

**Drs. Gordon Christensen & Paul Child: What Has Happened to Dental Assisting?**

November 2011 » Volume 12, Issue 11

# dentaltown

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Lighthouse PMG co-founders from left: Joel Kozikowski, Brian Smith and Allen Jorgensen.

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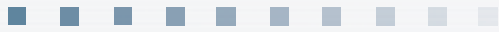
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Is it tougher for female dentists to manage a primarily female staff?

Female Dentists Search

## ▶ Resins and Fraud

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Do you use an electronic shade guide?

A. Yes B. No



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Google Reviews, Facebook, e-mail, Twitter, texting – these are all part of today's communications matrix. Learn how you can use these and other cyber tools to grow your practice.



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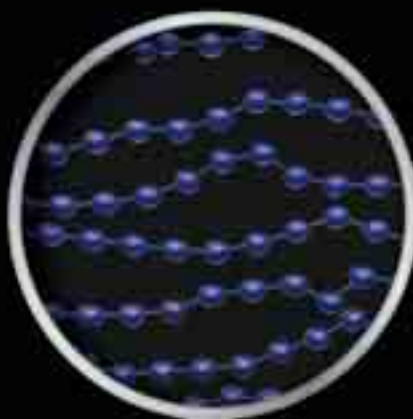
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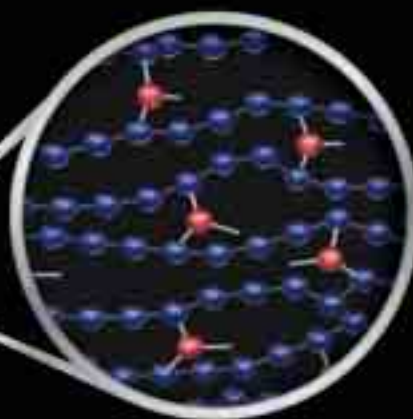


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# Shock Your System

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



According to statistics from the International Franchise Association, franchises employ a little more than 15 percent of the private-sector U.S. workforce. Anyone can open up a dry cleaner or a restaurant – but do they know the business of running a dry cleaner or a restaurant as well as a franchise? Nope. The reason people buy into franchises and pay franchise fees is because being part of a franchise gives your business a greater chance of being successful.

When I was 10 years old, my dad quit his job as a Rainbow Bread deliveryman and sank all of his money into purchasing a Sonic drive-in franchise. It was risky, but he had a friend who had done the same thing and – with the systems Sonic had in place – his friend ran a successful business. There weren't computers 40 years ago, but there was a company called National Cash Registers (NCR) that helped you run your franchise efficiently and effectively. I worked for my father from 1972 until 1982 and I saw, firsthand, the power of the cash register. Back then the cash register was a complete management system. It is the reason McDonald's has sold more than 50,000 franchises and they have only had a few of them go under. Do you know why those few McDonald's restaurants went under? Because the government would close down a highway after they built a new freeway. You literally have to take the street away from McDonald's to make it fail.

Today, technology can do some pretty amazing things in terms of practice management. Which practice management software does your practice use? Do you use one of the more popular systems that have evolved over the last two decades? Have you looked into or jumped onto the cloud? No matter which system you've purchased you're getting a pretty good tool to run your practice as efficiently as a franchise like McDonald's or Sonic. But, are you using your practice management software to its fullest potential? And is your practice management system performing the way you wish it could?

I have lectured to dentists for 20 years, and if I asked 100 docs in one of my lectures what their overhead is, maybe 10 of them could give me a straight answer. That's sad, baby! That should just be automatic. Why don't you know this? Maybe you don't care. Maybe your office manager knows the answer. Maybe your accounting software doesn't link with your practice management software.

Wait a second. Your accounting software doesn't link with your practice management software? Why not? It should, right? Is it because the practice management software you use doesn't have that capacity? If the software you're using doesn't there are some that do. What else would you like your practice management software to do?

I've met with the good people behind some of these practice management software systems. They develop software around the wants and needs of dentists. If enough dentists want something, they can make it happen! They like to hear from you. You asked for perio charting? *POOF!* They gave you perio charting. You asked for voice-activated charting? *BAM!* You've got voice-activated charting. You asked for a bridge to your X-ray machine? *BLADDOW!* You can now bridge your X-ray machine to your practice management software. That's all fine and dandy, guys, but *stop thinking like a dentist for one minute and start thinking like a business owner!* I know, very few of us were attracted to dentistry because of the businesses aspect of it, and we all tend to stay away from stuff we don't understand. It's time we all understand our business better. It's time to understand your numbers as well as you understand caries. It's time to take a look at your current practice management software and think of ways it can help you run your business more efficiently and effectively!

Your number-one cost is labor. Just imagine integrating a time clock with a payroll function like QuickBooks or Peachtree in your practice management software system. If your staff clocked in and clocked out on your practice management software, at the end of the day your system would know their wages. By having your schedule on your dental software, if you need to do \$2,000 a day to make your labor 25 percent and your overhead 60 percent, all you'd need to do is set it. Say you wanted to have 50 percent overhead; the practice management information system could tell you what your overhead is at the end of the first hour, and then you could adjust accordingly. It could tell you what your overhead is at lunch and then at the end of the day so you can see if you hit your 50 percent overhead goal.

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*continued on page 14*

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dures you're making money on, breaking even on or losing money doing? Let's say your software had your overhead figured into your schedule. Then let's say you sign up with a new PPO that only pays \$800 for a crown seating you usually charge \$1,000 for. And when your front desk staff schedules an hour and a half on the schedule, something flashes in red stating that you'll lose \$40.17. So she goes back into the schedule and blocks off only an hour – and now a green number pops up and says you'll make \$40.17 instead. Your front desk used pertinent information to make a quality scheduling decision. You and your staff could use something like this, right?! You've probably hired a CPA who uses QuickBooks and comes to your practice every quarter to discuss your report. It's helpful having a CPA around who will watch your numbers and try to keep you on track, but if you're getting your financials every quarter, it's too little too late. If you've got an issue in your practice, you need to look at your books on a weekly or daily basis.

What about knowing what your revenue per operatory hour was for the day and what your net or profit per operatory hour based on your overhead was for that day? What about the ability to adjust numbers in your budget to see how your overhead is impacted? For example, if you were to cut lab expenses by \$500, or if you closed your practice for three

days, what would happen to your overhead? This is all stuff you should *want* to know! If you could plug in daily amounts for all expenses and compare that to the production per hour, that would be huge!

Think about payroll; every week you're in the back trying to figure everything out on QuickBooks or Peachtree. Wouldn't it be awesome if you could bridge those programs to your practice management software? It would be so much easier because all the information you need would be in one place!

When I check into a Hyatt or a Hilton I am blown away by the data at their fingertips augmenting all of their decisions. They know my past. They know if I prefer king beds, smoking or non-smoking. They know everything about me. You don't know anything about your finances. You can't tell me what your return on assets was last year versus your return on equity. You can't tell me what your overhead is. You can't tell me if you are making money or losing money on any of the PPOs you take. You can't tell me what procedure fees you need to increase. You might be making money on crowns, root canals and extractions but losing your shirt on cleanings, exams, X-rays and fillings because of the time you have scheduled for each procedure and what the insurance company will pay. You should know whether you made \$20.13 versus \$20.14 or if you lost \$7.08 or \$7.09. Sure you can figure this all out on your own, but wouldn't it be so much easier if your practice management software did it for you?

This is already happening with businesses like Heartland Dental Care. All of their more than 300 dental practices operate with systems that help to ensure a practice's success. They know what makes money for a dental practice and where production needs to be tightened up. And other software companies are developing ways to bridge accounting information to your existing practice management software.

We can't say we're in a major recession anymore – we're in a major contraction! We don't have the luxury of working 32 hours a week anymore; most of us are working (or need to work) 40 or more. We can't raise our prices right now, and insurance companies are coming out with PPOs and discount plans left and right. Guys, you need to know your overhead, and it's inexcusable that you don't demand revisions to your practice management software to run your business more efficiently. Dental practices and practice management software companies are successful when they work together to provide the options you want and need. You've just read my practice management software wish list. Go on the message boards of Dentaltown.com and let's discuss what you'd like your practice management software to do. Now is the time that we should all be able to operate our practices with the same reassurances of success provided to franchised companies! ■

## Howard Live

Howard Farran, DDS, MAGD, MBA, DICOI, 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](mailto:colleen@farranmedia.com).

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# What's on Your Tray?

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



Once a year, I fly 2,487 miles to upstate New York for a golf and lake weekend with six of my classmates from dental school. If you have never been to the Adirondacks, you are missing one of the most beautiful parks in our country (Fig.1). Growing up, my family and I traveled from Syracuse to Big Moose Lake every summer for vacation; continuing the tradition with my classmates is truly a blessing.

Our group consists of three oral surgeons, two orthodontists and two general dentists. As you might imagine, some of our conversations focus on dentistry. We discuss materials, techniques and office management; the different perspectives are enlightening. This year, I had business meetings in Buffalo right after the getaway weekend, so I made a stop along the way, in Syracuse. There I spent time with one of my roommates from

dental school, Dr. Brian Tromblee, and he gave me a tour of his brand new office he just opened with his wife, Dr. Teri Forth (Fig.2).

While touring this beautiful space, I couldn't help but look inside the drawers and ask questions like, "Why do you use this?" "What do you use for that?" "Why is this stored in the operator?" and so on. A casual observer might think it was my first time in a dental office. Of course, nothing could be further from the truth. I have worked in and visited dozens of dental offices in my career, and knowing how different practices are from one another, I'm always curious to learn what sets each practice apart from one another. The dentists I have known since dental school do some things a bit differently from each other and myself and I often wonder how that evolved.

For a little more than five years, *Dentaltown Magazine* has delivered a beautiful feature article series titled, Office Visit. This is our special spin on showcasing dental offices in our magazine. We look for an office with a unique story and then interview the owner to learn about his or her practice philosophy and some of the decision making that went into building their practice. This continues to be a very popular feature and we are looking to expand on this concept of visiting with our colleagues.



I'm pleased to announce the newest feature for *Dentaltown Magazine* in 2012, "What's On My Tray?" If Office Visit is the macro view of a dental practice, our newest feature will be the micro view of a single procedure in a dental practice. Throughout 2012, we will feature the tray set-ups of various dentists throughout the profession. We need you to send us photos of your tray set ups for any of the following procedures:

- Composite/Restorative
- Dental implants
- Crown & bridge preparation
- Endodontics
- Scaling & root planing
- Temporary crown

For your reference and as an example of what we expect, I've included a photo from my practice as a sample (Fig. 3). Here is some criteria we'd like for you to follow:

- **The photo should be a clear representation of the specific materials and instruments you use for that procedure.**
- **We also require you to include a list of all items that appear in your photo to assist our team with identification and labeling.**



- **Send your photo and list to [tom@dentaltown.com](mailto:tom@dentaltown.com). Please write "What's On My Tray" in the subject line of your e-mail.**

Those who submit photos that meet the above criteria will receive a certificate for free online CE credit when you take your next course on *Dentaltown.com*. Dentists whose tray set-ups are chosen to appear in *Dentaltown Magazine* will receive a \$100 Visa gift card.

You can look forward to the first installment of this new feature in the January 2012 issue of *Dentaltown Magazine*. ■

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# Selling Yourself

by Nancy Lashley

*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*

I recently had lunch with the venerable Jerry Woolf, DDS, vice president of the American Academy of Cosmetic Dentistry, and he wanted to know what I thought dentists need from the dental industry right now.

My answer was "hope" – hope that you will be able to practice the type of dentistry you want regardless of the economy, work with the patients you want and ultimately create and enjoy the practice you always dreamed of. The form hope takes is different for each of us, but is absolutely attainable through proper marketing, as it turns out.

The only reason to market a dental practice is to keep the new patients flowing, the practice practicing; to keep you working on teeth. Regardless of whether you're a fee-for-service practice or an insurance-based clinic, regardless of what technology or training you have invested in, regardless of the demographics, the economy or sunspots, without new patients, you're stuck. Without marketing there are no new patients. By definition, without marketing, no one will find your front door.

Many dentists rely on insurance companies to do the marketing for them. When I ask these dentists what their marketing budget is, they typically reply, "I don't *have* to market. I get all the patients I need from insurance!" If insurance is keeping you in business, then keep insurance.

I would like to point out, however, that the difference between what your fees should be and what insurance will pay *is* your marketing budget. In most cases, that's a difference of around 20 percent, which is a very big marketing budget indeed, a Coca-Cola-sized marketing budget, if you will. And I would add that with insurance you have no control over who they send your way – some become excellent, happy, long-term patients, but most don't care one iota for dentists and would frankly rather not be there, even if your breath is sweet and your staff is kind. That's not exactly a fun place to be, for you or them.

Compare that 20 percent marketing budget with the modest five percent budget a hard-marketing practice

might invest. Add to that the control those hard marketers wield. Market correctly and you attract the right patients. Those patients then value your time and skill and ultimately accept and appreciate your treatment. You see, everyone wins!

I'm not saying you should drop your insurance; I am saying that it is up to you to become conscious of where your money, time and energy are all going. You have the power to create the practice of your dreams. There is hope and you hold the key.

Suddenly this whole question of whether and how to market takes on a whole new light. It's no longer about "deciding to market" but about "deciding to take control." Once you decide to take control, where do you begin? An innocent search online for "dental marketing" will leave you confused. Is a generic dental Web site by itself really marketing? What is marketing and what isn't? What is SEO? Social media? Do you really need that huge Yellow Pages ad? Who are these people making promises? And how do you know if you can trust their claims? It can become overwhelming very fast, so I don't blame those dentists who just want something someone else can implement for them so they can get back to what they love – practicing dentistry.

You say "I went to dental school in order to practice dentistry, not become a salesman, and I certainly don't want to sell myself!" Well, I'm here to tell you that this thinking is why you get into trouble. You are selling a service, not a widget. You are selling a promise and patients are purchasing trust. You are selling your interior design, your staff's compassion and your bedside manner, whether it is good or not. If you're lucky and good at what you do, they'll still have faith in you after the case has been delivered. But they had no way to know for sure when they said OK to your treatment plan that you would deliver – no, they had to trust you and your staff completely, which means they had to like you. You are selling yourself.

*continued on page 20*

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It turns out that when you are selling yourself, everything you do is marketing. It's time to take control and focus your energy so that you can continue to practice with joy and prosperity.

#### **Step 1: It All Starts with Vision.**

Stop thinking the same thoughts that got you where you are long enough to create a vision for your practice, and you become conscious of the messages you have been sending and are finally able to take control of their impact.

What if you woke up every morning eager to practice? What would it look like, feel like, *be* like? What kind of dentistry would you do, and for whom? Why would those people want to be part of your practice? Once you have the answer, once you have your vision, every decision you make becomes a conscious answer to the question: "Does this align with my vision or not?"

#### **Step 2: Put Your Vision to the Test with Goals.**

Without a destination, how do you know when you've arrived? Write down several specific goals and post them with your vision in a prominent area, like on the ceiling above your bed. Write how many patients you want per month or write how you want to feel each day. As you remain focused on your vision, over time you will get what you set out to accomplish.

#### **Step 3: Choose Your Budget.**

When you are selling yourself, you are marketing all the time. From the sweatpants you wear to Costco to the real patient photos (or lack of) on your Web site, you are sending messages. Take control of the messages you're sending.

You can take control with a shoestring budget or you can take control with the budget of a small country. It truly does not matter how much you spend; only how consistently you align your message to your vision. Choose to shell out an amount that you are comfortable with, even *happy* with, and then quit thinking about it. The more you fuss about the money, the more you distract yourself from reaching your ultimate goals.

#### **Step 4: Write Out Your Plan.**

When I create a marketing plan, I go nuts with a huge spreadsheet, tracking everything from the timeline to the estimated costs to the actual new patients who come in over the timeline and the treatment presented and accepted. If you love a good spreadsheet, you can easily do this yourself. If Excel gives you hives, simply type it up in Word or write it in your journal: your vision, goals, budget, methods and results. Don't skip this step; the simple act of writing it out will give you more power than almost any other step as you move forward.

#### **Step 5: Align Your Brand.**

Great branding gives you great control. Branding is where your vision comes to life. When you get your

brand consistently aligned to your vision, the perfect patients will know they belong with you before they ever walk in your door.

Your brand is made up of elements including logo, colors and a tagline, as well as layout, photos and text. These elements are then used in different combinations to build a simple marketing tool like a business card or a complex tool like a Web site. Simple or complex, your message needs to be instantly, visually, emotionally compelling. If you change your branding elements from tool to tool – or worse, build tools with generic or no branding at all – you lose control of your message and instead sound like Charlie Brown's teacher, so much noise lost amongst so much chaos.

#### **Step 6: Choose Your Methods.**

Admit it – you are sure that there is some magic marketing method out there, that the guy down the street is using it and that if you only knew what it was you'd have everlasting success and could get back to practicing dentistry instead of reading long articles about marketing.

Despite what some marketing companies and experts might tell you, there is no secret, no method that will give you everything you think you want. There are only choices and the right to make your own choices. I will *recommend* that you have a real Web site branded to your practice and filled with examples of work you've actually done on real patients.

Some examples of methods (to get your juices flowing) would be: direct mail campaign, magazine ads, internal marketing campaign, SEO, phone skills training for staff, an interior design upgrade, a Yellow Pages ad and a new patient package.

#### **Step 7: Building Tools for Fun and Profit.**

When you know what methods you want to use, you know what tools you get to build. Yes, I said "get to!" If you have to have a business card, why not make it amazing? Why not have fun telling people about yourself and make it easy for your staff and patients to send your message for you? Same with your recall card, or the book of happy patient testimonials in your waiting room or that little black and white ad they need for the little league directory.

This is your chance to boast about what makes you special. This is your chance to take a stand, put your message out there with aplomb and make the market want to listen to you. If you're not having fun, neither will they.

#### **Step 8: Just Do It!**

I've worked with hundreds of dental practices, and without exception, implementation is the scariest step. They are right, change is hard and putting yourself out there makes you vulnerable to judgment. Not everyone

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will be attracted to your message. But you are stronger than you know and your patients adore you for tangible reasons. So implement your plan; be patient, give yourself some grace and the time you need to achieve your vision.

**Step 9: Track and Evaluate Your Results.**

Technically, if you're still in business, your marketing has been a success. But don't you want to get to the next level, to take control of that success so that you wake up every morning excited to go to work and with no more worries than what to have for lunch?

So take the time to evaluate. Look at what you actually spent on your chosen methods, the quantity and quality of patients each method attracted and the amount of treatment presented and accepted. Compare the actual numbers to the goals you started out with. Look for fluctuations in the new patient flow so you can adjust for the next plan.

You'll find that perhaps spending all that money on SEO wasn't nearly as profitable as developing personal relationships with raving fans. Or perhaps it was, and your Internet patients are presenting the best cases, but might need more time with you in order to

build the trust to accept treatment. Or that the huge investment in your interior design this year was worth it, as evidenced by the happy patient testimonials you've so avidly collected.

If you don't take the time to analyze your data, you won't know any of this stunningly valuable information, and then you're the blind leading your own blind self.

**Step 10: Repeat as Necessary.**

Repeat these 10 steps as long as you want to be in business and every year you will find yourself more focused on what really matters and more successful at creating the practice you've always wanted. You have the power; you have the control. ■

**Author's Bio**

Raised by dental consultants, **Nancy Lashley** has a unique perspective on dentists and the dental industry and isn't afraid to share it. Lashley began Athena Marketing in 2002 and has worked with hundreds of dental practices and dental companies on marketing and branding, as well as the American Academy of Cosmetic Dentistry and the International Federation of Esthetic Dentistry.

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by Gordon J. Christensen, DDS, MSD, PhD and Paul L. Child Jr., DMD, CDT



Do we have to impress any dental practitioner about the importance of dental assisting? In our opinion, much of the success or failure of typical dental practices is directly related to the effectiveness of dental assistants. The public relations, the productivity and the revenue of a practice can be significantly increased when dental assistants are motivated, educated and trained in the essentials of dental assisting, and have become genuine “team” members (Fig. 1).

Several decades ago, many dental schools had a significant amount of integrated dental assisting-dentist education in their curricula. Usually, these programs were funded by federal grant programs, which subsequently have disappeared. Highly valuable studies to determine the desirable ergonomic characteristics for dental practices were also funded by the government at that time. The result was development of operating chairs of the most desirable size and function; recognition of the necessity for correct positioning of dentist and dental assistant; the most adequate sterilizing and storage systems; efficient instrument passing to dentists; simple infection control and myriad other important subjects directly related to effective dental assisting. Dr. Christensen was involved in structuring and teaching in these programs many years ago. Unfortunately, as these pro-

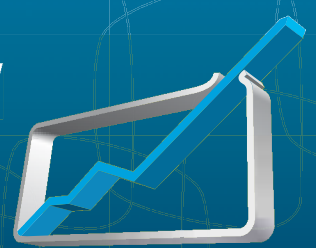
grams lost funding, most of the teaching of dentist-dental assistant interaction ceased. There are now many dental students graduating from dental school who have never worked with a dental assistant, and who have no idea about any of the necessary characteristics for optimum use of dental assistants. Poor habits and practices learned in other practices are often brought into the new dentist’s office because of this inexperience.



*Figure 1: Developing a genuine team requires proactive planning, organization and implantation of correct concepts by the dentist.*

continued on page 26

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In the following information, we will list and discuss the optimum characteristics of dental assistants, emphasize some of the most important clinical tasks that can be legally delegated to properly prepared dental assistants and make suggestions on how to best implement these important characteristics into your practice.

### Maximizing the Professionalism of Dental Assistants

Most dental assisting schools provide many of the aspects of becoming a true professional dental assistant. However, just as with new dentists, professionalism usually requires time for development. Over many years, we have heard and observed the dental assistant characteristics that are sought by dentists. See if you can develop these and other characteristics you might consider important in your dental assistants. Among the most important and desirable dental assistant characteristics to us are the following:

**Training/Education:** Although many dental assistants learn primarily by preceptor experience, we suggest for a person entering dental assisting, to enroll in and complete an accredited dental assisting program. There are many such programs available in local community colleges or private schools. The following Web site is an excellent source of information: [www.dentalassistantschools.net](http://www.dentalassistantschools.net)

**Constant Continuing Education:** Dentistry changes rapidly, and dental assistants must keep up with those advancements. We suggest you encourage your dental assistants to take CE on a scheduled basis. Taking CE courses periodically is mandatory to keep up with the ongoing changes in the profession. Dental assistants can gain significant useful information by attending courses that are primarily oriented toward dentists.

**Certified Dental Assistant (CDA) Designation:** Encourage your dental assistants to obtain the CDA designation. This distinction adds to their professional identification and enhances their self-esteem.

**Leadership:** Many people, including some dental assistants, are satisfied to let others lead them, while others are always thinking ahead and making suggestions for improvements in whatever they are doing. This characteristic can be stimulated by congratulating and thanking dental assistants for their creativity and innovativeness as they exhibit such characteristics. Some practices have incentive programs for dental assistants who provide methods for improvements in the practice, increasing revenue or cost savings.

**Outgoing and People-oriented:** An introverted dental assistant is a liability. These persons must have excellent interpersonal skills. They must be constantly looking for ways to make people feel welcome and comfortable in your office. Encourage the development of such characteristics.

**Cheerful and Optimistic:** This is an attribute that is extremely necessary in almost every vocation. A happy employee

makes happy patients. Encourage and praise these characteristics and be an example yourself. Your dental assistant can make people feel as though you have the best office and staff in the country, and that you, the dentist, are highly competent and qualified. Encourage such behavior by recognizing the optimism and thanking staff for their support.

**Empathetic Behavior:** Dental assistants are the staff persons who make your patients feel comfortable, informed and confident in your office environment. They should be thinking of the patients at all times, and recognizing the feelings of the patient. Give your dental assistants instruction on how to best develop and maintain this characteristic.

**Clean, Neat, Well-groomed:** This one goes without saying. However, it is a delicate subject to tactfully present your feelings to a dental assistant who might have dirty shoes, bad breath, smoke odor, body odor, greasy hair, too much makeup, potent perfume, dandruff, unkempt appearance or other unpleasant physical characteristics. We suggest personal interviews with individual staff persons on a routine basis, asking them to evaluate themselves. You should also critique your own behavior and demeanor, because you are the example for your staff. In a personal interview, the staff person's physical negatives will naturally emerge without significant embarrassment for either party.

**Clinically Competent:** Having dental assistants master the essentials of four-handed and six-handed dental assisting is a major asset to any practice. Such concepts greatly improve productivity, patient comfort, speed of operation, quality of the procedures and ultimately office revenue. If your assistants do not have these abilities, it is time to develop them as soon as possible. Within reason, adding an additional dental assistant almost always increases revenue beyond the expense of the additional salary. Expanded clinical functions can easily double the productivity of a typical general practice. However, it requires that the dentist and staff are willing to learn how to integrate the expanded clinical functions into office activity, create a true team and make practicing dentistry easy and enjoyable for all involved. The following section of this article lists and discusses many of such responsibilities.

### Expanded Clinical Activities for Dental Assistants

Dental practitioners are finitely limited in our productivity by our own two hands. Whatever we can do in a specific time period is readily identifiable. In spite of attempting to speed up clinical procedures, the outcome is limited to only minimal increases, unless you add additional staff. Adding more skilled hands to the clinical team can increase productivity significantly. The American Dental Association reports that the mean number of dental assistants used in most U.S. dental offices is slightly less than two (Figs. 2 & 3). However,

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What came first the decay or the abfraction? How often have you restored cases that look like this and didn't determine the cause?



Is this erosion, parafunctional wear, or bulimia?



Some think this is acid reflux and others think it is occlusal abfraction. What is your diagnosis?



How many times have you restored cases like this and never knew how to address the underlying cause?

continued from page 26

Figure 2: Properly implanted four-handed dentistry can significantly improve patient care, office efficiency and income. Figure 3: Developing the ability to use six-handed dentistry is a major advantage in a busy practice. Figure 4: Two dental assistants are average in the U.S. However, incorporation of expanded functions requires using additional assistants for optimum efficiency.



the dentist and this team of two dental assistants might still have limited productivity.

Dentists have only two methods to increase productivity and still maintain the production of quality services. They can increase fees, which is the mantra of some continuing education courses in practice management, or they can elect to educate staff members on how to accomplish some of the clinical tasks usually done by dentists.

Significantly increasing fees is not a viable alternative in most communities. Patients are educated to find those practitioners who have moderate fees, and third-party payers are critical of dentists who are charging fees significantly above the community levels.

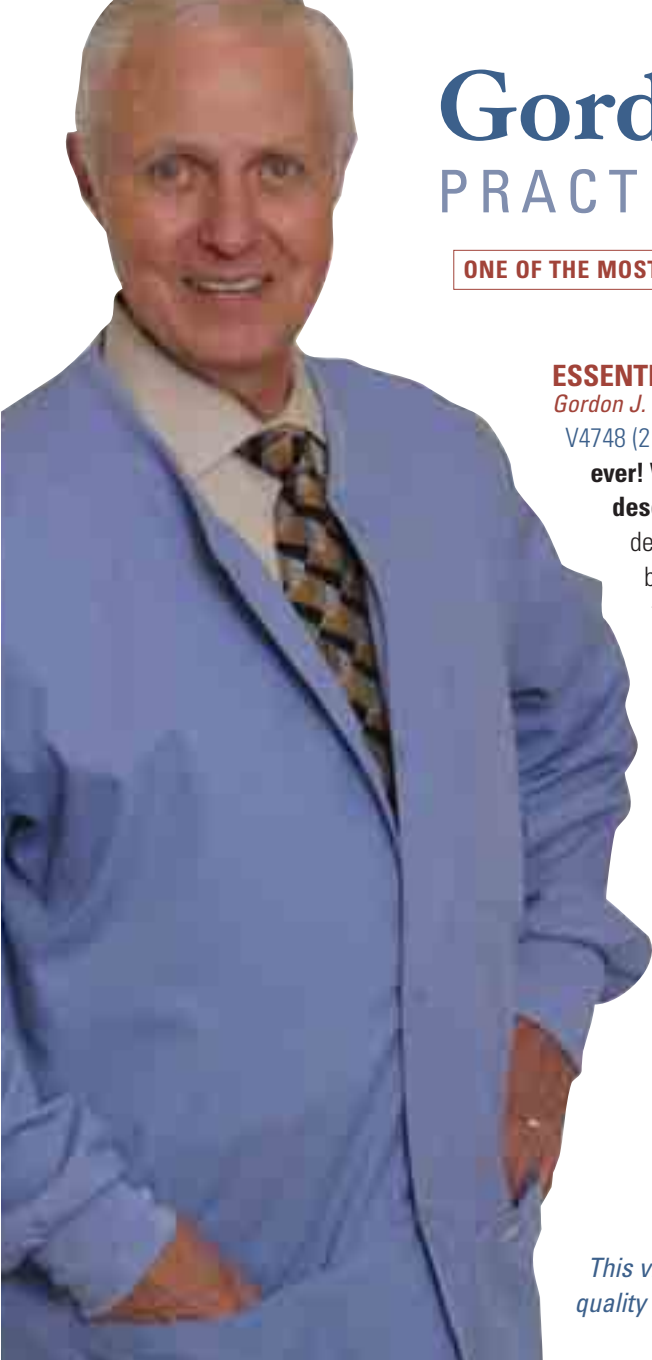
The most logical alternative for increasing productivity while still maintaining clinical quality is to delegate clinical tasks to qualified staff, increase practice organization and efficiency and obtain the fastest, easiest and best products for use in practice. Some states, provinces and countries limit the tasks that can be delegated to staff, while others are relatively liberal on this

subject. We suggest dentists limit themselves to doing only those tasks that no one else can legally accomplish. You need to obtain a copy of the practice regulations for your geographic area to determine the laws related to your practice activity.

The following tasks are some we have found to be very appropriate for delegation. Please look over the list and determine which of the tasks can be delegated in your practice. Do you have staff persons who are capable of learning to accomplish the specific tasks? Do you need to hire additional staff (Fig. 4)? Which tasks do you want to delegate? Are these tasks legal for staff in your area? Some might not be allowed in your area because of specific local regulations. We suggest that you compare the potential delegated staff tasks with your practice regulations to avoid delegating illegal tasks. The following tasks are listed alphabetically, and are not prioritized. You might already be delegating some of them. Some of them are what we call "escape tasks," in other words, they are dental assistant optional tasks that you, the dentist, might commonly accomplish, but a phone call, a hygiene check, a denture adjustment or whatever

Recommended Tasks	Optional Tasks
Alginate impressions Blood pressure testing Coronal polishing of teeth Crown try-in Custom impression tray fabrication Desensitizing teeth Diagnostic data collection Education of patients Face-bow application Fluoride application Healing cap removal and replacement Nitrous-oxide observation after initiation Occlusal splint construction and placement Periodontal local antibiotic placement, Arestin, Atridox, Periochip Photography	Pour and mount casts Prescription preparation Preventive appointment with tray fabrication Provisional restoration fabrication and seating Radiographs Relining dentures with temporary liners Removal of cement debris after cementation Rubber dam placement Scaling, root planing and tooth polishing (DH) Sealant placement Suture removal Telephone triage of emergencies Topical anesthetic application Vitalometer testing Whitening teeth in-office Whitening teeth out of office
	Bonding agent placement Denture adjustment Etching teeth Interocclusal record registration Liner placement Local anesthetic delivery (DH) <i>where legal</i> Matrix placement Periodontal pack placement Restoration placement & finishing <i>where legal</i> Retraction cord placement and removal Shade selection

continued on page 30



# Gordon J. Christensen

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interruption, takes you away from the patient being treated, and you delegate the escape task to a qualified staff person. We have noted the primary tasks by the word “recommended,” which a staff person usually accomplishes (Fig. 5), and those that are occasionally accomplished by staff as “optional” (Fig. 6).

Please note that the majority of the previously described recommended tasks are accomplished primarily by staff with dentist supervision required, and that the optional tasks allow the dentist to leave the treatment room when a need arises or can be accomplished by the dentist if desired.

In a typical general dental practice, delegation of the described and other tasks significantly increases productivity, allows treatment of more patients, increases gross revenue with only a moderate increase in overhead and provides a much more diverse and interesting vocational role for staff. After years of delegating all of the described tasks and many more, we can factually state that after an expected period of learning and repeating the tasks, the staff person to whom the tasks were delegated becomes more proficient in completing the task than the dentist who taught the person to accomplish the task. Additionally, the diversity of dental assistant activity provides much more job satisfaction for the staff person.

### In-service Education for Dental Assistants

In-service education sessions should be a part of every practice. These sessions are easy to organize and conduct. We suggest the following sequence of events:

1. Decide as a team the areas in which you need education (Fig. 7).
2. Decide which team member will provide the education.
3. Set a time. Early morning before practice is a great time. One hour before practice starts usually offers adequate time for the session, as well as a 10-minute “huddle” before the practice day begins. If more time is required, either use two separate one-hour sessions or a longer single one with lunch.
4. Start the session on time, provide the education, end on time and expect implementation of the concept immediately.
5. Continue the sessions as needed. Once per month is usually a good schedule.

### Summary

Dental school and dental assisting education could be integrated better to assist in producing more efficient practice characteristics, faster and better patient service, higher quality treatment and increased office revenue. Because of the need for more integration of dentists and dental assistants, dentists can overcome the challenge by proactive training/education of dental assistants and expanding clinical functions for dental assistants. This concept can improve patient care and make it easier, speed up procedures, create happy patients and also improve office income. n

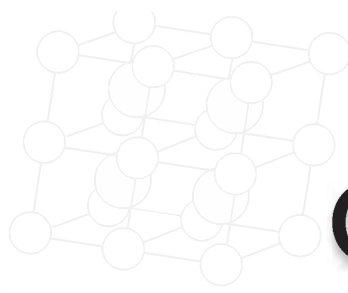


Figure 5: Some tasks, such as patient education can be delegated almost entirely to dental assistants and others, thereby freeing the dentist for clinical treatment. Figure 6: Some tasks can legally be accomplished by the dentist or qualified staff. Educating staff in such responsibilities allows dentists to leave the treatment room when other responsibilities or emergencies arise. Figure 7: Consulting with dental assistants on a routine basis allows the dentist to know the needs and the challenges faced in the office and potential methods to improve them.

### Author Bios

**Dr. Paul Child** is the CEO of CR Foundation, a nonprofit educational and research institute (formerly CRA). He conducts extensive research in all areas of dentistry and directs the publication of the Gordon J. Christensen Clinicians Report, and their other publications. Dr. Child is a prosthodontist, a certified dental technician and maintains a private practice at the CR Dental Health Clinic in Provo, Utah. Dr. Child lectures nationally and co-presents the "Dentistry Update" course with Drs. Gordon and Rella Christensen. He lectures on all areas of dentistry, with an emphasis on new and emerging technologies. He maintains membership in many professional associations and academies. Further information is available at [www.cliniciansreport.org](http://www.cliniciansreport.org).

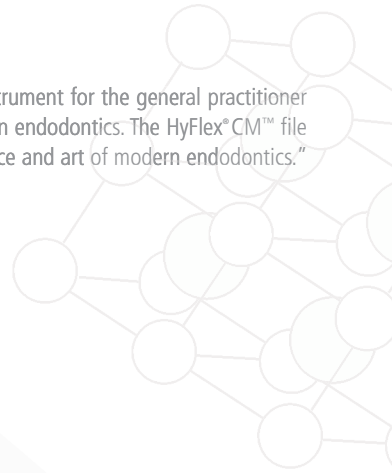
**Dr. Gordon J. Christensen** is founder and director of Practical Clinical Courses (PCC) in Utah. This group is an international continuing education organization providing courses and videos for all dental professionals. He is also co-founder of the nonprofit Gordon J. Christensen Clinicians Report (previously CRA), as well as an adjunct professor for Brigham Young University and University of Utah. He is a diplomate with the American Board of Prosthodontics. Dr. Christensen has presented more than 45,000 hours of continuing education throughout the world and has published many articles and books. Further information is available at [www.pccdental.com](http://www.pccdental.com).



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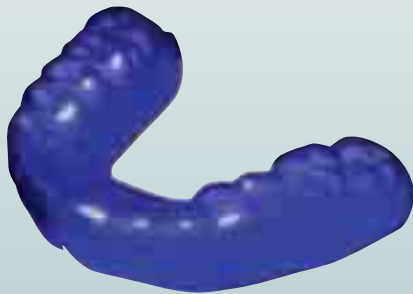
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# Simple Restoration of Rampant Anterior Caries

*There is a distinct difference between simple and easy. This is a great case of conservative treatment.*

drjamie

Posted: 11/10/2010

Post: 1 of 26

Patient desires to restore extensive lesions for cosmetic reasons. Is having no current discomfort or history of spontaneous pain, etc. Patient is a 25-year-old male. Elected simple composite restorations. Certainly potential for need of RCT in the future on any or all upper six anteriors. Additionally, potential need for post/core/crown in future. All teeth test vital at this time. All potential post-op options were relayed to patient and factored into decision making. Front six all done in one morning in about two and a half hours. Posteriors to be restored next. Three months ago, and no calls yet. We will see.



**Fig. 1:** No periapical lesions. All test vital.

**Fig. 2:** We are taking care of anteriors first. Will extract a few of the second molars, and restore what we can simply, i.e. no RCT/crowns.

**Fig. 3:** Other side.

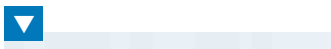


**Fig. 4:** Not much left on the laterals, but all test vital and no history of discomfort. I have seen this often in these slow progressing “black caries” lesions. All of the softened and decayed tooth structure is more insulatory than hard and shiny Class V erosive lesions. Therefore less sensitive, the tubules are clogged with soft infected dentin.

**Fig. 5:** Different lighting. Obviously, the patient would like to start by spending his money to restore the anteriors.

**Fig. 6:** Decay removal. Leaving a soft or affected dentin over the pulpal floor. Peripheral decay completely removed. Used three burs; 330, 4 round, 6 round.

**Fig. 7:** Note the extreme care taken to not nick or gouge any gingiva during decay removal. I beveled all enamel margins first and cleaned peripheral enamel with high speed, but 98 percent of excavation done with an E-type air motor with a 5:1 increaser (like what is used on an electric). This way I get more torque out



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Direct Composite Restoration of a Fractured off Buccal Cusp - Tooth #4  
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continued on page 36



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of the slow speed, better tactile sense. Additionally it can be used to remove amalgams often without anesthetic because no cooling air/water enters the field.



**Fig. 8:** NaOCl scrub, then Durelon bases placed. This shot is while Durelon is hardening and prior to Durelon clean-up/smoothing and evening with round bur.

Note a 00 cord is in place here for retraction. Whenever possible I leave a nice ledge of enamel/dentin gingivally, even if it is undermined. This makes composite placement much easier with little risk of fluid contamination at the gingival margin.

**Fig. 9:** After composite placed. I went a little heavy on the dentin shade and in the photo a tad bit opaque, but I didn't want any of the brown dentin coming through.

This is phosphoric etch/Clearfil Protect/Ivoclar A2 dentin/A2 enamel Empress aesthetic nanofil.

**Fig. 10:** Two shaping burs, 7901, 7408 finishing carbides. Used Cosmedent medium, fine, superfine discs and 3M narrow composite finishing strip.

Purposely elected diastemas and rotations. Gingival zeniths of laterals are too high, but were that way pre-op as well.

Oddly in the pictures these look very opaque, but look great under normal light. And the new Ivoclar Empress composite is very nice and smooth and cuts/carves/shapes quite easily.

A wonderful, simple, quick service for the patient. Additionally, this is extremely conservative and has such a life changing impact for a young person. Certainly RCT and posts/cores/crowns might be in this patient's future, but who knows when. We might get lucky and get more than 10 years out of these, you never know until you try it. Even then it is unlikely that they will all go necrotic at once, and the patient might be able to afford the treatment once a year. ■

**Michael Melkers**

Posted: 11/10/2010

Post: 2 of 26



Great service! ■

**drjamie**

Posted: 11/11/2010 ■ Post: 3 of 26

Building these up makes it easier for the endodontist when the time comes. ■

**mjborrok**

Posted: 11/11/2010 ■ Post: 4 of 26

Why Durelon for base instead of a glass ionomer? Does composite bond to it? ■

Durelon is supposedly kinder to the pulp than glass ionomer. Glass ionomer will actually draw water from the tubules and stress/kill pulpal cells. There isn't much bond to the Durelon, but that is insignificant in retaining these restorations. The peripheral enamel and dentin bond is all that can hold them. There would be poor bond strength to the remaining affected dentin as well. ■

**drjamie**

Posted: 11/11/2010

Post: 5 of 26

These are fun and rewarding cases. I have completed quite a few of them in the last year or so since I started at a public health clinic. If handled properly with a good pre-op diagnosis of pulpal health, very few complications will arise in my experience. I am sure the patient was very happy. Good job. I will just give a small plug here and say that since I started using the Greater Curve band for these, they have become much easier to restore. I love those things. ■

**toothshucker**

Posted: 11/11/2010

Post: 7 of 26

The patient was in the other day to start some work on the posteriors.

Here is a photo of seven months later. What was most exciting to me

was the gingiva! All these were subgingival caries when I restored them. I packed cord and left as much of an undermined gingival shell as I could to make finishing smoother. The results were fantastic gingivally.

[Posted: 4/20/2011]

This is a good contrast. Hard to believe it is the same person with just composite. This is that new Ivoclar Empress composite. All A2 some dentin, some enamel shade. ■

**drjamie**

Posted: 4/20/2011

Posts: 21 &amp; 22 of 26



For me the real work in a case like this isn't the technical work itself... it's the human side of things. Specifically two things. 1) An acknowledgement of how we got here (and how not to go back there) and 2) an acceptance that this is only a short-term fix for some of these teeth, like the laterals. Drjamie you did an amazing job here! ■

**CoachDDS**

Posted: 8/14/2011

Post: 25 of 26

I especially like how you handled the tissue. I hate when I cause bleeding when it could've been avoided. It takes so much more time to get isolation. I also like that you placed a base over the dentin. I want to see some long-term research on dentin bonding before I jump on the no-base needed bandwagon. Beautifully executed. ■

**pjmop**

Posted: 8/14/2011

Post: 26 of 26

Rampant Anterior Caries

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# In This Economy

*Is it a good idea to buy a practice or wait for better conditions?*

**crazy tooth**

Posted: 8/7/2011

Post: 1 of 44



Is it wise to buy-in/start up not knowing what the economy is going to be? Or should I just ride it out as an employee for a little longer and see what the economy is going to do? Just don't know if I want a huge note I have to pay off given the way things are going.

Any thoughts? ■

**GV Black**

Posted: 8/7/2011

Post: 2 of 44

If you are reasonably happy where you are now, why not stay put and see what happens? If an opportunity comes along that is a win-win and you can easily see yourself being not only paid but being able to reasonably afford the payback on the note, then by all means look at it. A lot of patients are scared right now and are putting off dental work... at least in my neck of the woods.

Unless you are in one of those exceptionally rare areas, a startup would be difficult at best. ■

**tiger cub**

Posted: 8/7/2011

Post: 3 of 44



I think it is a great time to buy-in, only I assume it would be an equity sale and a new operating corp. Make a provision for your new partner to "loan" seed money to the new operating corp. This should take a huge risk off you and make a great partnership in this uncertain future. I would think the owner wants to get 15 percent capital gains, which sunset December 2012. Plus he should like a 10 percent five-year loan investment. ■ **doug**

**brian**

Posted: 8/7/2011

Post: 9 of 44



This is the new economy and you have to work with it as it is. The old economy is gone, and most likely will never to return to its former self.

Society has changed. People have gone soft and expect too much to be given to them. Too few people want to work hard for their money.

As a result, the excessive entitlements have taken governments down. What to do in this profession? Find a location where the demographics are favorable. Pull up stakes in areas that aren't. Bail out of your comfort zone and get out of entitlement states where patients expect everything on a free silver platter. In a nutshell, get out of the blue states, and get into a red. At the very least, plunk yourself right down in the middle of a red county. ■

**wdtitusdmd**

Posted: 8/22/2011

Post: 12 of 44

I've been practicing for almost 20 years and this is the worst economy I've seen. From 2008 through 2010, I saw steady growth, but since the end of 2010, it's been downhill for production. Production down 50 percent last month from the previous year!

*continued on page 40*

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continued from page 38

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Search: *Economy*

How Much Working Capital to Keep for My Start Up?  
Search: *How Much Start Up*

Considering buying a practice now? No way, no how. You might be salivating at some good interest rates and some motivated sellers, but if you can't make your production goals in a new practice and pay the bills... How do you plan?

I have a lot of patients in my practice, but very few want to spend money on dentistry unless it hurts. Forget cosmetics and elective.

My advice? Ride it out as an associate until this economy does something. My opinion is that we are in a depression that rivals anything this nation has ever seen. Government spending, borrowing and printing of money is just masking the true magnitude of the problem and they aren't going to stop anytime soon. The numbers lie and no, you can't compare them to the Great Depression. There have been too many fundamental changes in monetary policy, spending and entitlement programs. Take all those away and see what things look like. ■

raclo

Posted: 8/22/2011

Post: 13 of 44



Of course you need to be informed and practical, but you will never know what the future holds for the economy. None of us did when we started out. That being said, I think this is a special circumstance this time around. I have been practicing for 26 years and have never seen so many patients deferring treatment like I have the past two years or so (and more this year than ever).

Polls show consumer confidence is extremely low; this has an impact on their dental spending as well. You will never know except by hindsight, if any time is a good time to jump in. I, too, caution against big additional debt right now. If you can swing a cheap buyout of a small declining practice that you could treat as a starter and energize, it might be the perfect time. If you need to do \$70K per month from day one to take anything home, think twice. Some, of course, do it, but most of us would find it difficult this year. Most of the dentists I know are working only about a true half schedule right now (spread out over the whole week).

The other thing to consider is the possibility of being laid off from your current position, perhaps not an issue, but something to think about. ■

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fliegenfischen  
Posted: 8/22/2011  
Post: 15 of 44



You can pick any spot in time and someone will say “in this economy,” “in these tough times,” “in this unsureness,” etc.

That's just an excuse for you not to do anything.

You know what? It's a great time to build. Why? Interest rates are low, building costs are lower (less construction so lower bids) and better negotiations for lease space!

You will always have an excuse not to do something (oh now I have a kid and two car payments and a mortgage, etc.). Find the reason to build. I built at

continued on page 42



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continued from page 40



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the start of the recession. Who cares? I'm doing way more than I did working for someone else. And if I do well during a recession that means I'll do even better when it passes. ■

**Rick Willeford, MBA, CPA, CFP, PFS**

Posted: 8/23/2011

Post: 16 of 44



Crazy Tooth, what is the economy like in your area? It varies widely across the country – and even

within the same town. We have many clients who weathered the storm reasonably well over the past few years. We also have a few who fell off the cliff. Those who did OK probably have a pretty stable patient base and did good old general dentistry.

I still think a lot of this recession is psychological. That does not make it any less troublesome, but many folks are simply being conservative with their funds, even though they have not personally been hurt. At least not yet!

Consider getting pre-qualified for a loan. That will let you move quickly if you find a good opportunity – and put you ahead of other buyers. In Atlanta there are not many good opportunities so they do not stay on the market long. Assuming they even make it to the market before being snapped up. ■

**Art Vandalay**

Posted: 8/23/2011

Post: 18 of 44

Rick is spot on here. The practices that have been hurt the worst since 2008 were the ones that were heavily into elective procedures. My practice is

working class and is devoted to routine dentistry. Our town has a lot of dental disease, high unemployment and a lot of patients with insurance. Endo, operative, perio, crown and bridge, dentures, oral surgery; not a lot of implants and virtually no veneers. The economy sucks, people are losing their jobs and we just keep making money. Get in the game. ■

**Steven Polevoy**

Posted: 8/23/2011

Post: 19 of 44



I've owned my practice for nearly 10 years, having bought it shortly after 9/11.

Throughout my ownership life, I've heard nothing but complaints about the economy.

continued on page 44

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Apparently, some of those years were “boom” years, although you wouldn’t know it listening to people at the time.

Apparently, now we are affected by high unemployment. The unemployment low mark was at the end of 2006, at 4.4 percent.

Go dig out some threads from that time. Everyone was complaining about the oil prices (which were the same as now, but at the time that was a record), and how with those prices their business was too slow.

It’s always the economy, but also, it’s never the economy.

I remember working for a guy after school, and it was always something external responsible for his slowdown. It’s too hot, it’s too cold, it’s before the holidays, it’s after the holidays, it’s back to school, it’s kids are away, it was always something.

Sure, I’d like to practice that perfect week, May 2 to May 9, and take the other 51 off... but it doesn’t work like that.

Don’t externalize your successes and failures. It’s all up to you.

The economy might give you headwinds or tailwinds, but you’re the one steering the ship. ■ **steve**

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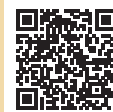
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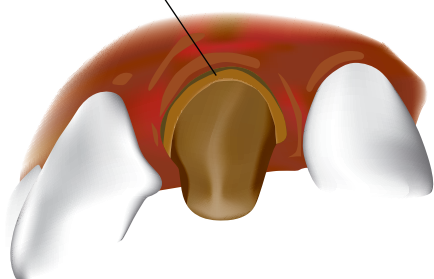


# All-ceramic Restorations: Preparation is the Key

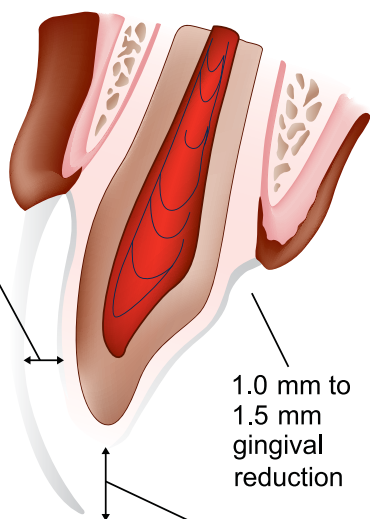
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## Preparation is the Key

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## Author's Bio

**Bill Warner** has more than 27 years of dental laboratory experience as a technician, supervisor and laboratory owner. Bill is an expert in all phases of fixed prosthetics, including product selection and planning for the most complex cases.

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# How to Avoid Swelling on Full-mouth Extraction Cases

There are many explanations for post-operative surgical swelling. You can learn from this discussion.

**RJ1965**

Posted: 8/26/2011

Post: 1 of 57

Almost every time I extract upper or lower anterior teeth and do an alveoloplasty, the patient comes the next day with bruising and swelling. Is there something I can irrigate the surgery site with to avoid this? Sterile gloves came to mind, and I will use them if they make a big difference, but I end up having to change gloves several times through a procedure, so the price would add up. Thanks a lot. ■

**Schnazbot**

Posted: 8/26/2011

Post: 2 of 57

I know some will disagree with this, but if you are doing a surgical case, particularly a full-mouth extraction case, you should be wearing sterile gloves. To be honest with you, the cost of gloves is minimal when compared to the overall case production. Do you really make that much less money that \$10 will make a huge difference in your net? Why do you feel it's necessary to change gloves multiple times? Are they tearing easily?

I don't know if wearing surgical gloves in and of itself makes a huge difference, but it makes me wonder about your aseptic technique. With due respect, are you using sterile water? Are you using a regular high-speed handpiece? Is this using bottled water or city water? Are instruments stored wrapped after sterilization? Is it your technique? What kind of case is it?

There are a ton of questions that bear asking. I would expect bruising and swelling after a long procedure like what you describe, but there are so many factors that are involved that it is difficult to say what is going on. Again, I wish to help and am not asking these questions disrespectfully, I am trying to gather info. ■

**skitter**

Posted: 8/26/2011

Post: 4 of 57

You could prescribe dexamethasone 1.5mg. Three the day before, three the day of surgery and two the day after. These are prescribed to take one in the morning, one in the afternoon and one in the evening. This will reduce swelling. ■

**fletch33**

Posted: 8/26/2011

Post: 6 of 57



It almost sounds like a technique problem. How are you doing the alveoloplasty? Bone file, rongeur or handpiece (what kind)? I irrigate with normal saline (isotonic). Are you reflecting a flap? Atraumatic extractions or are you tearing a lot of tissue? NSAID use? Coumadin? Elderly will bruise easier. The swelling can be helped with ice post-op and NSAID before, but they might bruise. ■ Fletch

**Chris Friedl**

Posted: 8/27/2011

Post: 7 of 57



RJ, without knowing a little more, there are a lot of variables to your question, as others have pointed out. We do a fair number of full-mouth extractions and here are a couple things.

Older patients will tend to bruise, sometimes a lot. Throw in some warfarin or aspirin and this is worse. Not a ton you can do about this,

their capillary beds are more fragile and sometimes just supporting their jaw during extraction can cause bruising. Maxillary injections if not properly aspirated can also cause bruising. That being said, as others have mentioned, being as atraumatic as possible is the best route to go. Take your time... its always easier to take a couple extra minutes elevating and rocking these out than to risk breaking a root tip and having to go fishing for it. Use a periosteal or a sharp mucoperiosteal elevator to loosen those teeth up and since we are talking anterior teeth here, rotate, rotate, rotate. Take out the proximal teeth and use it sideways to grab a little interseptal bone and the tooth if you have to (on the badly broken down ones).

I might be stirring the pot here but I do not think sterile gloves will make much difference at all. I have discussed this with several OS and they also agree on this. Implants, maybe; extractions, probably not. One even showed me a research study comparing the placement of implants with sterile vs. non-sterile gloves and there was no significant difference in success rates, so even this is debatable. These teeth are likely coming out for a reason that involves a bacteria-laden disease process, and as soon as the patient goes home, they will be "irrigating" your extraction sites with all kinds of non-sterile things. Debride any granulation tissue, curette until the socket is clean and irrigate with saline or Peridex.

As was mentioned, start the patient on NSAIDs before the surgery to help with the swelling. The dexamethasone might help too, but many of our patients have other medical complications that would preclude the use of this. Cold packs for the first 24-36 hours, not to switch to heat until a few days in. Suture close the big ones,



Read these other message boards to find out what other Townies do when swelling occurs after extractions.

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*continued on page 50*

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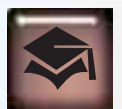
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especially if there is any chance they are going to smoke... throw in some Gelfoam for good measure with the smokers.

At a 24-hour follow-up there is not much you can do. These sites are going to ooze, the denture won't fit well, and if the patient left the denture in overnight, there is even a chance that they won't be able to get the denture out (or back in for that matter) due to the swelling. Get the patient expectations in line before the extraction. It can take several weeks for things to really heal up well and patients seem to become very worried when the large posterior sockets aren't closed, but the smaller anterior ones are. Warn them of this ahead of time. In their mind, if you call it ahead of time, you're the best dentist ever. If you try and explain this later, you sound more like you're making excuses.

What kind of alveoplasty are we talking? In the majority of cases, the only pre-prosthetic modifications I make are minor use of the rongeur and bone file and some heavy B-L squeezing pressure to re-approximate the bony plates as best I can. You can always stage these as a two-stage extraction if you want to minimize the consequences of a full-mouth extraction, but this puts the patient through the process twice so there are disadvantages as well.

It might be best to switch up your post-op regime. Have them come back in two to three days instead. There is more you can do with the denture, and the swelling will have just begun its decline.

Best of luck! ■

#### RJ1965

Posted: 8/27/2011

Post: 8 of 57

My technique involves extracting the teeth, most of the time not having to use the handpiece, using the handpiece to remove interseptal bone and then using the forceps to compress the bone. Most of the time I hear it crack. Never had to remove a sequestrum, however, so as long as the bone is attached to the periosteum the bone will re-approximate. I then use the rongeurs to snip off rough bone and then top it off with a bone file. Many times in the anterior I will attain primary closure.

Bringing patients back in two days sounds much better than 24 hours. I think I will start doing this. Also, the argument against sterile gloves is a sound one.

A few questions I have:

1) I checked with my boss regarding the water situation, and he said that lately when he has been draining the compressor that the water is rusty. Is this the same water that is going through the handpiece lines? Could this be a major cause of the swelling?

2) Taking NSAIDs the night before will reduce swelling? Would 600mg ibuprofen the night before be fine? Probably not a good idea to take the day of the surgery due to potential bleeding, right? I have heard Dolobid works wonders. Anyone try this?

3) Fletch mentioned using saline. How would using saline decrease potential swelling? Would using Peridex or Betadine work any better?

I appreciate everyone's contribution to this thread so far. ■

#### Chris Friedl

Posted: 8/28/2011

Post: 14 of 57



Post-op swelling and post-op infection are two separate but sometimes related entities. Post-op swelling is a product of the host response and how much damage you have done during the surgery. The more you manipulate, the more teeth you remove, the longer you take, and the more flaps and anesthetic you inject, the more swelling you will have. Those are the factors you have control over. Add in a pre-medication with an NSAID or a post-op steroid and you reduce the host response some.

continued on page 52



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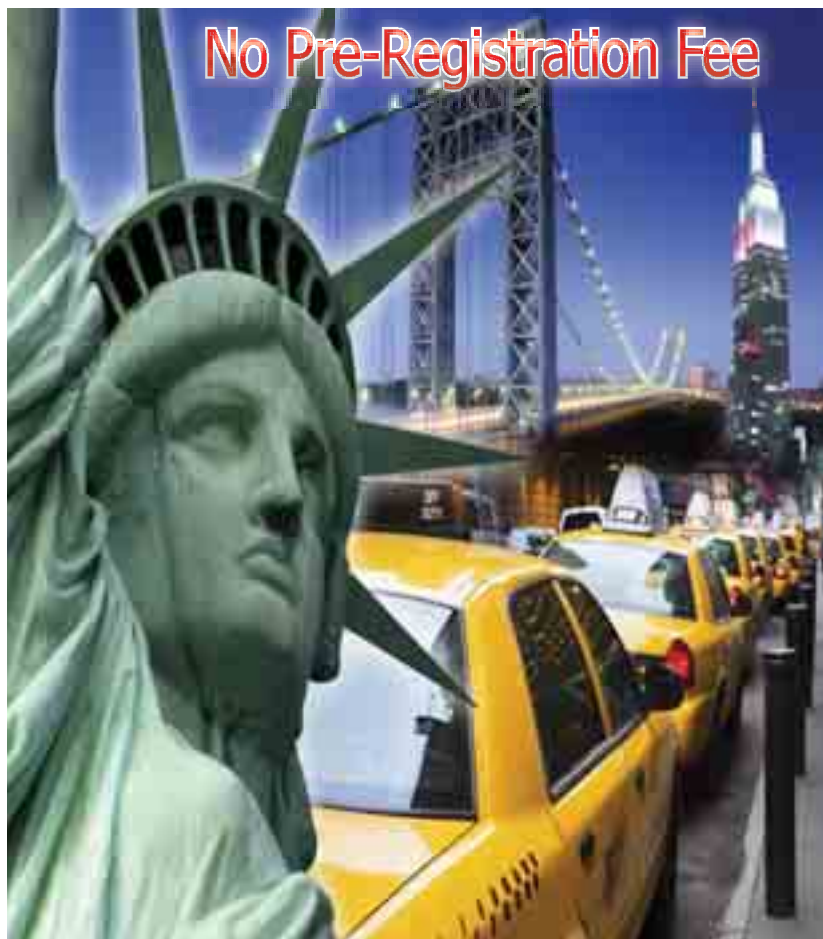
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Post-operative infection can cause swelling, but infection is not a super common occurrence. If you are dealing with compromised host immune response (i.e. uncontrolled diabetics, kidney failure, chemo, radiation therapy, aids), you should be pre-medicating similar to how you handle a joint replacement. Most oral surgery texts advocate pre-medication in these cases at a rate of two times the usual dose of the antibiotic, one to two hours prior to the surgery. Amoxicillin 2g one hour prior is the drug of choice. In most cases, infection is not a major issue, and thus, is not a major contributing factor to the swelling, which brings me to the issue of the sterile vs. non-sterile gloves.

In the case of an implant, where I am inserting a foreign body into living tissue and expecting it to not only stay put but integrate into said tissue, I want to do everything possible to assure that this happens. In this case, introducing foreign bacteria is a concern because we are dealing with a relatively clean surgical site that will be closed to some degree following surgery in an environment where post-operative infection can compromise the whole procedure. So here a sterile glove would definitely be justified. But in an extraction environment, which is often riddled with a higher degree of bacterial contamination from the host and offending teeth, with post-surgical wounds that are open not generally closed like the site once an implant is placed and low rate of post-operative infection that would (usually) not compromise the entire procedure anyway, I am not sure there is a major case for sterile gloves during extraction.

continued on page 54

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continued from page 52

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I certainly don't know how a sterile glove will reduce swelling in and of itself if there is no post-operative infection involved. Perhaps less bacterial inoculation to the surgical sites would yield less swelling, but I think that the mechanical factors mentioned above play a much larger role. That being said, they are not that expensive and if it can't hurt and might help you might as well give it a go. I find them to be more comfortable too since there are many more sizes.

I think the gist of it is to pay attention to atraumatic technique... get the teeth out efficiently but in a reasonably atraumatic fashion. Don't go crazy with flaps or alveoloplasty and know your patient medical history. I don't think there's any silver bullet to "cure" the swelling problem.

Happy extracting! ■

**TT** I'm a GP not an OS, but I do a relatively high amount of surgery.  
 Posted: 8/29/2011

Post: 15 of 57 My first associateship was at a group practice with an OS on staff, and I spent as much time as I could observing and learning from him. As a result, I have a high level of confidence with surgery.

A couple of things that I learned from him and along the way:

In many full-mouth extraction cases, alveoloplasty is simply not necessary.

I remember in dental school the model on which we fabricated our first full upper denture. This "perfect-looking" ridge with no irregularities or unevenness, and I think this is the model in a lot of docs' minds when they do the surgery. The big problem with this is once that bone is filed/burred/rongeured away, it isn't coming back. Further, by leaving irregularities and some undercuts, you will have much better retention of the prosthesis. The ridge might not look pretty or textbook, but it just makes sense to me to leave as much of the patient as you can.

Regarding the original poster's comment about "compressing the ridge with forceps." Yeah, don't do that. Cracking noises are really never a good thing. Additionally, anything you can do to decrease the amount of force used is a very good thing. If you're doing extractions and you don't use some sort of periosteal elevator, get one. Until you've seen what they can do, you simply can't believe how well they work.

One final point, which might draw some fire, is that I rarely suture. I have read some compelling research which shows that suturing, especially tightly,

continued on page 56



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can cause bone resorption. Also in order to suture it's often necessary to remove more bone or elevate more of a flap than you might otherwise need to.

I rarely have PO bleeding issues. I have seen ecchymosis maybe three or four times in 20 years, my immediates have a ton of retention and often don't require a relin for several months.

Hope this helps.

Peace. ■ TT

**RJ1965**

Posted: 8/29/2011

Post: 17 of 57

Bruising once every five years when doing a lot of surgery is pretty impressive. Yes, I have been trying to imitate that model that we use that depicts the perfect arch with no irregularities. What do you do in cases like the one below? Do you ever remove interseptal bone and compress the alveolus?

Here is a patient who wants a full upper denture. You can see she has a prominent maxilla and overjet. I can do it three ways.

1) Leave the bone as is after extracting. Advantages would be more bone for implants if she ever chooses to get them, better retention on her denture, and less chance of swelling and discomfort. Disadvantage would be the denture will make her maxilla look even more prominent and she might look Mr. Ed-ish.

2) Reflect a flap and remove buccal bone. This would be the most aesthetic but would not bode well for possible implants, retention and there would likely be swelling.

3) Remove interseptal bone with handpiece and compress alveolus but not fracture it. I am leaning toward this although she might not be happy with the aesthetic result as it might come across as too bulky.

Any opinions would be appreciated. ■



**TT**

Posted: 8/29/2011

Post: 18 of 57

I would possibly consider going flangeless in the anterior, at least for a few months until healing/remodeling has occurred. Generally when I do this I'll have the lab do it conventionally and then remove as much of the flange as I need to chairside.

Don't get me wrong... when bone is truly in the way or if there are sharp edges that will impede healing; I'm going to go after it.

But in this case, with an increase in vertical, proper tooth selection and thin to no flange I can see this working out nicely without too much removal of bone.

Would love to see a post-op on this one. ■

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# Lighthouse Automatic FOR THE PEO

by Benjamin Lund, Editor, *Dentaltown Magazine*

You love sending your patients appointment reminders – as long as you don't have to think about them, or remind someone in your practice to take care of them. "If only there was an automatic system that could do it for me," you say. Enter Lighthouse 360, a comprehensive patient communications system that integrates with your practice management software (PMS) and takes automation to a new level. Via this software, practices don't even need to think about sending out appointment reminders or birthday wishes. Lighthouse Practice Management Group (PMG) is dedicated to a single philosophy: the only real way to ensure the business side of dentistry is run at maximum efficiency and profitability is to install processes that are truly automated. To learn more, *Dentaltown Magazine* spoke with Lighthouse PMG co-founders Allen Jorgensen, Joel Kozikowski and Brian Smith.

## Please explain the history of Lighthouse. How did it start?

**Brian Smith:** Joel and I started PracticeWorks, where we worked for nearly a decade. We developed some pretty cool concepts in automation and customization. While those features made it into the product, we struggled to get the rest of the organization to understand our vision, especially after a major ownership change in 2000. In 2002, I left PracticeWorks and decided to do consulting for PracticeWorks users. I asked Joel and Allen – who was probably the best PracticeWorks user on the planet – to help me put on a seminar. Joel knew the technical details of the software, and Allen was one of the few users who *really* understood the automation concept. The seminar was such a success that we decided to build a business around it.

Between the three of us, we have a long history in practice management software development and a shared passion

for automation, so we created Lighthouse 360 as our platform for delivering automation to dentistry, regardless of the PMS an office uses.

**Allen Jorgensen:** The problem with in-office consulting is you can only help one office at a time. We wanted something that would scale better, so we created an online forum called "Club Lighthouse" that we used to reach many more practices at a much lower cost than we could doing on-site visits.

**Joel Kozikowski:** The problem with *that* business was it was limited to PracticeWorks users. We wanted to deliver our automation ideas to the entire dental profession. We were going to write an entirely new PMS with all the new Internet technologies built in, but decided not to, because it's such a huge disruption for an office to switch to a new PMS. We figured out how to deliver our automation ideas by simply "piggybacking" on all of the existing ones. That made it easier to write, and made it *far* easier for our customers to adopt.

## Can you explain what Lighthouse does?

**Allen:** We provide the office with an "artificial intelligence" worker that's programmed to do the critical tasks needed by every office. We completely automate the most important communications with patients that take place when patients are not in the office: appointment reminders/confirmation, recall, reactivation, post-visit feedback and "loyalty programs" (birthday greetings and e-newsletters). Every single message we send is 100 percent automated. For example, when it's time for a human to call a patient to schedule a hygiene visit, the staff is alerted – automatically. We do it by extracting data from the existing practice management system, so the office simply keeps doing what it has always done, and we build on that.

*continued on page 60*



*Lighthouse PMG co-founders  
from left: Brian Smith, Joel  
Kozikowski and Allen Jorgensen.*

### What is your current business philosophy?

**Allen:** If you're being honest, you know that people are unreliable. The only way to ensure that a business process is done consistently is to take the human element out of it and to completely automate it. We take these processes that are important for a dental office to do, and we do them 100 percent automatically. The humans get involved only when the computer detects something it can't deal with directly.

**Brian:** That is certainly our *product* philosophy. If you want to know our *business* philosophy, I would say we make the best product we know how to make, sell it for a fair price, treat customers the way they want to be treated and hire awesome people who understand how important all of that is. That might sound cliché, but how *else* would you run a business?

### Good point. So, how does Lighthouse stand out from the competition?

**Joel:** I think it's a combination of our knowledge of what dental practices need, and our "automation" philosophy. In our seminars, we talked about "automation" vs. "computerization." Take the recall system for example. Every PMS can print reports and postcards for people who are due or past due for recall. But the PMS won't *do* those things unless a human knows they need to be done, and knows how to tell the computer to do it. If you want to execute a comprehensive recall system, contacting patients multiple times, at strategically timed intervals, using all appropriate message types, you have to design your strategy, then someone in the practice needs to know what to do, how to do it and when to do it. That's "computerization." When we were consulting, we developed a comprehensive recall system, but it still required humans to execute it – and it didn't get done. With Lighthouse 360 we have automated that entire recall system, to the point that our clients don't ever need to run a recall

report in their PMS. Our competitors send e-mails and texts, but there is still a significant percentage of patients who don't have e-mail, don't want to get texts or don't read e-mail very often. How do you reach them? If you still have to manually print and mail even a small number of postcards every month, that's not automating the *entire process*.

### What is the one thing at Lighthouse you're most proud of?

**Brian:** The feedback we get when a client switches to Lighthouse 360 from a competitor, letting us know how much better it's working than their previous system. Just last week, a new client told me his practice is getting appointment requests from our recall system *every day*, but it almost never happened with the system he had been using. That's when we know that all of our hard work and experience are paying off.

### You have a very robust system... Do you ever worry that it's *too much* for a practice to handle?

**Allen:** Not at all. Remember, the core strategy is for the system to handle it all with no human interaction. It's true that we've built a lot of flexibility into the system, and with flexibility comes complexity, but we hide all of that complexity from our clients. They want a particular result, and we deliver that. How we do it is not their concern. It's like most patients – they want a nice smile and painless dentistry – they don't care if the dentist uses a pneumatic or electric handpiece, or what size the burs are, or what they're made of.

### How do you help practices find new patients?

**Brian:** We automate the process of asking patients to post reviews online (to Google, Yahoo and any other review site a client wants), and we have simple mechanisms for sharing great reviews on the practice's Web site, and through Facebook and Twitter. It's always up to the client to deliver the kind of patient experience that results in positive reviews, but if they do that, Lighthouse 360 will help get those reviews in front of prospective new patients.

We also make it very easy for an office to add some nice functionality on their Facebook page. Visitors can see great reviews, request an appointment, see office hours and even read a short bio about the doctor and team members – all with Facebook apps we've written, that install in minutes.

### How does your system address patients who don't use e-mail or cell phones?

**Joel:** Even though our system is very "high tech," we know that "low tech" communications (postcards, letters, phone calls) are still *required* to reach 100 per-



Training and support staff in our Sugar Hill, Georgia office: from left, standing, Brian Allen; kneeling, Ron Walton; Kurt Lee, Lighthouse co-founder Allen Jorgensen; Ann Lewis; kneeling, Jeff Gzyl and standing, Kevin Lewis.

continued on page 62

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cent of patients. More than 80 percent of Lighthouse 360 clients have us print and mail postcards for them for one or more purposes. These patients are not ignored by the system.

**Hypothetical situation: Mom and her kids all have their hygiene appointments at about the same time. Does she get one reminder, or several?**

**Allen:** Nothing hypothetical about that question! I sat “front desk” in my wife’s practice for years, and still do on occasion, so I’ve heard every complaint patients ever had, about everything. When we first released Lighthouse 360, we didn’t have a way to combine family members’ appointments – and I heard about it! The more kids mom was bringing in, the more she didn’t want to get separate messages. So now, we do “family clustering” of messages for every one of our message types – e-mail, text, automated phone calls, postcards and letters. Mom gets one message, makes one response, and all the appointments are automatically confirmed in the appointment book. Everyone’s happy.

**What can a practice expect when it signs on with Lighthouse?**

**Allen:** We typically install the system within two to three business days of the sign-up, and the initial training occurs within a week after that. Then we do all the customization of the messages in another few days, and we’re ready to “go live.” Offices are typically live within two weeks after signing up. Our training and support team is amazing – they routinely go above and beyond to meet the specific needs of our clients. In addition to the initial training session, there is a training about a month later. The system is so automated, there isn’t much to be trained on. And since we do all of the customization and configuration, clients don’t even have to learn how to do that – like everything else, it “just happens.”

**What does your system cost? And is there a contract?**

**Brian:** The monthly fee is \$269, which includes unlimited e-mails and text messages, the automated reporting we do each day and access to the practice’s data through our portal system (some call it a “dashboard”). It also includes our mobile app for smartphones, which makes it super easy to do patient follow-up calls and confirmation calls when not in the office. The optional message types (postcards, automated phone calls and letters) are charged “per message.” All pricing information is on our Web site, on the “pricing” page. No secrets. We’ve got nothing to hide.

And regarding contracts, we think it’s ridiculous to have a contract for a service like this. Dentists have to earn patients’

loyalty at every single encounter, and we feel the same way about our business. In fact, we hate contracts so much that if someone is in a contract with one of our competitors, we’ll waive our monthly fee for the last three months of that contract, and reduce it for all the other months, to make it easier for someone to switch to Lighthouse 360.

**If a practice is having a problem with your system, what do they do?**

**Allen:** Call or e-mail our awesome support team. While we think our product is pretty amazing, we know that we’re always going to be judged on the quality of our customer service, so that’s where all of our staffing growth is happening. Our goal is to take as many live calls as possible, and to reply to all others within one business day.

**What can current Lighthouse users expect in the next few years?**

**Joel:** Earlier, I mentioned that Lighthouse 360 started out as the platform for our next generation practice management system. It was never designed to be *just* a patient messaging system. We actually are watching a tremendous amount of valuable information flowing through the practice. We’ve started to work on a way to present that information to our clients in ways that will help them manage their practices better.

**Allen:** Lighthouse 360 is like an evolving “life form.” Every new client benefits from all that we’ve learned from past clients, and also helps us get better by communicating their unique needs to us. When we make an enhancement to handle those needs, the system just gets better, for that client, but also for all current and future clients.

**To learn more about Lighthouse PMG, visit [www.LPMG360.com](http://www.LPMG360.com) or call 888-207-9385. n**





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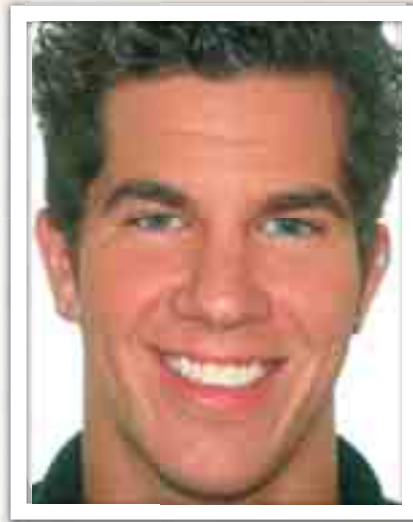
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Fig. 1



Fig. 2



Fig. 3



Fig. 4

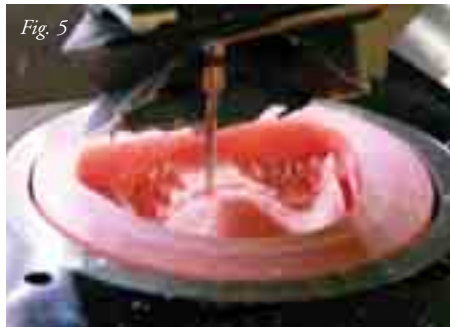


Fig. 5



Fig. 6

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## Contact Info

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A photograph of a dental operatory. In the foreground, a green tray is mounted on a stand, containing a white tray with various dental instruments including forceps, probes, and explorers. A white box is also on the green tray. In the background, a dental chair and other equipment are visible.

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3. List indicating each item appearing in the image
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5. Include “What’s On My Tray” for the e-mail subject line

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MDIs offer a less expensive, less invasive alternative to conventional implants and are an innovative solution for edentulous patients seeking long-term relief from denture discomfort. FDA-approved for long-term denture stabilization, mini dental implants can also be used to stabilize partial or upper dentures, place fixed restorations or for the long-term fixation of bridges.

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With the MDI mini dental implant system, 3M ESPE continues to improve upon its reputation as a leader in dental care solutions. MDIs from 3M ESPE have remained a market leader in small diameter implant systems by offering a product that is innovative, reliable and efficient. MDI mini dental implants from 3M ESPE offer a simple training process and a cost-effective implantology solution for dentists everywhere. n



## Contact Info

For more information and a calendar of upcoming certification seminars, visit [3MESPE.com/ImplantSeminars](http://3MESPE.com/ImplantSeminars).



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## MDI Mini Dental Implants

(Formerly IMTEC)

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**3M ESPE**

# Dentaltown Research: Practice Management

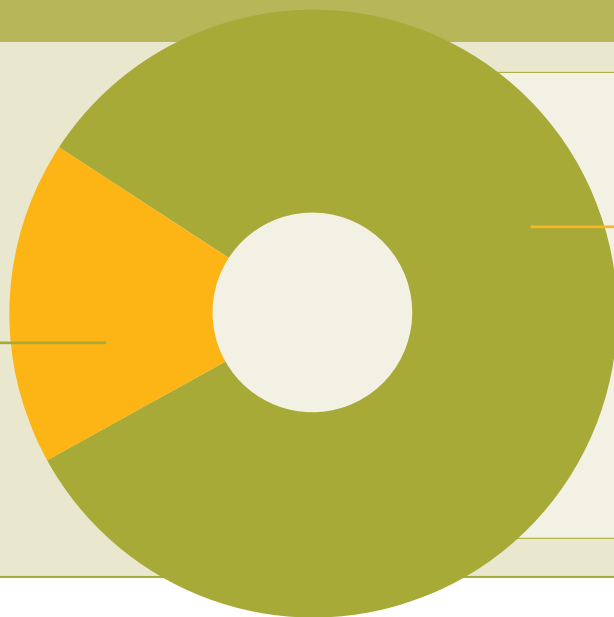
Dentaltown is digging a little deeper. Based on the monthly poll on Dentaltown.com we're determining explanations for each poll result. Included with the poll statistics are the most popular write-in answers as well as small fun facts and recaps of the Townie Choice Award winning categories that coincide 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 September 2, 2011 to September 23, 2011 on Dentaltown.com.

## Do you have computers in your operatories?

289 total votes

**17%**  
No

**83%**  
Yes



## Have you ever hired a practice consultant?

**51%** Yes

**49%** No

444 total votes

## If you have worked with a consultant in the past, was the advice and assistance worth it?

**39%** Yes

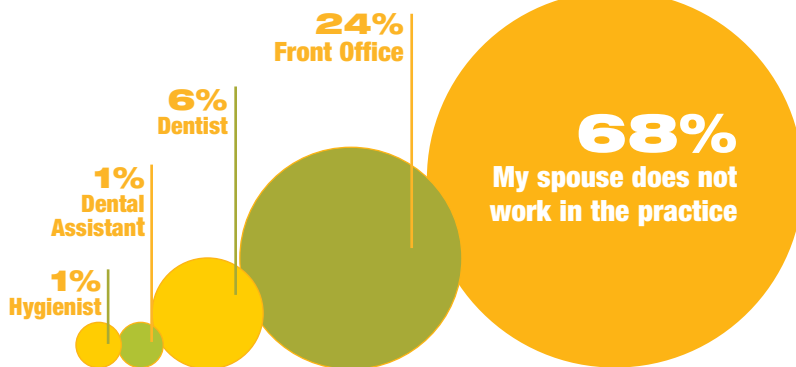
**19%** No

**42%** I have never hired a consultant

435 total votes

## If your spouse works in the practice, what position does he or she work?

434 total votes





### What equipment in excess of \$25,000 did you purchase in 2011?

Here are the top five answers:

- Digital X-ray
- CAD/CAM or upgrade for CAD/CAM
- Laser
- Additional operatories
- Office upgrades - computers, chairs, cabinetry, carpet

### Reasons for not making a purchase in 2011

- Slow economy
- Cash flow/Budget
- Don't need any new equipment
- Recently made big purchase
- Planning to make purchase next year

### The top three dental issues most likely to keep you up at night:

1. Patients (dissatisfied patients, getting new patients, no shows, patient retention)
2. Staff (staff issues and behavior, firing, hiring new staff, managing staff)
3. Money (making payroll, overhead, paying bills, collections)

### My dental practice is:

5% Part of a corporation of multiple offices

#### 50% Scratch start

40% I purchased from another dentist

5% Second- or third-generation (handed down from family member)

441 total votes

### Do you have an official office manager in your practice?

56% Yes

44% No

443 total votes

### How is your office manager compensated?

438 total votes

29%  
Hourly

30%  
Salary

41%  
I don't have  
an office  
manager

## Practice Management: 2010 Townie Choice Award Winners Recap

#### Dental Marketing:

Demandforce, Inc. – Demandforce D3

#### Equipment Finance:

Matsco

#### Internet Marketing & Web Services:

Demandforce, Inc. – Demandforce D3

#### Patient Finance:

Matsco

#### Practice Management Consultants:

Jay Geier - Scheduling Institute

#### Software – Patient Communication Systems:

Demandforce, Inc. – Demandforce D3

#### Software – Patient Education:

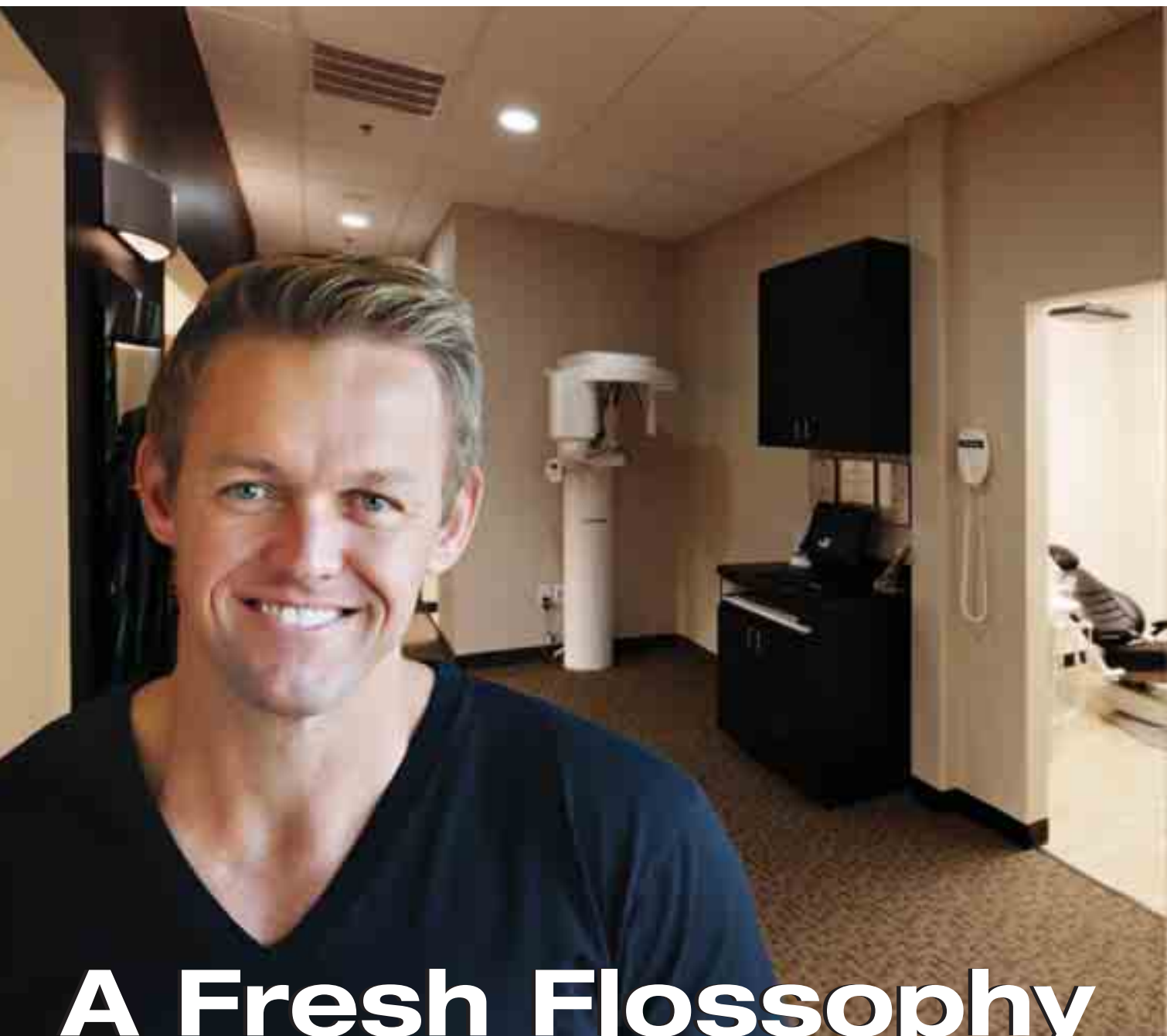
Patterson Dental – Caesy Education Systems

#### Software – Practice Management:

Henry Schein Practice Solutions – Dentrix

#### Software – Practice Management Enhancements:

National Electronic Attachments Inc. – NEA FastAttach



# A Fresh Flossophy

by Chelsea Knorr, staff writer, *Dentaltown Magazine*

*Dr. Clint Herzog doesn't believe in white coats. He wears his trusty Converse All-Star sneakers to work. And he believes in changing the animosity many people feel toward going to the dentist.*

*He has been criticized for his "outlandish" practice management ideas, but he wholeheartedly believes in his tactics. Herein, Dr. Herzog explains his practice model and the "Flossophy" which drives his 11 practices to success.*



## Office Highlights

### Bonding Agents

- Futurabond Self-etch and Bond System

### Burs

- Brasseler burs
- Carbide - #557, #330, #4 high speed round, football (course, fine, medium)
- Diamond burs - cylinder, Christmas tree, barrel and football
- Round bur - #4, 6, 8 latch

### Cements

- Maxcem Cement

### Front Desk Products

- BreathRX mouth rinse
- Opalescence toothbrush
- PerioMed
- PerioRX
- Sonicare Toothbrush

### Implants

- MIS System

### Impression materials

- Alginate for retainers/NG
- Flexitime for Invisalign impressions
- House brand for final impression

### Patient Financing

- CareCredit
- ChaseHealthAdvance

### Restoratives

- Xtra fill for compactable composite
- House brand for flowable

### Technology

- Digital sensors
- Intra-oral imaging
- VELscope oral cancer screening

### Whitening

- Boost 40% One-Hour Whitening, 35% for trays
- Treswhite
- Zoom pens

### What inspired your decision to go into dentistry?

**Herzog:** I have always been interested in medicine. I thought I would enjoy the patient interaction and I like helping people fix a problem. I had no idea I would discover so much more with dentistry. I have learned to communicate with people by maintaining long-term patient relationships, which has really helped me to grow as a person and a doctor. I am very grateful.

### The feel of your practice is very modern and high-tech. Can you explain your inspiration and model for this?

**Herzog:** I always cringe when I hear patients say they hate going to the dentist. So I set out to change that. We built a new experience around what patients want, which includes the idea of dentistry in a modern, trendy, high-tech environment. We play host to our patients from start to finish, making sure we cater to their every need, even before they know it's a need. That's the "new experience in dentistry." It's boutique dentistry with in-network pricing.

*continued on page 72*

*Photography by Tessa Michelle MacLeod*



Name: **Clint Herzog, DDS**

Graduate from: **Texas A & M University, 1996**

**University of Texas San Antonio Dental School, 2000**

Practice Name: **FLOSS Dental**

Practice Locations: **11 locations across Dallas, Fort Worth, Houston and Austin, Texas**

Practice opened: **First location opened in 2007 in Dallas**

Web site: **www.flossdental.com**



One thing that makes it different too is that we try to level with patients from the time they walk in the door to the time they leave. When they first walk in, they are offered beer, wine, soda or water. This helps to alleviate anxiety and make the office a personable and unthreatening environment. We all dress trendy-casual – no white coats. We want patients to feel like we're on the same level as them.

#### Using three adjectives, describe your practice?

**Herzog:** High-energy, fast-paced and fun.

#### What is your practice philosophy?

**Herzog:** It's all about the patients. Patients. Patients. Patients.

#### You have 11 locations throughout Texas. How do you explain this growth and what is your role now?

**Herzog:** I learned to be unique, set myself apart and go for it. If I want to be competitive, I can't be just like the doctor next door. With FLOSS' unique atmosphere and attention to customer service, our biggest source of new patients is referrals from families, friends and co-workers. Converting to being an in-network insurance partner has also helped our growth. We decided to convert because it's what our patients asked for.

As far as my role, I used to work at all the locations, but we have grown to the point where I train and work with the associates at all the locations. This allows me to focus on the growth of the business.

#### What are some of the challenges you came across as you have established yourself in the profession?

**Herzog:** Well... patients aren't always nice. I thought if I had their best interest at heart they would see that and respond. Not always true. Most are great, but I have learned from the difficult ones. I don't take things personally anymore and this has helped me to really focus on their needs. I think it has been the largest impact on FLOSS' success. I have learned that, yes we are a profession, but at the end of the day, we're a service.

#### What advice would you give to a new dentist?

**Herzog:** Don't act like a doctor. Do whatever it takes to meet the patient's needs and go out of your way to make an impact on your staff. They will appreciate it and work harder.

#### What do you look for in hiring dentists and staff for each location?

**Herzog:** When hiring dentists and staff we look for people who are committed to quality dental care, who are able to connect with people, are open to personal and professional development and have an eagerness to learn.

#### What types of services does FLOSS offer? And what is your favorite procedure to perform?

**Herzog:** We offer all general dental procedures, as well as endo, perio and oral services. We are an Elite Preferred Provider of Invisalign and do quite a bit of cosmetic work. My favorite cases are the ones that involve full-mouth rehab and cosmetic cases. It's awesome to make an impact on someone's life and be a part of his or her transformation.

#### Who are your mentors?

**Herzog:** Chuck Kolb, DDS – he taught me to put the patient first. And John Durham – he's my business mentor. I will never forget when John told me, "Everyone can be successful, but not everyone is willing to pay the price."

#### Your practice expresses a passion for philanthropy and supports numerous charities. Why is this important to you?

**Herzog:** We are blessed, and it is a way we can give back and bless others directly (charity cases) and indirectly (sponsorships).

#### What do you like to do when you're not working?

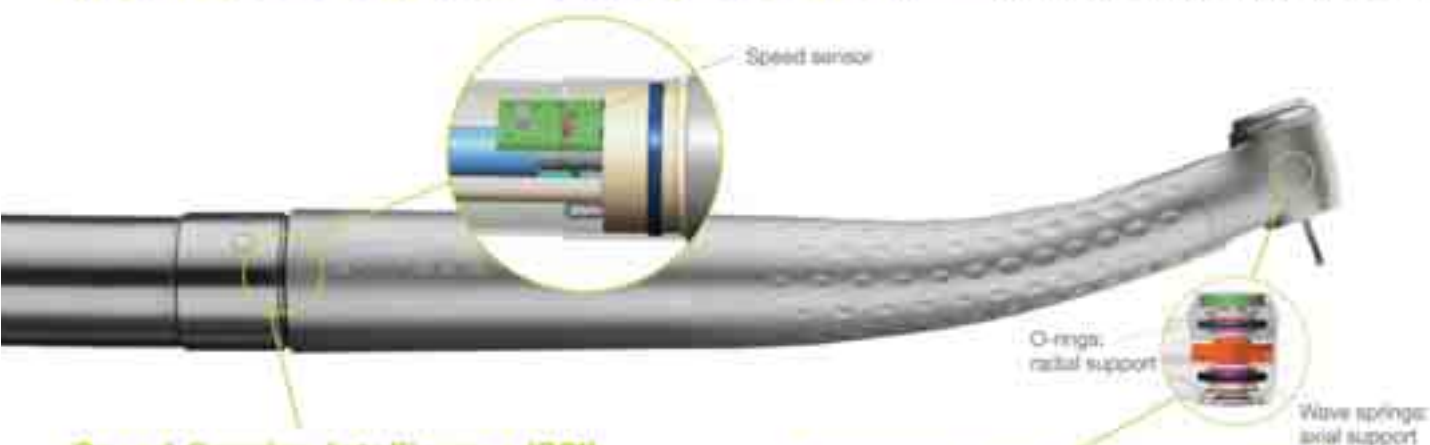
**Herzog:** I like to spend time with my children – my four-year-old daughter, Parker and four-month-old son, Hudson. I love playing golf and exercising, and spend as much time at the lake as I can! n

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# I'm a Dentist and a Drug Addict

*Following is a true story of one dentist's struggle to overcome his drug addiction, and the help he received through the Well Being Program of the Missouri Dental Association. The dentist has requested that his identity be kept confidential.*

Growing up, I watched alcohol destroy my father's life. As a result of his drinking, my home life was volatile and unpredictable to say the least. As a very young man, I vowed not to follow in my father's footsteps.

In high school and college I did experiment with alcohol. I was very careful to control my intake of alcohol because the few times I actually got drunk, I became violently ill.

I thought this was a good thing and I would not follow in my father's footsteps.

During dental school, alcohol was always at social functions but it was rare that I actually got drunk. I did however greatly enjoy drinking a few beers with my classmates after class. Prior to a very stressful day in dental school, one of my classmates gave me a few 10mg Valium tablets. The feeling I had after taking the Valium was far better than any effect I had previously from alcohol. I had never felt so good! I also discovered that drinking a few beers with the Valium potentiated the wonderful feeling I had experienced.

After graduation, I began solo private practice in a small community. I was married and had a little girl. The practice took off quickly and I found myself working six days a week. To relax after a long day, I would occasionally take a Valium and have a few beers. I justified my drug usage rationalizing that if I worked hard, I could indeed treat myself to some good feelings.

It was also about this time, I became a workaholic. My second child was born and my home life deteriorated to the point I was in an extramarital affair. I found out later, this is one of the early indicators of an alcohol or drug problem. Being involved in an affair and working to excess created even more stress. I handled the stress by increasing my use of Valium. I found however, that as I increased my use of Valium, the wonderful feeling I first had never quite returned.

The Missouri Dental Association held a continuing education course on alcoholism and addiction geared toward helping dentists with these types of problems. I went because I wanted to help my colleagues that were suffering like my father was. At the time, of course, I did not believe I had a problem. I did learn that alcohol and drug addiction are diseases. I also learned that growing up in an alcoholic home made you a co-dependent and that co-dependency is a disease. I learned how the mechanism works to help dentists that were suffering from these diseases begin to recover.

I learned that I was at very high risk to become addicted to either alcohol or drugs because the disease tends to run in families. This fact did not slow my drug use at all. I felt I was in control and I would certainly not become addicted. I learned this was my first symptom of the disease – denial. I denied I had any problems with drugs.

I was having some deeply distressing personal problems. I headed for the office in search of some Valium to help me cope. I could not find any and the pharmacy was closed. I did find some Demerol that I had in the office for over a year. I drew up 50mg and injected it into my thigh. Within minutes I had the most wonderful feeling; far better than Valium and it lasted even longer. As the drug took effect, my problems seemed to leave my mind.

I would “treat” myself to a Demerol cocktail at the end of my working day. Then after a few weeks, I would not only “treat” myself to one after work, but one just before bedtime. I did not think I had a problem because I did not use during the day and my technical abilities had not suffered.

I needed to keep taking more and more of the drugs just to maintain an adequate feeling.

By this time, I realized I needed to quit taking these drugs. I tried to quit on my own, and did actually quit for nine days; then I started right up again.

By this time I had begun using both Valium and Demerol during the day just to maintain a certain feeling of being normal. My office staff certainly knew something was wrong, but did not know how to confront me. My colleagues who knew me well also knew something was wrong, but again did nothing. Later I learned not saying anything is called “the conspiracy of silence.”

Finally one night I attempted to end it all. I said goodbye to my sleeping children and attempted to take a fatal overdose. Much to my surprise, I awoke the next morning and was finally able to ask for help. At last I stopped denying I had a problem; I had just gotten sick and tired of being sick and tired.

*“I learned that I was at very high risk*

*to become addicted to either*

*alcohol or drugs because the*

*disease tends to run in families.*

*This fact did not slow my drug use at all.”*

I sought the advice of a nearby psychiatrist thinking he could help me. He told me there was very little he could do for me other than detoxify me. He suggested I contact a treatment center. At this time, I remembered the continuing education course the Missouri Dental Association had put on. I called the “hotline” number six times before I left a message with my name and number. I reached a member of the Well Being Committee who was a recovering alcoholic himself and he helped me lessen my fears about being an addicted dentist. I entered a treatment center within a few days.

While in treatment, I learned more about the disease I had – a chronic progressive and fatal disease if not kept in remission. This helped me to realize I was not weak-willed, crazy or evil, but just plain sick. I also learned that I had followed in my father’s footsteps. The disease was passed down through the generations. I became acutely aware that I was not responsible for my disease – but even to this day, I am responsible for my recovery from this disease. Keeping my disease in remission means not taking any mood altering drugs.

Another eye-opening fact was that I was poly-addicted to both Valium and Demerol. I can never return to social

*continued on page 76*

drinking since drinking even moderately could cause my disease to reactivate. Following my 29-day stay in the primary treatment center, I was treated on an outpatient basis for several months.

Times following the initial treatment were very trying. I had to deal with problems with the State Dental Board, the State Bureau of Narcotics and the DEA, but through the help of the committee members I was able to face these trials sober. I successfully completed my probationary period with all the regulatory agencies.

Life has been much better since I have been in recovery. There have been setbacks, such as a divorce, severe financial pressures and the death of my father who at the time of his death was still untreated for alcoholism. I have faced each of these trials sober.

Perhaps the greatest part about the journey into recovery is learning to deal with life on life's terms. When I was in dental school and early practice, I blamed dentistry for my stresses and my disease which justified my drug usage. It

took some time, but I am at peace with who I am and I actually really love practicing dentistry.

I have remarried and have a wonderful relationship with my wife and my children. I have a support system through Alcoholics Anonymous and other recovering health-care professionals who I can turn to for assistance. I have a relationship with my higher power, God, which is the cornerstone in my recovery.

Also, I try to carry the message to those in our profession and in my practice who still suffer from the same disease. I would urge anyone reading this article who thinks he or she might have a problem with alcohol or drugs to get help. It is only a phone call away. To those who know colleagues with a problem, help them get some help because they cannot reach out on their own.

Today, I am very grateful to the Well Being Committee with the Missouri Dental Association for helping begin my recovery. Again, I can deal with life on life's terms without the aid of mood-altering chemicals. I do this by living one day at a time and following a simple program. n

*Acknowledgement: The original article appeared in The Missouri Dental Journal, July-August 1990, p. 16-19. It is being represented with the acknowledgement of the Editor of The Focus, the publication of the Missouri Dental Association.*

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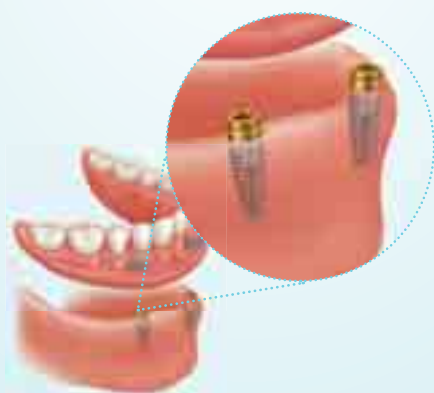


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# Short-term Ortho Changes Everything

by Ryan B. Swain, DMD

As we continue to endure a down economy, dentists have an opportunity to boost their revenue and increase production across a broad service mix by satisfying the needs of an adult patient population suffering with crooked, crowded and unpleasant-looking smiles. Unwilling to succumb to years of comprehensive orthodontics or the expense of restorative smile makeovers, many adults haven't found a minimally invasive option to straighten their teeth and beautify their smile.

Fortunately, adult short-term orthodontic treatment eliminates the time-consuming nature of straightening teeth. By offering an option, like the Six Month Smiles system, that adult patients are excited about, it also sets the stage for additional, life-changing and minimally invasive services such as whitening, composite bonding, minimal preparation veneers and better hygiene maintenance. This has a positive impact on other areas of the practice.

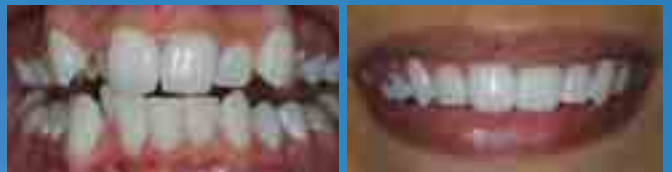
Adult short-term orthodontic treatment focuses on the patient's chief cosmetic concerns and not on completely revamping the patient's occlusal scheme. It is not a replacement for comprehensive orthodontics but is a great solution to address aesthetics. In approximately four to nine months, and with very light forces, significant tooth position discrepancies can be corrected. As a result, patients can avoid years of metal braces, yet the results are life-changing with regard to the dramatic improvements to the overall symmetry and harmony of the smile.

Most general practitioners (GPs) graduate from dental school with very little practical orthodontic experience, there are many reasons to get involved with cosmetic braces, even if they never considered the possibility before. These reasons include the following:

1. In the midst of a struggling economy, dentists are striving to offer services that patients want and will pay for.
2. Advancements in orthodontic materials enable a much more favorable learning curve, and easier and more efficient tooth movement.
3. Clear aligners have created many frustrations for dentists, including high laboratory fees, an inability to predict treatment times and lack of control over tooth movement.

## Greater Case Acceptance

After learning how to provide short-term orthodontic treatment, general dentists have the ability to offer an incredibly attractive and valuable option to their adult patients who are



*This short-term orthodontic case was completed by Dr. Dale Hardy in just five months using the Six Month Smiles system.*

unhappy with how the appearance of their smile has negatively impacted their life. Most adults with crooked teeth feel stuck. While they might want a more attractive smile, they just won't pursue traditional orthodontics due to the time it involves. On average, treatment time for short-term ortho is about six months.

### Practice Growth

Because there is a huge population of adults who can benefit from short-term ortho treatment but aren't aware of it, the option is needed in the profession. General dentists have the ability to tap into the pent-up demand for patient-focused cosmetic braces and, once trained to properly provide this service, they'll see more adults interested in straighter teeth in a shorter period of time.

### Practice Profitability and Staff Enrichment

While some patients might shy away from more expensive veneers or smile makeovers costing upward of \$20,000, they're also shying away from even "needed" dentistry if they don't perceive value – such as a posterior crown for a cracked tooth that isn't hurting them.

Providing patient-focused cosmetic dental treatments that are affordable and have high perceived value garners greater acceptance. This produces more revenue for the practice.

For example, the average fee charged by providers of a systematic short-term ortho treatment is \$4,300, and one case per month can easily add more than \$50K to the practice. Additionally, for those dentists involved with veneers and other cosmetic procedures, a short-term ortho system can complement those services by setting up cases for future restoration placement like leveling and aligning the arches and idealizing gingival margin positions.

By combining the reliability of braces with the ease of use of clear aligners, short-term orthodontic systems enable general dentists to begin implementing treatments without any orthodontic experience.

Whether alone or in combination with other cosmetic procedures like tooth whitening, direct composites or minimal-preparation veneers, short-term orthodontic treatment is the GP-friendly solution for adult patients with crooked teeth who want a great looking smile for the long term. □

### Author's Bio

**Dr. Ryan Swain** is a graduate of the University of Florida College of Dentistry. He practices in Rochester, New York, and focuses on short-term ortho and other conservative cosmetic dental procedures. He is CEO and clinical director for Six Month Smiles, Inc.



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# Removable Smile Design: The Core to Full-mouth Reconstructions



by John Nosti, DMD, FAGD, FACE

The year was 1996; it was my sophomore year in dental school and the administration took away a portion of our removable education in favor of hands-on education in oral implantology. The reason for the change in curriculum was that complete edentulism was falling in statistics nationwide with more patients holding on to their teeth longer. It was even stated by a few professors that traditional full dentures would eventually be a lost art form, and no longer needed. It is currently estimated that 10 percent of the U.S. population is edentulous.<sup>1</sup> This number is expected to grow due to the amount of aging adults in the United States. Likewise the effect of the economic downturn and illicit drug use has not been taken into consideration.

From 1996 to 2005, the amount of methamphetamine users doubled on average in the United States<sup>2</sup> and in some states that number quadrupled. In 2003, it was estimated that six percent of the U.S. population was using methamphetamines.<sup>3</sup> In 2010, while some sources indicate the population using illicit drugs

has decreased; those same sources indicate the users requiring specialized treatment for a drug abuse problem increased.

No matter how you look at it, dentures will continue to be an essential part of dentistry. Many practitioners shy away from removable prosthetics due to the variability of procedures throughout the fabrication process resulting in an unpredictable outcome. I have spoken with many doctors who favor traditional fixed smile design over removable smile design. I will challenge, that in order to become proficient in fixed smile designs and full-mouth reconstructions, one must become proficient in removable prosthetic “reconstructions.” With the addition of some simple tools to your armamentarium, removable dentures will be an enjoyable and profitable process that can add to your cosmetic dentistry portfolio.

Figure 1 shows the Smile Design Kit by Ivoclar. The Papillameter (Figs. 2 & 3) is used to measure the maxillary lip length by using the fixed landmark of the incisive papilla. By



Fig. 1



Fig. 2



Fig. 3

determining the length between the maxillary lip at rest and the incisive papillae, the lab has an exact measurement to construct the wax rim or placement of the incisal edge in the wax setup. Transferring this information to the lab when ordering baseplates and wax rims allows the lab to custom make the wax rims and facilitates a faster secondary appointment for wax relations. The doctor is not left “eye balling” the ideal incisal edge position and wasting time cutting down a stock wax rim that is 6mm too long; or worse having to add wax because the rim is too short. Once the incisal edge position has been located, it can become much easier to focus on recording the proper midline and high smile line.

The Wax Rim Former (Fig. 4) is designed to facilitate the development of the occlusal plane once the desired incisal edge position has been achieved. Ensuring parallelism between the maxillary and mandibular rims is essential for a correct bite registration. When aligning the rims to Campers plane it is particularly important to be able to melt the rims uniformly. The ledge of the rim former fits precisely into the hamular notches on the maxillary cast. The hamular notches are always parallel to one another and to the midlevel of the face;<sup>4,5</sup> it is important to have your base plate impressions detailed enough and free of distortion in these areas. The 5mm ledge present on the rim former ensures that when the maxillary wax rim is melted down to the desired incisal edge position (chosen by using the papillameter and marked on the wax rim), the occlusal plane will be uniform on both right and left side, and should be parallel to Campers plane. This

process saves a great deal of chair time and allows the dentist to be more proficient.

The wax rim former can be used in conjunction with the Alma gauge (dental gauge) (Fig. 5). This gauge allows you to measure both vertical (Fig. 6) and horizontal (Fig. 7) position of the maxillary anteriors from the incisive papillae on an existing denture or base plate. The average patient’s incisal edge is approximately 8-10mm facial from the incisive papillae.<sup>6,7,8</sup> This allows you to measure the facial extension of the denture rim from the incisive papillae and make any corrections from both a visual confirmation with the patient, and a standard approach chairside. If the patient has an existing set of dentures that he or she would like duplicated, the arch form can be traced on the plastic sleeve (Fig. 8) of the Alma gauge and sent to the lab so that duplication of the arch form can be achieved. The vertical position of the incisors can also be recorded on the plastic sleeve so that the lab knows the precise horizontal and vertical position of the incisors.

The bite plane (Fig. 9) is used to confirm a proper occlusal plane by using the interpupillary line and Campers plane (the ala-tragus line). By determining the correct incisal edge position with help of the papillameter, rim former and bite plane, the facebow transfer in dentures becomes less important considering that the wax rim has been perfected to the proper occlusal plane and incisal edge position. For those wanting to use a facebow transfer, the Kois Earless Facebow (Fig. 10) can be utilized once the desired incisal edge position has been achieved. The Kois Earless Facebow is an excellent tool in communicating and



continued on page 82

transfer of the maxillary model to the lab for mounting on either the Panadent or Stratos articulator. This facebow utilizes a removable mounting plate to record the facial-incisal edge position of the maxillary central incisors. The average position of the maxillary central incisor is approximately 100mm from the condylar axis. There is a vertical component to the facebow to achieve the facial midline, as well as a horizontal component to match the interpupillary line and horizontal plane. Once your wax rim has been set to the ideal incisal position, this facebow can now be utilized.

Taking the bite relationship and setting up the occlusion on complete dentures is probably the single most important step in denture construction. Over the years I have consulted with many patients who were complaining that their brand new dentures, constructed in other offices, were ill-fitting. Many times the only treatment rendered to these patients was to equilibrate their dentures and correct the improper occlusion. The ideal way to record a centric bite registration is with a needle-point tracing technique. I have found the Gnathometer-M by Ivoclar to be useful in that it allows for both chairside bite registration technique and functional impression taking if desired. In basic terms, the Gnathometer consists of a marking pin that fits over the lower rim and opposes a striking plate that is fixed to the maxillary rim. The marking pin is adjustable, which allows for changes to the vertical dimension. The Gnathometer is mounted to base trays in the laboratory and returned for the same visit with the wax rims. Once the vertical dimension has been set with the wax rims, the bite registration can be completed. If desired, the functional impression can be completed on the base trays followed by the bite registration. The vertical dimension on the Gnathometer is adjusted until it is the same as was established with the wax rims. Once this is completed, the striking plate is marked with black marker, occlude spray or wax color (China Marker). The patient is instructed to move the mandible into protrusive, backward, followed by left and right lateral excursions (repeat process). The marking screw contacts the opposing plate, resulting in an arrow formed on the marking plate. The point of the arrow is equivalent to centric relation. A fixation device is placed over the point of the arrow and the upper and lower elements can be fixed together with bite registration material.

The cosmetic outcome of your denture is highly reliant on tooth selection and custom processing of the denture base by your laboratory. Depending on your case fee several denture tooth options present themselves from basic to premium in aesthetics and function. Both the Blue Line and PHONARES by Ivoclar are two excellent options in the premium and ultra premium range. Tooth selection is facilitated by the interala distance as measured by the Facial Meter (Fig. 11). Teeth are offered in small, medium or large molds with

choice of bold or soft forms, each offered in long or short for age appropriation.<sup>9</sup>

When restoring a fixed full-mouth rehabilitation the standard of care is to always work out the aesthetics, occlusion, function, etc. in temporaries. The thought of preparing rehabilitation and inserting a mouth full of ceramics without utilizing temporaries is absurd. So, why then do we do our removable reconstructions without temporaries?

Are you tired of seeing your patient for 20 post-op adjustments after the denture has been completed and “searching” for their sore spots? Have patients ever returned unhappy with the aesthetics of the denture after they are processed and after they have approved them at the wax try-in visit? I would strongly consider your first option of fabricating a diagnostic denture and utilizing a functional impression technique followed by a final denture fabrication. This two-denture process will allow you to make any changes to the aesthetics because the patient is allowed to “try out their smile,” rather than approving their smile during a 10-minute wax try-in appointment. The recoding of the functional impression over a period of time allows you to capture the patient’s musculature in motion and function, rather than relying on a single static impression completed in office.

The second option is to utilize the functional impression technique in your fabricated denture and relines once the kinks



Fig. 11

are worked out. When the patient returns for scheduled post-op visits, the denture acrylic will bleed through the functional impression material where adjustments are necessary. Many times your scheduled adjustment visits are prior to the surfacing of sore spots on the patient. This secondary option relies more on the occlusion being correct at insert and will most likely require further equilibration due to the potential increase in vertical caused by the relin.

Whether your reconstructions are removable or fixed, having a step-by-step process and the correct tools allow you to be more proficient, predictable and profitable. With the elimination of unpredictability the process of denture fabrication becomes a more enjoyable experience for both the patient and practitioner. With the aging population increasing in the United States, and the expected increase in edentulism, higher demands will be made for high quality removable prosthetics. Some of the most dramatic "cosmetic makeover" patients, and most appreciative are those who have undergone removal prosthetic treatment. n

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#### Author's Bio

**Dr. John Nosti** practices full time in Mays Landing and Somers Point, New Jersey, with an emphasis on functional cosmetics, full mouth rehabilitations, and TMJ dysfunction. Dr. Nosti's down-to-earth approach and ability to demystify occlusion and all-ceramic dentistry has earned him distinction among his peers. He is privileged to instruct and mentor live patient and hands on programs with the Clinical Mastery Series and Dr. David Hornbook. He has lectured nationally on occlusion, rehabilitations and technology. He is a member of the American Dental Association, American Academy of Cosmetic Dentistry and American Academy of Craniofacial Pain. Dr. Nosti also holds fellowships in the Academy of General Dentistry and the Academy of Comprehensive Esthetics.



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# Why You Should Know:



# PostcardMania

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

*Joy Gendusa, founder and CEO of PostcardMania, started a company in 1998 with zero capital. Her vision was to create postcards that spanned several industries and could get a trackable marketing message out to a large amount of people. The company, which has grown vastly since its beginnings, now has 192 employees and is on track to break \$20 million for the first time this year. Herein, Gendusa explains her ideas about marketing and why she still believes in snail mail.*

## The genesis of PostcardMania was sparked by an incident of bad service. Tell me about that.

**Gendusa:** I owned a small graphic design firm. It was me and a couple other people. I had a handful of large clients and I was (very transparently) brokering printing as well. I had one big client who I could see was going to go down in flames. I received a promotion from a company out of New York and I called them and ordered postcards. They were really inexpensive. When I got my proof they had added their 800 number to the back of the card. I called them up and asked them to remove it and they promptly told me it would be \$50 to do so. I was annoyed. I hung up the phone and went to my tiny team and said, "We are starting a postcard company. We are going to call it PostcardMania." I had something in my mind; I knew there was something on the tip of my universe that I was going to stumble upon. I knew it was there. So that was the moment.

## One of the things I found unique about your company is that you didn't use outside financing. Many companies can scale up a lot faster if they grow with outside financing. Why did you decide to do this?

**Gendusa:** Probably because I am not only in it for the money and the growth. I just decided to grow organically.

## Who do you look up to in marketing?

**Gendusa:** The number-one person I look up to is Flint McLaughlin. He owns a company called Marketing Experiment. He makes marketing look like a math formula and he explains each part of it and when you understand how to create want and how to get somebody to take action on your Web page, it is very analytical. He is a genius.

## You have described yourself as a disciple of repetition when it comes to marketing - for example, sending a message out more than once. How many times is enough and how often should the message change?

**Gendusa:** It depends on so many factors. To market a den-

tist, for example, you have to look at how many dentists are in your region of where people would drive to a dentist. You need to understand who your competition really is and how much effort he or she is putting into the marketing. Then you can understand how many times your message can go out and what your message should be. How you differentiate yourself as a dentist is important because when you are putting that message out over and over again, only a handful are going to do it right and do it consistently.

## In the postcard business, one of the challenges is proving reach. When you send postcards you don't know what the receiver will do. How do you handle that objection?

**Gendusa:** In defense of postcards, when you are going digital, you're one of many. To your question of tracking, what we have been doing for a number of years is putting specialized phone numbers on the cards and all our ads online. So if you are trying to get somebody to make a call or go to your Web site, you definitely want to send them to a landing page and have a different landing page for every direct mail piece so you can see exactly if that piece got them to take action. At that point, if they make it to the landing page but they don't convert to a lead, you see that they made it there. Then you can optimize that page for conversion. You can go to the page and figure out why they are leaving. You can fix every point along the way so it can become a lead.

## What are things people do that bug you when it comes to marketing?

**Gendusa:** They give up. They say I tried that and it didn't work. It is giving up and not taking the time to understand that bothers me. One of my passions is to really empower small business owners and teach them. I have a 10,000 page Web site and it consists mostly of organized content they can learn from. I really want small business owners to succeed.

**Congratulations on your success and thank you for your time.** n

**I**mportant things are going on at Google's headquarters on Amphitheatre Parkway in Mountain View, California, and it involves the fate of your dental practice. This time on stage for performance is a secret operation that involves robots that plan to change the face of the dental marketing industry as we know it today. This isn't a story about spaceships or aliens landing just yet, but hold on to your seat for this one. What we are about to announce will likely be the most vital topic you have ever read concerning the survival of your practice in this mobile Web time continuum.

Behind the curtain, Google has released Google-Bot Mobile. It is scanning dental practice's Web sites searching aggressively for quality mobile content. We'll define what's quality and what's not later, for now, let's talk about the "bot" which is defined as a software application or program that runs automated tasks through the Internet. Generally speaking, bots perform tasks that are complicated or simple and structurally repetitive, at a much higher rate than would be possible for a human alone. It's a new robot search engine program that is now scanning Web sites every two weeks to see if they have high caliber mobile solutions associated with them. If this content is located, then it reports back to Google's indexing engine that is

now partitioned just for mobile users that are browsing and delivering their results independently and uniquely from normal Web site results.

### The Problem

The problem is that the majority of all dental Web sites don't have this solution and coupling that with the fact that Google's ranking is now different from the standard desktop Web results, there should be an alarm going off in your head as you read these words. Google's goal, as we all know, is to try to deliver the most appropriate content for the user's who are browsing, and with there being five mobiles for every one computer (and growing), the majority of searches are now coming from mobile users. This means that dentists who are spending excessive amounts of money on SEO for their Web sites, spending thousands of dollars to keep up with their competitors only to "raise the bar" to get unreliable results, now have a new weapon to launch in their local town. Some dentists have even been seen defecting back to Yellow Pages' last attempt to survive on their slowly fading landscape of the Internet by cloning/mirroring sites only to potentially damage Web ranking results by being blacklisted by Google for the "cloning or mirroring."

# Google Releases A MOBILE ROBOT on Your Dental Practice's Web site

by Scott Helter



*continued on page 88*

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## The Mobile Market

This is now a huge opportunity for dentists to jump on the bandwagon early and to get mobile with Google. If you remember the day (years ago, of course) when dentists were trying to figure out how their competitor down the street was building patients at an unfathomable rate, and they found out that he had this thing called a "Web site," they all soon got one and the race was on. However in the mobile community, the numbers are more than five times that and growing exponentially!

In addition Google is all about history, meaning the longer you have been reliable to them and allowed them to deliver your results to users, this gives you extra weight above newer competitors who will soon come on board to realize the power of mobile six to 12 months from now. What this means is that a dentist who gets a quality mobile solution for his Web site prior to his competing practices, is going to have an amazing advantage and create a ranking curve for slow adopters.

Patients now search on their mobile all the time. During the day corporate workers are now being outsmarted by their network admins who block all access to the Internet in an attempt to make the workday more efficient by restricting Google browsing, Facebook, Twitter, etc. However, now with our handy mobile weapons and 3G/4G networks, the solution is in the palm of their hands to bypass big brother and network restric-

tions. Not to mention, they can use the Internet anywhere. Stay at home moms and dads out to lunch, at Starbucks, waiting in the school lot for kids to get off school, on the way to soccer or football practice are all using their phones to surf the Web.

## Web sites are Slowly Becoming Obsolete

Each day Web sites are becoming more and more obsolete due to the high usage of mobiles. Dentists should all look to see how their Web site appears on a mobile phone; they might be surprised and severely disappointed with not only the aesthetics, slow load times and puzzling navigation, but the fact that Google's mobile engine passed them by with no good grades for search results.

## The Solution

Quality mobile content refers to solutions that go beyond old technologies of the past such as basic mobile plug-ins and standard mobile Web sites since these are essentially just compacted versions of their Web site with stripped down images and text that are stuffed into a small area of real estate in an attempt to fit our mobile device's screen size. These are not solutions since they are only pulling or copying content from your Web site to a smaller page. You'll find some companies starting to offer this service and although it might seem new or affordable (they run about \$500 on average), it's already outdated in most cases. Keep

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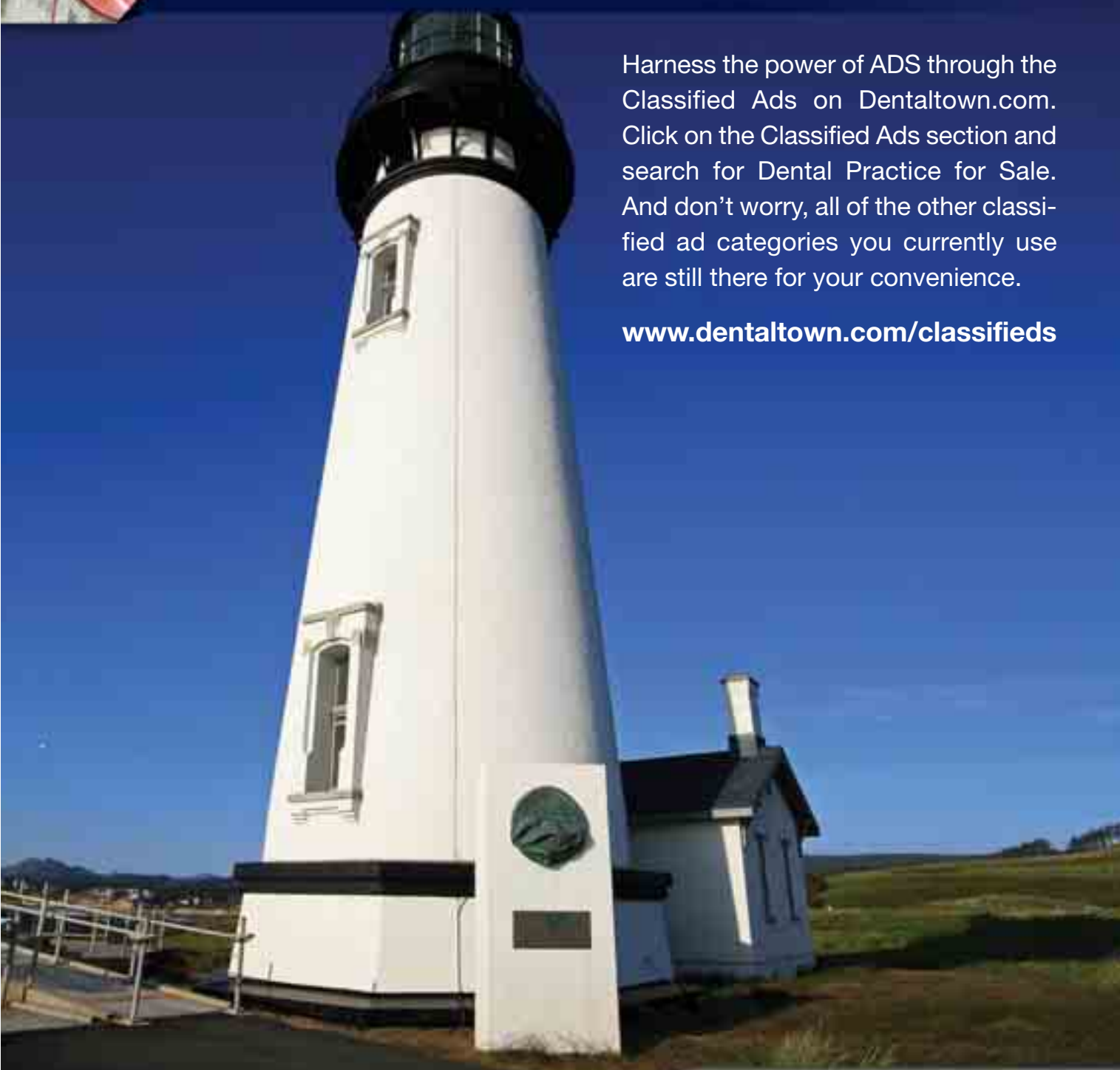


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in mind that a small paragraph or even a few sentences from your Web site looks much longer on a small screen. You don't want to make viewers scroll for too long.

Mobile Web sites are like dinosaurs that are now long extinct and there's a new breed of solutions available in the tool belt of dentists called a mobile app. Getting a mobile Web site versus a mobile app would be the difference between having an amalgam filling versus a composite filling. Mobile apps have features such as scheduling, ability to add custom icons to the home screen of your phone, smile galleries and testimonials all which support the phone's orientation.

A mobile app runs in the cloud or from the Web and is independently built from your Web site, but conveniently integrates without requiring you to modify your Web site. It is not something that Web site designers are generally capable of creating, as it requires a separate set of skills. So beware if you are offered something from your Web site designer or hosting company, it's most likely a mobile Web site and not a mobile app. Mobile app development requires an expert very well-versed in app technology and the investment is a bit more (normally about \$1,900-\$2,900). One patient alone will pay for it and then some.

A dental mobile app delivers a similar high quality look, feel, navigation, speed and interactivity of an native application without the need to download. A mobile app is an advanced programming platform that eliminates specific phone dependencies so that the patients or "soon to be" patients browsing from their mobiles don't have to have a certain type of phone. Be sure that you work with professionals only and spend the extra money.

A dental mobile app can be developed to work on any mobile phone (Droid, iPhone, LG, Nokia, HTC, Motorola, even the iPad just to name a few) and can be programmed to automatically appear when a dental practice's Web site is visited on a mobile. It integrates with every dental practice's Web site and does not require any modifications to the site either. Even better, it's not cloned or mirrored content, but a custom-created solution that is specifically designed to solve the mobile content solution and to ecstatically communicate to Google's new "bot" that this practice has stepped in bounds and is ready to be beamed up to the top of ranking results. It's worth your practice's weight in gold to investigate this if you plan on competing on the Web going forward.  $\square$

### Author's Bio

**Scott Helter** has worked as an SEO specialist and Web developer since 1998. He now focuses his energy on the latest technologies for mobile marketing and patient building for the dental and orthodontic industry. He enjoys connecting with doctors and keeping them up-to-date on the most current information and techniques to keep their practices on the cutting edge. He can be contacted at 513-445-2008 or [info@promeddevs.com](mailto:info@promeddevs.com).

# Incorporating Invisalign



Name: **Austin Reed, DDS**

Graduated from: University of Iowa, 2006

Practice name: Peosta Family & Aesthetic Dentistry in Peosta, Iowa

Year practice started: 2006

by **Chelsea Knorr**, staff writer, *Dentaltown Magazine*

What is the implementation of Invisalign like from day one? Dr. Austin Reed was his own first Invisalign subject. After taking the needed continuing education, trying the treatment on himself and integrating the service into his practice, he tells *Dentaltown* readers about his positive experience, his reasons for taking on orthodontics in the first place and the process of implementing Invisalign, from start to finish.

## What factors did you consider in making your decision to add orthodontics to your practice?

**Reed:** I decided to add orthodontics to my practice for several reasons. First, I practice in a young community with many young families with children. I was referring a lot of orthodontics out and I decided I wanted provide some basic services to my patients. My practice is about 15 minutes outside of a larger town and my patients appreciate that they can stay in my office and receive a variety of services. Secondly, I had a lot of patients asking me how they could improve their smile. As I said, most of my patients are younger and I didn't necessarily want to see them doing veneers when ortho would be a much better option. Many were reluctant to do traditional orthodontics, so I looked for another option for them. We try to emphasize the many benefits of having properly aligned teeth in addition to just the cosmetic benefits – like decreasing the risk of periodontal disease (and all of the general health effects that it has), reducing premature wear and chipping of teeth, reducing abfraction forces, reducing TMJ pain and improving the overall prognosis for all the teeth to be maintained for a lifetime.

## After incorporating Invisalign, would you consider any traditional orthodontic methods?

**Reed:** I am not currently doing any traditional orthodontics. At this point, we have chosen to keep things simple. Getting started with Invisalign does not require a lot of extra instruments or equipment. There is an orthodontist in the larger town next to us who does Invisalign. If there is a complicated case we feel uncomfortable treating, we know we can still refer it out. Also, Invisalign is constantly updating its product and making it better. There really aren't a lot of things that Invisalign can't do at this point. So if we find one of those things, it is probably best to refer anyway.

## How do you decide what types of cases you want to treat? How about what products or brands to work with?

**Reed:** Clear Essentials I, Invisalign's first course, does a good job teaching which cases are easily treated with Invisalign and which cases are more difficult. When I came back to my office after the course, I had a concept of where I wanted to start (Class I occlusion, mild crowding or spacing). After I gained some experience, and took some more continuing education, I was able to increase the difficulty level of the cases I treat. As far as what products I work with, Invisalign is flexible, so doctors can use the products they feel most comfortable using. We use a basic putty and a light body PVS material for our impressions and get great results.

*continued on page 92*

### What were key factors in getting started?

**Reed:** The first step in getting started is obtaining the proper education. I had a base knowledge of orthodontics from dental school and I combined that with Invisalign's Clear Essentials I and II. Following those two courses, I have taken online seminars and classes available free of charge on Aligntech Institute's Web site. Once I was comfortable with the process, it was important I start talking to patients about the new service. I was amazed how many patients had heard about Invisalign and had actually thought about getting Invisalign. Most patients don't bring up these topics, but when I start the conversation it is easier for them to ask questions. Commitment to talking to all of your patients about Invisalign is the biggest key to getting a great start.

### As far as training, what did you and your staff need to feel confident about the process?

**Reed:** The first thing the staff need to know about Invisalign is what type of cases it can treat. The easy answer is that it can treat just about everything. Over the years Invisalign has continually improved, and now with Invisalign G4, there are very few cases it can't treat. With that said, each doctor needs to decide what his or her own personal comfort level is and what types of cases he or she wants to treat. If the staff understands the type of cases the doctor is comfortable treating, they can start the conversation with patients and gauge their interest level. Invisalign's Clear Essentials I class also covers how Invisalign works and what the benefits are for having Invisalign treatment. Most people are concerned about cosmetics but it is our job to inform them about the other, more important, reasons to have Invisalign.

### How did you ensure your team was prepared and motivated to support the new offering?

**Reed:** Once the team was properly educated, it was very easy for them to buy into the concept of Invisalign. It is a great service we can offer to our patients that will not only make them feel better about their teeth and smile, but also benefits their long-

term oral health. Both myself and another staff member decided to have Invisalign treatment, so it didn't take us long to become experts for our patients about what to expect.

### How did you set production goals?

**Reed:** We initially started out with a goal of one case every other week, or 24 for the year. Quickly, we realized we were setting the bar too low.

Figure this: If a practice with two hygienists should see at least 64 hygiene patients a week, and half of those people have teeth that have some sort of crowding or spacing issue, then you will see 32 people per week who could benefit from Invisalign. If you and your staff are committed to talking to these people about Invisalign, one patient, out of 32 per week is not a very hard goal to meet.

### What was the support from Invisalign like?

**Reed:** Excellent. Invisalign, through its Aligntech Institute, offers everything a practice needs to incorporate and thrive with Invisalign. It offers a full range of marketing materials, both direct and indirect, to help incorporate and build the Invisalign brand in your practice. These products are crucial in letting patients know you offer Invisalign and what benefits they will receive from the treatment. On the technical support side, Aligntech Institute offers continuing education that is available online and free of charge. If there is a specific type of case I am struggling with, I can go online and view a presentation on how to best manage that type of case. Doctors are also well-supported by Invisalign territory representatives to help with any other hiccups along the way.

### I understand you were your own first subject. How did you "select" your first case? Can you walk me through how you did this?

**Reed:** Case selection is explained in detail at Invisalign's first course Clear Essentials I. Obviously some cases are going to be harder than others, so it is best to start with easier cases to improve your chances for success at the beginning. I had ortho



Fig. 1: #23 in need of endo.



Fig. 2: Pre-Invisalign photo.



Fig. 3: Post-Invisalign photo.

as a teen, and as many teens do, I did not wear my retainers for the prescribed amount of time. So my case started with posterior Class I occlusion, with moderate lower anterior crowding. I also had a small black triangle between #8 and #9. In my case, #23 had moved lingually and supra-erupted. Due to my occlusion, tooth #23 and tooth #10 had premature incisal wear. Tooth #23 had even become non-vital and needed to have endodontic treatment. I had previously consulted with an orthodontist to see what I could do to fix my lower anterior crowding. They had suggested full ortho. I really didn't want to do full ortho again at my age, like many adults. So I started with Invisalign and have had great results.

### How to do market the service?

**Reed:** Our marketing approach is two-phased. First is our internal marketing, we have all sorts of signage in the office letting our patients know that we offer Invisalign. We have pamphlets, posters, signs, the works. We even have the Invisalign logo on our scrubs. If you walk through our office and don't know we offer Invisalign, you have had your eyes closed. Second, we have a strong external marketing presence as well. Radio has been incredibly successful in our area. It has really pulled patients into our practice that otherwise probably would not have been. To go along with that, we believe a strong Web presence is essential. People like to get information at their own pace and after they hear our radio ad, or see a brochure in our office, it is important to have more information available to them on the Web. This way they can learn more about Invisalign and be even more excited about it when they get to my office.

### How do you approach case selection?

**Reed:** As I stated earlier, there are very few cases Invisalign can't treat. I only pick cases that I am comfortable with so I know we will get great results. As with anything in dentistry, you should only treat what is within your comfort level. I still refer more complicated cases to an orthodontist. It is nice to have a local orthodontist who will treat more advanced cases with Invisalign so that we can offer the service to everybody.

### How much time do you schedule for patients?

**Reed:** The discussion of Invisalign starts at the hygiene appointments. If the patient needs or wants Invisalign, we set up a 45-minute appointment in our overflow chair. I will stop in during this appointment to answer any questions the patient might have and continue the message about the benefits of Invisalign. I have my staff discuss fees and payment options at this appointment. Once the patient is committed to begin treatment, I have an expanded function assistant take a series of photos, PVS impressions and a bite registration. Roughly three weeks later, we see the patient for a 30-minute appointment for

the ClinCheck. At this appointment we review the virtual models, estimated treatment outcomes and estimated treatment time. This is something that could be done by office staff but I prefer to do myself. Our delivery appointment is 30 minutes in the overflow chair. This appointment can be done mostly with auxiliaries depending on your state law.

### How do you handle patient compliance?

**Reed:** Invisalign Assist and Invisalign Teen have compliance indicator tabs on the buccal surface of the second molars. These help parents know if their kids are wearing the aligners for the desired 22 hours a day. We don't have many problems with compliance though. Most patients are excited. They realize Invisalign usually has a shorter treatment time than traditional orthodontics and patients are eager to wear the trays to keep treatment on schedule.

### How is the relationship with orthodontists in your area?

**Reed:** We have an orthodontist locally who also treats with Invisalign. We have a typical GP-specialist-type relationship. It works well to have someone I can call if needed.

### How many patients have you treated? Were there any you couldn't finish with Invisalign?

**Reed:** We've treated 36 total, 33 this year, and none we couldn't finish.

### What is the hardest part of becoming an Invisalign provider?

**Reed:** Becoming an Invisalign provider is easy. The hardest part is committing to making it a point to tell all your patients about it. Providers will be surprised how many of their patients don't know what services are offered. They will also be surprised at how many people are interested in Invisalign treatment.

### Can you summarize the integration process?

**Reed:** Invisalign has been successfully integrated into our practice. We are getting referrals from patients and parents who we have treated with Invisalign. We have a marketing strategy in place that is effective but also continues to evolve. My recommendation for GPs who do offer orthodontics – Invisalign is a great service you can offer to your patients. Properly aligned teeth provide so many benefits. Getting started is easy, and once you have it fully incorporated into your practice it will provide personal and financial rewards. A new service like Invisalign can re-energize your practice because many of your patients are already thinking about and wanting Invisalign.

**Thank you for sharing your experience with our readers. n**

# “GERO ENDO DON'TO LOGY”

## and Its Clinical Challenges

by Drs. Kenneth Koch and Dennis Brave

2012 is an election year and we have already heard heated debate about both Social Security and Medicare. The common denominator for each of these issues is elderly or retired individuals. The simple truth is that we are living longer than ever before. This is a good thing. In fact, we hear “The Graying of America” all the time. It certainly applies to dentistry as we are seeing increasingly more geriatric patients. Although it is surely wonderful that more geriatric patients are actively seeking dental treatment, it is also true that endodontic treatment for these patients is far more challenging. Let's look at some of the difficulties we face in performing root canal therapy for these patients.

First and foremost, geriatric patients require a thorough medical history to confirm that they can safely handle anesthetic requirements and other medications given during the course of dental treatment. Once we are assured that they can indeed handle the procedure, and after establishing an endodontic diagnosis, the next step is access and instrumentation. But how difficult are these to accomplish in the geriatric patient?

The most challenging aspect in performing clinical root canal therapy on geriatric patients is finding the canals. Access is important for all endodontic cases, but this can be an especially huge challenge with the elderly. Many geriatric patients have pulp chambers that no longer contain any pulp tissue. The pulp tissue in these cases has receded into the root as a result of previous



restorative materials or hyper-occlusion. The challenge in these cases is to create access (and locate the canal orifices) without perforating the floor of the chamber. A good way to avoid perforating the floor is prior to treatment, place a bur alongside an X-ray to determine the depth of the chamber. The determination of depth will act as a governor when making the access. Therefore, if you find yourself getting close to the critical depth, yet you are not exactly certain where you are, stop and take an X-ray.

As previously mentioned, quite often with geriatric patients, there is little or no pulp in the chamber and regardless of how careful we are, perforations can and will occur. But how are they best handled? Three things are crucial to perforation repair: time, size and location.

It is absolutely critical (for the long-term success of the tooth) to repair a perforation as soon as it happens. This applies to both large and small perforations. Do not reappoint the patient to further evaluate the situation. Simply seal the perforation at the time of its occurrence.

The second key element is size; the smaller the perforation, the better its long-term prognosis. There is a big difference between a perforation with a #10 hand file and a #4 round bur.

The third factor is location; the more apical the perforation, the better the prognosis. Where did the perforation occur? A perforation in the apical third with a small hand file can be considered somewhat like an accessory canal. Make certain the canal has been cleaned and irrigated properly and then obturate like normal. This is where a bioceramic sealer can be a huge help.

The most common perforations we see with our geriatric patients are floor perforations and perforations in the coronal area. Although a perforation in the coronal third of the root has a reduced prognosis, it is still quite good. However, a perforation that occurs directly at the CEJ has a reduced prognosis due to the percolation of oral fluids from the gingival sulcus. Nonetheless, the overall prognosis, if handled correctly, is also quite good.

Therefore, the next question should be "What is the best way to repair a perforation?"

Historically, all kinds of materials have been utilized in perforation repair. Granted, when MTA was introduced it was a significant advance in perforation repair. However, the challenge to some has been its lack of handling ability. It does not come premixed and therefore must be mixed by hand, can be difficult to use and has such a large particle size that it cannot be extruded through a small syringe. Nonetheless, it's a good material and has a number of favorable characteristics including a pH of 12.5 which is quite anti-bacterial. The science of repair materials has continued to evolve to a higher level through nanotechnology. This is why you should be using a true bioceramic material for perforation repair.

As mentioned in previous articles, EndoSequence Root Repair Material (Brasseler USA) is a true bioceramic which

comes premixed in a syringe, or as a putty form. This is a tremendous help not just in terms of assuring a proper mix but also in terms of ease of use. Consequently, for the first time, we have a root repair material with an easy and efficient delivery system that can deliver excellent results.

When using the putty, simply remove a small amount from the room temperature jar and knead it for a few seconds with a spatula or in your gloved hands. Then start to roll it into a hot-dog shape. This is very similar to creating similar shapes with desiccated ZOE or SuperEBA (Bosworth). Once you have created an oblong shape, you can pick up a section of it with a sterile instrument and use this to deliver it where needed. This is an easy technique for perf repairs, resorption defects and even for apico retro fills. After placing the putty into the apical preparation (or defect) simply wipe with a moist cotton ball and finish the procedure.

Once proper straight-line access is created, finding all the canals can also be a chore. A good help (in fact, we believe a necessity) is the use of a piezo electric ultrasonic to remove secondary dentin and coronal sclerosis. We particularly like the Varios 350 (Brasseler USA) to remove these obstructions.

While the size alone distinguishes this unit from all others, there is another feature that makes it outstanding. The Varios 350 comes with a fiber-optic light source that is actually built into the handpiece. The brilliance of this design is that the fiber optic is protected and its arc of light is precisely directed to the field of treatment. This is unlike any other fiber optic in that the light is completely circumferential and surrounds the tip. The primary benefit of having a fiber optic built into an ultrasonic is enhanced vision. In addition to length control, the biggest challenge facing the general practitioner (in all patients) is finding the canals. Endodontic cases with elderly patients are becoming increasingly difficult, particularly, those cases where the orifice has become occluded by secondary dentin. You cannot perform root canal therapy unless you find the orifice and can then enter the canal. Piezo electric ultrasonics are excellent for removing the secondary dentin that often slopes off the mesial wall. This is what blocks the MB-2 canal in maxillary molars. It is particularly in these maxillary molar cases, when looking for the MB-2, that the Varios 350 becomes invaluable. Another tip to remember when searching for hidden canals, is that secondary dentin is generally whitish or opaque, while the floor of the chamber is darker and more gray in composition. The fiber optic can really help the clinician in these cases by making this an obvious distinction.

The Varios 350 is especially helpful at breaking through the calcification that covers the canal orifice. A troubleshooting tip is a good choice for this task. We prefer the E-14D, E-9D and E-15D Brasseler diamond-coated tips for gaining access. Since we are seeing more coronal calcification with these

*continued on page 96*

patients, the solution is obvious. You need to have a piezo electric ultrasonic.

Another aid in the treatment of geriatric patients is the use of transillumination. The technique is quite simple. Turn off all the lights in the treatment room and turn off the light on the dental unit. Proceed to shine the fiber optic light (whether on a handpiece or ultrasonic) through the tooth at the CEJ level. The tooth will appear like a "Jack O' Lantern." Calcified canals will appear as dark dots, not as wide canals. Transillumination is also a good way to diagnose cracked and fractured teeth.

The root canals themselves associated with the elderly can be sufficiently cleaned and shaped if you can take the preparation to a fully tapered .04 taper. This generally can be achieved, although quite often we have to employ a hybrid technique utilizing both hand files and rotaries. Additionally, Dr Ali Nasseh discussed in a previous *Dentaltown Magazine* column the use of the new Scout Race files. To quote Dr. Nasseh:

*The Scout Race Files offer the same predictability in efficient cutting of dentin that I've come to expect from their sister files, the EndoSequence File Series. These files have the additional benefit of being very useful in thinner, more curved roots found in most molars. With these small sizes, the clinician can bypass the tedious work of hand instrumentation in smaller sizes and can benefit from the super elasticity of the NiTi metal with the efficiency of rotary instrumentation vs. hand filing.*

*Following the use of a size 6 or 8 hand file, and some coronal enlargement (as recommended in all crown down techniques), the size 10-20 (or merely 10 and 15) Scout Race files can rapidly enlarge the canals and create a patent canal that can then be instrumented predictably and safely with the EndoSequence Files or your rotary instruments of choice.*

*I've used these files now for several months and have been extremely happy with their performance in the more difficult and more curved molars. They have made my more difficult cases easier to manage than when I used mere hand instrumentation to scout the canal prior to the use of rotary files.*

One other thing that needs to be mentioned is that we believe the use of .02 taper rotary files (whatever system) should be limited to those dentists with considerable experience with rotary files. If one's endodontic clinical experience is somewhat limited, the clinician is best served using hand files (which are also .02 taper) in these challenging narrow canals.

Once the canals have been adequately prepared, the majority of these canals can accommodate a simplified obturation technique. This is where a synchronized hydraulic condensation technique (utilizing a bioceramic sealer and coated cones) should be used. Not only is this an excellent technique but it is also quick and reduces the time in the chair for the patient.

In fact, "time in the chair" is a serious consideration with the elderly patient. With our regular patients, we try to do as many

cases as possible in one visit, but a word of caution is necessary for geriatric patients. Don't make the appointments too long and remember, many of these individuals do not do well placed way back in the dental chair. Try to keep the appointments to 45 minutes and certainly no longer than 60. This of course depends upon the individual.

An appropriate way to complete this article is to have an experienced endodontist share his opinions on treating our elderly patients. Here is what Dr John Gatti, a noted endodontist in Lee's Summit, Missouri, has to say. In his own words...

*The 80-year-old patient today is the new 60. Although, medical history at any age is an important aspect in the diagnosis and the treatment of a patient, age alone should not deter endodontically treating our senior patients. In the capacity of endodontics, an 80-year-old tooth is just that, an 80-year-old tooth. One thing for sure will be the diminished canal space. The progression in endodontics from hand filing to the use of nickel-titanium rotary instrumentation was not only a tremendous advantage in the way in which teeth were endodontically treated, but a true advancement for treating our seniors because it allows thorough cleaning and shaping with predictable results in an efficient manner.*

*Many senior patients enjoy going to the dentist. Often, it is a planned event which takes precedent over everything else for them. It is important to take note of this, as a mere "thank you for coming in today" can be the precursor to a successful appointment. In particular, following six principles in treating seniors will allow for a very successful appointment. 1) Sense. Use the 'sixth' sense, by being aware of a patient's faculties. This is important as to how they will be communicating. 2) Engage. It might be a smile, a pause (slowing down the pace) or even an initial handshake. 3) Nice. Sometimes our seniors don't feel well and often for good reason. Being extremely pleasant can often change a patient's attitude for the better, than might otherwise be construed as defiant. 4) Include. Include these patients in treatment. Patients might not grasp everything being explained, but they do understand when they are included, and that is a very good feeling. 5) Observe. Most of the time, the endodontic treatment is the lesser of the difficulties in the treatment of our seniors. Make sure to observe their movements and watch their body language, especially when the patient is prepped and ready for root canal access. 6) Respect. Respect is a very easy task, but commonly ignored. Many seniors feel unimportant. A patient can feel respect by the way we as practitioners communicate. There is no better feeling than a senior patient being able to leave an appointment feeling respected.*

*Case: 81-year-old woman presents as an active senior. Generally good health and active lifestyle, yet very small stature. She prides herself in walking one mile each day.*



Fig. 2: Severe angulation of #15 file placed in distal canal.



Fig. 3: Conservative access, location of juxtaposed mesial canals (a). Microscopic location of distal canal, evaluation of pulp floor; removal of decay/no crack observed – canal seal (b & c).



*Initial considerations of this case are a thorough medical history and diagnosis of the patient's pain. Medical history was non-contributory and it was concluded that due to the recent FPD placement, an irreversible pulpitis ensued. Clinical and radiographic evaluation revealed a very thin mandible, small mouth, with limited opening. The pre-operative radiograph exhibits a large FPD restoration with an angulated root system. This type of configuration requires special attention during access. A greater portion of porcelain and metal will be thicker toward the mesial as required for proper occlusion, thus access should be done incrementally (initial removal of the porcelain with a diamond burr, small pilot hole with a #4 round burr, followed by using a trans-metal burr to make conservative ovoid access in the first 2mm of the crown. Once this has been initiated, the round bur is then used to penetrate closer to the chamber, while also using ultrasonic instrumentation for removal of calcifications). Natural tooth support can always be taken away, but not put back. If the access is properly performed, location of the canals becomes exponentially easier. Remember, tooth anatomy will not change even when clinical perception can cast doubt on the root system. In other words, what appears in the mouth might not conform with the root system.*

*This case also presents with two other concerns: the coronally calcified mesial root, as well as the S curved distal root. As shown in the microscopic photo, the mesial canals are very close together and the distal root required hand file patency prior to using rotary instrumentation. This along with synchronized hydraulic condensation made this difficult case very manageable allowing for a successful result.*

Geriatric patients can and should be an integral part of your practice. Hopefully, we have given you some tips on how to make "geroendodontology" easier for both you and the patients. n

## Author Bios

**Dr. Dennis Brave** is a diplomate of the American Board of Endodontics, and a member of the College of Diplomates. Dr. Brave received his DDS degree from the Baltimore College of Dental Surgery, University of Maryland and his certificate in endodontics from the University of Pennsylvania. He is an Omicron Kappa Upsilon Scholastic Award Winner and a Gorgas Odontologic Honor Society Member. In endodontic practice for more than 25 years, he has lectured extensively throughout the world and holds multiple patents, including the VisiFrame. Formerly an associate clinical professor at the University of Pennsylvania, Dr. Brave currently holds a staff position at The Johns Hopkins Hospital. Along with having authored numerous articles on endodontics, Dr. Brave is a co-founder of Real World Endo.



**Dr. Kenneth Koch** received both his DMD and certificate in endodontics from the University of Pennsylvania School of Dental Medicine. He is the founder and past director of the new program in postdoctoral endodontics at the Harvard School of Dental Medicine. Prior to his endodontic career, Dr. Koch spent 10 years in the Air Force and held, among various positions, that of Chief of Prosthodontics at Osan AFB and Chief of Prosthodontics at McGuire AFB. In addition to having maintained a private practice, limited to endodontics, Dr. Koch has lectured extensively in both the United States and abroad. He is also the author of numerous articles on endodontics. Dr. Koch is a co-founder of Real World Endo.



# What Do You Do First Thing in the Morning?

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

“Brush after meals.” That’s the message we’ve heard and repeated for decades. It’s not just dentists and hygienists sharing this message, toothpaste companies also tell consumers to brush after meals. But is this idea based on science or simply a tradition that has been repeated so often it’s become dogma, without any scientific substance? Research shows that if the meal consists of any high acid foods or beverages brushing right after eating can be detrimental. The acids in orange juice or soda pop will actually soften enamel and dentin enough to make them susceptible to abrasion when brushed with toothpaste. Based on these findings, researchers suggest waiting 60 minutes after eating to brush. Dr. Martin Addy and his research team at the University of Bristol in the U.K. who did the acid testing suggest brushing before eating rather than after to prevent acid production.

Plaque bacteria produce acid right away. According to research published by Dr. John Featherstone of University of San Francisco, acid production occurs within seconds of bacteria’s exposure to sucrose or fermentable carbohydrates. This acid production will drop the salivary pH from a neutral of 7 to an acidic level of 4.5 within just five minutes. It then takes 30 minutes to return to a pH of 7. Waiting to remove bacterial plaque biofilm until the meal is over allows the bacteria ample time to produce acid.

Brushing and flossing first thing in the morning to remove the plaque biofilm thoroughly before introducing fermentable carbohydrates prevents acid production. If you wait to brush and floss your teeth until after breakfast, it’s too late. Sure, you will now remove both bacterial biofilm and food particles, but if you’ve had orange juice or other acidic foods, it might cause microscopic damage to the enamel. According to Dr. Addy brushing after the acid is produced is no longer preventive. Preventive interventions occur before the event – in this case, prevention would occur before acid production by *Strep mutans*, not after.

To consumers, brushing after meals make sense because they equate brushing to removing food particles; however, toothbrushing research focuses on plaque removal, not food removal. We have no research suggesting that toothbrushing is effective for food removal. Food particles generally remain between the teeth, not on the facial and lingual surfaces reached by the toothbrush. Rinsing works to flush out food particles, so using an oral irrigation device after eating makes more sense than brushing after meals.

Another tradition without supporting science suggests that brushing last thing at night is more important than brushing in the morning. When asked, Addy said that, although brushing before going to bed might be convenient, he’s not sure what it achieves except to remove acid-softened enamel or dentin. Since soda and alcoholic drink consumption in the evening is a common practice, both in England and the United States, it makes more sense to brush when you get home from work, before having dinner, rather than after softening the enamel with acidic foods and beverages.

It looks like our brushing traditions are just that – traditions. Based on what we do know, however, it makes more sense to brush before eating. That way, plaque is removed before ingesting sugars, and if acidic foods and beverages are ingested, we avoid compounding the erosion with toothpaste abrasion.

What about you? Do you brush and floss first thing in the morning or wait until after breakfast? Base your decision on scientific evidence, not tradition. n

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# Perio Reports vol. 23 No. 11

*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.*

## New Tip for Air Polishing Reaches Subgingivally

Following periodontal therapy, subgingival microflora returns within days, necessitating periodontal supportive therapy (PST) visits every few months to maintain periodontal tissue health. Mechanical disruption of the subgingival microflora has long been accomplished with hand instruments. Scraping of the root surfaces removes cementum, creating irreversible hard tissue damage and in some cases, recession.

Air polishing traditionally uses a sodium bicarbonate powder that effectively removes plaque and stains from tooth surfaces, but damages gingival tissues when directed subgingivally. To solve this problem, a glycine powder was recently introduced that does not cause tissue trauma when directed subgingivally. To enhance subgingival cleaning, EMS designed a tip to direct the glycine powder subgingivally with lower jet spray flow and lower pressure than is used supragingivally.

Researchers at the University of Geneva in Switzerland compared air polishing with glycine powder using the new subgingival tip to hand instrumentation in 50 periodontal maintenance patients. These subjects all had at least two residual pockets measuring 5mm or more in two separate quadrants. Sites for each patient were randomly assigned to test and control treatments. This seven-day study measured subgingival microflora and bleeding upon probing.

Air polishing time averaged 30 seconds per site compared to curette use averaging 1.4 minutes per site. Bleeding upon probing was reduced for both groups, with greater reduction in the control group. No differences were observed for subgingival microflora between test and control groups. No tissue trauma was noted with air polishing. Patients preferred air polishing over curettes.

**Clinical Implications: The new subgingival air polishing tip provides an alternative to hand instruments for PST.**

*Moëne, R., Décaillet, F., Andersen, E., Mombelli, A.: Subgingival Plaque Removal Using a New Air-Polishing Device. J Perio 81: 79-88, 2010. n*

## Subgingival Debridement Effective with Air Polisher

Periodontal therapy patients are seen frequently for supportive periodontal maintenance visits to control subgingival microflora. This is usually done with curettes or power scalers. A new subgingival approach uses glycine powder in an air polisher.

Researchers at the University of Gothenburg in Sweden compared subgingival air polishing with glycine powder to ultrasonic scaling. Perio maintenance patients with two probing sites measuring 5 to 8mm in different quadrants were included in this two-month study. The control group was treated subgingivally with the EMS Piezon Master piezoelectric scaler set at 75 percent power with water coolant. The test group was treated with a new subgingival tip on the EMS Air-Flow air polisher with glycine powder.

Subgingival bacterial samples were collected before treatment, right after treatment, two days later and at 14 days. Clinical indices were taken before treatment, 14 days and at 60 days.

A total of 20 patients were treated with air polishing at a test site in one quadrant and ultrasonic scaling at a second site in another quadrant.

Both treatments resulted in significant reductions in subgingival bacteria immediately after treatment and two days later. By day 14, both groups returned to baseline levels of subgingival bacteria.

Clinical reductions in probing depths and bleeding scores were significant for both the treatment and control sites. Patients were also asked to rate comfort with each procedure. Air polishing was found more comfortable than ultrasonic scaling.

**Clinical Implications: Subgingival air polishing with this new tip and glycine powder could replace ultrasonic instrumentation during periodontal maintenance visits.**

*Wennström, J., Dahlén, G., Ramberg, P.: Subgingival Debridement of Periodontal Pockets by Air Polishing in Comparison with Ultrasonic Instrumentation during Maintenance Therapy. J Perio 38: 820-827, 2011. n*

## Air Polishing Treats Peri-implantitis

Peri-implant mucositis is inflammation limited to the mucosa, while peri-implantitis is characterized by changes in bone levels plus bleeding. The three primary risk factors for peri-implantitis are poor oral hygiene, smoking and a history of periodontal disease.

Non-surgical treatment of peri-implant mucositis including mechanical instrumentation, ultrasonics and delivery of chemicals is usually successful in reversing the infection. Not so in cases of peri-implantitis which has unpredictable outcomes limited to six to 12 months.

The use of air polishing has not been an option with the traditional sodium bicarbonate powder because it damages implant surfaces. With the introduction of amino acid glycine powder, air polishing can now be used on implants.

Researchers at Heinrich Heine University in Dusseldorf, Germany, compared air polishing using glycine powder and the new subgingival Perio-Flow tip from EMS to the use of carbon currettes and subgingival delivery of chlorhexidine.

One month prior to baseline, the 30 patients with early to moderate peri-implantitis received a prophylaxis and oral hygiene instructions. This protocol was repeated at base-

line and every two weeks for three months and then monthly for the next three months.

Both treatments resulted in reduced probing depths of half a millimeter. Bleeding was reduced more in the air polishing group, from 95 percent to 50 percent compared to a reduction from 95 percent to 84 percent in the curette and chlorhexidine group.

**Clinical Implications: Air polishing with glycine powder using the new subgingival tip provides another option for treating peri-implantitis.**

*Sahm, N., Becker, J., Santel, T., Schwarz, F.: Non-Surgical Treatment of Perio-Implantitis Using an Air-Abrasive Device or Mechanical Debridement and Local Application of Chlorhexidine: A Prospective, Randomized, Controlled Clinical Study. J Clin Perio 38: 872-878, 2011. n*



## Air Polishing and Laser Both Effective for Treating Peri-implantitis

Peri-implantitis is difficult to treat. Fortunately, the success rate of implant placement is around 95 percent. As more and more implants are placed, the incidence of peri-implantitis might increase, posing major treatment challenges. Implant surfaces and threads pose significant challenges to mechanical disruption of bacterial biofilm. In a recent consensus report it was concluded that traditional non-surgical therapy for peri-implantitis was not effective. Slightly better results are possible with the Er:YAG laser.

Researchers at Kristianstad University in Kristianstad, Sweden, compared the new EMS glycine air polishing powder with the EMS new disposable subgingival tip to the KaVo Laser 3 Perio laser for treating peri-implantitis with 21 subjects in each group over six months time.

All test subjects received a Philips Sonicare FlexCare power toothbrush, detailed oral hygiene instructions and new brush heads every three months.

Both groups showed significant healing with 25 percent of

subjects in the laser group with average probing depth reductions of 1mm and 38 percent of those in the air polishing group showing a 1mm average probing depth reduction. Laser treatment resulted in improved health at 44 percent of implant sites and air polishing at 47 percent of sites.

Although both the laser and the air polishing did help some sites with severe peri-implantitis, neither therapy provided predictable treatment for severe peri-implantitis.

**Clinical Implications: For severe peri-implantitis both air polishing with glycine powder using the disposable subgingival plastic tip and laser treatment using an Er:YAG might improve some lesions, but not with any degree of predictability.**

*Renvert, S., Lindahl, C., Jansaker, A., Persson, G.: Treatment of Perio-Implantitis Using an Er:YAG Laser or an Air-Abrasive Device: A Randomized Clinical Trial. J Clin Perio 38: 65-73, 2011. n*

*continued on page 102*

## Metronidazole Alone or with Amoxicillin – Which is Better?

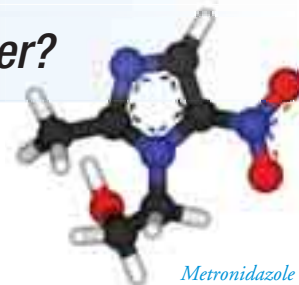
Systemic metronidazole is an effective antibiotic against strict anaerobic bacteria, those characteristic of chronic periodontitis. In the late 1980s, Van Winkelhoff suggested an antibiotic cocktail combining metronidazole and amoxicillin for aggressive periodontitis, specifically *Aa* infections. In the late 1990s, the Van Winkelhoff cocktail also proved effective in the treatment of chronic periodontitis. Systemic antibiotics are combined with scaling and root planing (SRP).

Researchers at Guarulhos University in Sao Paulo, Brazil, compared SRP alone or combined with metronidazole alone or metronidazole and amoxicillin. They created two test groups and one control group, with 17 subjects in each. All subjects received four to six SRP visits using hand instruments under local anesthesia. Test subjects took assigned antibiotics three times daily for 14 days. Placebo pills were used so all subjects took the same regimen.

Clinical indices and subgingival plaque biofilm samples were taken at baseline and three months post therapy. All groups showed significant healing, but still had probing depths 5mm or deeper at three months. The SRP group began with an average of 40 sites 5mm or deeper and ended with 13, the metronidazole group began with 35 and ended with nine, the antibiotic cocktail group began with 39 and ended with five. Clinical attachment gains in pockets 7mm was 2mm in the SRP group, 2.7mm in the metronidazole group and 3mm in the cocktail group.

**Clinical Implications: In non-smoking patients with chronic periodontitis, there are some short-term benefits from using metronidazole and amoxicillin with SRP.**

*Silva, M., Feres, M., Siroto, T., Soares, G., Mendes, J., Faveri, M., Figueiredo, L.: Clinical and Microbiological Benefits of Metronidazole alone or with Amoxicillin as Adjuncts in the Treatment of Chronic Periodontitis: A Randomized Placebo-Controlled Clinical Trial. J Clin Perio 38: 828-837, 2011. n*



Metronidazole

## Azithromycin Provides No Added Benefit over SRP Alone

Infections are often treated with antibiotics, and periodontitis is no exception. Metronidazole and amoxicillin are widely used, with some recent interest in azithromycin. This is a promising semi-synthetic, broad spectrum, bacteriostatic drug that is rapidly absorbed by cells. Drug concentrations at the site of inflammation are 10 to 100 times higher than in serum. Patient compliance is better with the once-daily dose for periods of three to five days.

Researchers at Guarulhos University in Sao Paulo, Brazil, compared SRP alone in 19 patients and SRP plus azithromycin once daily for five days in 19 patients. Clinical indices and subgingival plaque biofilm samples were taken at baseline, six and 12 months.

Full-mouth SRP was provided in four to six two-hour appointments over a two-week period using hand instruments under local anesthesia.

At the end of one year, both groups showed significant healing, with no differences between test and control groups, yet disease still remained. Despite ending the study with an average of three or four sites per patient that were 5mm or deeper with bleeding, the SRP group showed an average pocket depth reduction of 3.8mm. This is likely due to the number of very deep pockets at baseline. As the authors observed, “very deep sites” were converted to “deep sites” rather than being eliminated.

**Clinical Implications: Good SRP and oral hygiene instructions are still the cornerstone of non-surgical therapy for chronic periodontitis. Antibiotics might be effective for some cases, but not all antibiotics will enhance healing.**

*Sampaio, E., Rocha, M., Figueiredo, L., Faveri, M., Duarte, P., Lira, A., Feres, M.: Clinical and Microbiological Effects of Azithromycin in the Treatment of Generalized Chronic Periodontitis: A Randomized Placebo-Controlled Clinical Trial. J Clin Perio 38: 838-846, 2011. n*

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Safely



## the Dental Neighborho

Sugar is back in the news. After decades of struggling with the low-fat paradigm, the Standard American Diet (SAD) and the Fast Food American Diet (FFAD), consumers are again being warned about the health risks of sugar overuse.<sup>1</sup>

Popular dietary advice and consumer attitudes about sugar can impact dental health. The 1986 Report of the Sugars Task Force published by the United States Food and Drug Administration concluded that high sugar usage contributes significantly to caries experience, and that the consumption of sucrose and fermentable carbohydrates facilitates the development of plaque, dental caries and periodontal disease.

Our dental health perspective should be broadened to include consideration of health effects throughout the body.<sup>2</sup> The American Heart Association (AHA) links excessive sugar consumption to disrupted metabolism, obesity and vascular disease. A recent AHA recommendation places an upper limit of added sugars at 25 grams (less than an ounce) per day for women. Just one 12-ounce cola contains nearly 40 grams of added sugars and more than 150 calories.

Many leading health authorities now agree that preventable disease conditions result from frequent and massive overconsumption of sugars in a largely sedentary society. Nearly one-quarter of our calories come from added sugars.

Dentally, a major concern is the frequency of exposures to sugar. For overall health, the key is the total amount of sugars added beyond those encountered in fruits and vegetables. Among proposed solutions are strict sugar restriction or sugar substitution with low-calorie, non-cariogenic sweeteners.

### What is Sugar?

Sucrose is common table sugar. The source, cane or beet, does not matter. On food labels, “sugar” means “sucrose.” The term “sugars” refers to all mono- and di-saccharides, with the “-ose” ending.

Glucose and Fructose are both monosaccharides. Sucrose is a disaccharide (Fig. 1). In the oral cavity, glucose and fructose are in themselves cariogenic. Sucrose is potentially even more dangerous. Most dietary sugars are based on a mono-saccharide unit with a six-carbon-

atom backbone. The reactive carbonyl (aldehyde or ketone) functional group allows monosaccharides to link together to form disaccharides or polymer chains of oligosaccharides (oligo- “a few”) and polysaccharides (poly- “many”). For example maltose is a disaccharide of two glucose monosaccharides, maltodextrin is an oligosaccharide usually up to 20 glucose units and starch is a glucose polysaccharide that might have more than 1,000 glucose molecules linked together.

The more polysaccharides are processed and cooked, the more readily they break down into component sugar molecules in the oral cavity and are therefore included as “fermentable” (particularly to lactic acid) carbohydrates. There are differences in cariogenic potential of different sugars in a range from highly cariogenic (sucrose) to low cariogenic (lactose) or even non-cariogenic (tagatose, cellobiose). However, the majority of dietary sugars are generally considered acidogenic and potentially cariogenic.

### Good or Bad Sweeteners

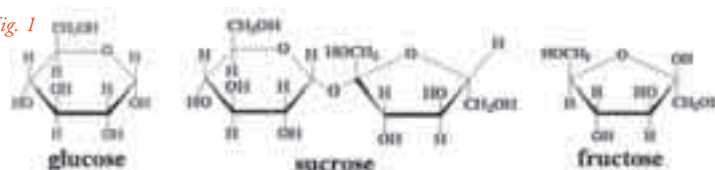
Realistically, there are no intrinsically good or bad sweeteners because potential benefit or harm depends on so many diverse factors in application and usage in the overall diet. It is helpful to recognize some of the controversies and see how dental and systemic health might be involved.

Dentally, consider the impact on our natural protective factors such as saliva, pH, mineralization and oral flora. Metabolically, it is useful to see how sweeteners affect digestion, blood sugar, energy, lipids and other parameters.

### Bulk Sweeteners

Bulk sweeteners are sugars – including ordinary common table sugar – and sugar alcohols. The goal of bulk sweetening is to match or exceed the qualities of sucrose at comparable or reduced cost. Bulk sweeteners provide both sweetness and func-

Fig. 1





## Food Part 1 by Dr. John Peldyak

tions such as volume, texture, “mouth feel,” humectancy, calories and might assist in food preservation.

### Sugar Alcohols

Sugar alcohols are reduction products of sugars, where the reactive carbon to oxygen double bond carbonyl group is “reduced” by hydrogen to a hydroxyl or alcohol. Sugar alcohols are closely related to sugars but are generally more slowly absorbed, lower in calories, less reactive and less cariogenic than their sugar counterparts. High cost, lower sweetness and possible laxation at higher doses (similar to dietary fiber) limits full substitution for sugars in many products.

### High Intensity Sweeteners

Intense (high potency) sweeteners are much sweeter than sugar by hundreds or even thousands of times. They can have a cloying or bitter aftertaste with prolonged use or high concentration. High potency sweeteners are considered non-nutritive or non-caloric and contribute only sweetness to a product. They are most popular in liquids where water provides the bulk. Stevia is a plant extract; the others are artificial. Although artificial sweeteners are supposed to help displace caloric and cariogenic sweeteners, caution is advised regarding the overall product. The volume of high intensity sweeteners is so small that tabletop packets require added bulking agents – usually glucose (D-glucose or dextrose on labels) and maltodextrin – which are not safe for teeth. Diet beverages used throughout the day are usually highly acidic which can contribute to erosion and select for acid-tolerant microflora. Also beware that daily consumption of artificially sweetened “diet” soda might double the risk of obesity, and increase vascular events by 50 percent. Despite reduction in

#### Intense, High Potency Super Sweeteners

- Acesulfame Potassium (Ace K) (130x)
- Stevia (steviosides, rebaudiosides) (150x)
- Saccharine (180x)
- Aspartame (200x sweeter than sucrose)
- Sucralose (600x)
- Neotame (up to 13,000x)

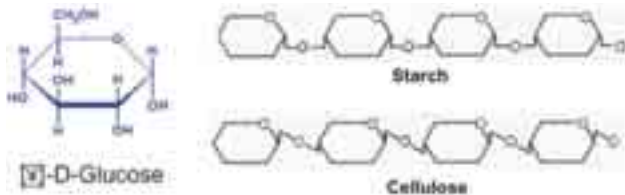
*continued on page 106*

calories, some artificial sweeteners have been implicated in appetite stimulation.<sup>3</sup>

### Complex Carbohydrates

An earlier term complexed carbohydrates referred to carbohydrates present in unprocessed whole foods. The current definition of “complex carbohydrates” is based on molecular weight of polysaccharides, but provides no functional meaning for metabolism, ability to raise blood sugar, or cariogenicity. Differences in how even the same sugars are molecularly linked can make a big difference in digestion and metabolism. Glucose polymer (as starch, maltodextrin) can be broken down rapidly to cariogenic sugars, or (as cellulose, polydextrose) can be resistant to digestion and function as dietary fiber. Likewise “simple sugars” such as xylose can be non-cariogenic.

Insoluble fiber such as bran is metabolically inactive but assists regular elimination. Soluble dietary fiber forms a viscous gel that can be broken down by bacteria in the colon. Soluble fiber is known as “prebiotic” favoring healthy intestinal flora. Adequate consumption is associated with reduction in colon cancer, stabilizing blood sugar and improving heart disease markers.



### Sucrose is Special (Dentally)

The disaccharide sucrose is readily digested to its monosaccharide components, and is metabolically similar to equivalent loads of glucose and fructose.

In the oral cavity, glucose and fructose are by themselves cariogenic, but sucrose is potentially even more dangerous. Acidogenic bacteria such as the *mutans* group of *streptococci* cleave the disaccharide bond for energy, and use the resulting glucose and fructose residues for more energy and lactic acid production. During times of sugar availability, remaining glucose and fructose molecules are reassembled into intracellular polysaccharide for energy storage, and extracellular glucans and fructans (branched glucose and fructose polymer) that form much of the sticky, protective matrix in biofilms. Frequent sucrose exposure leads to plaque that is abundant, adhesive, acidic and irritating to the tissues.

### Glucose

Glucose is absorbed rapidly by active transport and quickly raises blood sugar levels (high glycemic). Glucose is the monosaccharide that can be utilized for energy throughout the body. Excess glucose can be stored as glycogen, a glucose polysaccharide known as “body starch.”

### Glycemic Index

The Glycemic Index (GI) was developed in the early 1980s to measure the effect on blood sugar of the same amount of various carbohydrates. Some early surprises confirmed that different carbohydrates have widely different glycemic impact. For example, plain white bread topped the chart, whereas some sweet fruits like cherries and plums registered very low, even less than barley. The confusion and controversy over the reliability and utility of the GI continues.

It should be apparent from scanning GI lists that many polysaccharide “complex carbohydrates” such as cooked starch are rapidly broken down to monosaccharides. This agrees with dental researchers who warn that starchy carbohydrate foods are acidogenic.

Cardiologists Dr. William Davis<sup>4</sup> and Dr. Frederick Vagnini<sup>5</sup> point out the dangers of a high-glycemic diet rich in sugars and starches. Processed starch, even whole wheat bread, raises blood sugar more than pure sucrose sugar. Those fluffy fast food hamburger buns are even worse.

Repeatedly or persistently high blood glucose triggers correspondingly high insulin levels promoting efficient fat storage. The cycle progresses as more fat accumulation causes inflammation leading to insulin resistance, poor lipid control and tissue damage of the pre-diabetic and diabetic states.

### High Fructose Corn Syrup (HFCS)

Some looked at the early GI data and concluded that sugar is no worse than starch for glycemic control, so go ahead and enjoy! The focus was locked on calories and fat. It was noted that perhaps the very low GI of fructose would have a metabolic advantage, particularly for diabetics. Fructose was rapidly gaining popularity since an enzyme process began commercial production in 1975. Corn starch polysaccharide is first broken down (with water, heat and acid) to glucose syrup, and then some of the glucose is enzymatically converted to fructose. The result is a high fructose corn syrup consisting of 58 percent glucose and 42 percent fructose which has the same sweetness as sucrose, or could be concentrated to 45 percent glucose and 55 percent fructose. The HFCS 42 could easily be incorporated into processed foods, and the HFCS 55 is commonly used in beverages at lower costs than sucrose. Being even sweeter than sucrose HFCS 55 allows manufacturers to mask diuretics such as caffeine and sodium to encourage more consumption. By now HFCS seems to be in most processed foods, including baby foods and infant formula.

HFCS has displaced sucrose in many applications, especially in soft drinks. Metabolically, it does not seem to make much difference if these sugars are ingested as monosaccharides or disaccharides. Dentally, the disaccharide sucrose is more harmful.

### Fructose

Evidence is accumulating that excess consumption of fructose is particularly harmful. Although fructose is sometimes promoted for a small glycemic impact, it is absorbed fairly rapidly.

Unlike glucose, most fructose is processed in the liver. A rush of fructose overloads a processing bottleneck in the liver, where excess fructose is efficiently converted to triglycerides and fat.

Dr. Robert H. Lustig, UCSF professor of pediatrics in the division of endocrinology<sup>6</sup> and Dr. Richard Johnson, University of Colorado<sup>7</sup> interview with Dr. Joseph Mercola<sup>8</sup> and point out potentially devastating effects. Compared to glucose, isocaloric loads of fructose have greater effect on:

- Increased appetite
- Increased triglycerides
- Induced insulin resistance
- Impaired glucose tolerance
- Decreased leptin and insulin (satiety) signaling
- Dyslipidemia (high LDL, low HDL)
- Pro-inflammatory markers
- Increased oxidative stress
- Damage to pancreas beta cells
- Increased blood pressure
- Increased uric acid

Chronic sugar, particularly fructose overconsumption might contribute to:

- Obesity
- Premature aging
- Metabolic syndrome (prediabetes, eventually diabetes)
- Vascular disease
- Heart disease
- Fatty livers (non-alcoholic fatty liver disease)
- Kidney disease
- Gout

## Maillard Reaction

Carbonyl group of sugars can also link with amino acids. The Maillard reaction is a familiar non-enzymatic “browning” that occurs in cooking where sugars react with proteins. Non-enzymatic implies “uncontrolled” reactions in the body. Sugars build up on and crosslink these glycosylated proteins. This leads to the formation of “AGEs” – Advanced Glycation End products – which are useless molecules that clog up normal pathways. Eventually there is loss of function, elasticity and structural support (think of browning toast, age spots, gingival recession, wrinkles and accelerated aging). Persistently high blood glucose (can be determined by measuring glycosylated hemoglobin in the HbA1c blood test) and fructose cause more AGE formation. Fructose is particularly dangerous, as it is up to seven times more likely to glycosylate than glucose.

## How Much is Too Much?

Close to half of our sugar is in the form of fructose. Overall consumption of sugars is now almost 140 pounds per person per year, in spite of all the intense sweeteners that were supposed to depress sugar demand. About one-third of adult Americans are already obese, and the rest of the world is catching up. It is variously estimated that our ancestors normally consumed only

about one ounce of sugars or about 15 grams of fructose naturally in fruits and vegetables daily. Very physically active individuals can usually tolerate higher amounts. In times of abundance that amount could be much higher. Fat storage then was a survival mechanism for lean times. But, most consumers now are regularly getting many times those amounts. Access to sugars is just too easy, and the products are just too enticing.

Although fructose is associated with fruit, consumption of moderate amounts of fruit is almost universally considered healthy. The amount of fructose in berries and most fresh fruit is modest – generally less than 10 grams per serving. Fruit contains fiber along with many valuable nutrients and contributes to favorable potassium to sodium balance. However, dried fruits, fruit juice and sweetened fruit-flavored beverages can quickly add to the overall fructose burden.

## The Trend is to Blend

The large manufacturers are already beginning to respond to public awareness concerns about sugar overload. Watch for more selections of “low sugar” or “reduced sugar” in packaged product introductions. The trend is to replace some, but not all, sugar with combinations of polyols and intense sweeteners. Additional claims for reduced calories go along with using less sugar. If “resistant” starch and “resistant” maltodextrin are incorporated, a fiber claim might also be made. Such products, even those that tout “no sugar added,” should be evaluated individually, as they might still contain acidogenic sugars and polysaccharides.

Another trend is to go back to using sucrose instead of HFCS. Some consumers are influenced to perceive “pure natural cane sugar” is superior to HFCS. The corn syrup lobby is fighting back, insisting that there is no difference metabolically. Their contention might be valid, and sucrose might actually make the product more harmful dentally.<sup>9</sup>

Sugars can be problematic dentally and metabolically. What steps can we take to enjoy the sweet benefits and minimize the damage? ▢

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## Author's Bio

**John Peldyak** is a general dentist in Michigan. He received his DMD degree from Southern Illinois University in 1980 and was a member of professor Kauko Mäkinen's University of Michigan xylitol research group on sugar substitutes from 1986-1992. Dr. Peldyak is also a founding member of the American Academy of Oral Systemic Health.



# Gross Debridement

Insurance code D4355 is designed to be used for the removal of calculus deposits that are so heavy accurate periodontal probing cannot be done.

**oldrdh**

Posted: 5/22/2011

Post: 1 of 7

I am looking for documentation to present to my dentist that D4355 (gross debridement) isn't considered standard of care. Any feedback would be appreciated. ■

**konarocky**

Posted: 5/23/2011

Post: 3 of 7



What do you mean it is not standard of care? How is it being used in your office? ■

**scottingham**

Posted: 5/25/2011

Post: 4 of 7



The definition of the D4355 is: full-mouth debridement (FMD) is done to enable comprehensive evaluation and diagnosis. The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures (as stated in the CDT 2011-2012).

This code does not indicate that if a patient has not had his or her teeth cleaned in a couple of years he or she must have a FMD and then a prophylaxis. This code is not to be used if you simply think it's going to take you longer. This code shouldn't be used just because you heard at some seminar it's a great way to increase production.

The D4355 is only used in order to facilitate the examination of the teeth! Which means, by definition, it should come before the comprehensive exam and some insurance companies will not allow it to be billed on the same day as the comprehensive exam. The exam has to come after the FMD.

Standard of care is to complete the proper diagnostics, examine all structures, periodontal chart, review health history and all of the other details required in a detailed comprehensive exam, and determine what the best course of action for the patient is. If the exam could not be performed due to not being able to see the teeth, then stop the exam, remove the excess build up and reschedule for the comprehensive exam after the tissue has had a chance to settle down. Then you can get an accurate picture of what will best benefit the patient. ■

**twigs**

Posted: 5/31/2011

Post: 5 of 7

I have used this code a number of times, and I do tell the patients to come back for a full exam and periodontal charting after the debridement and explain to them that cleaning is not complete and I just need their tissues to heal a bit. Also give them some home care instruction. Eight out of 10 times they never return and the boss' wife is angry at me because we lost the exam and any work, so I've been told I'm not allowed to do FMDs anymore. If they don't need quadrant scaling, I'm just to do what I can. Frustrating! ■

**konarocky**

Posted: 5/31/2011 ■ Post: 6 of 7

I've often wondered how "gross" does it have to be to properly use the D4355 code? I've seen many patients who present with gross supra only around 22 to 27 or

23 to 26 that prevents accurate probing. Do we need a partial mouth debridement (PMD) code for cases like this or is it OK to bill a D4355 FMD? ■

As I previously discussed, the FMD is really an over-used and mis-used code for the most part. If we consider that the majority of the population has some form of periodontal disease then why are we not diagnosing the condition and providing the necessary treatment (SRP) more often?



**scottingham**

Posted: 6/2/2011

Post: 7 of 7

Personally I rarely used the D4355 when I practiced clinically, as the areas of town that I worked in did not have a clientele that required the service, so there was more treatment going directly into SRP.

If there are areas of the mouth that cannot be diagnosed due to the amount of calculus, then you can use the D4355 code. So if the lower anteriors are heavily loaded, this would apply. It is overkill if you are moving right into SRP and it is a clear cut perio diagnosis. The question is does doing an FMD prior to SRP make your job easier or harder? I would love to hear your responses. ■

Gross Debridement



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# This is What a Pack a Day Can Do For You

*Amazing that a person will tolerate a lesion this big without seeking dental care.*

rdh1982

Posted: 9/2/2011

Post: 1 of 8



This is what a pack a day can do for you.

This photo is of a 75-year-old female who smoked a pack-a-day for more than fifty years. She had no intent to quit smoking despite repeated warnings from hygienists, dentists and twice by an oral surgeon. She was on three-month recare visits, however, due to “family problems” couldn’t keep her scheduled appointments for the past 18 months. Her main concern with hygiene visits was removing “all the black stain off because it is ugly.” By the way, she dressed very well, nice make-up and appeared to have her hair done professionally.



Every time we showed or mentioned the recurrent white lesions under her tongue her response was indifference and she would say something like “it doesn’t hurt me and I’m not going to worry about it.” This statement made after two oral surgery tissue biopsies, one brush biopsy and one “light system” oral cancer exam.

At her last visit, 18 months ago, there were several wide, smooth, flat and white shiny elongated lesions under her tongue (seemingly unchanged from previous visits and oral cancer exams). Past tissue biopsies from the oral surgeon reported lichen planus mixed with keratotic and inflammatory cells. Again, repeated strong warnings and recommendations to stop smoking were given, yet she continued to smoke and ignored all warnings.

Fast forward... she called our office a few weeks ago stating that she had a “sore spot under her tongue” and wanted to schedule an appointment with the doctor. He took this photo with another immediate referral to the oral surgeon. This time the report comes back with the diagnosis: squamous cell carcinoma.

My point being there doesn’t appear to be any 100 percent effective early cancer diagnostic devices available yet, especially when dealing with the most unbelieving, stubborn tobacco-addicted patients. Our office will diligently continue to perform thorough head and neck exams also utilizing the latest technology and oral surgery referrals. All unusual lumps, bumps, discolorations and lesions need to be documented, tested and retested while constantly coaching and teaching our patients the rules of prevention. ■

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One summer day, Mark and Tony decide to try bungee-jumping.

After a full day of bungee-fun, Mark says, "You know, Tony, we could make a lot of money running our own bungee-jumping service in Mexico."

"You're right," Tony says.

So Mark and Tony pool their money and buy everything they'll need – a tower, an elastic cord, insurance, etc.

They drive from San Diego to Mexico and set up their equipment on the edge of a cliff. While they construct the tower, a crowd assembles at the bottom of the cliff, to watch.

Hours later, Mark and Tony finish. Mark climbs the tower, straps himself in and jumps.

When he bounces back up, he's got a few cuts and bruises. Tony tries to catch him, but Mark spirals back down. When he bounces up the next time, he's bruised and bleeding. Again, Tony reaches for his friend, and again, he misses.

When Mark comes back up a third time, he's brutally beaten, almost unconscious. Luckily, Tony catches him and drags him onto the platform.

"What happened?" Tony says, horrified.

"Was the cord too long?"

Mark says, "No, the cord was fine. But what the heck is a piñata?" ■





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