing education, ethical standards and periodic renewal of coaching credentials are essential.

Kingsbury's comments on the most common problem dentists face:

Dentists, having received all their training and development as individuals competing against their classmates, rarely experience a collaborative, cooperative environment. Because of this, dentists are naturally ill equipped in three areas: communication with staff, management of their practices as a business and leadership.

Where Kingsbury feels he makes the most difference with clients:

I work to change a dentist's practice from the inside out, rather than from the outside in. It is not about what they need to do to become successful, it is about who they have to become. I'm talking about whom they have to become in order to do what they already know they need to do to achieve the results they want. Most dentists already know what they need to do; they just don't do it.

Kingsbury's leadership and life coaching vision:

My vision is to promote an empowering context for the dental industry: to empower others through communication in service to what they are committed to or dealing with.

To operate within my core values: service, communication, integrity, partnership and transformation.

To create a new context for dentists: "humane human beings helping human beings." By this I mean seeing yourself in partnership with your patients in their world and not simply a fixer of their dental problems.

Additionally, Dan has provided the dental community a valuable resource called *The Vision Game*. Dan's goal is to provide a gentler, more inclusive form of practice leadership. It takes four hours total with AGD/PACE course credit and Dan can facilitate by phone for a very reasonable fee. For more information, contact Dr. Kingsbury at the citation on the previous page.

An introduction to *The Vision Game* may be found in a Dentaltown online course at www.towniecentral.com/Dentaltown/OnlineCE.aspx?action=DETAILS&cid=115.

As is the case with many coaches, Dr. Kingsbury's group also offers specific consultation services.

For our consultant, we go to Sandy Pardue of Classic Practice Resources (CPR).[2] Sandy is an internationally recognized lecturer, author and practice management consultant. She has assisted hundreds of doctors with practice

2. Find Ms. Pardue's Web site at www.classicpractice.com.

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expansion and staff development over the past 20 years. Sandy is also the Energizer Bunny of Dentaltown's practice management threads, providing almost 24/7 advice.

Sandy's comments on the most common deficiencies in practices:

Most practices lack organization and exact processes. Teams are not rowing in the same direction; dentists are stressed and overworked.

Most practices contact me for help in the following areas:

1) *Patient recall and retention*
2) *Controlling overhead and practice income*
3) *Treatment acceptance*
4) *New patient numbers*
5) *Doctor and hygiene schedule*

Dental employees need training and direction so they can do more to help the dentist achieve the practice goals. Zig Ziglar said, "The only thing worse than training an employee and losing them is not training them and keeping them." This is especially true in the dental practice.

Where Sandy feels she makes the most difference with practices:

I uncover missed opportunities. The largest impact is in the areas of patient retention, practice profitability and staff contribution. One of the first things I implement is a reactivation program. The program will get back up to 19 percent of the overdue patients. This, along with working on team communication skills, gives the practice a huge boost in production and morale. Another system implemented with a lot of success is the tracking of practice monitors. This gets the staff involved in improving the practice as a team and working toward a common goal. I provide feedback to help them continue to improve.

Sandy's vision:

My passion is to help dental teams explode practice productivity and profitability. I enjoy training staff to take control over their daily work life. It is extremely rewarding to see them become more confident in their positions.

Each practice is unique and has special needs. I am known for implementing time-tested systems that are tailored for each practice. Once implemented, they give predictability, increase revenue, reduce stress and allow dentists to enjoy relaxed time away from the office.

Please note that there are many competent and ethical consultants to choose from in the dental profession. As for coaches, there are many that claim the title, yet proper credentialing and education with an organization such as IFC is important.

How does a dentist evaluate either a business and life coach or a business consultant before hiring?

During the initial call, evaluate who is talking more. If the coach/consultant talks more, you might be receiving a sales pitch. If you talk more, the potential hire is finding out about you – a very positive sign.

Ask the coaches/consultants what their strengths are. What are their areas of expertise? What are their weakest areas? If they claim no weaknesses, that's negative. You are looking for someone you can trust with both positive and negative communication from both sides.

Does the person have real passion for what they do? You need to work with someone who will engage you to the core.

What's your gut feeling about this person?

Get references. Call them. The big question is, "Would you hire the person again?"

This all sounds much like an employee interview and really is similar. You are essentially hiring another employee. Treat that person as such.

In the final analysis, I feel strongly that all dentists should engage a business and life coach every few years to reinforce core values, leadership, communication and transformation. Also, a consultant should periodically re-evaluate and monitor all systems listed above by Ms. Pardue. The cost is minimal compared to the stress and unhappiness many a harried dentist endures.

Back to Drs. Yanni and Botch: Yes, Yanni can find new life with a business and life coach and Botch needs a batch of systems help from a consultant. Yet realize that whomever you choose, the vetting and interviews beforehand are key. Make sure your coach/consultant makes you the star of your practice, not the coach or consultant! ■

Author's Bio

Douglas Carlsen, DDS, founder of Golich Carlsen, has provided independent financial education to dentists since retiring from his practice in 2004 at age 53. Golich Carlsen, an approved AGD PACE organization, delivers common sense consulting, efficient CE lectures, and smart continuing education CD/workbooks – all backed by academic research. Visit www.golichcarlsen.com for archived articles, information on services and to sign up for Dentist's Financial Poll and Newsletter. Contact drcarlsen@gmail.com or 760-535-1621.

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by Jay B. Reznick, DMD, MD

A question that comes up very frequently in my courses and in discussions with dentists is the topic of placing patients on antibiotics when they need a tooth extracted. Just like anything we do in dentistry, there is not a single answer to this question. The best answer I can think of is… "it depends!"

The first question has to do with *why* the tooth is being removed. Is the tooth acutely or chronically infected? If we are dealing with a tooth that recently fractured and there is no evidence of infection, and if we are simply removing the tooth with no plan to replace it, then antibiotics serve no purpose. The same goes for routine removal of healthy teeth for orthodontic purposes or for the removal of non-pathologic third molars. In these cases, prophylactic antibiotics do not significantly reduce the risk of post-operative infection and increase the likelihood that, if a post-operative infection does develop, it might be resistant to the first-line antibiotics we normally use for treating dental infections. So, in this scenario, the risks outweigh the benefits.

Now if the tooth is infected, we need to know whether the infection is confined to the periodontal ligament (PDL) space or whether the infection has spread into the bone or soft tissues. If the infection is limited to the PDL space, then generally, removal of the offending tooth is all that is necessary. However, if the infection has spread to the bone, and especially into the soft tissues, then the benefits of treating with antibiotics will outweigh the risks. Generally for infected primary teeth with a moderate amount of root resorption, even with a small area of soft tissue swelling, removal of the tooth alone will suffice. This is because the infection is relatively superficial in the alveolus.

There is an old wives' tale in dentistry that says that an acutely infected tooth cannot be removed without placing the patient on antibiotics first, in order to "cool down the infection" before extraction. This is a bunch of rubbish, as it is the necrotic tooth that is *the source* of the infection, and until it is removed the infection will not resolve. It is like having an infected splinter in your finger. The treatment is not antibiotics; it is removal of the foreign body. The antibiotic is just an adjunct to help resolve the spread of the infection. So, if feasible, the tooth should be removed immediately and post-operative antibiotics prescribed as recommended above. It is also not a bad idea to give a loading dose of the antibiotic prior to removing the tooth. But, notice I said "if feasible" because sometimes theory and clinical practice clash. In other words, in addition to wanting to get the patient back to health, we also want our patients to like us. We learn from experience that local anesthetics do not work

well in infected environments. The lower pH in infected regions reduces the efficacy of the anesthetic drug. It might not be possible to remove the offending tooth without causing the patient great discomfort, which is something we all would like to avoid. We would like the patient to return for their next visit and to maybe refer a friend or two.

This is especially true when dealing with an endodontically treated lower molar, for example. As long as it does not place the patient at risk, rather than immediately extracting the tooth I will sometimes place the patient on antibiotics and then schedule them to return for the extraction in a day or two when I know that I will be able to get more profound local anesthesia (or in my practice, do the procedure under general anesthesia). If there is a fluctuant swelling, I might elect to do an incision and drainage procedure at that initial appointment in order to make the patient more comfortable and prevent further swelling, abscess formation and spread of infection. It also reminds them that they need to return to you for definitive treatment. This goes a long way to be able to provide a positive experience for the patient, rather than one they would like to forget about. In the maxilla, it is generally easier to get adequate local anesthesia, especially when using articaine for infiltration. So, that might make immediate removal of the tooth a more likely scenario.

A specific dental infection that earns its own category is pericoronitis. With most odontogenic infections, it is the diseased tooth that is the source of the infection, so the primary goal of treatment is to remove that source either by extraction or endodontic therapy. With pericoronitis, it is not the tooth itself, but rather the surrounding soft tissue operculum that is the problem. The tooth is generally vital and otherwise healthy. With this clinical entity, immediate removal of the tooth is the worst thing to do. It is imperative that the patient be placed first on antibiotics and the infection brought under control with the help of local measures, such as frequent saline rinses and irrigation under the operculum with an irrigating syringe. This is because manipulation of the tooth right away will most likely result in spread of the infection through the soft tissues and possibly to the lateral pharyngeal and retropharyngeal spaces. This can lead to a serious medical situation where hospitalization might be necessary and the airway might be compromised. Depending on the severity of the infection, I will have the patient on one to three days of antibiotic treatment before scheduling for removal of the offending tooth. It is also acceptable to use laser or electrocautery to remove or reduce the operculum initially, to make the patient more comfortable and make the area easier to irrigate. But this is only a very temporary measure before the tooth is removed. In very severe cases, where the patient has notable trismus, difficulty swallowing, airway compromise or appears toxic, hospital admission, intravenous antibiotics and immediate surgical management is in order. Luckily, this is a rare event.

So far, I have been discussing how to manage these clinical situations in relatively healthy young patients. Throw in some medical complications and we have to modify our treatment plan. Generally, in older patients I tend to be more cautious. The capacity to fight an infection diminishes with age. A patient in their 20s or 30s with an acute dental abscess confined to the socket will do just fine after the tooth is removed, but I have seen quite a number of patients in their 70s and 80s who returned with problematic infections after the same treatment. So, my bias now is to cover all older patients with antibiotics peri-operatively, even with seemingly minor dental infections. The same holds true for patients with diabetes. In dental school and residency we were told that non-insulin dependent diabetics could be managed just like any other healthy patient. My experience from clinical practice is that they are also at increased risk of problems, just like a poorly-controlled insulin-dependent patient, although to a lesser extent. Again, in my practice, this group also gets peri-operative antibiotic coverage as a routine.

The answer to this simple question is not so simple. The bottom line is management of a surgical problem requires the clinician to "think like a surgeon" (see my column in the March 2009 issue of *Dentaltown Magazine)* in order to provide the best care for the patient. Not only does the clinical situation need to be analyzed, all the patient variables need to be considered in deciding management. For the clinician who needs help in sorting all this out, assistance is no further than a phone call to a local oral surgeon, or the pages of the Dentaltown.com Oral Surgery forum. n

Author's Bio

Dr. Jay B. Reznick is a diplomate of the American Board of Oral and Maxillofacial Surgery. He received his dental degree from Tufts University, and his MD degree from the University of Southern California, and trained in oral and maxillofacial surgery at L.A. County-USC Medical Center. His special clinical interests are in the areas of facial trauma, jaw and oral pathology, dental implantology, sleep disorders medicine, laser surgery and jaw deformities. He also has expertise in the integration of digital photography and 3D imaging in clinical practice. Dr. Reznick is one of the founders of the Web site www.onlineoralsurgery.com, which educates practicing dentists in basic and advanced oral surgery techniques. He is the director of the Southern California Center for Oral and Facial Surgery in Tarzana, California. He can be reached at jreznick@sccofs.com.

Working Length

by Dave Carter, DMD

You're short. Again.

How many times have you instrumented a canal completely, went to fit your gutta percha point, and it was short? Even worse, you proceed smoothly through a root canal treatment, and leave your assistant to take a final radiograph. Upon returning to the treatment room, after removing the rubber dam, after placing the provisional and telling the patient that the worst is over, your root canal fill is not quite what you had expected.

We can pretend it doesn't happen. But it does. A lot. The ability to establish and maintain working length is critical to complete debridement, disinfection and obturation of the root canal system. Successful completion of these steps is essential in the long-term success of endodontic therapy. So why does this scenario occur, day after day, to dentist after dentist while performing endodontic therapy? It happens to both experienced and neophyte clinicians. It happens while treating vital teeth, necrotic teeth and in retreatment as well. The truth is, there are a number of reasons this can occur. Let's talk about why, and how we can prevent it in the future.

Reason 1: You Never Had an Accurate Working Length

The establishment of working length is a critical step in delivering predictable endodontic care. The first aspect of this is length determination. The most common method of length determination is the use of a periapical radiograph taken with a file placed to the desired length.

The use of an apex locator, such as the Root ZXII shown in figure 1, is another means of length determination. The simple explanation of the modern apex locator is that it measures the relationship of two inputs providing visual and auditory feedback to the operator in realtime. The resistance of the oral mucosa and the periodontal ligament are measured, and the apex locator compares these inputs. Upon the completion of a circuit, the operator is notified by the apex locator. Unlike the sole use of working length radiograph, the apex locator can accurately provide feedback on the location of an anatomical structure, the periodontal ligament.

Another method of working length determination is the tactile method. This involves the use of small files to feel the apical constriction. While this method can be effective, it is not recommended as a sole means of length determination. In addition, in many necrotic cases the apical constriction is not present, making this method less than desirable.

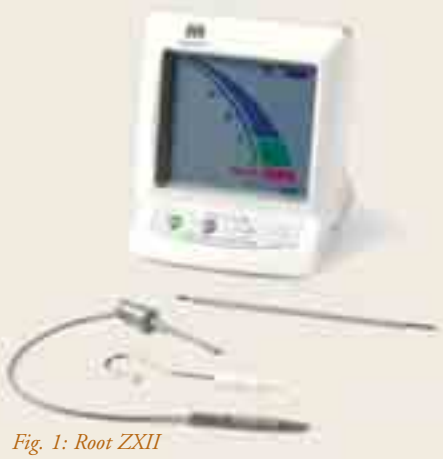

Fig. 1: Root ZXII

Whatever method is selected, it is imperative that working length is established, documented and the operator takes every step to ensure that this length is maintained throughout the procedure. The approach of estimating the working length is a recipe for unpredictable outcomes. I prefer to use the periodontal ligament as my landmark, as it is the only reliable anatomic measurement available. When using a Root ZXII, this is the full-tone or apex reading. I typically will subtract 0.5mm from this measurement to determine where I should terminate instrumentation in vital cases. In necrotic cases, I will usually instrument to the periodontal ligament.

Fig. 2: Reciprocating handpiece – Brasseler USA

Fig. 3: Pathfiles

Reason 2: Poor or Non-existent Glide Path

Procedural errors can occur at any stage of non-surgical endodontic therapy. However, the incidence of such errors is significantly lower after a smooth, progressive, repeatable glide path has been established. The first step in glide path formation is coronal shaping, which can be performed using a variety of instruments. I prefer to use the Gates Gliddens (particularly #2) in conjunction with the ProTaper shaping instruments, taking the tip of the instrument no further than the junction of the coronal and middle third of the canal. Following this, the operator has three options: hand instrumentation, reciprocation or the use of rotary nickel titanium instruments.

The most technique-sensitive approach is hand instrumentation. This requires a great deal of time and precise fine motor movements. Out of the techniques, it is the most difficult to perform well. The second method, and one that is a nice compromise, is hand instrumentation, followed by the use of reciprocation. I favor working each hand instrument to length, starting with size eight or 10, and then using a reciprocating handpiece at working length to expand the shape apically. I recommend using each handpiece for approximately 10 seconds at working length, followed by another 10 seconds using a 1-2mm vertical component. I strongly discourage the use of reciprocation at any length short of full working length, in an attempt to bypass initial placement of the handfile at full working length. I have not had success with this approach. The handpiece I most favor using is the ER10/TEP-Y combo which is a 10:1 reduction, available from Brasseler USA (Fig. 2). This is compatible with an E-type slow-speed handpiece.

The final method for glide path formation involves the use of rotary nickel titanium instruments. A popular system is the PathFile (Fig. 3), created by Tulsa. This includes the use of a 10 handfile to working length, then using a 13/02, 16/02 and 19/02 file to establish a glide path. A regimen that includes initial handfiling and reciprocation using size eight and 10 files followed by PathFiles would allow practitioners to use a rapid, user-friendly method to establish a bulletproof glide path prior to proceeding with canal preparation.

3. Working Length Reference Point Not Well Defined

One of the most common errors is the failure to define a coronal reference point. This is challenging on nearly all posterior teeth, as there are cusp tips and fossae that don't behave as reliable reference points. As a referral-based practice, all of the patients I see are returning to their referring doctor, usually for a full-coverage restoration. As such, I try to ensure that the tooth remains as intact as possible to facilitate the fabrication of a provisional restoration or the fabrication of a CAD/CAM restoration. For those of you who are performing endodontics on your own patients, take a pre-operative impression or image for fabricating a provisional crown or CAD/CAM restoration. After accessing and locating the canals, don't hesitate to flatten the occlusal surface in order to establish an easily repeatable plane to use as a reference point. I prefer to use an 909 diamond wheel, available from SS White. It is both fast and efficient.

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References:
1. Ragin CC, Modugno F, Gollin SM. The epidemiology and risk factors of head and neck cancer: a focus on human papillomavirus. *J Dent Res.* 2007 Feb;86(2):104-14.
2. Fakhry C, Gillison ML. Clinical implications of human papillomavirus in head and neck cancers. *J Clin Oncol.* 2006 Jun 10;24(17):2606-11.

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4. Ledging

At any given length along the canal, if an instrument is allowed to linger in the same position longer than a couple of seconds, or is coupled with excessive apical pressure, a new path can be cut that deviates from the original canal form. I commonly see this with the over-enthusiastic use of non-landed rotary files. This is one of the reasons I tend to favor the use of files with a radial land (i.e. K3 or ProFile) when instrumenting apically. A well-defined glide path is also helpful in preventing ledge formation. For those of you who can drive a car with a manual transmission, imagine that you put your car in first gear on level ground. The sensation you get from releasing the clutch slowly without pushing the gas is the same sensation you should have when using rotary files. These instruments are designed to cut and it is our job to position them and hold them steady with very slight pressure to allow them to engage and progress.

5. Debris Packing

We attempt to remove debris created during canal preparation by the use of irrigation. In addition, many of the nickel titanium files we use have flute designs that facilitate the coronal movement of such debris. Unfortunately, this debris can collect apically, creating a barrier that prevents access to the apical third. It can also deflect instruments, creating other iatrogenic errors. Presuming that a solid glide path was initially formed, the placement of a small diameter instrument to working length after using each rotary instrument can ensure that this debris is broken up. It is then easily removed using irrigating solutions. An EndoActivator (Fig. 4) is also helpful in removing debris.

6. Predictability is Lacking

I love the working length radiograph. The primary benefit is that it allows the clinician to establish a working length relative to the radiographic apex early in the procedure. The reason this is beneficial is that the apical extent of the filling material is usually assessed relative to the position of the radi-

Fig. 4: EndoActivator

ographic apex. If your apex locator is giving you an apex reading at 2mm short of the radiographic apex, dry your canals, ensure that there are no interferences and accept that this is where your final fill should terminate if all available information is in line with this. The time to find out where you will be radiographically is not after the case is completed and you are uncertain if you lost length or folded a gutta percha cone. One of my attendings in my endodontic residency would frequently ask me: "Do you like surprises?" To this day, I still prefer to practice with no surprises. A case with no surprises is predictable, and predictable is what my referring doctors and their patients are looking for.

7. Variable Anatomy

The relationship of the radiographic apex to the canal terminus can be influenced by the variability of the position of the terminus. It can also be affected by the angle that the radiograph is taken from, as well as the relationship of the terminus to the greatest convexity of the root surface projected on the radiograph. As a general rule, a working length determination that is within 2mm of the radiographic apex is likely accurate if verified by another means. In my practice, I strive to have my root filling terminate in the same position where my file terminated in my working length radiograph (Figs. 5, 6 & 7).

8. Gutta Percha Size

Anyone who has performed endodontics has prepared a canal to a specific size only to discover that the corresponding gutta percha point does not go to length. In the days of hand preparation, a lack of coronal shaping would often cause this scenario. Nowadays, many systems have gutta percha that is supposed to match each file. A little-used device known as a gutta gauge is a very helpful adjunct (Fig. 8). This gauge allows us to verify the apical size of the cones by allowing us to trim the cones to fit. It is alarming when you see how often the number on the box doesn't match the information you get from the gauge. Most of the cones I trim are smaller or larger than the number on the box. Trimming the cones takes a few minutes each week, but can save you a great deal of worry chairside.

Conclusion

The loss of working length is a common clinical problem. Once a working length has been determined early in the procedure and a glide path has been established, a predictable outcome is our goal. Good endodontic treatment and outcomes are a benefit to both specialist and generalist, regardless of who performs the treatment. n

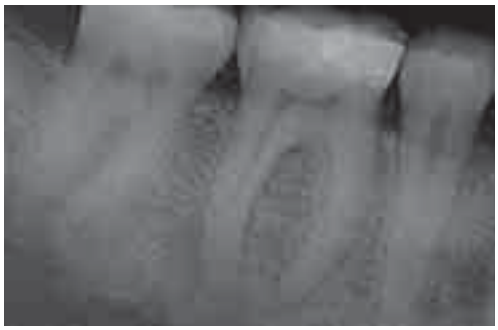

Fig. 5: Start film – sample case

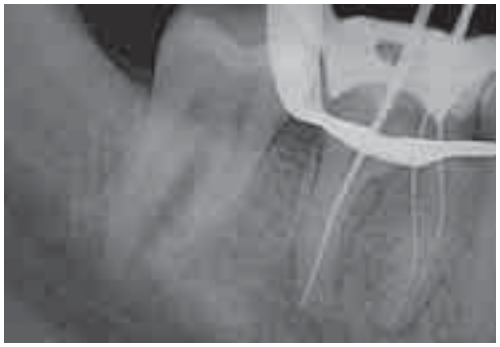

Fig. 6: Working length film – sample case

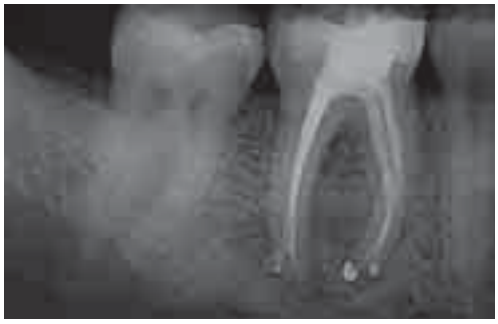

Fig. 7: Final film – sample case

Fig. 8: Gutta gauge

Author's Bio

Dr. David Carter received his DMD from the University of Connecticut School of Dental Medicine. Upon graduation, he completed a general practice residency at Newark Beth Israel Medical Center. After eight years practicing all phases of general dentistry, Dr. Carter earned his endodontic certificate from Lutheran Medical Center in Brooklyn, New York. He currently owns and operates Precision Endodontics, Ltd., a private practice limited to surgical and non-surgical endodontics in Tempe, Arizona. He is a fellow in the Academy of General Dentistry, and is recognized as Board Eligible by the American Board of Endodontics. He can be reached at drc@endoltd.com.

Never Do Just an "Oral Cancer" Exam!

by Scott D. Benjamin, DDS

The most important function of dental care is a thorough assessment and evaluation of the patient's oral and related systemic health. An exam should never be focused on just one condition, and that includes cancer. One of the biggest mistakes that clinicians make is understating the true value of an oral screening for a multitude of conditions and over-hyping a single disease. The improper communication of these procedures has greatly reduced the perception of the significance and importance of the examination process.

It is not uncommon to see dental office promotions offering a free exam or free consultation. These loss leaders are used to entice patients to a practice so more profitable procedures can be performed. These types of statements greatly misrepresent the significant amount of knowledge, technology and expertise required to perform these valuable procedures properly. This has significantly and erroneously devaluated the perceived importance, benefit and reimbursement of a complete and thorough enhanced examination for the patients, clinicians and third-party payers.

For the most part, patients understand that the dentist and hygienist are comprehensively evaluating the dentition and surrounding tissue looking for cavities and gum disease. Too often, patients assume the primary goal is to find a problem, which they will need to pay to have fixed. Other patients feel the importance of a preventive dental/hygiene appointment is to prevent decay and maintain a beautiful smile; they too have missed the real value and true benefit of a thorough oral examination.

When we state we are going to do an "oral cancer exam," it implies that it is the only abnormality we are looking for. The real goal is to discover any abnormality, no matter what it might be. Why not call it an "enhanced oral exam" rather than an "oral cancer exam" – looking for everything from a cavity, to a cheek bite to cancer.

Proper communication is critical in the examination process. No matter how a practitioner presents findings after an "oral cancer exam," it can cause undue anxiety for the patient. This is especially true if an area has an appearance that deviates from a completely normal healthy appearance. In these situations the patient often perceives this abnormality to be cancer.

The entire team plays a strategic role in the data collection, discovery and diagnostic process. From the patient's very first contact with the dental office, whether it is on the phone, through the practice's Internet portals or in person, the importance of a consistent message on the value and necessity of an enhanced oral examination cannot be overstated. Today's advanced technologies are increasingly giving practitioners the ability to detect and discover mucosal conditions at their earliest stages.

No single device can deliver 100 percent accuracy or effectiveness in detecting conditions. Detection and diagnosis is accomplished with the accumulation of data from multiple sources and modalities. Today's diagnostic aids can have a significant impact on the assessment of the patient's health and well-being. These modalities range from specialized visual enhancement products that allow practitioners to see deeper into soft tissue, simplified tissue and cellular sampling techniques, to computerized databases that forewarn of possible conditions, side effects and interactions that might be caused by the patient's medications or conditions, especially as they relate to the oral cavity. As our patients' systemic and dental health situations are becoming increasingly more complex, and with an increased number of medications, the need to use advanced technologies to assist in the diagnostic process has never been greater.

Computerized Pharmacology and Medical Condition Databases

Lexi-Comp Dental Reference Library (Lexi-Comp, Inc., Hudson, Ohio) is an Internet-based collection of interactive databases and reference manuals that are continually updated as the FDA and drug manufacturers announce changes to their drug information and systemic conditions with a specialized focus to their relationship to dentistry. With more than 800 medications that have a xerostomic effect and more than 400 drug formulary changes weekly, it is impossible for a clinician to stay current without computerized assistance. This database is designed to allow dental professionals to access critical information on drug interactions that influence oral conditions quickly and simply. The database is oriented to dental-specific applications to help ensure the correct diagnosis and the appropriate care is rendered for each patient's situation. The complete library also includes a reference manual for the diagnosis and management of oral soft tissue diseases. This manual assists clinicians by providing information on the most common oral conditions divided into sections based on the visual appearance, provides images of the abnormalities and assists in the establishment of the differential diagnosis. Once a clinical working diagnosis has been attained there are suggestions for possible treatment and management.

Salivary Diagnostics

Salivary diagnostics are used in dental offices today by simply having patients rinse with specialized solutions and expectorating into a funneled collection tube that is processed and analyzed at the lab. Due to the simplicity and non-invasive nature of salivary collection and testing, these screening modalities have a significant amount of appeal to clinicians. The saliva that is collected can be evaluated at the laboratory for the status and susceptibility to both oral and systemic conditions. OralDNA Labs (Nashville, Tennessee) has developed a salivary test to identify the patient's genetic susceptibility and inherent risk to periodontal disease by evaluating his or her interleukin-1 (IL-1) gene cluster. MyPerioID PST identifies an individual's genetic susceptibility to periodontal disease. The test enables the clinician to establish which patients are at increased risk for more severe periodontal infections due to an exaggerated immune response. This lab has another salivary test MyPerioPath that identifies the type and concentration of 13 pathogenic bacteria that are known to cause periodontal disease. Identifying these bacteria assists in the diagnosis and management of the condition.

Several strains of human papilloma virus (HPV), especially types 16 and 18, have been associated with oropharyngeal cancer. The OraRisk HPV test by OralDNA Labs is another non-invasive, salivary screening tool to help identify patients that might be at an increased risk for this type of cancer and assist in developing the appropriate referral and surveillance recommendations.

Salivary stone with standard white light (VL) and with florescence using VELscope.

Visual Enhancements for Soft Tissue Diagnosis

Any device that improves our ability for early detection of soft-tissue abnormalities, especially those that are neoplastic in nature, is an invaluable asset to our diagnostic armamentarium. Any visual enhancement is to be used in combination with a conventional visual oral mucosal examination to improve the evaluation, identification and monitoring of oral mucosa and abnormalities. Imaging modalities available include the use of reflectance and fluorescence technology to evaluate tissue under various illumination (lighting) conditions. Fluorescence technology, in particular, enables the chemical and morphology of the various tissues and substances within the oral cavity. This visualization, which can be either direct (viewed directly by the eye) or indirect (viewed on a monitor or screen), gives the clinician even more information to aid in the assessment of the status and health of the oral cavity. Fluorescence can aid in the evaluation of both the hard- and soft-tissue structures, as well as the biological activity of the flora and other microbial activity. The fluorescence technologies do not require the use of any mouth rinses or stains and the process is simply repeating the visual exam with the aid of the device(s).

The battery handheld VELscope Vx (LED Dental, Inc., Burnaby, British Columbia) enables clinicians to quickly visually scan the entire oral cavity looking for changes in the fluorescence pattern of tissue which might indicate an area of concern. This area can then be more closely evaluated to determine an appropriate course of action. A unique feature of this device is the ability to attach an inexpensive camera system to easily photo-document any area that has been detected. These images can assist in the monitoring, referral and education process attaining improved care, management and outcomes.

The DentLight Oral Exam Kit (DentLight, Inc., Richardson, Texas) uses a battery handheld light source to stimulate a fluorescence response that is emitted from the tissue. The clinician views the tissue that is being stimulated with this specialized light through specific filters that are attached to the magnification optics of their loupes. If an area of concern is detected, the area can be photographed with a standard handheld digital

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camera with the supplied filter that can be attached to a lens filter adapter.

The Identafi (DentalEZ Group, Malvern, Pennsylvania) uses a multi-spectral fluorescence and reflectance technology to enhance visualization of mucosal abnormalities. The small, cordless, handheld device uses a three-wavelength optical illumination and visualization system. It has a disposable mirror attachment that also assists in visualizing the area in an indirect manner.

ViziLite Plus with TBlue (Zila, a Tolmar Company, Fort Collins, Colorado) is a disposable handheld device that produces a diffused light created by a chemiluminescent light stick that is also used as a tissue retraction device. After the conventional visual and tactile exam, the patient rinses with a flavored one percent acetic acid pre-rinse solution and then expectorates it. The tissue is then dried with gentle flow of air or gauze and is re-examined using the disposable chemiluminescent light source in a dim environment. If an area of concern is detected it is marked with the supplied TBlue swab to help further visualize and document the area.

Microscopic Evaluation and Cytology

It is extremely important to remember that a surgical biopsy with a microscopic examination is the only accepted method of diagnosing cancer and many other mucosal conditions. The role of a biopsy is to rule out a malignancy and to establish the appropriate diagnosis for the patient's condition. All other modalities, including cytology, are adjunctive procedures to aid in the determination if and where a surgical biopsy would be appropriate and most beneficial. Cytology is not a substitute for the traditional, "gold standard" surgical biopsy technique that removes architecturally intact tissue. In the majority of cases, a lesion that is worthy of a cytology procedure is better served by a surgical biopsy that will render a diagnosis.

Brush cytology is a another adjunctive screening procedure that involves a minimally invasive collection of transepithelial mucosa cells by means of a sterile, plastic-handled nylon bristle brush, with minimal or no discomfort to the patient. The technique involves the collection of disaggregated epithelial cells by vigorous brushing of the oral lesion with a sterile nylon bristle brush. It is primarily used to screen a suspicious leukoplakia or erythroplakia of the mouth in order to aid in the determination of the presence or lack of premalignant dysplastic change. The OralCDx Brush Test (OralCDx Laboratories, Inc., Suffern, New York) is an extremely effective system for ruling out the presence of abnormal, atypical and dysplastic cells in areas that have been properly brushed with the cells placed and fixed on a glass slide.

Liquid-based cytology of the oral cavity is a relatively new screening technique that has also been proven very effective. The tissue is brushed and the cells are transferred from the brush into a special liquid preservative/fixative bottled solution by twirling the brush in the solution to remove the collected epithelial cells from the bristles and the nylon brush is separated from the plastic handle and placed within the bottle. Other oral conditions such as herpes simplex infection and candidiasis can be diagnosed by this procedure. Liquid cytology might also aid the clinician in determining if the lesion detected should be observed or have an immediate invasive full thickness biopsy procedure with intact architecture performed.

Education

One of the most overlooked aspects of incorporating any new technology into a dental practice is education and training on that specific technology and fully understanding its true role and value, but even more importantly, its limitations. The education and training needs to encompass the entire team. It is important to remember that the first place most patients turn to for advice and comfort on any procedure is the office's staff. This aspect cannot be understated!

Reimbursement

Many dental patients today have the unfortunate misconception that if the dentist has not picked up a handpiece and performed a definitive procedure that nothing has been done. The true significance of the diagnostic process has been undervalued by the patient and the clinician alike. As dentistry moves forward into the medical and wellness model, this must change. Despite the fact that there is an ADA CDT code for an "adjunctive pre-diagnostic test," the lack of insurance coverage is one of the greatest impediments to the adoption for many of these advanced diagnostic technologies.

Conclusion

In closing, understanding and properly communicating the true benefits of the enhanced exam and other diagnostic procedures is imperative. Remember the goal of all health-care professionals is to achieve better patient outcomes and to enhance and improve patients' quality of life. n

Author's Bio

Dr. Scott Benjamin is in private practice in rural upstate New York, and has faculty appointments at the SUNY at Buffalo School of Dental Medicine and the NYU College of Dentistry. He is an internationally recognized authority on oral cancer and advanced dental technologies and was a participant in the WHO Collaborating Centre Working Group on "Potentially Malignant Oral Mucosal Lesions and Conditions."

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by Jack Maggiore, MS, PhD and
Ronald L. Schefdore, DMD

Course Objectives

At the end of this program, participants will be able to:

1. List the most common risk factors of diabetes.
2. Explain the importance of recognizing the symptoms of diabetes.
3. Describe the connections between oral inflammation and systemic disease.
4. Detail the benefits of a dental practice engaged in active screening for diabetes and other metabolic disorders.

Course Summary

Diabetes in America is prevalent and excessive. Described in this program is an easy-to-implement dental office program for diabetes detection and risk assessment. Dr. Ron Schefdore, a practicing dentist and founder of Healthy Heart Dentistry, and Dr. Jack Maggiore, a medical technologist and chief scientific officer of Healthy Heart Dentistry provide a detailed overview of the importance of the dental professional's role in the identification of diabetes mellitus.

With the prevalence of diabetes exceeding 1 in 12 Americans, and the number of Americans at risk for diabetes exceeding 57 million,[1] action is required to tackle this runaway epidemic. This article provides a detailed overview of diabetes.

Diabetes Risk Assessment

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Diabetes does not occur overnight. Individuals do not go to bed perfectly healthy and in the morning wake up as a diabetic. Think of diabetes as a progression from the ability to normally process sugars into energy, to a state where sugar metabolism slowly becomes compromised, to a state where sugar metabolism cannot occur without medical intervention.

Most basically defined, diabetes mellitus is a disease in which the body does not produce enough, or does not properly respond to insulin, a pancreatic hormone. Insulin is needed to deliver energy in the form of glucose to the cells. In diabetes, the body either doesn't make enough insulin or can't use its own insulin as well as it should, or both. This causes sugar to accumulate in the blood, often leading to serious complications.

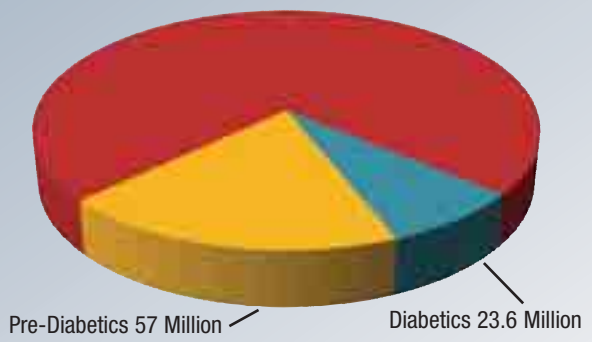
The public health and epidemiological concerns about diabetes stem from the fact that about eight percent of Americans have diabetes (Fig. 1). Just about every person knows someone with the disease, with one in three families affected by diabetes. Of the nearly 24 million people with the disease, about one-third are unaware and undiagnosed.[1] Why 6.2 million people remain undiagnosed is attributed to the lack of diabetes screening by a primary care physician, and the use of an ineffective and insensitive clinical test in fasting glucose being used to detect the disease. Somewhat surprising to many people is that 93 percent of all diabetes is of the type 2 variety, and the primary cause for this is obesity.[2]

Diabetes prevalence among adult age groups shows a dramatic increase occurring around age 40, and then age 60 (Fig. 2). Approximately 23.1 percent of all Americans over age 60 have diabetes.[2] Keeping in mind that one-third of our population is 65 or older, one can see why the prevalence of diabetes is projected to be much higher for the foreseeable future and why diabetes is perceived as a true threat to both our national healthcare system, and to our nation's economy.

Despite advances in medical technologies and treatments, diabetes is still a deadly disease, with a quarter of a million people dying each year. This does not include those dying from heart disease secondary to diabetes. Amazingly, more than 50 percent of those who seek medical attention for complications of diabetes are unaware that they have diabetes.[2]

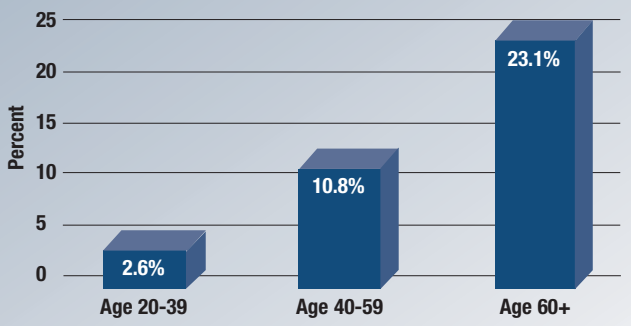
A comparison is detailed in figure 3 of the primary types of the diabetes – type 1 and type 2. Type 1 is also called insulin-dependent diabetes, as the pancreas stops producing insulin in type 1 diabetics. Type 1 is usually detected in children and is also called juvenile diabetes. Its cause is better understood as of recent years, and is known to have an autoimmune cause where the body produces antibodies that attack the islet cells of the pancreas which produce the insulin. There might be a viral component that sparks the autoimmune process, but that mechanism is not well delineated. Type 2 diabetes used to be seen only in adults – that has changed over the past two decades as lifestyle

Fig. 1: Diabetes – the Sobering Statistics



- **23.6 million** Americans have diabetes, or 8% of the population
- **6.2 million** (or nearly one-third) are unaware and undiagnosed
- **1 in 3 families** are touched by diabetes
- **93% of diabetes is type 2** or adult onset, with obesity serving as the primary risk factor

Fig. 2: Diabetes Prevalence



Estimated prevalence of diagnosed and undiagoned diabetes in people age 20 years or older, by age group, Unites States 2007

Source: 2003-2006 National Health and Nutrition Examination Survey estimates of total prevalence (both diagnosed and undiagnosed) were projected to year 2007

Fig. 3: Type 1 vs. Type 2 Diabetes

Type 1
- Insulin dependent
- Pancreas does not produce insulin
- Usually manifests in juveniles
- Autoimmune cause
  - Viral component
  - Body destroys insulin-producing cells
- ~7 percent of all diabetes

Type 2
- Usually adult onset
- Strong genetic link
- Lifestyle triggers
  - Obesity
  - Lack of exercise
- Pancreas produces insulin
- Usually managed by oral medication and diet
- ~93 percent of all diabetes

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triggers like obesity and lack of exercise are known to bring about the disease in those with a genetic predisposition. Since the pancreas still produces insulin in this type, the condition is managed primarily with diet, exercise and oral medications to help the body better metabolize glucose or blood sugar levels.

A discussion of the diabetes detection process needs to include an overview of the diabetes risk factors (Fig. 4). Those who are of African American, Hispanic or American Indian heritage have double the risk, as does having an immediate blood relative with diabetes. Also, being over age 45 places a person at an increased risk. Unfortunately those three factors are not in a person's control. The key preventable risk factors are lack of physical exercise, high blood pressure and being grossly overweight.

Diagnosing diabetes requires a medical doctor, who combines clinical findings with laboratory data. According to diagnostic guidelines set by the American Diabetes Association, a fasting glucose of 126mg/dL or higher is diagnostic for diabetes, as is a blood glucose of 200mg/dL following a two-hour post-glucose load. In all cases, repeat testing is required to confirm a diagnosis of diabetes. Newly proposed is the use of Hemoglobin A1c (HbA1c) as a diagnostic test, where results greater than 6.5 percent are diagnostic for diabetes and values between 5.7 and 6.4 percent are considered at increased risk for diabetes.

A review of the common symptoms of diabetes is essential to this overview. Somewhat surprising to many individuals is that bleeding gums are now recognized as the first symptom of diabetes.[3] Gums bleed in diabetics because the capillaries in these thin tissues are more fragile due to the rapid changes in blood sugar levels. With high blood glucose, cells dehydrate and lose their water content to the blood. Then when blood glucose levels fall, the cells and tissues quickly rehydrate and swell. This process occurring several times per day affects the microvasculature throughout the body, and is noticed in the mouth, eyes and kidneys, typically in that order. The other more recognized symptoms of diabetes include thirst, hunger, urination, fatigue and vision changes, which are often ignored by many individuals. Not until something debilitating occurs, like numbness or slow healing wounds do people seek medical attention. Please note that slow healing sores associated with diabetes are due to poor delivery of oxygen and nutrients to the tissues, causing the inflammation to persist.

The inability to maintain blood glucose levels in a controlled fashion leads to a number of serious diabetes complications. The wide range of glucose or blood sugar levels quickly reaps havoc on the body. Diabetes is the most common cause for kidney dialysis and renal transplants, and also causes blindness.[1] Many diabetics will have a cardiovascular event such as a heart attack or stroke. The peripheral complications like foot ulcerations and neuropathy often lead to foot and leg amputations. Depression and mental impairment are now recognized as complications of diabetes that might manifest at any stage of the disease.

Fig. 4: Type 2 Diabetes Risk Factors

- **Ethnicity – African Americans, Hispanics and American Indians** are more than twice as likely to be diagnosed with type 2 diabetes.
- **Family History –** Having a father, mother, brother or sister with diabetes increases your risk of type 2 diabetes.
- **Age –** Being over age 45 is a risk factor for type 2 diabetes.
- **Physical Inactivity –** Lack of regular cardiac exercise places you at increased risk of type 2 diabetes.
- **Hypertension –** High blood pressure increases the risk of type 2 diabetes.
- **Body Weight –** Obesity is at epidemic proportions and has become the fastest growing preventable cause for type 2 diabetes.

When the body starts to have problems with maintaining healthy levels of glucose, there are clinical symptoms and blood indicators that provide clues that a progression toward diabetes is occurring. This state is called "pre-diabetes." Below are some of the statistics of pre-diabetes.[2]

- In 1999-2000, seven percent of U.S. adolescents age 12-19 had impaired fasting glucose (IFG) metabolism, or pre-diabetes.
- In 2003-2006, 25.9 percent of U.S. adults age 20 or older had IFG, increasing to 35.4 percent of adults 60 or older.
- An estimated 57 million American adults age 20 or older had pre-diabetes in 2007.
- After adjusting for population age and sex differences, IFG prevalence among U.S. adults age 20 or older in 2003-2006 was 21.1 percent for non-Hispanic blacks, 25.1 percent for non-Hispanic whites and 26.1 percent for Mexican Americans.
- The Diabetes Prevention Program, a large prevention study of people at high risk for diabetes, showed that lifestyle intervention reduced developing diabetes by 58 percent during a three-year period. The reduction was even greater, 71 percent, among adults age 60 or older.

Progression to diabetes among those with pre-diabetes is not inevitable. Studies have shown that people with pre-diabetes who lose weight and increase their physical activity can prevent or delay diabetes and return their blood glucose levels to normal.[4] Research has found that lifestyle interventions are more cost effective than medications at reversing the progression of pre-diabetes.[4] But until these at-risk individuals know that they are progressing to diabetes, intervention cannot be initiated. This is why it is so essential to provide accurate and convenient diabetes screening.

In this day and age of advanced medical technologies, it is shocking that not until January 2010 did the primary test for diabetes change. Until this date, the fasting blood glucose test remained the primary test used to diagnose diabetes. Despite the fact that glucose testing has become highly standardized, many people being screened for diabetes with fasting glucose tests are not identified as being at increased risk. The challenge in this public health crisis is not only getting people screened, it is a matter of screening with the right test. A much more sensitive test called Hemoglobin A1c (HbA1c), typically used by diabetics to check long-term glucose control, is now being touted as a screening test for diabetes, as it does not miss episodes of high blood sugar. The American Diabetes Association is now proposing that an HbA1c of 6.5 percent or higher be considered as diagnostic for diabetes.

Medical Expenditures Attributed to Diabetes

The morbidity of diabetes is more costly than any other non-infectious disease in the world. $174 billion is the annual cost of diabetes in the U.S. alone, and it might top $500 billion annually by 2020.[2] A 2007 report from the U.S. Center for Disease Control and Prevention shows the annual per capita costs of health care for people with diabetes is $11,744, of which $6,649 (57 percent) is directly attributed to diabetes itself.[2] The annual direct costs of diabetes are estimated at $116 billion, including $27 billion for care to directly treat diabetes like insulin and oral medications, as well as glucose testing; $58 billion to treat diabetes-related chronic complications like kidney dialysis and transplants, cardiovascular events like heart attacks and stroke and vision-related treatments; and $31 billion for general medical costs, such as emergency room visits. On average, people with diagnosed diabetes have medical expenditures that are approximately 2.3 times higher than those without diabetes. Diabetes-related hospitalizations totaled 24.3 million days in 2007, which is an increase of 7.4 million from the 16.9 million days in 2002. That means that within a five-year period a 40 percent increase was realized in the number of hospitalization days directly attributed to diabetes. A look at the indirect costs of diabetes shows that diabetes cost the U.S. economy an estimated $58 billion in 2007, accounting for 15 million work days absent, 120 million work days with reduced performance, six million reduced productivity days for those not in the workforce and an additional 107 million work days lost due to unemployment disability attributed to diabetes. One out of every five health-care dollars is spent caring for someone with diagnosed diabetes. It becomes rather obvious that when the annual costs of a single disease approach $200 billion, diabetes is at the top of chronic medical conditions contributing to U.S. health-care crisis.

If this were a weather forecast, residents would be evacuating for safer cover. Look at these contributing factors. Diabetes rates are doubling every 10 years. Obesity, the top contributing factor, is out of control and at epidemic proportions exceeding 30 percent of the population. Our population is aging, with more than one-third of the U.S. at retirement age when diabetes risk is at its highest. Our health-care costs are skyrocketing, and when Americans really need to be seeing a primary care physician for preventive medicine, they skip these visits for a variety of reasons. Then, when Americans do see their doctors, medical advancements do not include new and advanced diagnostic tests for diabetes. All of these factors make up the elements for "the perfect storm."

Money spent on treating complications would be far better spent on diabetes screening and preventing the onset of these complications. Dental professionals are in an ideal position to participate in diabetes screening, as more patients see their dentist than their primary care physician.[5] The Diabetes Risk Assessment Kit, first introduced to dental professionals in 2007, remains the only kit that combines fasting glucose with HbA1c to look at both a snapshot of the current glucose level, and a look back at the previous 90 days of glucose control. This kit provides the means to assess glucose intolerance with a single drop of blood. This combination test increases the likelihood of detecting diabetes. The best news is that it could be administered chairside, or sent home with the patient for easy-to-perform self-testing, which requires no special certification by CLIA laboratory license to collect the finger nick blood sample.

Advantages of this Diabetes Risk Assessment Kit test versus an over-the-counter glucose test:

1. CLIA license is not needed by a dental office to collect and transport a blood sample to a licensed clinical lab, and no exposure to the dental office to a random government inspection.
2. Reduces the liability of a dental professional reporting an inaccurate reading.
3. Professional lab report faxed to dentist and mailed to patient to permit follow up, and dentist can fax the lab report to the patients' physician with a letter to start a mutually referring relationship.
4. Accuracy: DRA Test 99 percent versus 85 to 90 percent for over-the-counter blood glucose meter test.
5. Convenient and inexpensive for the clinician and for the patient.

Figure 5 shows the Diabetes Risk Assessment Kit, as distributed by Healthy Heart Dentistry, which contains everything needed to perform the glucose and Hemoglobin A1c tests – the instructions, test requisition, patient consent form, blood collection materials, instant glucose test and transport materials to

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ship the sample to the lab for HbA1c testing. The rapid glucose of the Diabetes Risk Assessment is performed on an ChemCard (Fig. 6). A single drop from a finger nick of blood is dropped onto the test area. The control dot turns red. After three minutes, the tab is lifted and the test area will have turned one of the shades of green shown on the right side of the slide. The green shade is compared to the shade on the reference card, just like color matching a paint chip. The color shade corresponds to a value between 50 and 150mg/dL. Glucose results 75 or above should be confirmed using the HbA1c test. The top tab of the glucose ChemCard traps the red blood cells. This top tab is sent to the laboratory for HbA1c testing, which determines the long-term glucose control. Our clinical laboratory, Healthy Life Laboratories, analyzes Hemoglobin A1c using the established reference method – HPLC, high performance liquid chromatography, which is the most accurate and precise measurement available for HbA1c.

The laboratory report (Fig. 7) shows the HbA1c result compared to the target range. The fasting glucose result is plotted on the X-axis, and the HbA1c result on the Y-axis of the graph. The point where the two values meet is shown as a black diamond, labeled "your result." The risk assessment chart then depicts where your result places you in the diabetes risk category – low, medium or high risk. High risk strongly suggests a diabetic state, and the patient is prompted to seek immediate medical attention. Similarly, medium risk suggests a pre-diabetic condition and that medical attention be sought. Even in cases of low risk, the continuity of care with the patient's primary care physician is suggested; if the patient is experiencing any diabetes-related symptoms and this screen proved negative, additional testing as directed by a physician might be needed.

Like all medical products, the Diabetes Risk Assessment Kit should be stored out of reach of children. The kit is for *in vitro* use only, and should be used only with finger nick blood. While testing is appropriate for all ages, use of the lancets should be restricted to those over the age of three.

The primary reasons for people not being tested for diabetes include: lack of awareness, incomplete education, misconceptions about testing and the absence of a professional's call to action. Through a single point of contact between dental professional and patient, this runaway epidemic of diabetes can be tackled. A new program, called Dentistry Against Diabetes caters to each of these four categories.

Awareness

Awareness is provided through a clipboard questionnaire that introduces the Dentistry Against Diabetes program to the patient upon arrival to the dental office when updating his or her insurance and medical information. The Dentistry Against Diabetes program starts with each dental patient completing this six-question checklist developed from the American Diabetes Association diabetes online risk assessment. Any affirmative answer to these questions places the participant at an increased diabetes risk and suggests the need for diabetes diagnostic testing.

Fig. 5: The Healthy Heart Dentistry Diabetes Risk Assessment Kit combines FDA-approved technologies of rapid fasting glucose and laboratory-tested Hemoglobin A1c. The kit contains illustrated instructions, blood collection materials, laboratory requisition and patient consent forms and specimen transport system.

Fig. 6: The ChemCard for glucose is a three-minute determination of blood sugar. A single drop of blood is added to the test area, and the control dot turns red to indicate that sufficient blood exists. After three minutes the tab, which traps the red blood cells, is removed. The shade of green color of the test pad is compared to the reference chart and the best match provides the glucose level in mg/dL. Glucose results 75mg/dL or higher are confirmed with Hemoglobin A1c testing, which is performed on the blood cells trapped in the top layer of the card tab.

Fig. 7: The Diabetes Risk Assessment laboratory report provides the results of the glucose and Hemoglobin A1c tests, compared to the target range. The results are plotted on a special matrix, which generates a risk indicator for diabetes. This patient is at minimum risk with a glucose level of 125mg/dL combined with an HbA1c of six percent. This suggests a state of pre-diabetes and recommends that the patient follow up with his or her physician.

Education

The reverse side of the Dentistry Against Diabetes questionnaire summarizes easy-to-understand diabetes facts to provide education on the risk factors, symptoms and complications of the disease. This page is the essential take-home message that also serves as a dialogue starter when the educated patient follows up with his or her primary care physician.

Diagnostic Testing

Screening is only effective if the testing is accurate, precise, sensitive and reliable – four of the attributes of the Diabetes Risk Assessment Kit.

Call to Action

Once an individual is screened for diabetes, a call to action is critical to the next steps in maintaining good health, or implementing effective lifestyle changes and treatment. The lab report serves to reinforce the need to discuss the results with a physician to determine the best course of action.

If you suspect that a patient is diabetic based on the patient's history or known risk factors or symptoms, you must first determine if he or she is a diabetic before performing any invasive procedures; by failing to do so you greatly increase your liability. Diabetics and pre-diabetics with poor glucose control are more likely to have complications and treatment failures.

Late in 2008 the *Journal of the American Medical Association* (JAMA) provided a physician's perspective of the link between oral health and diabetes.[6] It is indeed a two-way street, with one condition affecting the other. The AMA and ADA are in strong agreement that professionals must work together for the sake of patients, and for the future of our country. On an informal survey of physicians receiving blood lab reports from dentists, these physicians perceive these dentists as being more advanced and tend to refer their patients to them. Patients also perceive the dental office as being advanced, and many more periodontal treatment programs are started and finished in these offices. CLIA is a federal law that specifically lists licensed dentists as authorized agents to order laboratory tests, however, some state laws place limits or restrictions on such testing. We recommend that you check with your state's department of professional regulations to inquire as to whether dentists are allowed to test for diabetes. n

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Author Bios

Dr. Jack Maggiore is president and chief scientific officer of Healthy Life Laboratories, and is a medical technologist, certified by the American Society for Clinical Pathology, with a Master of Science in Clinical Chemistry and Doctorate in Pathology from the University of Illinois. He holds several medical device patents for his product developments and innovative enhancements, and has authored more than 35 abstracts, publications and textbook chapters. Dr. Maggiore has delivered more than 100 presentations at national and international scientific meetings on topics ranging from disease pathophysiology to clinical laboratory method validation, and has consulted for a number of government agencies, including the U.S. Centers for Disease Control and Prevention. His expertise includes clinical trials and regulatory affairs, having cleared six medical products through the U.S. Food and Drug Administration. His clinical research interests include diabetes disease management, and development of novel biomarkers for chronic diseases. Dr. Maggiore is active in the American Association for Clinical Chemistry, where he has served as chair of the editorial board for *Clinical Laboratory News* and serves on the Chicago Section Executive Committee. Dr. Maggiore's mission is to work with health-care professionals to empower consumers to take a more active role in their health maintenance.

Dr. Ronald L. Schefdore has been in full-time private practice since graduating from Southern Illinois University School of Dental Medicine in 1983. He practices general dentistry in a western suburb of Chicago. His practice profits have consistently been in the top five percent for all general dentists for the past 25 years. His seminars focus on how to improve patient health, provide exceptional service and how to communicate with physicians to start a mutually referring relationship. His Healthy Heart Dentistry periodontal treatment and wellness protocol, FDA-approved blood screening kits for the dental office, and evidence-based periodontal nutritional supplements, are a few of the topics covered in his seminar. Dr. Schefdore has been recognized for four consecutive years as one of the top speakers by *Dentistry Today* Magazine. He is the author of "Better Service, Better Dentistry, Better Income," more than 50 published dental articles including a cover story in *Dentistry Today,* and has been cited in *US News and World Report, The Wall Street Journal, Readers Digest,* NBC-TV Chicago and affiliates, and FOX News. The special NBC report, "Can a trip to the dentist save your life?" featured him for being the first dentist to achieve certification to perform accurate and simple FDA-approved blood screening tests on periodontal patients for early detection of underlying medical conditions. Thanks to the efforts of Dr. Schefdore and his colleagues, a major paradigm shift in dentistry is underway, where dental professionals are being called upon to step to the front line in systemic disease detection.

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Post-test

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1. Which of the following is not considered a common symptom of diabetes?
   a. Unexplained weight loss
   b. Bleeding gums
   c. Rapidly healing wounds
   d. Frequent urination

2. Which of the following would a physician consider as diagnostic for diabetes?
   a. Fasting glucose less than 100mg/dL and Hemoglobin A1c less than five percent
   b. Fasting glucose between 100mg/dL and 125mg/dL
   c. Fasting glucose above 126mg/dL and Hemoglobin A1c above 6.5 percent
   d. Hemoglobin A1c between six and 6.5 percent

3. The fastest growing preventable risk factor for type 2 diabetes is:
   a. Hypertension.
   b. Anemia.
   c. Obesity.
   d. Family history.

4. Dentists are being called upon to screen for diabetes since:
   a. dental caries are the very first sign of diabetes mellitus.
   b. only dentists are licensed to perform the latest screening test for diabetes.
   c. oral inflammation can mask the ability to diagnose diabetes.
   d. more people see their dentist than their primary care physician.

5. What is true about diabetes?
   a. Type 2 is more common than type 1 diabetes by more than 10 to 1.
   b. Type 1 diabetes is also known as adult-onset diabetes.
   c. Type 2 diabetes is only diagnosed in adults.
   d. Type 2 diabetes is also known as insulin-dependent diabetes.

6. Which is a true statement regarding pre-diabetes?
   a. Pre-diabetes only occurs in advance of type 1 diabetes.
   b. Pre-diabetes might be reversible with a commitment to lifestyle changes including weight loss and increased exercise.
   c. Pre-diabetes is not recognized by the American Diabetes Association as an official classification between normoglycemia and diabetes.
   d. Pre-diabetes affects more than half of the population in the United States.

7. Which intervention could serve to avoid the progression of pre-diabetes to diabetes?
   a. Provide diagnostic testing those at-risk for pre-diabetes
   b. Encourage a more sedentary lifestyle
   c. Encourage a diet rich in simple carbohydrates
   d. Delay any treatment until the onset of serious medical complications

8. Despite decades of advances of medical technology, the glucose test remains the primary diagnostic tool for diabetes. Which test has recently been proposed to serve as a diagnostic test for diabetes?
   a. C-Reactive Protein
   b. HDL-Cholesterol
   c. Interleukin 6
   d. Hemoglobin A1c

9. What do diabetes, osteoporosis, anemia and heart disease have in common?
   a. They are chronic diseases that manifest in the oral cavity.
   b. They have a common genetic link.
   c. They are diagnosed with the same blood test.
   d. They are diseases that are known to occur without symptoms.

10. Which statement is not true regarding the testing of glucose and Hemoglobin A1c in a dental setting?
    a. Dental offices that use point of care instruments or over-the-counter devices to test glucose or Hemoglobin A1c are required to obtain a CLIA license or CLIA certificate of waiver and can open the office up to a CLIA inspection.
    b. The American Diabetes Association has recommended that point of care devices for Hemoglobin A1c not be used to diagnose diabetes.
    c. Current over-the-counter devices for Hemoglobin A1c are prone to interference from sickling hemoglobins and have a significantly higher degree of inaccuracy than laboratory-based testing.
    d. The collection of blood for purposes of transporting to a clinical laboratory for HbA1c testing requires the dental office to obtain a CLIA license.

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Diabetes Risk Assessment and Today's Dental Professional

by Jack Maggiore, MS, PhD and Ronald L. Schefdore, DMD

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- o Periodontics
- o Periodontic Resident
- o Prosthodontics
- o Public Health
- o Radiology
- o Speaker
- o TMD Specialist
- o Other

YOUR PHONES: A "JOY" or an "OUCH"?

by Rhonda R. Savage, DDS

How do we get patients on board with the dentistry they deserve? First, you've got to get them in the door!

The emotional side of the patient says, "I know I should do this, but I don't want to spend the money or go through the discomfort." Learning and reviewing verbal phone skills that influence and persuade are important. Intellectually, patients know how important the treatment is, but that's not all they need.

To get the patient to listen, the person answering the phones needs to develop the relationship. Here are tips on how to accomplish this:

The new patient call begins with a great phone voice. Your voice should be warm, caring, empathetic, intelligent and relaxed. It's difficult to do this in a busy office. Have a signal ready that demonstrates you're working with a new patient; a folded yellow card that says "On Call" is a good visual.

For training purposes, let's list what we're looking for in the call:

1. Get the patient's name and use it all the way through the call.
2. Ask how the patient heard about the practice. You need to track your ROI (return on investment) for your marketing efforts.
3. Reassure the patient that he or she has made the right choice; your practice is a great place to be!
4. Talk up the doctor; be confident about his or her credentials.
5. Express empathy; ask questions and show concern.
6. Ask about dental and health concerns.
7. Talk about the value of the appointment before you talk about money.
8. Then talk about money or insurance; don't trap the dentist with a specific quote since you don't yet know the patient's exact needs.
9. Get the patient's contact information.
10. Offer an appointment. Guide the patient by giving specific options for scheduling. (Example: "I have 8 a.m. Monday or 2 p.m. Tuesday. Will either of these work for you?")
11. Follow up with the patient who didn't appoint in 24 to 48 hours to see that his or her needs were taken care of.

This list is meant to be a summary. Conversations flow and should feel natural. With all scripting, the person taking the call should internalize the components listed and make their "script" feel completely natural. Patients do not like to be "scripted." Here is an example in action:

The name: "Thanks for calling, Mrs. Parker!"

How they found you: "How did you hear about our practice? ...Oh, Mr. Bell is a wonderful patient. How do you know him?"

Reassure: "You know, Mrs. Parker, I do understand how hard it is to choose a new dentist and I just want to let you know you've chosen the right practice to call! Dr. Posada is a wonderful dentist. He's so kind and caring; I'm sure you'll really enjoy meeting him. He's been practicing now for 14 years. He loves helping patients with their needs; he's also really active at the dental school and volunteers a lot in the community."

Value: "About your appointment, if you have just a moment, I'd like to let you know what to expect at the first appointment. We'll gather any necessary X-rays, talk to you about your health history and the doctor will do a thorough exam. He'll look at all your teeth and also your gums."

Dental Concerns: "Do you have any gum-related concerns? When was your last cleaning?"

Reassurance: "It's been difficult for you to have dentistry in the past? Not to worry, Mrs. Parker, the doctor is the best! Many of our patients feel just as you do! He's so gentle!" Note: If your office offers different forms of sedation, be prepared to address the patient's questions with scripting from your doctor.

Health Concerns: "Do you have any health concerns we need to be aware of?"

Insurance: "Mrs. Parker, do you have dental coverage that we should know about? Yes, we do work with your plan; we have a lot of patients who have your plan that choose to come here. You do have a deductible and your fee for the day will be $75.00." (If you reqiure payment at the time of service, say so.)

Give an "Out": "Will that be OK for you?" Give the patient the "out" if it's not OK for the patient financially. Be clear about financial obligations so you do not surprise the patient at the appointment time. There are some that say to never talk about money over the phone, yet, money is one of the chief concerns of patients. To surprise a patient is to lose a patient. A surprised patient turns into an embarrassed patient, who then becomes an angry patient (see below regarding the shopper patient and quoting a fee).

Appoint: "I'm really looking forward to meeting you, Mrs. Parker! We have a 1 p.m. opening this Wednesday or a 10 a.m. next Monday. Would either of those times work for you?" The new patient should be seen within seven to 10 business days. Create flexible time in the schedule to get the new patient in quickly.

Greet: When the new patient arrives, stand up and warmly shake the patient's hand. Smile and look the patient in the eyes. Demonstrate confidence by squaring your shoulders and having a straight posture. When shaking the patient's hand, use the same level of pressure that the patient extends to you. Be careful with elderly patients or with a female patient; generally the hand shake is not as firm or strong. "Mrs. Parker, it's wonderful to meet you. I'm Sarah; I made your appointment."

The Shopper Call

The shopper call is handled similarly as you did with the new patient. The shopper's first initial phone question will be:

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"Do you accept my insurance?" Or: "Hi! I'm just calling around. I need a cap on my tooth and I don't have insurance. How much is a cap in your office?"

Say, "Absolutely; I can help you with this. Could I get your name, please?" Use it all the way through the conversation; follow the same scripting as mentioned previously.

Ask your doctor about how he or she wants these types of calls answered; be clear about the financial policies in your office. Have the financial policies in a written form and handy at the front desk. If you're going to quote fees, I recommend you give the patient a range of fees, explaining that you can't determine the exact fees over the phone since he or she has not yet had a consultation.

If the patient is on a plan that you do not accept or must choose a dentist off a list (Medicaid, HMO or PPO plan), you'll need to answer the patient's question directly. Say, "Mr. Humphrey, are you free to choose your dentist? No, I'm sorry, we do not accept Medicaid reimbursement." If your practice is in a heavily PPO/Medicaid area and you don't accept a particular plan, ask this question near the beginning of the call.

"I only want my teeth cleaned!": This is another entire article. In summary, you need current X-rays to protect the practice from malpractice as well as to deliver the care the patient deserves. For a handout on this topic, e-mail me at rhonda@milesandassociates.net.

"Is the doctor a "Preferred Provider?": If the patient is covered by a plan that you do accept but you are not "on the list" as a PPO provider, then lead the patient forward by saying, "Mr. Humphrey, we do have many patients that come to us with your particular plan. Dr. Johnson is not a contracted provider for this plan, but the patients choose to see him because he provides all of his patients with the same high quality of care. He made a decision early in his practice that he wanted to provide the best materials, train his team and have up-to-date equipment so his patients could get the care they deserve. We are thankful that you have your plan as many of our patients don't have dental coverage. Your portion for the appointment will be (your fee or range of fees). Will that be OK for you?"

The Emergency Patient

Emergency patients are great practice builders. Plan to triage the patient; prepare the patient for the triage appointment on the phone. Your tone of voice should project empathy and concern. Ask about their symptoms. For all new patient contact and emergency contact, have a systematic way of gathering information: use a contact form. Write down the patient's concerns and communicate them to the back staff; this allows the entire office to look knowledgeable and professional.

"Carrie, we can get you in right away and look at your tooth. Can you tell me how you've been feeling? Is it hot or cold sensitive? Have you been kept awake at night from the pain? Is it bite sensitive? Is it sweet sensitive? Have you noticed any swelling? When did the swelling begin?"

"Carrie, we need to take an X-ray and have the doctor look at the tooth. I'm not certain we'll be able to provide care today; it depends on what you need. We might need to make another appointment for you so you can have the time you deserve."

"I have 10:30 or 2:15 today. Which time would work for you? 2:15? Great! I have you down at 2:15. Our team will take really good care of you!"

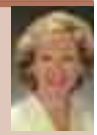
"Carrie, we do accept reimbursement from your dental benefit plan; you'll have your deductible to meet for the year. Your fee for today will be (your fee or range of fees)."

"Yes, I can help you with financial arrangements, Carrie, we do accept checks and also Visa, MasterCard and American Express. We also have a resource called CareCredit; we can make your treatment fit your time and your budget. You would need to take care of your non-insurance portion at the time of service. Will that be OK for you?"

With emergency patients, provide care only if you do not keep your regularly scheduled patients waiting and you have clearly defined, written payment arrangements!

People buy based on emotion and reason it out afterward. To get your new patient in the door, you must connect with them emotionally, reason with them intellectually and make it easy by helping them make the appointment. Phone skills and how we say things matter and are the first step to a great patient relationship. ■

Author's Bio



Dr. Rhonda Savage began her career in dentistry as a dental assistant in 1976. After four years of chairside assisting, she took over front office duties for the next two years. She loved working with patients and decided to become a dentist. Savage graduated with a BS in biology, cum laude, from Seattle University in 1985; she then attended the University of Washington School of Dentistry, graduating in 1989 with multiple honors. Savage went on active duty as a dental officer in the U.S. Navy during Desert Shield/Desert Storm and was awarded the Navy Achievement Medal, the National Defense Medal and an Expert Pistol Medal. While in private practice for 16 years, Savage authored many peer-reviewed articles and lectured internationally. She is active in organized dentistry and has represented the State of Washington as president of the Washington State Dental Association. Savage is the CEO for Linda L. Miles and Associates, known internationally for dental management and consulting services. She is a noted speaker who lectures on practice management, women's health issues, periodontal disease, communication and marketing and zoo dentistry. To speak with Dr. Savage about your practice concerns or to schedule her to speak at your dental society or study club, please e-mail rhonda@milesandassociates.net, or call 877-343-0909.

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Where are the OLIVES in Your Practice?

by Joe Steven Jr., DDS

For years all my team ever heard from me was "Production! Production! Production!" Twenty-some years ago I had a goal for a million dollar practice so we were always striving to efficiently provide the best dental care to as many patients as we could in order to reach that goal. After attaining that goal, I told them that I was not really interested in shooting for higher production numbers because I had another goal in mind.

My new primary goal was to be as efficient as possible in all our systems for better "peace of mind." By that, I meant I wanted to know that we were doing everything as efficiently as possible to keep our costs down while providing excellent patient care. I expressed to them that I didn't want our production and collection figures to drop by any means, and that our numbers would gradually increase anyway because of our new endeavor. It's ridiculous to keep going year after year knowing you're losing profit dollars because of inefficiency. Since we had attained higher goals consistently, I wanted to concentrate on the icing on the cake. I wanted us to fine tune every system. I've been a fanatic all my career on watching the bottom line and being as organized and efficient as possible, but there's always room for improvement.

At one of our regular staff meetings, I read the following story which was the main emphasis of my new found goal. I would strongly suggest that you read this to your staff at your next meeting. It's not only interesting, but it will help you and your staff look at the business side of your practice in a whole new light.

A Little Goes a Long Way

For more than a decade United Airlines has been saving more than $40,000 a year by simply removing one olive from

each salad they serve in First Class. This point is brought out to demonstrate how something as small as an olive, something that easily could be overlooked, could have such an impact on the bottom line. What little olive does your practice have that could be costing you thousands of dollars every year? You might be surprised if you and your staff were to sit down and brainstorm just how many different little olives your practice has. Olives that if put to a better use could dramatically change things with your business and maybe even allow for some little perks that before were not available.

The staff was just as intrigued with that story as I was. I explained to them that I realized no one is going to receive immediate gratification by not wasting cotton rolls, or not using too much topical anesthetic, or not leaving the nitrous units on accidentally. But it all adds up, and that's money that can be used for a staff trip or for their pension plans. Or, it could be used for office improvements that everyone enjoys. It's simply ridiculous to keep wasting money when we all work so hard to produce and collect it.

"You might be surprised if you and your staff were to sit down and brainstorm, just how many different little olives your practice has. Olives that if put to a better use could dramatically change things with your business and maybe even allow for some little perks that before were not available."

Following that meeting it seemed like just about every other day or so someone pointed out another "olive." My hygienists got together right away and found a different brand of fluoride that saved us about 50 cents per bottle.

Obviously, supply purchases are the best examples of big "olives," but, there are many others. During one of our meetings, we reviewed our Staff Policy Manual and went over time clock policies. I pointed out that mistakes with time recordings usually fall at the expense of the practice. I asked our payroll person if this was true, and she admitted that sometimes it can be a pretty big "olive."

We found another "olive" while reviewing our uniform policy. Over the years, we drifted away from our daily matching scrubs policy. As a result, the practice was paying out too much for individual preferences of uniform colors which resulted in more scrubs than needed. Our policy has a 50 percent uniform allowance that the practice reimburses to the staff members. We reorganized and saved another "olive" there.

We reviewed and revised a few of our checklists which are easily overlooked or forgotten in a busy office. Simple things like turning off the treatment room lights and televisions during lunch might seem insignificant, but really do add up in the end. My pet peeve has always been finding a running nitrous unit with no patient at the other end. Worse yet is leaving a unit on and someone forgetting to turn the main tanks off when leaving the office. We reviewed our policy as to when to remove nitrous from a patient for specific procedures. If a patient receives a mandibular block, it's a waste to leave the nitrous on until they are numb. With many local infiltrations, we'll leave the unit on since we won't have to wait as long for the anesthetic to work. I pointed out to my staff to use their own discretion with each individual patient but to be aware of this little "olive."

"Olives" can also take the form as mistakes within a practice such as laboratory case inefficiencies on our part. Even though many of us all experience those busy, chaotic days, we have to take the time to be explicit and thorough on our lab directions for every case. Having to reschedule a patient because a case wasn't back on time, or worse yet, wasn't completed properly is an easily avoidable "olive" that costs us valuable chair time and needless negative patient goodwill. Likewise, lab cases sitting in the bins for over a month need to be reviewed so that these cases can be completed. In our practice, that's a specific duty assigned to a particular assistant.

Another seemingly trivial "olive" that really adds up is the office thermostat. If you don't have one of those programmable thermostats, you're probably over-spending $100 each month in wasted energy. There is no reason to have the AC running during the evening or on weekends at the same setting as you do during work hours. During our afternoons off, we manually

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raise the temperature about six or eight degrees before we leave the office just to save a few bucks.

Of course it's always great to find some large "olives" to really reduce your overhead. For years I have been receiving a 10 percent discount at the dental lab I use because I prepay my account with a credit card. Now that's a big "olive"! Check with your lab today and ask if they provide that courtesy; many labs do.

Here's another big one – get a quote on credit card processing fees. There are so many hidden bank fees that we tend to overlook month after month. Between my practice and KISCO, I am saving several hundred dollars per month after evaluating these fees. Nice "olive"!

Want another big olive? About 80 percent of the doctors ask their labs for high noble or semi-precious metal. The lab I use saves many doctors money by suggesting they use non-precious metal as long as it doesn't contain nickel or beryllium. I've been using non-precious metal for most of my PFMs for years and cannot see one negative thing from using this material.

Many "olives" can be eliminated by a team management approach by which each employee is assigned specific duties and responsibilities. Respective checklists should be used for these assigned duties to guarantee that everything is being done properly. Go ahead and schedule an "olive" meeting with your staff and get your team's input and suggestions for finding "olives" in your practice. Many times your team will come up with more ideas than the doctor for finding "olives" and improving your bottom line. So, where are the olives in your practice? ■

Author's Bio

Dr. Joe Steven graduated from Creighton Dental School in 1978 and has been in solo practice in Wichita, Kansas, up until June, 2007 at which time his daughter, Dr. Jasmin Rupp joined him. He is president of KISCO, a dental products marketing company, providing "new ideas for dentistry," and is the editor of the KISCO Perspective Newsletter. Dr. Steven, along with Dr. Mark Troilo, presents the "Team Dynamics" seminar. Dr. Steven also presents three other seminars: "Efficient-dentistry," "Efficient-prosthetics," and "Efficient-endo." Dr. Steven also provides the KISCO Select Consulting Program to dentists in the form of a monthly audio CD recording. He also offers a coaching consulting program called the KISCO's 21 Club. Contact info: jsteven@kiscodental.com; 800-325-8649; www.kiscodental.com.

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VivaPen

A Time-saving Innovative Delivery Form for Adhesives

Usefulness

One of Ivoclar Vivadent's newest product introductions, the VivaPen, has been developed to provide time-saving and economical application of adhesives directly in the mouth. The VivaPen system features a unique ergonomic design that allows for easy and clean application of adhesives during dental restoration procedures. These features also enable faster application times while eliminating the need to utilize other tools during the bonding process.

Functionality

Featuring a simple-to-use, one-click dispenser located on the side of the unit, the VivaPen system has been ergonomically designed to offer comfort to the operator. Snap-on cannula brush tips have been specifically engineered to maintain a minimal residual volume when compared to traditional metal tips. This allows clinicians to apply the exact amount of adhesive, eliminating product waste and cutting costs. Additional applications may be applied as necessary since more adhesive is just one click away. Each VivaPen contains enough adhesive for approximately 120 applications and includes a fill-level indicator allowing clinicians to closely monitor the remaining amount of adhesive.

AdheSE One F AND ExciTE F

The VivaPen was specifically designed to dispense adhesive products such as AdheSE One F, a seventh-generation self-etch, and ExciTE F, a fifth-generation total-etch. AdheSE One F and ExciTE F have been developed to provide considerably higher bond strengths and a marginal seal, reducing post-operative sensitivities. Both adhesives achieve bonding with the added bonus of fluoride release. Utilizing the VivaPen system, ExciTE F and AdheSE One F offer predictable, consistent solutions for a variety of restorative procedures.

Benefits to Clinicians

With the VivaPen delivery form, clinicians now have the ability to consistently provide patients with perfectly sealed and bonded restorations. VivaPen provides more precise placement for both direct and indirect restorations (using ExciTE F), allowing clinicians to cut costs since only one delivery tool is needed. Using the VivaPen is simple, cost-effective (approximately 120 applications per unit) and predictable. Clinicians need only attach the cannula brush tip, position it properly for optimal placement and "click" the mechanism to saturate the brush with adhesive. With this direct and accurate placement, clinicians can expect a perfectly seated restoration, with little-to-no patient post-operative sensitivity. n

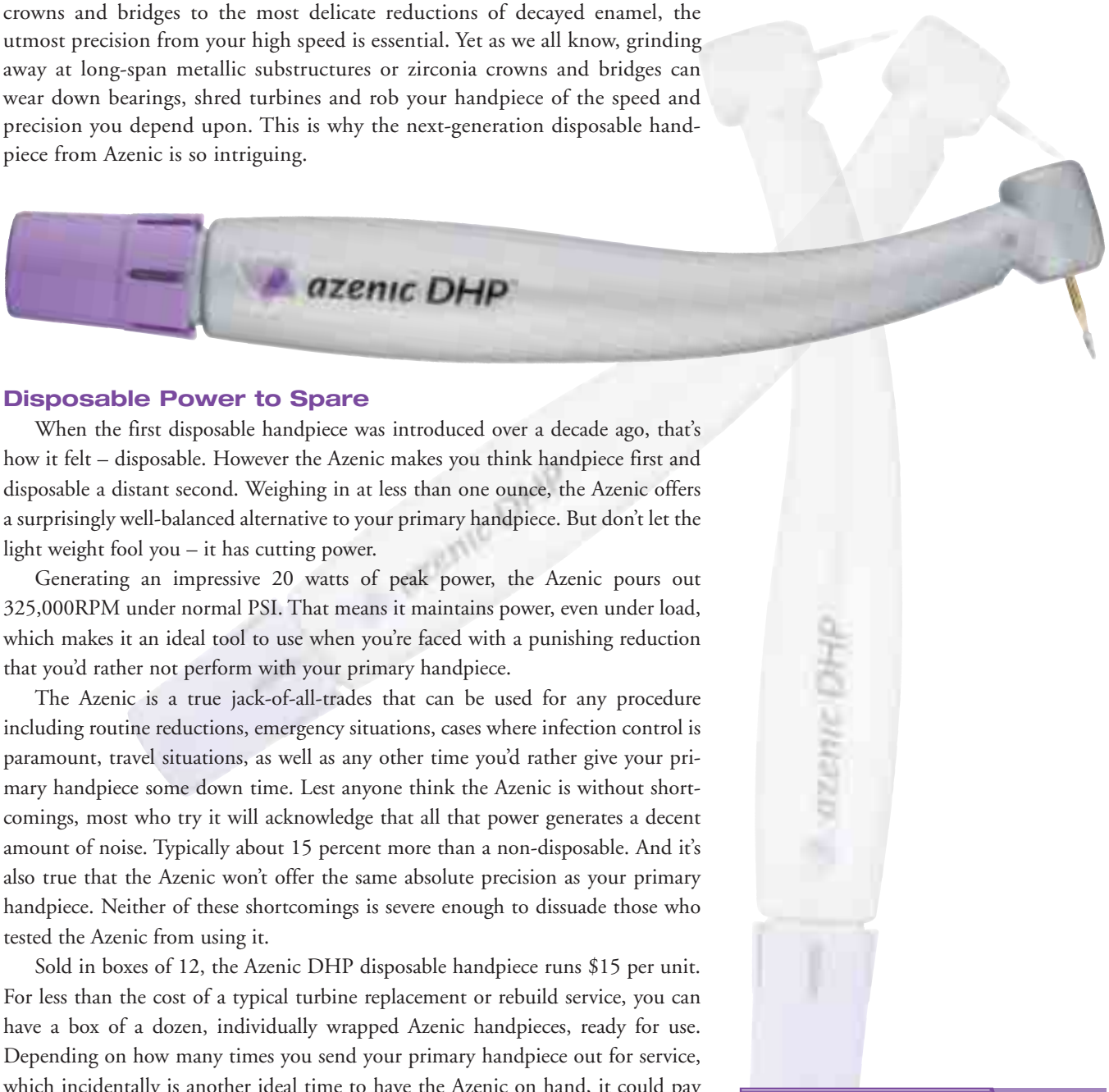
Company Contact

For additional information, visit www.ivoclarvivadent.com or call 800-533-6825.

Azenic Disposable Handpiece

The Azenic DHP Protects Your Investment in Your Primary Handpiece

Whether it's a KaVo, Midwest or Star, your high-speed handpiece is the most indispensible tool in your operatory. From final finishing touches on crowns and bridges to the most delicate reductions of decayed enamel, the utmost precision from your high speed is essential. Yet as we all know, grinding away at long-span metallic substructures or zirconia crowns and bridges can wear down bearings, shred turbines and rob your handpiece of the speed and precision you depend upon. This is why the next-generation disposable handpiece from Azenic is so intriguing.



Disposable Power to Spare

When the first disposable handpiece was introduced over a decade ago, that's how it felt – disposable. However the Azenic makes you think handpiece first and disposable a distant second. Weighing in at less than one ounce, the Azenic offers a surprisingly well-balanced alternative to your primary handpiece. But don't let the light weight fool you – it has cutting power.

Generating an impressive 20 watts of peak power, the Azenic pours out 325,000RPM under normal PSI. That means it maintains power, even under load, which makes it an ideal tool to use when you're faced with a punishing reduction that you'd rather not perform with your primary handpiece.

The Azenic is a true jack-of-all-trades that can be used for any procedure including routine reductions, emergency situations, cases where infection control is paramount, travel situations, as well as any other time you'd rather give your primary handpiece some down time. Lest anyone think the Azenic is without shortcomings, most who try it will acknowledge that all that power generates a decent amount of noise. Typically about 15 percent more than a non-disposable. And it's also true that the Azenic won't offer the same absolute precision as your primary handpiece. Neither of these shortcomings is severe enough to dissuade those who tested the Azenic from using it.

Sold in boxes of 12, the Azenic DHP disposable handpiece runs $15 per unit. For less than the cost of a typical turbine replacement or rebuild service, you can have a box of a dozen, individually wrapped Azenic handpieces, ready for use. Depending on how many times you send your primary handpiece out for service, which incidentally is another ideal time to have the Azenic on hand, it could pay for itself rather quickly.

Having a box of Azenic's on hand will enable you to delay costly and inconvenient handpiece repairs, extend the life of your favorite handpiece by a few years and protect your patients from cross contamination. n

Company Contact

For more information, visit www.azenic.com or call 888-347-7576.

RateYourSmile.com

Online Consultations and the Virtual Dental Professional

Until now, patients who wanted to have answers to their smile dilemmas had to book an appointment, take time off work and sometimes travel long distances to see their favorite dentist. Now they can get complimentary advice quickly and confidentially with RateYourSmile.com (RYS). The program helps dental professionals make an important first impression with people interested in a more attractive smile.

Star Appeal

One of television's brightest smiles, Stephenie LaGrossa from TV's *Survivor* has joined up with RYS to offer some unique marketing opportunities. LaGrossa is featured on one of several audio CDs in the associated "Ticket to a New Smile" promotion. She recently married Phillies pitcher Kyle Kendrick and their glamorous wedding photos grace the cover of one of the custom CDs titled, "Smile Makeover Tips for the New Bride."

How it Works

Once a clinician registers with RYS, he or she uploads his or her practice information and a link is generated. Dentists can use this link on their own practice Web sites and in online ads. Virtual patients select a member by city listing and can upload questions, photos or a video link. The beta-testers have found most respondents are female and about half of those that decide to post a question soon end up in the doctor's office. To reduce patients from "shopping," the virtual patient is allowed only one member selection every 72 hours.

The beta-testers have found most respondents are female and about half of those that decide to post a question soon end up in the doctor's office.

VIP Program

For a modest premium, members can upgrade to the "Featured Smile Expert" level, which immediately give the doctor a higher profile. These members are listed in the top three for the city selected, and have access to the marketing upgrades including recorded interviews and marketing audio CDs. They also become the company spokesperson for the local media. There are currently four niche CDs covering cosmetic dentistry, orthodontics, short-term braces and a bridal version (all produced in cooperation with recognized authorities in their fields, including Dr. Brian LeSage). CDs can be customized and feature member practice information which produces a marketing piece that beats a business card/brochure. By teaming up with a corporate disc company, the CDs can be sent to targeted lists to provide a soft sell for the member.

Great ROI

One beta-tester found herself featured in three separate TV appearances and immediately noticed a bump in new clients. Another doctor uses the system to prescreen potential patients who are sometimes a hundred miles or more away. RateYourSmile.com is set up to pay for itself after the first new lead, but if a savvy dentist makes full use of the strategies suggested, the upside can be stellar, and let's be honest, it could be fun to analyze smiles poolside with an iPad. n

Townie Choice Awards Public Notice

This notice is to provide the purpose, methodology and input required from dental professionals, dental companies and Dentaltown.com and Hygienetown.com, divisions of Farran Media, LLC, regarding the Townie Choice Awards.

Purpose of the Townie Choice Awards: To provide dental professionals with an impartial resource to assist them in their selection of dental products, equipment and services.

Fees to participate: None

Methodology: Categories of the most common dental products, equipment and services are developed, with the aid of multiple industry resources and the Dentaltown.com and Hygienetown.com online communities. For each category, all dental manufacturers are given the opportunity to submit up to three products of their choice. Dentaltown and Hygienetown do not attempt to make any recommendations on inclusion or exclusion of any products, equipment or services listed on the voting ballots. Please note that all entries are subject to review.

Voting process: Voting is done online. One ballot per licensed clinician.

Results: Results will be electronically tabulated and the winning entries for each category will be published in the December issue. The results will be made available online at www.dentaltown.com and www.hygienetown.com after the December issue is printed and delivered.

Responsibilities of each party:

Dental Community:

- Vote! Let your voice be heard. Share your experience with fellow dental professionals.
- Provide feedback as to the process of the awards to help make this resource useful to dental professionals.

Dental companies:

- Participate in the Townie Choice Survey. Enter your products to be included on the ballot.

Steps to participate:

- Farran Media will send an e-mail notice so products can be loaded in a secure ballot.
- Load your products into the online ballot May 18-June 6, 2011.
- Any questions, contact Leah Harris at leah@farranmedia.com or 480-445-9693

Farran Media, LLC:

- Send the manufacturers a notice that will allow them to enter products on the ballot.
- Offer a non-biased platform to dental companies to participate in the survey.
- Provide a non-biased platform to dental professionals to benefit from the survey.
- Offer all dental companies an equal opportunity to list their products, equipment and services.
- List product choices in alphabetical order.
- List winners with product images and descriptions in December special edition of *Dentaltown Magazine* at no charge.
- Display the top Townie Choices in each category with voting details including number of total votes and votes per product on www.dentaltown.com and www.hygienetown.com.
- Provide the Townie Choice Award artwork/logo to winning companies to use on their marketing materials at no charge.
- Will not rent, sell or otherwise make available dental professionals names and their corresponding choices.

Schedule:

July 13-August 19, 2011 – Townies vote for their preferred products online

Mid-September 2011 – Farran Media will notify the 2011 TCA winners

September 30, 2011 – Deadline for the winning companies to submit product information and images

December 2011 – The 2011 TCA winners are revealed in *Dentaltown Magazine!*

Don't Wait! Plan Today!

Five Alternative Exit Strategies

by John F. McDonnell

Over the years while attending state and national dental conventions, I will run into dentists I have known for years and during our conversations they tell me that they will be ready to sell their practices in five years and will call me at that time so I can help them.

I see these same dentists every year at conventions and each year they tell me that they will be ready to sell in another five years. Sometimes 10 years have gone by before they finally contact me. Each year I encourage them to plan their transition now and not wait. Many of these dentists are friends of mine and will eventually contact me to help them. If you are planning to exit your practice within one, five, 10 or 20 years, the time to plan is today.

Benefits of planning today for your exit strategy:

1. You will have the peace of mind of knowing that your exit strategy and retirement from dentistry is planned. This means that you, your family, staff and patients will all benefit.
2. Having a plan assures that you are more likely to sell the practice at its peak and not when it is in decline.
3. Planning now gives you an opportunity to have higher earnings during the years between the start of the plan and your exit.
4. Implementing a plan allows your staff and patients to have a clear path to remain with the practice as they will be taken care of and work with your heir apparent.
5. Having a plan assures that you will pass on the legacy of your long-term practice to a worthy successor.
6. A plan gives you a form of insurance in the event that a death or disability was to occur.
7. Planning ahead allows you to explore multiple alternatives for the transition of your practice.

Planning now is a form of insurance to protect one of your most important and most valuable assets. Here are five alternatives:

Option 1: Sell the Practice and Leave

Selling the practice and leaving is still the most common of practice sales in our industry. With this option the seller normally leaves immediately following the sale or within a three- to six-month period. The reason for leaving so soon is that many of the solo practices do not have enough patients or a space large enough to have two full-time dentists in the office simultaneously. As the buyer needs to pay the overhead of the practice, themselves and the bank loan for the practice purchase, there is nothing left for the seller.

Benefits and reasons:

1. The dentist is ready to retire and not practice any longer.
2. The dentist has health issues and has to retire and turn over their patients to the new buyer.

3. The seller avoids having to commit to a new long-term lease as the buyer will be the one to sign the new lease.
4. The senior dentist has other interests, hobbies or businesses.
5. In most cases the seller receives 100 percent of the sale price at the closing.
6. In most cases, in addition to the sale price, the seller receives the accounts receivable.
7. Currently the seller can take the 15 percent capital gains tax rate.

Option 2: Sell the Practice and Stay on After the Sale

What if you could sell your practice and stay on after the sale continuing to enjoy performing dentistry and earning a fair compensation for two to 10 years? When we interview dentists who are preparing their exit strategy, the common theme we hear is that they still enjoy doing the dentistry, taking CE courses and seeing the patients, but they do not like running the business, dealing with insurance companies and handling staff issues.

Benefits and reasons:

1. Dentist is tired of being a business owner and manager 24/7, 365 days a year.
2. He or she has the peace of mind of completing an exit strategy while still able to practice dentistry.
3. We find that dentists in their 30s to 50s who have good practices but due to a large debt service and high monthly bank payments find it stressful that their earnings are not as high as expected.
4. Owners with a full-time associate realize that they can switch roles with the associate and stay on after the sale.
5. Some baby boomers have a set goal of selling their practices after reaching age 55 and this strategy allows them to sell now but continue earning income after the sale to increase their investments and offset the losses they might have due to the recent economic downturn.

Option 3: Delayed Sale of the Practice

This option is becoming more popular as it allows the seller to stay in control of the practice, maximizes earnings and gives an opportunity to sell the practice at its peak. This option requires the office space to be large enough for at least two full-time dentists. It also requires the practice to either have enough patients and work for two full-time dentists or have the potential of patients to be served. If not, the practice will need to have a proactive marketing plan for new patients so that the two dentists can be productive full time.

This option is similar to the sell and leave strategy in that there is a signed asset purchase agreement with a specific target date for the practice sale. There is an associate with an employment agreement for the period of time between joining the practice and the targeted sale date. This time period is normally one to five years depending on the needs of both the seller and the future buyer associate. At the end of the one to five year period the associate purchases the practice by borrowing 100 percent of the sale price to be paid to the seller on the prearranged target date for the closing. A methodology is agreed upon in the beginning to calculate the sale price at the time of the closing and is part of the mutually beneficial agreement signed at the start of the process. This agreement includes a three- to six-month time period during which both the host dentist and associate can ter-

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minate the delayed sale purchase agreement without any penalty in case they do not work well together.

Benefits and reasons:

1. The seller can remain in control of the practice longer. Some dentists prefer to be in control and do not want to have a partner.
2. The seller can maximize his or her income in the final years of practice. Because the associate is going to be the future owner, his or her commitment to the practice and the performance are at a higher level. The practice normally will grow during the period before the targeted sale date and the earnings are higher during that period.
3. Because the value is based upon the most recent year's performance (with consideration to the buyer for his or her contribution to the growth of the practice) the seller is likely to receive a higher sale price at the closing then the foundational value at the beginning of the process.
4. The buyer has a chance to get to know the patients in the practice, the staff and the office systems. By the time the delayed sale is implemented, a smooth transition should occur.
5. Because the practice has two full-time dentists at the targeted delayed sale date, the seller has the option of remaining with the practice after the sale and becoming the associate of the practice.
6. The seller has the peace of mind of knowing that the associate has committed to the delayed sale thereby avoiding failed associates coming and going. As the sale agreement is signed in the beginning this keeps the associate there.
7. The seller has the chance to pass on the legacy of patients and staff to this chosen heir apparent who has already been with the practice for a time period before the targeted closing date.

Option 4: Equity Buy-in Buy-out (Partnership)

Over the last 30 years, approximately 25 percent of all dental practices have chosen to be partnerships. This percentage has not fluctuated more than two percent over those years.

This option requires a space and practice large enough for at least two full-time dentists. The number of years needed to justify this option for the senior dentist is five to 20 years from the retirement of the host seller. If a dentist has practiced solo for more than 30 years and is in his or her 60s, we do not feel this option is viable at that stage of practice.

This option is particularly applicable to an owner who currently has a good associate in place or is in the process of choosing a new associate. This strategy is for the owner who wants the peace of mind of having the heir apparent under contract with a plan for the equity buy-in buy-out partnership in place. Often good people (owners and associates) say they will discuss a transition plan in the future and the future never comes. And without a win-win plan they normally fail in their attempt to have a partnership. We suggest that the discussion happen early on and that agreements for the partnership be signed by all in the beginning. This will insure the successful process of a buy-in buy-out partnership strategy.

Benefits and reasons:

1. This option gives the seller the peace of mind of having the heir apparent on board and a transition plan underway.
2. This option allows the owner to have a future partner with whom to share the burden of managing the practice.
3. The owner has a trusted equity partner in the office.
4. As the equity partner is normally younger, the practice will be attractive to young couples with children thus lowering the average age of the patients.
5. Often the new partner might do some specialty procedures that are traditionally referred out of the practice. That work/income and can now remain in the practice.

Option 5: Merge-in Merge-out

When a dentist practices in a home office or does not want to sign a new long-term lease in a professional building, the merge-out strategy is a good option. The practice can be merged into a larger practice close by and the selling dentist can move with the patients for a period of time earning compensation after the sale. When the selling dentist can come with the patients for a period of time this assures the buyer that the patients will come to the practice.

Assuming that the selling dentist's office is large enough for two full-time dentists or more then the merge-in strategy can be implemented. If a young dentist in the area has a smaller office space or a following of patients, he or she can purchase the seller's practice and merge the patients and practice into the larger space. This again might allow the seller to remain in the practice to continue to see patients.

The merge-in merge-out option allows the seller to get the maximum practice sale value. When merging the practices many of the expenses are lower while the earnings in the joined practice are positive so a positive cash flow for the buyer should result as well.

Benefits and reasons:

1. The problem of the home office practice sale is solved by the merge-out option. This allows the seller to market the house sale to a larger buyer pool then just dentists. In most states home offices are very difficult to sell.

2. This strategy solves the problem of a senior dentist who is faced with signing a long-term lease for the office space.
3. This option allows the seller to receive the Fair Market Value price for the practice when they agree to move with patients to the new office for a period of time.
4. This strategy allows the seller to stay as an employee dentist post-sale for a period of time earning compensation.

Less than five percent of dentists have a plan for their exit strategy. The good news is that whether you plan to exit in one to 20 years, you can still have a plan and have time to implement it. The longer the time between the start of the plan and the exit, the more time you have to explore the five alternative strategies. However, even if you need to sell in the near future, planning ahead is always the best course of action.

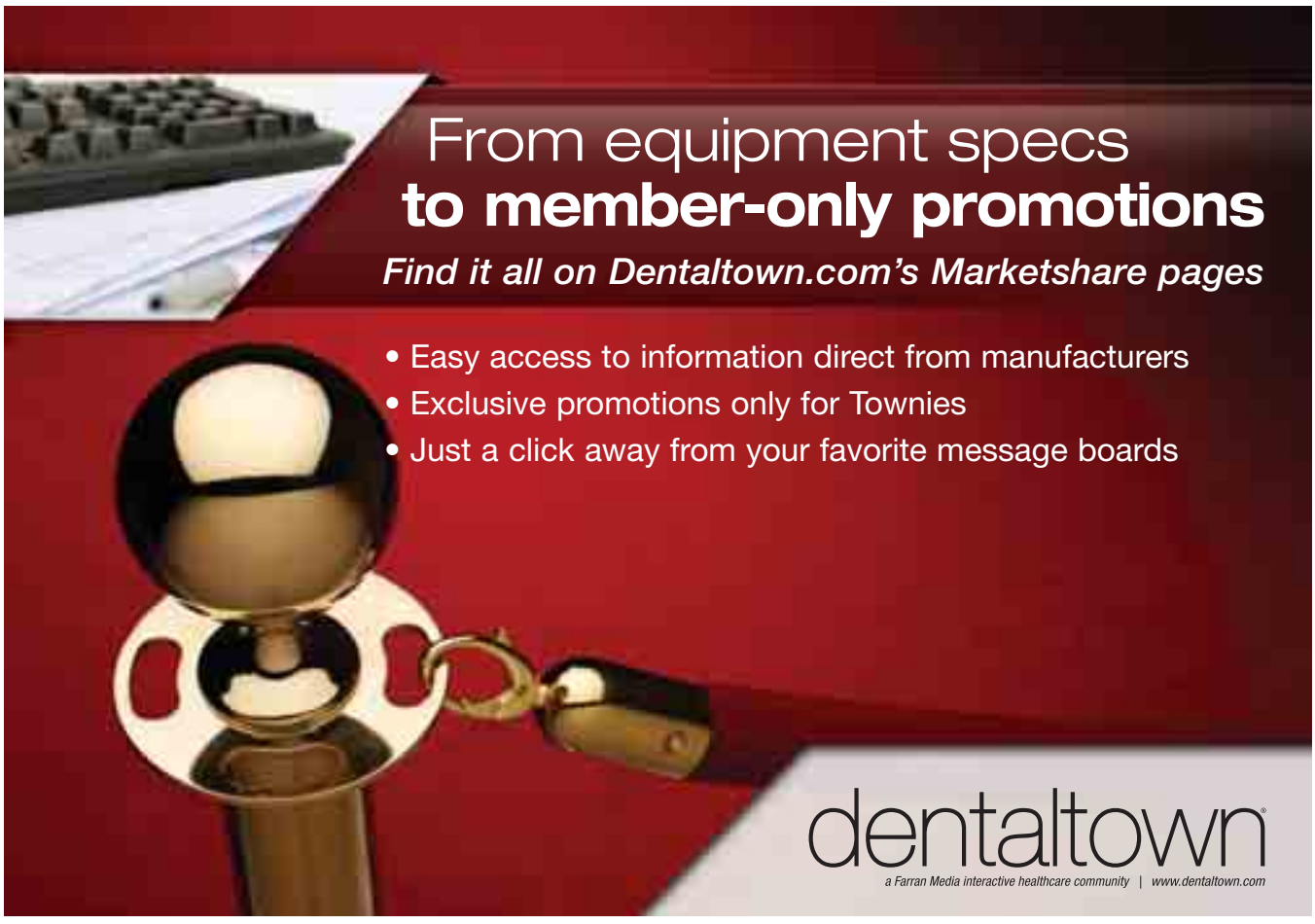
Suggested steps to take to plan your exit strategy today:

1. Choose a transition organization that specializes in practice transitions 24/7 365 days a year and does not have other products and services to sell.
2. Have your practice valued by a qualified, experienced transition specialty organization in the dental industry. This foundational valuation will inform your choices with the five alternatives.
3. Choose a dental CPA to work along with the transition speciality organization as part of your advisory team.
4. Have a written financial plan completed by a qualified planner and have it monitored on a yearly basis.
5. Decide what you want to do about your exit strategy timetable. Plan your transition now, including how long you want to remain in practice after the sale.

You have the choice. Plan your exit strategy *today!* n

Author's Bio

John F. McDonnell, as president and founder of ADS McNor Group has served dentists for more than 40 years in the area of practice transitions in Maryland, Virginia, DC and Pennsylvania. Three generations of his family have worked with dentists in these states for more than 60 years. He is the former president of ADS, the largest dental practice brokerage company in the United States. He has lectured locally and nationally on the topic of dental practice transition. Mr. McDonnell is an expert in assisting dentists in joining and leaving dental practices as well as facilitating all types of transitions. He can be reached at johnfm@adstransitions.com or 888-419-5590 x410.



Townie Meeting Recap

There are dozens of dental meetings that take place around the world each year; but there's only one meeting where members of the Dentaltown community specifically get together to celebrate, for camaraderie and some continuing education. From Sydney, Australia to San Diego, California – Townies from everywhere attend lectures, engage in poker and golf tournaments and have a few cocktails with friends and party in true Las Vegas fashion.

This year's Townie Meeting took place May 4-7, at Caesars Palace. Attendees took part in a vast array of activities, the liveliest of which was the Cinco de Mayo party where Townies dressed up in everything from sombreros and ponchos to a six-pack of Coronas.

The poker tournament took an interesting turn this year. Fred Joyal of 1-800 DENTIST was the chip leader after the first round, but asked for a proxy since he had to catch a flight. Proxies aren't allowed, but Glen Hanf, organizer of the tournament, made a deal with Joyal – "If your proxy wins any money, the winnings have to go to Children's Dental Center of Los Angeles." Joyal smiled and agreed. No one expected it, but Joyal's stand-in, Ralf Ijano, won the first place prize of $3,000, which, as agreed, has been donated to CDC.

Next year marks the 10-year anniversary of the Townie Meeting. So start preparing yourself now for the Vegas celebration! n

Photos 1, 2, 3 and 6 courtesy of Chip Payet (http://DentalDigitalPhotography.com). Photos 4 and 5 courtesy of Townie Meeting. Photo 7 courtesy of Amy Leal.

Photos 8, 10 and 11 courtesy of Chip Payet (http://DentalDigitalPhotography.com). Photos 9, 12 and 14 courtesy of Townie Meeting. Photo 13 courtesy of Howard Goldstein.

Townies donned sombreros and ponchos (or Corona-bottle costumes) and danced the night away on May 5, 2011 (or "Cinco de Mayo" – a day of celebration and pride for those of Mexican heritage – and the theme of this year's Townie party).

Townie Bike Giveaway

The gang at Dentaltown hosted a sweepstakes for two official "Townie" Bikes. (Nice coincidence, right?)

Just as the Townie bike has several differences vs. standard road bikes, we at Dentaltown believe the Townie dentist has several advantages over the typical dentist. These include but are not limited to: 1) In touch with thousands of colleagues; 2) Continually reviewing best practices; 3) Uses efficient methods of gathering and processing information and 4) Remains energized from ongoing Townie community involvement.

The first winner, Dr. Sumeet Beri (left) was congratulated by Dentaltown founder and CEO, Dr. Howard Farran, after Beri answered the question, "How many pages have there been in Dentaltown Magazine from May 2001 through May 2011?" Beri guessed within a remarkable 10 pages of the actual answer, which was 11,260.

"Townie" bike winner Dr. Sumeet Beri with Dentaltown founder and CEO Dr. Howard Farran

Dr. Kent Jackson won the second day. After he selects the color he wants, we will be shipping his bike off to Maryland! Jackson answered the question, "Since the beginning of Dentaltown, what is the cumulative number of times that all topics and threads have been viewed?" with the answer of 35 million views. The correct answer is 35,069,048.

Congrats to both Townie bike winners!

Making the Connection

by Trisha E. O'Hehir, RDH, MS, Hygienetown Editorial Director

The mouth is the doorway to the body and research is accumulating that links oral bacteria to infections, diseases and conditions in many parts of the body. Cause and effect has yet to be proven, but the bacteria do travel to other parts directly from the mouth. Oral bacteria can be aspirated into the lungs, enter the Eustachian tubes and move to the middle ear, or enter the blood stream and travel to distant parts of the body.

According to the American Rhinologic Society, each year Americans suffer more than one billion upper respiratory infections (URI) or the "common cold." URIs have increased six percent per year since 1970, due in part to increased use of daycare centers and over-the-counter use of antihistamines and decongestants. Children in daycare experience an average of six URIs per year. The upper respiratory tract begins with the nose, includes the sinuses, pharynx and larynx. It leads to the lower respiratory track made up of the trachea, bronchi and pulmonary alveolar spaces. We don't usually think of the nose and sinuses as part of the oral environment we deal with, but bacteria and viruses found in oral biofilms do contribute to URIs and otitis media infections.

Within the oral pharynx, the Eustachian tubes connect the oral cavity with the ears. These tiny tubes provide a passageway connecting the upper part of the throat to the middle ear. To picture where the Eustachian tubes are located, imagine pointing your finger all the way to the back of the throat, and then turning it slightly to the side and going a bit higher. You can't see it, but that's the location of Eustachian tubes, one on each side of the nasopharynx, near the adenoids. The Eustachian tubes supply fresh air to the middle ear, drain fluids and maintain air pressure between the nose and the ear. They are generally closed, and open for a fraction of a second to equalize the pressure between the middle ear and the atmosphere.

Bacterial biofilm accumulating in the Eustachian tubes can trigger inflammation, swelling and blocking the drainage from the middle ear, causing an ear infection or otitis media. In infants and children, the high incidence of otitis media is due in part to small, narrow Eustachian tubes positioned horizontally, making it difficult for fluid to drain out of the ear. With age and skull growth, the Eustachian tubes will move up and slant downward.

Controlling the accumulation of oral biofilm and keeping the *Streptococcus* bacteria in check is important for more than just dental health. It will also help control URI and the incidence of otitis media infections, especially in young infants and children. Educating parents about the importance of good oral health should also include education about good upper respiratory health.

Physicians have learned the value of xylitol in controlling bacterial biofilm formation. Oral xylitol in the form of gels, syrups, wipes, gums and candies reduces bacterial counts. This also leads to prevention of otitis media infections. In addition to oral use of xylitol, it is also offered in a mild saline nasal spray to control bacteria and virus attachment to nasal and sinus tissues. Just as bacteria slide off the teeth with oral xylitol use, bacteria are unable to attach to soft tissues when xylitol is delivered to the nose in spray form. With this information we can broaden the scope of oral hygiene education to include prevention of URI and otitis media infections. The mouth, nose, sinuses and ears are definitely connected. n

In This Section

Look for additional content in the Hygienetown Magazine *digital edition.*

CHANGE YOUR PATIENTS' POINT OF VIEW

Tell them about the Spry Dental Defense System.®

You are about your patients' oral health, even when they're not in the dental chair. That's why you should share the news about Spry. Our entire line of oral health products features Xylitol, which offers some substantial benefits to your patients.

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Perio Reports Vol. 23 No. 6

Perio Reports provides easy-to-read research summaries on topics of specific interest to clinicians.

Perio Reports research summaries will be included in each issue to keep you on the cutting edge of dental hygiene science.

Hospitalization Bad for Oral Health

For hospitalized patients, oral health and oral hygiene are not usually top priorities. Consequently, poor oral health and hygiene impact quality of life, nutrition and general health. Poor oral health and hygiene are associated with hospital-acquired infections, specifically respiratory diseases with intubated patients.

Researchers at the Eastman Dental Institute in London, U.K. reviewed the research to determine oral health changes during hospitalization. More than 9,000 potential records were found in a literature search and of these 37 full articles were evaluated and five papers fit the study design criteria for the systematic review.

Four of the studies included patients in intensive care (ICU) and the other study included both ICU and cardiac surgery patients. Two studies were from the U.S. and one each from the U.K., France and Holland. Patients in three studies were intubated. Oral hygiene for study patients varied considerably from wiping the mouth with a sterile cloth or using a sponge swab to using toothbrushes with toothpaste. Frequency also varied from twice to six times daily.

Plaque levels were monitored and showed significant increases during the hospital stay in four of the five studies. One study reported baseline plaque scores of 23 percent and 93 percent after 10 days hospitalized. Gingival inflammation was also reported to increase during hospitalization. Intubated patients experienced increased mucositis compared to non-intubated patients.

Clinical Implications: Hospitalization is associated with an increase in plaque and deterioration in oral health. Encourage patients who are hospitalized to maintain oral health or seek the help of dental professionals to ensure good oral health and hygiene during hospitalization.

Terezakis, E., Needleman, I., Kumar, N., Moles, D., Agudo, E.: The Impact of Hospitalization on Oral Health: A Systematic Review. J Clin Perio 3, 2011. n

Non-invasive Periodontal Diagnosis

Periodontitis is primarily diagnosed with radiographs and clinical examinations using periodontal probes to measure probing depths, attachment levels and bleeding. Going to the next level, genetic and laboratory tests measure oral microbiology, one aspect or bacteria at a time. The future will bring non-invasive modes of diagnosis.

Non-invasive diagnostic methods do not use ionizing radiation, are not uncomfortable for the patient and do not manipulate the tissue. Non-invasive diagnostics will provide information about current disease and also predict disease progression. Three approaches being investigated are: infrared spectroscopy, optical coherence tomography and ultrasound imaging.

Infrared spectroscopy distinguishes between healthy and diseased tissue by detecting through the tissue chemical bonds and molecular and sub-molecular profiles. Covalent bonds vibrate and absorb energy from the infrared light. This information creates a unique molecular fingerprint of the tissue. If the disease progresses or treatment is provided, the fingerprint will change. Infrared spectroscopy analyzes complex biologic systems, rather than single biomarkers. Infrared spectroscopy can also analyze gingival crevicular fluid, detecting an entire spectrum of biomarkers related to various stages of health and disease.

Optical coherence tomography creates a high-resolution cross-sectional image of periodontal soft tissues and bone using low-level laser light. These three-dimensional images capture micro-structural details of the periodontium without having to touch the tissue.

Another imaging modality widely studied in dentistry is ultrasound, producing ecographs of bone and tissue without radiation to the tissues.

Clinical Implications: One day periodontal disease will be diagnosed with non-invasive modalities, providing more information in less time and without discomfort to the patient.

Xiang, X., Sowa, M., Iacopino, A., Maev, R., Hewko, M., Man, A., Liu, K.: An Update on Novel Non-Invasive Approaches for Periodontal Diagnosis. J Perio 81: 186-198, 2011. n

Disease and Risk Scores Predict Tooth Loss

One goal of periodontal therapy is to stop bone loss and prevent tooth loss. Calculating a mean tooth loss rate among those with periodontitis is difficult due to variation in disease severity among people. Those with the most severe disease experience the most lost teeth. Those diagnosed with early periodontitis who receive treatment are less likely to lose teeth.

Researchers associated with the PreViser diagnostic and risk assessment system and periodontists in clinical practice evaluated patients who had periodontal treatment to determine tooth loss levels, associated disease severity and risk level at the beginning of treatment.

Nine periodontists using the PreViser system entered data on a total of 776 patients who received treatment between 1971 and 2003. The average treatment time was 13 years, ranging from three to 33 years with a total of 980 teeth lost. The PreViser system provides a disease score from one to 100. For this study, the disease scores were grouped into nine categories: health (1), mild periodontitis (2, 3), moderate periodontitis (4, 5) and severe periodontitis (6, 7, 8, 9). The majority of subjects, 98.5 percent, were in categories 4 to 9.

No teeth were lost by 61 percent of the group. No one with a disease score of 1 or 2 lost any teeth. Seven percent lost four to six teeth (advanced periodontitis group) and two percent lost 10 teeth or more and they were in disease score categories 8 and 9. The higher the disease score and the risk score, the greater the tooth loss risk.

Clinical Implications: Diagnosing and treating periodontitis early provides the best chance of preventing future tooth loss.

Martin, J., Page, R., Loeb, C., Levi, Jr., P.: Tooth Loss in 776 Treated Periodontal Patients. J Perio 81: 244-250, 2010. n

Local Delivery of Statin Drug for Bone Regeneration

The local delivery of drugs sub-gingivally is used to improve periodontal healing after instrumentation. Several drugs are now available for local delivery: tetracycline, minocycline, doxycycline, metronidazole and chlorhexidine. Delivery systems now include gels, cellulose fibers, ointments, chips and microspheres.

Researchers at the Governmental Dental College and Research Institute in Kamataka, India evaluated a new local delivery system using a methylcellulose gel of the statin drug simvastatin. This six-month study evaluated clinical and radiographic outcomes after scaling and root planing (SRP) plus the new local delivery drug or a placebo.

A total of 60 patients with chronic periodontitis participated, 30 in the test group and 30 in the placebo group, each with one test or control site. After SRP, the 1.2 percent simvastatin gel (SMV) or the placebo was injected into the pocket areas using a blunt cannula. No periodontal dressing was used and patients were instructed to refrain from interdental cleaning for one week.

Data collection included clinical indices, radiographs and gingival crevicular fluid (GCF). Plaque reductions were similar for both test and control groups. Significant healing was evident in both groups, but the test group showed more significant probing depth reductions, attachment level gains and gingival index reductions than the placebo group. The test group showed significant bone regeneration interdentally compared to the control group. Evidence of the SMV drug in GCF was measured at all test points, up to and including day 30.

Clinical Implications: Drugs other than antimicrobials and antibiotics might soon be available in local delivery systems to not only enhance healing but also to stimulate bone regeneration.

Pradeep, A., Thorat, M.: Clinical Effect of Subgingivally Delivered Simvastatin in the Treatment of Patients with Chronic Periodontitis: A Randomized Clinical Trial. J Perio 81: 214-222, 2010. n

continued on page 100

continued from page 99

NovaMin Compared to Potassium Nitrate

NovaMin is an amorphous sodium calcium phosphosilicate that was first developed as a bone regenerative material for long bone fractures. In smaller particle size, it is now available in dental products to occlude open dentinal tubules associated with root surface sensitivity.

Researchers at the SDM College of Dental Sciences in Dharwad, India compared a toothpaste containing five percent NovaMin, a toothpaste containing five percent potassium nitrate and a control toothpaste with fluoride. Thirty patients with sensitivity volunteered for the study. All received a prophylaxis and two weeks later, the study began. Baseline sensitivity was measured using three tests: tactile with a dental explorer, air using the air syringe and cold water by placing melted ice water on the surface.

Subjects were randomly assigned to one of the three toothpastes and told to brush twice daily as usual and to refrain from eating or drinking for 30 minutes after brushing. Patients were seen at two and four weeks to measure sensitivity. Both the NovaMin and the potassium nitrate toothpastes reduced sensitivity compared to the control toothpaste. NovaMin was more effective than the potassium nitrate in reducing the subjects' reported pain on the three sensitivity tests.

Dentin discs were also tested in the lab by brushing with the three toothpastes and evaluated for tubule closer after two, 10, 30 and 120 minutes. NovaMin was the only toothpaste that blocked the open tubules. Potassium nitrate works by blocking nerve transmission, not by blocking tubules, explaining why the tubules were still open.

Clinical Implications: New toothpastes containing NovaMin provide an alternative choice for patients seeking relief from dentinal hypersensitivity.

Salian, S., Thakur, S., Kalkarni, S., LaTorre, G.: A Randomized Controlled Clinical Study Evaluating the Efficacy of Two Desensitizing Dentifrices. J Clin Dent 21: 82-87, 2010. n

NovaMin Compared to Potassium Nitrate and Stannous Fluoride

Hypersensitivity affects as much as 57 percent of the general population. Desensitizing toothpastes work in one of two ways, either occluding open dentinal tubules or depolarizing nerve conduction. Fluoride occludes open tubules and potassium nitrate depolarizes the nerve. NovaMin, a new ingredient for the treatment of dentin hypersensitivity, occludes open dentinal tubules.

Researchers at the Armed Forces Medical Center in Pune, India compared three desensitizing products: 7.5 percent NovaMin toothpaste (Soothe Rx), five percent potassium nitrate toothpaste (Sensodent K) and 0.4 percent stannous fluoride (Colgate Gel-Kam). The 12-week study included 120 subjects who were sensitive when tested with an explorer along the cervical areas of the teeth. All received an ultrasonic prophylaxis, followed by a four-week wash-out period before the study began.

Sensitivity was measured on the facial surfaces of incisors, cuspids and premolars with a blast of cold air and melted ice dripped on the cervical area from a micropipette. Subjects reported their pain on a visual analog scale from zero to 10. Sensitivity was measured at two, four and 12 weeks.

Subjects were randomly assigned to one of the three test groups and instructed to brush twice daily with their assigned toothpaste and refrain from eating or drinking for 30 minutes after brushing.

All three test products reduced sensitivity significantly by 12 weeks. NovaMin was able to reduce the sensitivity earlier and more significantly than the other two products.

Clinical Implications: Toothpaste containing NovaMin reduces dentinal hypersensitivity faster than potassium nitrate or stannous fluoride.

Sharma, N., Roy, S., Kakar, A., Greenspan, D., Scott, R.: A Clinical Study Comparing Oral Formulations Containin 7.5% Calcium Sodium Phosphosilicate (NovaMin), 5% Potassium Nitrate, and 0.4% Stannous Fluoride for the Management of Dentin Hypersensitivity. J Clin Dent 21: 88-92, 2010. n

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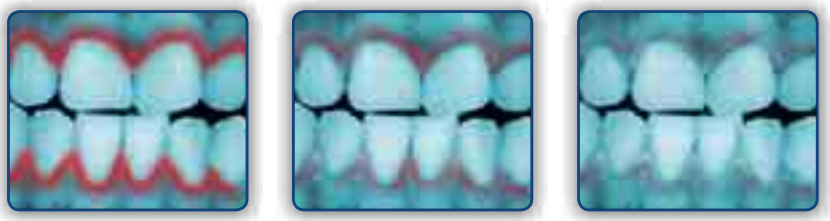

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Continuing the Care That Starts in Your Chair

The New Standard for Preventio

by Trisha E. O'Hehir, RDH, MS

Despite what you're hearing about immune response and genetic predisposition, the primary etiologic factor for both caries and periodontal disease is still bacterial biofilm. Bacterial biofilm accumulates in areas that are well protected, specifically between the teeth and under the gums. Areas between the teeth, just below the contact point are also the places carious lesions begin. The bacteria metabolize sugars and produce lactic acid that melts the enamel. Caries is as much about pH as it is about bacterial biofilm. Periodontal tissue under the contact, called the col area, is less keratinized than facial and lingual tissue and thus more susceptible to the toxic waste products released by the bacterial biofilm. The toxic waste products trigger the immune response and white blood cells are dispatched to the area to attack the bacteria, but on the way to the sulcus, they destroy connective tissue and bone. Caries and periodontal disease are still significant problems that can be prevented.

According to text books authored by Dr. Per Axelsson, both caries and periodontal disease are more prevalent between the teeth than on facial or lingual surfaces. Despite this fact, oral hygiene instructions of the past put greater emphasis on brushing surfaces than on interproximal surfaces, the surfaces at greatest risk of disease. Brushing was always taught first, followed by flossing. Occasionally an interdental brush was recommended, rarely was oral irrigation suggested and xylitol was a well-kept secret. To this day, many think oral hygiene instruction means brushing and flossing. That was the standard of care, until today.

Today is the dawning of a new standard of care for oral hygiene instructions. This is the new prevention, where brushing comes last, not first. Prevention is no longer simply a stick with bristles and a piece of string – both of these require skill by the user. What about children, teens, the elderly, nursing home residents, people with arthritis or those in hospitals? Prevention needs to work even when individuals don't have skills or dexterity to brush and floss. The new standard for prevention controls bacterial biofilm first with xylitol and oral probiotics and then with sticks, picks, interdental brushes or water between the teeth and brushing comes last.

Bypass Mechanical Skills with Xylitol and Oral Probiotics

Brushing and flossing require skill and dexterity to effectively remove bacterial biofilm. Reviewing the research, Dr. van der Weijden reported a 50 percent reduction (at best) in plaque and gingivitis scores with oral hygiene instructions and prophylaxis. This is not a very good success rate, primarily because of a lack of dexterity and accuracy with a toothbrush and dental floss. Also lacking is a way to measure if the plaque is successfully removed.

There is a way to reduce plaque levels 50 percent without relying on the skill and technique needed for brushing and flossing. According to research published in the 1970s by Drs. Scheinin and Makinen, five exposures of xylitol each day will reduce plaque levels up to 50 percent. That's comparable to the effect of daily brushing and flossing. Introducing xylitol five times daily will change the bacterial environment by blocking the metabolism of sugar. Xylitol is a natural sweetener, but it is a five-carbon molecule rather than a six-carbon molecule like fructose, glucose and sorbitol. The smaller molecular size allows the xylitol to pass through the bacterial cell wall. However, the bacteria is unable to metabolize the xylitol and has to use its own membrane pump to pump out the xylitol molecule. The xylitol molecule simply turns around and goes back inside the bacteria, creating a cycle of energy use by the bacteria with no energy being derived from the xylitol molecule. The bacteria cannot produce more acid, cannot communicate with neighboring bacteria and therefore no polysaccharide slime is produced to keep the biofilm intact. The biofilm dissolves and the bacteria simply slides off the teeth and down the digestive tract. At the same time, the oral pH is elevated.

Oral probiotics are now available to change the balance of bacteria in the mouth to a balance that favors health. The bacterial make-up of a healthy mouth is much different from a mouth full of cavities or periodontal disease. By studying the healthy mouths as well as those with disease, researchers have identified bacteria present in healthy mouths that are missing from diseased mouths. Oral probiotics deliver the missing bacteria in a xylitol mint or candy to be dissolved in the mouth, thus delivering millions of colony-forming units of the missing bacteria to change the balance of bacteria in the oral cavity. Creating a healthy mix of bacteria in the mouth prevents caries and periodontal disease. Xylitol and oral probiotics provides reliable measures to reduce bacterial biofilm without depending on manual dexterity skills to mechanically remove bacterial biofilm with a toothbrush and dental floss.

The first two steps in the new standard for prevention require no skill on the part of the user, simply use xylitol products five times daily and oral probiotics twice daily. Xylitol is available in many forms – gums, candies, gels, baby wipes, toothpaste, mouth rinse and packets for eating. Xylitol is also used to sweeten oral probiotics. Look for products like those from Spry that are 100 percent xylitol-sweetened and available in health food stores or online. Evora probiotics provide the missing oral bacteria to establish a healthy oral flora.

Mechanical Disruption

With the bacterial biofilm reduced significantly with xylitol and the bacterial balance shifted toward health, it's time for the mechanical disruption of the remaining plaque biofilm. Since disease begins between the teeth, it makes sense to start the mechanical disruption of biofilm between the teeth, using sticks, picks, interdental brushes or oral irrigation. Flossing statistics from Drs. Steward and MacGregor confirm what dental professionals already know – two to 10 percent of people actually floss on a daily basis. It seems the only people who floss regularly and effectively are hygienists and dentists! Patients are skillful at putting floss between their teeth without ever touching the plaque or going below the gingival margin. Offer other alternatives that are easy to use and comfortable. The most overlooked option for interdental plaque disruption is oral irrigation; it's like flossing with water. Oral irrigation is effective in blasting off huge sections

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of biofilm both supra and subgingivally. It's also easy to do; simply aim the jet tip 90 degrees toward the interproximal space and hold for a few seconds. Done.

The last step in the mechanical disruption process is the toothbrushing. Working with what people are already doing will make this part successful. According to Dr. Beals, people in the U.S. spend only 37 seconds brushing their teeth. Using this as a starting place, the only toothbrush to cover all surfaces in such a short time is the 30-Second Smile power toothbrush. This brush is a car wash for the mouth. Simply bite on the brush head and it will brush top, bottom, inside, outside and biting surfaces all at once, taking only 30 seconds to cover the entire mouth. This brush removes the need for skill in placing and moving the toothbrush correctly. Many standard power toothbrushes now have two-minute timers to ensure adequate time to move the brush around to all surfaces of the teeth.

For those using a manual toothbrush, the short brushing time is due to the foaming and bubbles of toothpaste. Without toothpaste, people brush much longer and more evenly around the mouth. Plaque biofilm levels are the highest on the lingual of the lower teeth, especially the right side. This is where toothbrushing should start. Instruct patients to start brushing on the lower lingual surfaces and brush until all the teeth feel clean and taste clean. When the biofilm has been removed, then add toothpaste and brush once more around the mouth. Brushing without toothpaste allows the patient to feel the bacterial biofilm before and after brushing, something not possible when using toothpaste due to the flavor and wetting agents. Toothpaste makes the mouth feel clean when it's not yet clean. Dry brush first until the teeth feel clean and taste clean, then add toothpaste.

The tongue also needs to be cleaned to remove bacterial biofilm and volatile sulfur compounds. No gold standard has yet been identified for tongue cleaning, so recommend what you prefer to use yourself. Some prefer a brush, others prefer one of the many tongue scrapers now available. Gentle brushing or scraping will remove tongue biofilm.

Self-tests for Prevention

Feeling bacterial biofilm on the teeth, testing the salivary pH and checking for bleeding between the teeth are three easy self-tests. Before any action to control the biofilm, teach patients to feel the biofilm in their own mouth using their tongue. Focus on the lingual of the lower posterior teeth along the gingival margin and along the gingival margin on the facial surfaces of the maxillary molars. Using the tongue they can feel for biofilm before and after each oral hygiene session and throughout the day as biofilm accumulates. Knowing where the biofilm is before taking action will provide the feedback to evaluate toothbrushing effectiveness. In order for the tongue to evaluate bacterial biofilm removal, toothbrushing needs to be done first without toothpaste until the bacterial biofilm is removed. After the teeth feel clean to the tongue the toothpaste can be added.

Testing salivary pH is easy using a piece of litmus paper or a pH strip. Simply spit into a spoon and then apply the pH strip and check the color change. The pH strip is also good for checking the pH of foods, drinks and oral hygiene products. People are surprised that drinking coffee all day will lower their salivary pH.

The Eastman Interdental Bleeding Index (EIBI) is a toothpick test for interdental bleeding developed by Drs. Caton and Polson. It was shown in a study by Dr. Bliedin to be more reflective of interdental inflammation than bleeding on probing scores. Where interdental space allows, insert a triangular wooden stick from the facial and push in and out four times, looking for bleeding within 15 seconds. This can be done in all interproximal areas to check for bleeding, a sign of infection. Although no research has been published using plastic sticks, they just might provide similar information about interdental infection when used to do the EIBI test.

Five Parts of the New Standard of Prevention

1. Xylitol five times a day
2. Probiotics
3. Start cleaning in between
4. Dry brush
5. Tongue cleaning

Conclusion

It's time to move beyond brushing and flossing to the new standard for prevention. Today prevention focuses first on changing the oral environment with xylitol and oral probiotics before cleaning between the teeth and eventually brushing and tongue cleaning. Feeling plaque biofilm with the tongue before and after brushing, testing pH of the saliva and checking for bleeding between the teeth are easy ways to monitor success. Giving patients the science, ingredients and tools to effectively control bacterial biofilm and salivary pH is the new standard for prevention. n

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Running Behind

It happens to all of us sometimes. When it does, what do you do to remedy the situation?

aer
Posted: 2/5/2011
Post: 1 of 20

How many offices run late in the hygiene department? ■ anita

trishaohehir
Posted: 2/6/2011
Post: 2 of 20

The worst is running late on the first patient of the day! I remember days when everything went wrong with the first appointment – the doctor would arrive late, the patient would need radiographs, we would have equipment problems, the doctor would spend way too much time talking with the patient and the rest of the morning was a blur of rushing. We were able to reach some patients to ask them to come 10 to 15 minutes later. Of course there was no lunch break, just started all over at 1 p.m. ■

coloradordh
Posted: 2/6/2011
Post: 3 of 20

I encourage the doc to come in early in the appointment. If it looks like he is going to be late or my next patient is in the waiting room I'll move the patient to another room or take the next patient's X-ray then reseat them in waiting room if there is a room "crunch." If the patient is late, I will only do exam and X-ray or prophy only. If it looks like I'll be running behind, I'll alert assistants so they can get X-ray and maybe exam first. If the patient has been kept waiting through no fault of their own, we will send some sort of gift for their patience. Definitely a team effort to keep the schedule running smoothly. ■

Trish (was 230)
Posted: 2/7/2011
Post: 7 of 20

You hit the nail on the head! If the whole team makes it a priority to stay on time then it can happen. In our practice we have two hygienists and a dedicated hygiene assistant working four rooms. We are rarely running behind, but it does take resources to make it work. The doctor is free to check patients at any time but usually still waits until the end unless there is a "crunch" going on.

Late patients are told that they can wait for an opening (the one often created by the patient who showed up a little ahead of schedule – we can simply flip-flop the appointments, even trade with the other hygienist – whatever it takes to make it work. Rarely do we reschedule someone who is late unless they are at the end of the day. ■

JGonzalesRDH
Posted: 2/8/2011
Post: 9 of 20

I agree, it takes teamwork. I work with four hygienists and two docs. We have one sterilization/hygiene assistant. Perfect example, this morning my first patient was 10 minutes late (we book 60 minutes) and needed full-mouth X-rays, exam, full-mouth prophy and of course is perio maintenance. I alerted the hygiene assistant that I was going to run late, set up a second op for a complete exam and seat my "on-time" 9 a.m. patient (which she can take images and update med history, take blood pressure and complete the dental charting.). Fortunately, we had the space to accommodate that this morning.

Our office uses a walkie-talkie system with ear buds. We stagger our hygiene start times every half hour (two appointments at 7:30, two appointments at 8 a.m.). After

obtaining all diagnostic records, we polish and radio we are ready for an exam at any time. This tells the dental assistants and doctors they can stop by to check the patient, even if we're still cleaning their teeth. If the doc doesn't show up by the time we are done, we radio "we are ready for an exam." The dental assistants know they need to respond with an ETA for the doc's arrival. ■

skr RDH
Posted: 2/8/2011
Post: 10 of 20

Yes, hygiene must run on time. No excuse for being more than five minutes late starting the next patient. Many of these folks have made special arrangements to get off work for enough time for this and we have to appreciate that and manage our time accordingly. We use MessagePal computer messenger for this and many other things. The good thing is that this software puts a huge popup on the screen for all to see. And the doc can't see his radiographs without dismissing the message first. We have a one-hour lunch, so the last patient in the morning or afternoon can run over without inconveniencing the next person. ■

Roniz
Posted: 2/11/2011
Post: 12 of 20

Oh my goodness... this is such an acute issue for me. Meaning that I've been running anywhere between five and 20 minutes late almost consistently. If anyone has any tips or ideas about what I can do it would be much appreciated. ■ Roni

awhung
Posted: 2/11/2011
Post: 13 of 20

My office runs late because patients always show up late. It's mainly due to lack of parking and a younger population. I think younger adults tend to be more flakey and tardy. In my office it's 60 minutes no matter if it's a new patient or a recall, so by the time they finish their paperwork, X-rays and treatment/payment planning it's already 30 minutes past. Therefore I'm always running 20-30 minutes late when this happens. Furthermore my doctor is always double-booked, so it's common for me to just wait for her to get an exam. The only way for me to catch up is with cancellations and during lunch. It's hard to complain to the owner when she is always running an hour or two behind. Yesterday, she was running three hours behind, but that's how she likes it. ■

skr RDH
Posted: 2/11/2011
Post: 16 of 20

Most folks I have worked with – including dentists – have no problem letting us do what we can in the appointed time and then bringing back the patient for another appointment to finish. Just today I had two new patients back to back in my schedule. I could not quite finish the first one (five years since last visit to a dentist, 10 bombed out teeth and tobacco-related moderate perio), so I had another staffer finish her while I moved on to the next new patient, whom I started only five minutes late. Everyone was happy and the schedule stayed intact, even though the doc had a big cosmetic case on the go and two hygienists running simultaneously (other one had new patients also). We do it all the time – bring patients back another day for their polishing, fluoride, impressions, quad scaling, etc. The schedule is gospel because we respect our patients (and our sanity). ■

Running Behind

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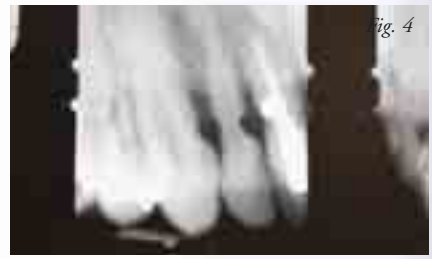
www.hygienetown.com

Advanced Attachment Loss Due to Aggressive Oral Hygiene

Aggressive oral hygiene with heavy pressure, especially with an interproximal brush, will cause recession and loss of tooth structure.

periosupport
Posted: 11/16/2010
Post: 1 of 34

These are photos of a patient who over many years continued to experience significant attachment loss in spite of excellent compliance in attending our office for professional cleanings.



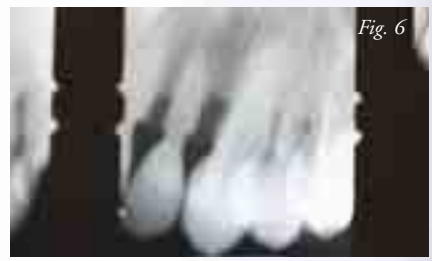


Fig. 1: Note the gingival recession and interproximal notching of the root surfaces due to excessive proxy brush use.

Fig. 2: Similar damage noted on the left view.

Fig. 3: Note the instability of the marginal gingival tissues on teeth #6 and #8.

Fig. 4: Right side radiographic view of the osseous levels and extensive notching of the root surfaces.

Fig. 5: Anterior radiograph and damage to the root surfaces.

Fig. 6: Left side radiographic view.

The patient continued to deny any aggressive oral hygiene techniques and in spite of soft tissue grafting procedures, professional cleanings and meticulous oral hygiene instructions, the case continued to go downhill. It is imperative that we assure that our patients are removing plaque on a daily basis utilizing proper techniques and pressures. ■

periopeak
Posted: 11/17/2010
Post: 4 of 34

Wow, Albert. Thanks for posting this. I am anxious to hear more about what this patient is doing as far as home care.

We have all seen this on lower anterior teeth, usually in a perio office too, but I've never seen it on the maxillary teeth. I always thought it was from hand scaling damage. Is there any sensitivity? This patient appears to be one of those "chronic inflammation" cases causing attachment loss, especially on the prominent canine teeth (then add occlusion issues and aggressive home care). I can see this patient has it posterior too. I would definitely have this patient on SDD (or Periogain to down-regulate collagenase and hyaluronidase). Maybe you could do a PST test and let us know if this patient has hyper-inflammatory response. Could you share host factors? Any history of heart disease here? ■

periosupport
Posted: 11/17/2010
Post: 5 of 34

This patient has no medical problems and is in his early 60s. There is likely a genetic component since his problems began in his 20s. Unfortunately he is slated for full-mouth extractions and dental implants. ■

JERSEY DEVIL
Posted: 11/19/2010
Post: 11 of 34

When I worked, I would brush the patient's teeth for them so they could learn the amount of pressure that should be placed on the teeth. They were quite surprised that it didn't take much pressure to remove the plaque, just the correct technique. And the two most important things I taught were holding the brush vertical in the anterior area and using it dry first in any problem area. I would have them feel their teeth afterward to "see" if their teeth were clean. If they still felt fuzzy I would instruct them to go one more time around the mouth (using the same pressure), and then feel again. ■

periosupport
Posted: 11/20/2010
Post: 25 of 34

In the case posted, the entire dentition over time (25 years) continued to develop attachment loss. The patient had no muscular occlusal complaints, TMJ dysfunction or any symptomatology. There were no underlying medical problems such as diabetes. He was not immunodeficient. He checked out absolutely normal from a medical perspective. He exercised and was not overweight. What is also interesting is that the tooth mobility patterns were minimal in spite of the significant horizontal bone loss. He does have a thin periodontium, which could have predisposed him to the recession noted. Even with connective tissue grafting the gingival margins did not stabilize. This patient had treatment by a very experienced hygienist in our office. He attended all the recommended recall intervals. He had courses of antibiotics and irrigation with iodine. He was using 0.12 percent chlorhexidine gel twice a day. I believe we were able to slow the disease down but were unable to stabilize him. Occlusion could be a factor but I have never seen such resistance to all our treatment strategies. ■

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Loop Care for Dentinal Hypersensitivity

by Sheri B Doniger, DDS

Approximately 45 million Americans suffer from dentinal hypersensitivity. It appears that the ages of 25 to 50 are most affected, and there is a slight predilection for women. With age, there is an increase in reparative dentin; hence sensitivity might decrease over time. A reaction might be elicited from cold or hot temperatures, or change in oral pH. Sweets might also be the culprit. Another reason for dentin hypersensitivity is lost cementum due to either the toothpaste used with aggressive toothbrushing or recession. One of the most common causes of tooth sensitivity today is post-operative teeth whitening. Post-periodontal therapy tends to increase tooth sensitivity, as well.

Dentin is not normally exposed to the oral cavity. Enamel, although it is the hardest tissue in the human body with its hydroxyapatite formation and lack of nerve cells, is fairly impervious, but not immune to many types of chemical and tactile attacks. Enamel is primarily hydroxyapatite and crystalline, while dentin contains more organic components and water. Dentin is usually covered by enamel and cementum. It is composed of tubules that extend from the enamel/cementum, traversing through the core of the tooth, with the cell bodies located in the pulp. Dentinal sensitivity occurs primarily due to tubules open to the oral cavity. Thermal, tactile or osmotic changes in the mouth might elicit the sharp, momentary pain that is not due to a frank carious lesion, but rather changes within the dentinal tubules.

As professionals, decreasing a patient's dentinal sensitivity can be accomplished by occluding the tubules to prevent the fluid shift and hence, eliminate the pain of sensitivity. There are several treatment modalities available, ranging from topical applications of fluoride, varnishes, various dental restorative materials and lasers to periodontal grafting procedures. Plaque control is paramount in decreasing the acid environment and maintaining a healthy oral flora.

A new combination of an in-office treatment and an at-home regimen shows promise in relieving dentinal hypersensitivity. The therapy begins with an in-office treatment utilizing a fluoride prophy paste containing NovaMin. This is followed with home use of a therapeutic toothpaste also containing NovaMin and 5,000ppm fluoride.

NovaMin is a calcium sodium phosphosilicate bioactive glass, originally created as a bone regenerative material. It has the capacity, when it interacts with saliva, to release calcium and phosphate ions, which remineralize the enamel matrix by forming hydroxyapatite. Sodium ions in the bioactive glass react with hydrogen ions, causing an increase in salivary pH. This allows rapid release of calcium and phosphate ions into the saliva.

Nupro prophy paste has been available for more than 25 years and was extensively used for stain removal and selective polishing. Dentsply has now added Novamin to Nupro prophy paste to occlude the dentinal tubules and reduce hypersensitivity while polishing the teeth.

GSK has created a brand of Sensodyne toothpaste which contains 5,000ppm fluoride toothpaste plus NovaMin. This will further continue the therapeutic levels of available NovaMin at home daily, providing continuous benefits to both occlude the tubules and rebuild the tooth. Proper recall and maintenance are recommended to ensure patients' continued health.

Combining Nupro prophy paste containing NovaMin and Sensodyne 5,000ppm fluoride toothpaste with NovaMin offers a dual-therapeutic treatment for continuous care of dentinal hypersensitivity, both at the office and at home, providing a closed loop of care for patients suffering with dentinal hypersensitivity. ■

Author's Bio

Sheri B. Doniger, DDS is a leading dental clinician, author, educator and consultant who currently practices dentistry in Lincolnwood, Illinois. Dr. Doniger has authored numerous articles and has presented many lectures with a focus on women in the dental industry.

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7 ways to intimidate your daughter's date when he comes to pick her up

Nonchalantly clean your hand-gun, knife, lead pipe, candlestick, etc., while reviewing curfew.

Sprinkle some dust on your daughter before she leaves. Explain, "It makes fingerprinting easier."

Challenge him at arm wrestling.

Introduce him to your good friend Chuck Norris.

Casually show him your collection of five shrunken heads then yell up to your daughter, "Number six is here."

Come to the door bare-chested. Do a lot of flexing.

Introduce him to the family by calling each family member to the living room using a whistle, then making them stand at attention and salute.

Answer the door in a straitjacket.

Walk on stilts.

As they leave, talk into a walkie-talkie, "Subject is wearing khakis and a blue polo shirt, driving a green Ford."

Say, "Let's pray."

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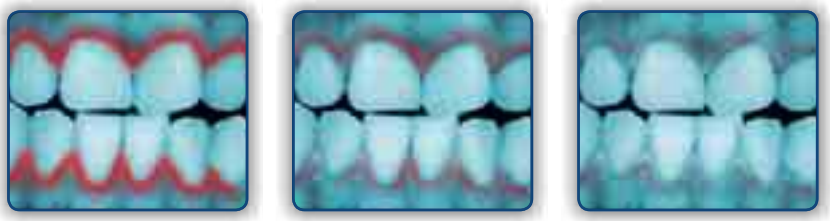

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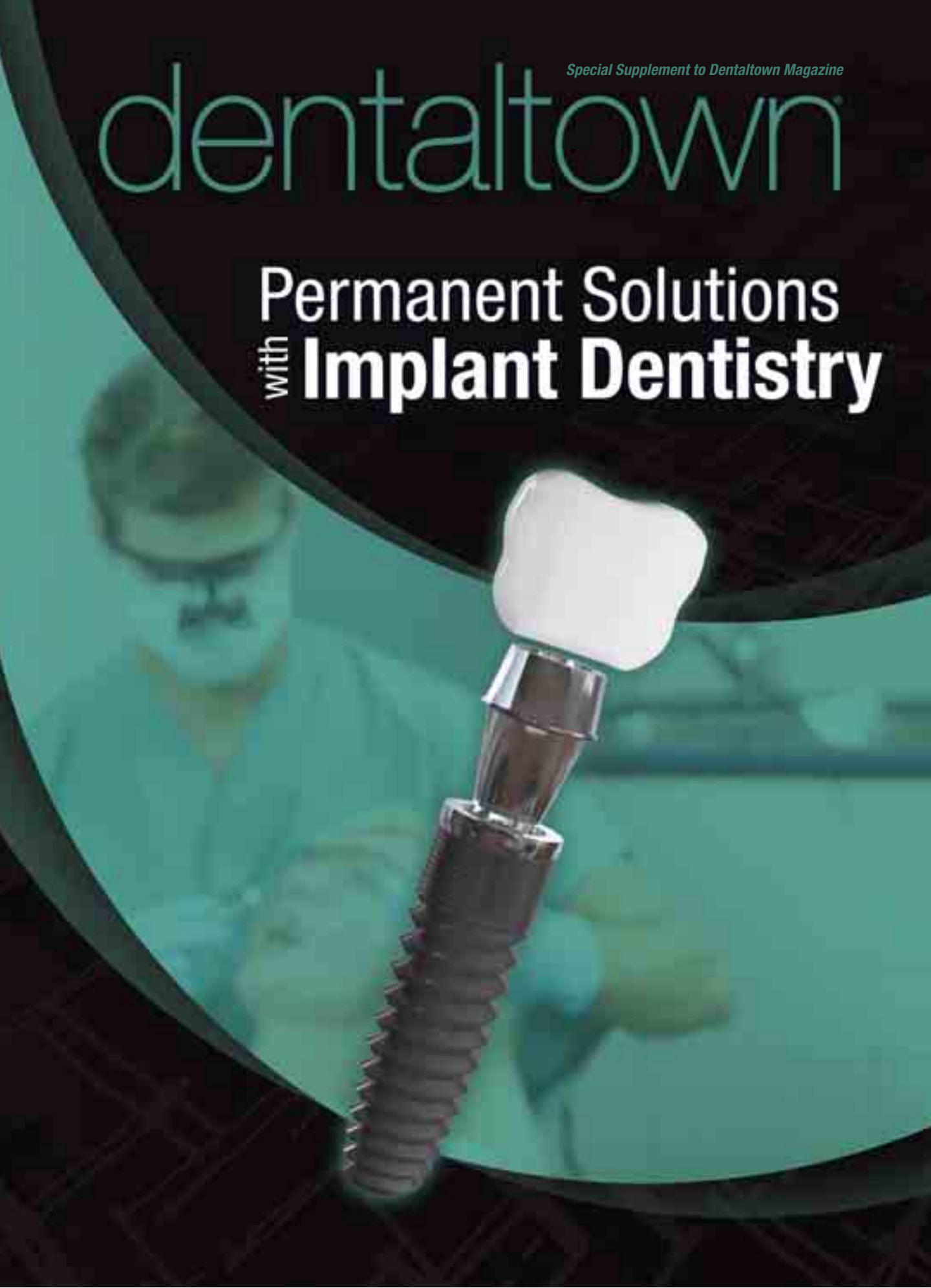


Permanent Solutions with Implant Dentistry

Dental implants are one of the fastest growing treatment options in our profession. Implants are nothing new; they were first placed more than 60 years ago. Dr. Leonard Linkow, considered by some to be the father of modern implant dentistry, placed his first root-form implant in 1952 only four months after his dental school graduation. That fact would lead some to argue that placing an implant is so easy a new graduate can do it.

All joking aside, the proper placement of root-form implants requires proper training, detailed diagnostics and a complete treatment plan. The companies featured in this supplement support our community and they are interested in helping you get started with implants in your practice. If you are not currently restoring implants, this is a great place to start. Beginning with single teeth, you will get comfortable with the components and the process. This experience can serve as a springboard to pursue training for the surgical placement of implants.

I have selected two terrific implant cases from the message boards of Dentaltown.com that will appeal to dentists at any level. These cases are well-documented and have generated great discussion online. This is only a small sample of the resources available to you on Dentaltown.com. We appreciate your support and wish you the best on your implant journey.

Sincerely,
Thomas J. Giacobbi, DDS
Editorial Director, *Dentaltown Magazine*

Extraction 9, 10; Immediate Implant Placement 9, 11, 13 with Concurrent Ridge Expansion & Crestal Approach Antraplasy

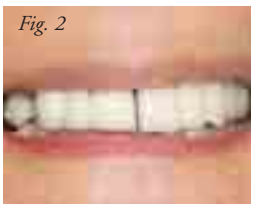
Dan Haghighi, DDS ▫ Posted: 12/5/2010 ▫ Post: 1 of 25 ▫ From the message boards of Dentaltown.com

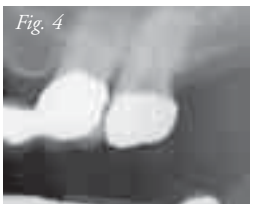
This was a fairly complicated case, which required a good amount of pre-treatment planning. But all went as planned and at one week the healing looks to be excellent! So both the patient and I are off to a fantastic start.

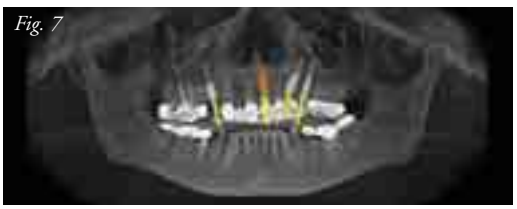
Given its complexity, I thought this would be a good case to post from start to finish.

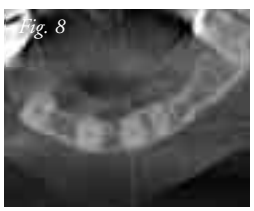
The patient at hand is a 59-year-old healthy female. She is a patient from a managed care setting, but was referred to my office for the replacement of failed fixed bridge 9(a), 10(a), 11(p), 13(p), 14(a) with an implant-supported prosthesis. Both #9 and #10 had failed (just a few days prior) and were non-restorable. The referring dentist had re-cemented the bridge to #14, thus on the treatment photos you will see some distortion where the bridge undercuts were blocked out to prevent dislodging the bridge for diagnosis and temporary prosthesis casts.

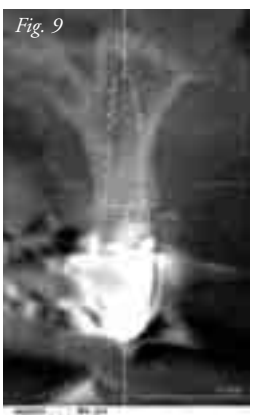
My original prosthetic plan for the case was to restore implant #9 with crown, #10 cantilever and #11 and #13 as separate crowns. However as I got down to specifics of available bone volume, angulation and spacing it became apparent that I could only use 3.75 diameter implants and thus I will be restoring the case with a fixed bridge implant #9(a) , #10(p), implant #11(a), implant #13(a). The abutment platform for all internal hex AB implants is at 3.75 so the implant diameter selection will not have an effect on the emergence profile of the final prosthetic. An implant will be placed into the #5 position at a later date. The photos outline the surgery sequence.

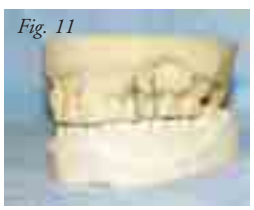












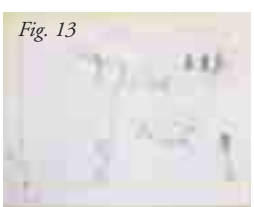


Fig. 1: Pre-op; note displaced bridge
Fig. 2: Extra oral pre-op
Fig. 3: Pre-op radiograph anterior segment
Fig. 4: Pre-op posterior segment
Fig. 5a,b: Pre-op CT planning #13 position and available bone volume for 3.75x11.5mm AB I-5
Fig. 6: Radiologic evaluation of sinus membrane area to be moved
Fig. 7: Pre-op 2D rendering of implant positions
Fig. 8: Pre-op axial view with measurements
Fig. 9: Pre-op planned position of #9 with AB 3.7x11.5mm
Fig. 10: Rectifying implant positions against cast measurements of existing bridge
Fig. 11: View of area to be restored
Fig. 12: Note #7 is slightly less wide than #10; #8 and #9 are almost the same width. This really helped a lot for the placement of #11 implant
Fig. 13: Pre-op sketches and planning; I do a lot of this for larger cases
Fig. 14: Bridge secured with floss; not a good idea to start the case with an aspiration event
Fig. 15: Bridge sectioned from #14 and removed

continued on page 3

continued from page 2


Fig. 16


Fig. 17


Fig. 18


Fig. 19


Fig. 20


Fig. 21

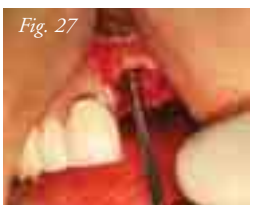

Fig. 22


Fig. 23


Fig. 24


Fig. 25


Fig. 26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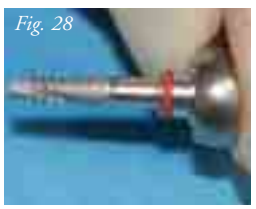


Fig. 28

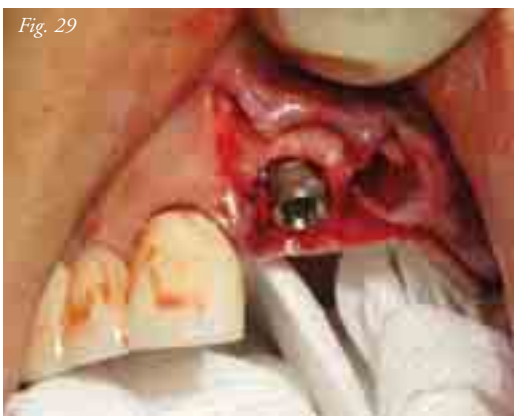


Fig. 29

Fig. 16: Periotome application #9 and #10
Fig. 17: Making progress
Fig. 18: Prepping canal #10 for Benex post
Fig. 19: #10 bidding farewell to his friends; note I was able to stabilize, just barely, the shims onto #8 and #14
Fig. 20: #10 looking a bit like a salmon
Fig. 21: I was unable to stabilize the shims against teeth on both sides; this is how I stacked the shims to remove #9
Fig. 22: Atraumatic extractions completed; now on to the meat and potatoes
Fig. 23: Dissecting the flap away from the alveolus with the aid of gauze
Fig. 24: Determining the apical position of #9 relative to the margin of #8; papilla sparing approach along mesial release
Fig. 25: Beginning osteotomy with piezo tip; this allows for precise placement of osteotomy which in this case began slightly mesial/lingual and coronal to the socket apex; the pilot was prepared to depth
Fig. 26: The osteotomy was completed (widened) at 50RPM no irrigation using the AB drill stopper kit
Fig. 27: Checking to ensure five walls of integrity
Fig. 28: AB I-5 with clip carrier and drive wrench
Fig. 29: Implant placed an engaging alveolus, clip carrier easily removed


Fig. 30

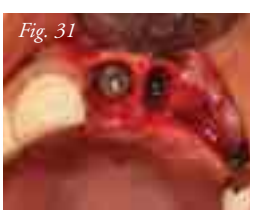
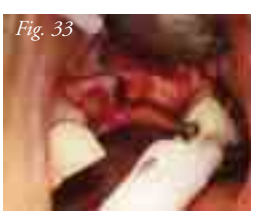


Fig. 31


Fig. 32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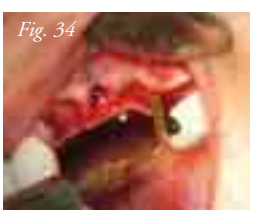
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Fig. 35


Fig. 36

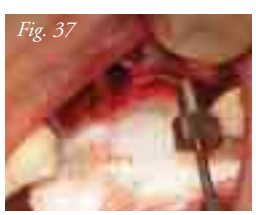
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Fig. 38

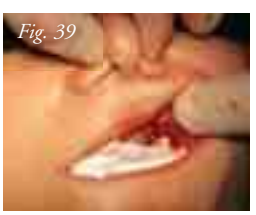
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Fig. 40

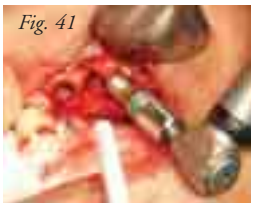
Fig. 41


Fig. 42


Fig. 43


Fig. 44


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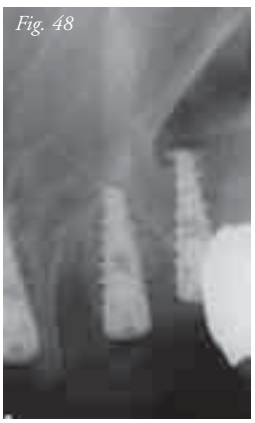
Fig. 46


Fig. 47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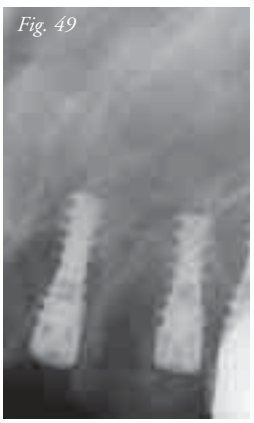
Fig. 49


Fig. 50


Fig. 51

Fig. 30: Complete final seat of implant with hand drive for accuracy of implant position
Fig. 31: Implant and cover screw correctly placed; note slight gap around coronal aspect of implant
Fig. 32: DynaGraft paste packed around #9; also identifying the undercut on the buccal alveolus in the implant #13 bone bed site
Fig. 33: Shelf of alveolar bone removed, borders of ridge to be expanded are now well-defined
Fig. 34: Starting crestal incision approximately 6mm deep in the #13 area and approximately 13mm deep in the #11 area
Fig. 35: #11 area at approximately 13mm of depth
Fig. 36: Crestal incision complete, distal through cut releasing incision; the #10 socket acts as the mesial release
Fig. 37: Stoma spacing kit; 1.5mm wings with 3.8mm barrel with centering osteotome
Fig. 38: Beginning the expansion; I used a combination of Meisinger and BSB expanders; hands down the BSB expanders were superior
Fig. 39: Verifying integrity of the Schneiderian membrane
Fig. 40: Packing CollaPlug into expansion before going to a larger expander size
Fig. 41: Finishing expansion, note angulation of alveolar bone volume relative to #14
Fig. 42: Inserting DynaGraft paste
Fig. 43: Placing a "plug" of CollaPlug over the DynaGraft paste
Fig. 44: Placing the #13 implant AB I-5 3.75x11.5mm; note angulation relative to #14; flat tips of AB I-5 implants work extremely well for pushing the plug and therefore paste into the lift area
Fig. 45: Clip transfer removed, finishing placement of #13 implant with hand driver and re-angualting the implant
Fig. 46: #13 has now opened the crestal expansion to allow for the placement of #11 AB I-5 3.75 x13mm
Fig. 47: Check film; #13 excellent, #11 slightly tilted to the distal
Fig. 48: Repositioned; new check film; everybody is happy
Fig. 49: Anterior check film
Fig. 50: Three little piggies all in a row
Fig. 51: DynaGraft paste to fill expansion and osteotomies

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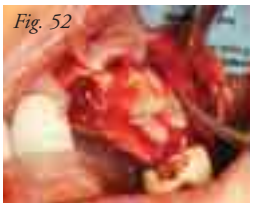
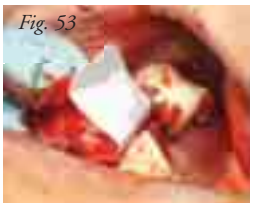
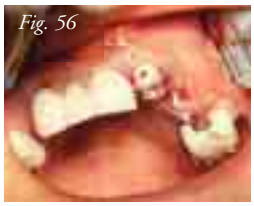
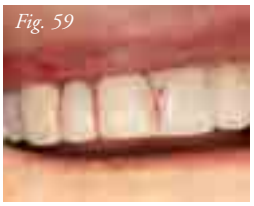



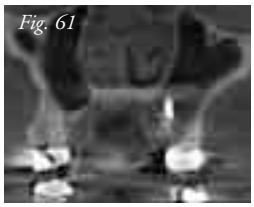



Fig. 52: Pericardium placed over expansion
Fig. 53: dPTFE membrane placed over the pericardium
Fig. 54: Flap released; flap re-approximated; socket of #10 protected by layer of dPTFE; not quite done yet
Fig. 55: Fabricating custom healing abutment using an AB peek abutment and flowable composite
Fig. 56: Custom healing cap in place
Fig. 57: Temporary acrylic RPD (removable partial denture) seated and hollowed out over surgery site
Fig. 58: Coe-Soft added to temporary prosthesis
Fig. 59: Immediate post-op view of prosthesis
Fig. 60: Check film for seating of custom plastic healing abutment
Fig. 61: Post-op CT demonstrating good containment of graft; area of lift quite visible
Fig. 62: Skeletal view of all three implants
Fig. 63: One week post-op
Fig. 64: One week post-op

Conclusion: Whew! This case took almost two hours to complete. Luckily, all went as planned. I will be posting follow-up photos and radiographs as the case progresses. I plan to restore the case in about six months. n

Jonathan Abenaim DMD FICOI DICOI n Posted: 12/5/2010 n Post: 3 of 25

Flawless. Why pericardium and dPTFE membrane? No need for double barrier. Other than that, great job. Makes me want a piezo more and more. n

Dan Haghighi, DDS n Posted: 12/5/2010 n Post: 4 of 25

I don't know about flawless; thanks though. The tissue around socket of #10 was left un-advanced and open. Therefore a barrier of dPTFE was required to protect the pericardium covering the graft material and mesial edge of #11 implant. Otherwise you are correct, no barrier required. To be honest, I wasn't expecting to get such good primary closure given the amount of expansion, so I did not bother trimming the dPTFE membrane to just cover the #10 socket area. n

UTprosthodont n Posted: 12/5/2010 n Post: 6 of 25

Can you elaborate what type of soft-tissue flap design you used for both sites? I usually do papilla sparing full thickness for the anterior and for expansion depending on bone thickness I split for the narrower ridges. Otherwise

I treat like I would for block grafts. I do not own a Piezotome, but had a few opportunities to use it for splits. I still do it old school... a mallet, blade and perhaps a 169L on a 45-degree handpiece to get the split started. n

Dan Haghighi, DDS n Posted: 12/5/2010 n Post: 8 of 25

I used a papilla sparing distal release on #14. In retrospect I could have made crevicular releases along #14, #15. As for the Piezotome I got quite a good deal four years ago on the Mectron unit I own.

I don't have any real cumulative experience with chisels in that I started these advanced procedures after purchasing the Mectron. Mallets and chisels get the job done and are a bit more fiscally responsible. n

cbesso n Posted: 12/6/2010 n Post: 10 of 25

Nice case. Why did you remove bone on buccal before expanding? Also, is it always better to leave periosteum on the bone when expanding? I either go in flapless with a 15 blade and mallet to start, or if it is really thin just a crestal envelope to visualize. Your way will work often, but you will have fewer complications the other way. n

Dan Haghighi, DDS n Posted: 12/6/2010 n Post: 11 of 25

The overhanging lip of alveolus had to be removed to visualize the correct dimensions of the occlusal table of crestal bone to be expanded.

As far as full thickness vs. partial thickness approach, I believe case selection and surgical technique play a much more vital role. I believe that the reason so many individuals advocate for partial thickness is due to the fact that their expansions end up being a bit sloppy i.e.: fractured cortex, uneven splits, thin expanded walls, etc., and the unlifted periosteum and added blood supply allows them get away with that by acting as a barrier membrane and keeping an intact blood supply. By not elevating the periosteum the amount of expansion is also limited by tension.

Cortex thickness also plays a determining role in case selection and predictability, especially in the posterior mandible. There is some good literature on this subject. I would consider a partial thickness or two-stage approach in the posterior mandible with a region that had thick cortex, where as in an area with thin cortex I would have little concern about full thickness vs. partial thickness.

But the two-stage still allows for full visualization of the surgical field at some point in the process which is key in my opinion.

For instance it is a well-accepted surgical procedure to simultaneously place an allograft block or particulate over a portion of an implant or osteotomy at the time of the procedure and close with a dual membrane technique. So how is this surgical approach "less" biologically compatible than the aforementioned procedure I completed using the patient's own bone?

By utilizing a full thickness flap, good visualization, slow expansion with screws vs. chisels, a center trough which decreases the amount of expansion, dual membrane closure and most importantly at least 1-1.5mm minimum of crestal bone against the coronal portion of the implant results, at least in my hands this procedure is very predictable.

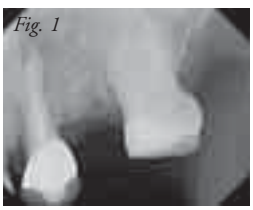
So I guess I would say your way will work but you will have fewer complications the other way. n

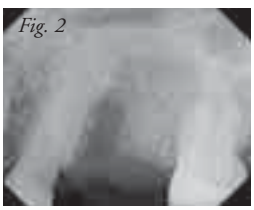
#12 and 13 with a Surgical Stent

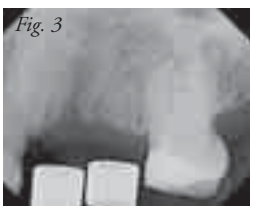
RLang ▫ Posted: 3/23/2011 ▫ Post: 1 of 8 ▫ From the message boards of Dentaltown.com

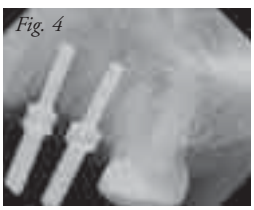
Introduction:

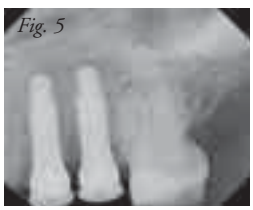
This was a routine case with a little bit of everything. Lab made surgical stent, two implants BioHorizons 3.5X12mm D3, bone spreading and particulate grafting. Oh yes and #14 needs endo.

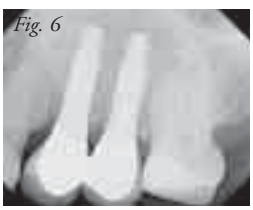


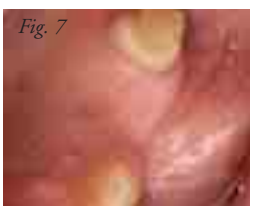


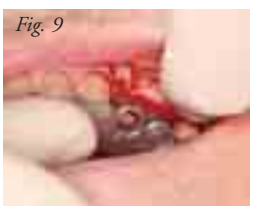


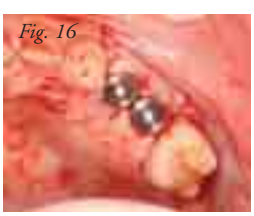












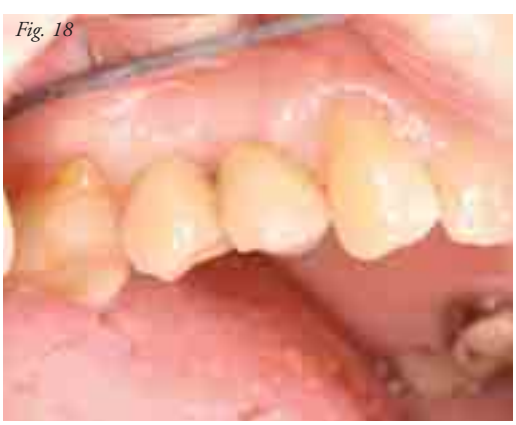


Fig. 1: #12 cracked root
Fig. 2: Post-extraction
Fig. 3: Three months later, stent try-in
Fig. 4: Guide pins to verify position from stent
Fig. 5: Healing collars in place post-surgery
Fig. 6: Final case
Fig. 7: Ridge post-extraction before surgery
Fig. 8: Try-in of surgical stent
Fig. 9: Flap and stent evaluation
Fig. 10: Initial osteotomies
Fig. 11a,b: Evaluating position of osteotomies
Fig. 12: BTI expanders used to expand ridge
Fig. 13: Guide pins

Fig. 14: Implants placed
Fig. 15: MinerOss with collagen membrane placed on buccal
Fig. 16: Sutured case
Fig. 17: Final crowns
Fig. 18: Final splinted implant porcelain fused to metal (PFM) crowns.
Conclusion:

This patient came in today and I thought I would post her case for discussion. Sometimes I get a surgical stent made or I make one myself and when I go to place the implant the ridge is not where I wanted it to be. In this case it required some spreading to obtain the desired width. I added MinerOss to the area that I spread on the buccal as I felt it was a little thin.

Thanks for your comments. n Robert A. Lang Jr., DDS

emilverban ▫ Posted: 3/23/2011 ▫ Post: 2 of 8

Robert,
Very nice and well thought out. The expansion with graft was necessary. n Emil

Louis Beaudoin ▫ Posted: 3/23/2011 ▫ Post: 3 of 8

Nice result!
Did you do any socket preservation?
Did you use a CT to aid in planning?
How do you communicate with the lab regarding the stent fabrication? Who decides the position?
Thanks for sharing. n Louis

vinson ▫ Posted: 3/23/2011 ▫ Post: 4 of 8

Robert,
Super nice placement. It is always good to use a guide. Was it necessary to splint them?
Thanks for posting. n Doug Vinson

RLang ▫ Posted: 3/23/2011 ▫ Post: 6 & 7 of 8

Louis,

Thanks for your comments. I did not do socket preservation with this case; if you look at the X-ray I was lucky my osteotomy was where it was because there was still a defect. I did not use a CT and for a case like this would rarely do so. I told the lab the diameter of implants I was using and they set up the stent. It has different diameter inserts for my drills, I took an X-ray to make sure they were the way I wanted. I have a little protractor they gave me to make sure they are heading in the right direction.

[Posted: 3/23/2011]

Doug,

I always splint them; Misch has many reasons for doing so. Many do not and I have seen many discussions here on Dentaltown about all that. These are long enough that I might have been able to not splint but I was worried about this patient's occlusion. It is all about what Kool Aid you drink, I can send you some of mine to drink.

Thanks for the comments. n Robert A. Lang Jr., DDS

Predictable Long-term Aesthetics in Single-tooth Implant Restorations

Fig. 1: Close-up view of the all-ceramic crown (Cercon [DENTSPLY Ceramco]) (over implant) restoration for tooth 7.

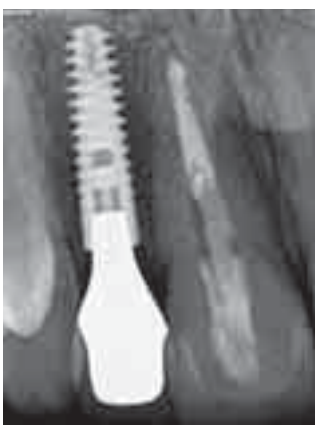


Fig. 2: Three-year post-operative radiograph of implant (ANKYLOS, DENTSPLY Tulsa Dental Specialties) showing zirconia abutment.

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by David Little, DDS

In order to achieve maximum aesthetics and function for single-implant tooth restorations, the following points must be carefully considered. Every case must be precisely diagnosed and the treatment procedures planned. The implant must be inserted in the correct position to allow the fabrication of an aesthetic and functional single-tooth implant restoration. The implant components must be mechanically stable and biocompatible, and the abutment must be anatomically shaped to allow for each specific clinical situation so that a natural emergence profile for the crown can be formed within the peri-implant soft tissue.

Diagnostic models, digital radiography and CT scans should be incorporated to plan implant placement, ensuring that sufficient, stable bone exists and that where the implant is placed will promote optimal retention.[1,2] CBCTs allow dentists to view cross-sections with zero distortion, enabling them to measure the exact width and depth of hard tissues.[3,4]

Case: The implant was placed (ANKYLOS, DENTSPLY Tulsa Dental Specialties) using a surgical guide and a provisional abutment and crown. After osseointegration, a fixture level impression allowed fabrication of a zirconia abutment and zirconia crown. The all-ceramic zirconia restoration and zirconia abutment Cercon (DENTSPLY Ceramco) provides great biocompatibility and aesthetics. The clinical photo and radiograph show results three years post-op. (Figs. 1, 2). It is nearly impossible to differentiate natural teeth from the implant restoration. By visualizing the end result first and using advanced diagnostic technologies, predictable aesthetics were accomplished with hard and soft tissue stability including a gain in papilla height.

All oral implant systems rely on the abutment part of the implant to provide stability for the dental prosthetic. The TissueCare connection of the ANKYLOS implant offers precisely machined, tapered-cone abutment (Morse taper) connection. This tapered abutment connection provides high resistance to bending and rotational torque during clinical function, which significantly reduces the possibilities of screw fracture or loosening. This increased stability of the abutment/implant interface is critical in the stability of the hard and soft tissues and thereby providing predictability with aesthetics. The extremely accurate ANKYLOS TissueCare connection has no micro-movement.

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Experience with the TissueCare connection and the ANKYLOS system with single-tooth replacement indications may be considered positive with regard to the aesthetic and functional results of the treatment. Because of the lack of mechanical complications and problems with the hard and soft tissue in the loading phase of the implants, healthy and stable implant restorations can be achieved.[5,6] n

David Little, DDS, received his dental training at the UTHSCSA and now maintains a multi-disciplinary practice in San Antonio, Texas.

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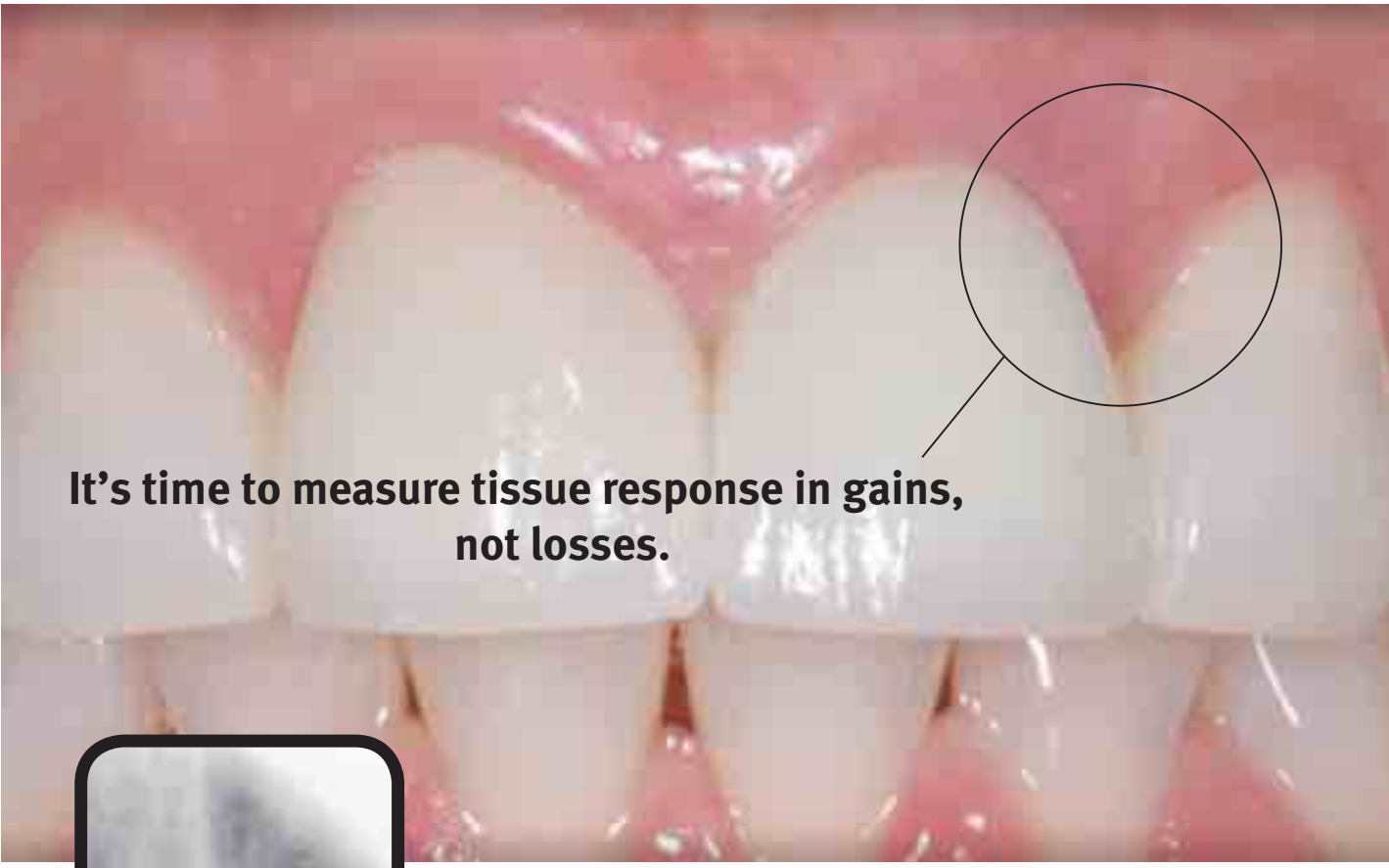

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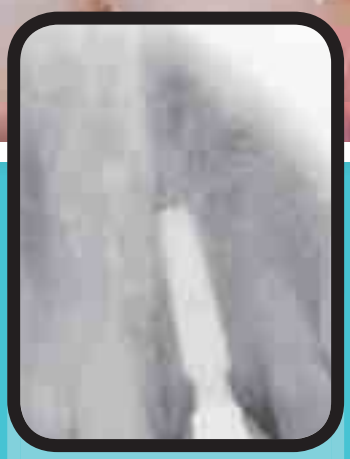

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1. The ANKYLOS tapered connection shows no micromovement as shown by Zipprich using a chewing simulator. No clinical data is available. Zipprich, H., et al., *Erfassung, Ursachen und Folgen von Mikrobewegungen am Implantat-Abutment-Interface*. Implantologie, 2007. 15(1): p. 31-46.
2. The ANKYLOS offset tapered implant abutment-connection provides long-term hard and soft tissue stability over a mean period of 56 months as demonstrated by Nentwig's clinical observation of no progressive bone or peri-implant mucosa loss in 95.8% and 97.8% of 5439 cases respectively. Nentwig, G.H., *Ankylos implant system: concept and clinical application*. J Oral Implantol, 2004. 30(3): p. 171-7.
3. Abboud noted that clinical observation showed esthetic outcomes and a gain in interdental papilla height in 16 patients when the ANKYLOS offset tapered connection was used. This effect persisted for a period of over 12 months after implant placement. Abboud, M., et al., *Immediate loading of single-tooth implants in the posterior region*. Int J Oral Maxillofac Implants, 2005. 20(1): p. 61-8.

Case provided courtesy of Drs. Gary Brousell and Dana Fallon

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Gregg Fink, DDS; Newark, Delaware



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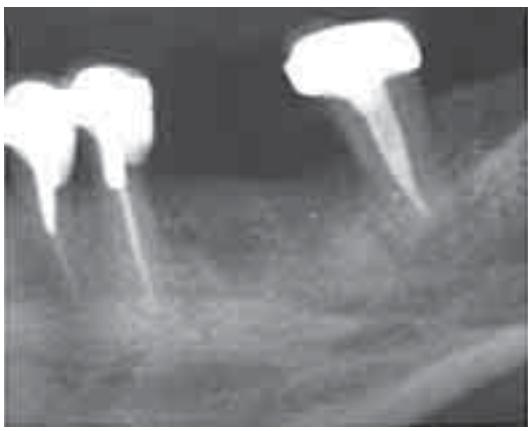
BondBone from MIS Implants

With more and more patients making the decision to move forward with a treatment plan for dental implants, the concept of socket preservation takes on an even more important role. This simple procedure can give the practitioner more predictable bone height and width to accept these implants than allowing the site to heal on its own.



Calcium sulfate has been used as a bone augmentation material for more than a century. It has advantages that make it an excellent material for socket preservation. Among these are its biocompatibility, osteoconductive qualities and its resorption rate which is comparable to normal bone formation.

MIS Implants Technologies, Inc., offers a calcium sulfate product that can be used for socket preservation as well as other procedures. BondBone is biphasic calcium sulfate in a granulated powder form. This material has been developed to combine the best qualities of the hemihydrate and dihydrate phases of calcium sulfate into one simple-to-use product. It has the advantages of the hemihydrate phase (being moldable and cementable) along with the advantages of calcium sulfate in the dihydrate phase (having high strength, a resorption rate equivalent to bone growth, and the ability to set in the presence of blood and saliva). Another positive feature is the way it is packaged. BondBone comes in a "driver" in which the product can be mixed and delivered directly to the intended site. The procedure time, from the beginning of the mixing phase to the completion of the placement, can be accomplished in two to five minutes.

Small Defects

In areas that are less than 10mm in width and have at least three-wall bony support, BondBone can be used on its own. Sterile saline is injected into the driver's head until the BondBone is completely saturated. Excess liquid is expelled, the driver's head removed, and any remaining excess liquid should be absorbed using sterile gauze. That's all there is to the preparation step.

The BondBone is then expressed into the defect, being sure to have good bone-to-product contact and to fill the defect completely. The BondBone can then be shaped and should be condensed with gauze for three to five seconds. The final step in the placement of the product is to wet a sterile gauze pad with sterile saline and place it on the graft for approximately 30 seconds. The BondBone is now set and you will not experience the particle migration that is seen with traditional particulate materials. The stability of the BondBone will keep it from collapsing as the area is filled with new bone. Primary closure can now take place.

Larger Defects

When a defect does not meet the criteria mentioned above, BondBone can be mixed with other granular bone augmentation products to create a cementable composite graft material. To achieve this composite, the recommended ratio of BondBone to your chosen particulate graft material is 2:1. The two dry materials should be mixed completely in a sterile bowl, sufficiently saturated with sterile saline and mixed thoroughly. Excess liquid should be absorbed gently with sterile gauze. The newly mixed composite can be placed in the driver, using a technique similar to loading amalgam into a carrier. Application of the composite is identical to that of using BondBone alone. The defect needs to be filled completely, compressed with dry gauze and then with sterile saline soaked gauze.

BondBone is a bone graft material that should be considered for socket preservation procedures as well as other procedures needing bone graft products. Because of its ability to be combined with other graft materials, it is very versatile. It is available in 0.5cc and 1.0cc drivers. For more information, please visit www.misimplants.com or call 866-797-1333. n

BOND BONE

INNOVATION

IT'S ABOUT TIME...

BONDBONE™ is a resorbable, osteoconductive bone grafting material, taking the best qualities of hemihydrate and dihydrate calcium sulfate and combining them into a unique new product. It can be used on its own, or mixed with other granular bone grafting materials to form a composite that will help to prevent migration of particles and often eliminate the need for a separate barrier. The pliable paste will set in approximately 2-5 minutes, allowing for ample working time.

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MIS offers a wide range of implant designs and restorative components, along with innovative kits and accessories for the varied challenges encountered in implant dentistry. To learn more about MIS visit our website: misimplants.com or call us:

866-797-1333 (toll-free)

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