Howard Farran: It is an extreme honor today to be here with everyone's idol and mentor on Dentaltown.com, uh, Dr. Jay Reznick. I could read you resume for 40 days and 40 nights and not cover it, but you are absolutely the oral surgeon of oral surgeons, and there is so much I want to talk to you about. Um, Jay, first of all, I…

Jay Reznick: Hey, you're making me blush, Howard.

Howard Farran: Well, you are, and I know Jay. Um, Jay is a triathlete, he's an Iron Man, but most importantly, um, he's just a quality guy, I mean, he never lies, cheats, steals, he's humble, he's honest, he incredibly honest, and the questions that people ask you on Dentaltown, you always take the time to answer the questions. You're the go-to oral surgeon, you answer all the oral surgeon questions no matter how infantile the question, you treat it with dignity and respect, because you know, some of these people are in dental school and some are just out and um, I just…thank you, Jay, seriously, for all that you've done for Dentaltown.

Jay Reznick: Well, thanks Howard. It's just been my honor and privilege to be associated with Dentaltown for all these years. Uh, I remember when we first met, uh, gall, a long time ago…I think at the second, first or second Dentaltown meeting, and at the time, you know, I was sort of the typical oral surgeon, um, in my practice, in a suburban area in Los Angeles, and you know, thinking that all the general dentists refer all of their wisdom teeth, implants, etc. to the specialists, and I didn't realize there were so many dentists out there in more rural settings, in clinics where they didn't have the option of sending to a specialist, who really were in desperate need of some guidance and some counseling and some continuing education to make them more comfortable with day-to-day oral surgery, basic procedures that they didn't really learn well in dental school, and you know, I think it was Samir Puri who hooked us up together and I think it was, uh, a match made in heaven for both of us in the sense that I was able to bring a lot…I think I was the first oral surgeon really posting anything on Dentaltown, and we were able to bring a lot of education, a lot of peace of mind, um, to those dentists out there in practice who were struggling with getting through some oral surgery problems and procedures. So, it's just been, it's been wonderful.

Howard Farran: And Jay, I want to give you some feedback, um, last month, I was, I lectured in four continents in 29 days, uh, the United States, uh, alright, North America, Europe, Africa, Australia…um, I remember going on one tour where I was in Hong Kong, _____, Katmandu, Nepal, and New Delhi, and when I've…

Jay Reznick: All the same day…

Howard Farran: All, all the same trip, and I, Jay, what's amazing is Dentaltown is 180,000 townies, and right at about 15-18% of them are non-US, and I'll never forget walking into the only Dental office in Katmandu, and so many people think that, you know, America is this one town with one street light, and they would name these townies like you as in they thought that, you know, I have dinner with you every night because we're both from America and we live a block apart, and um, and I just want to tell you that, um, um, one thing they're always requesting when I go around the world, and I've been meaning to tell you that, is that um, you know, in America we've got 250 online CE courses and so much of it is

CAD-CAM and CBCT and all this fancy stuff, and the world has two million dentists and 500,000 of them can listen to it at what we're doing, but a 1,500,000 just need so much more basic oral surgery, attitude to a partial, a flipper, and you are a legend in so many of these dental schools. I mean…

Jay Reznick: Well thanks, Howard.

Howard Farran: Yeah, I mean, they call you by your first name.

Jay Reznick: Yeah.

Howard Farran: I mean, I was in a dental school in Katmandu, could barely understand their English, they're saying, well, Jay says blah, blah, blah, blah, and Jay says, and Jay says, because in Africa, Asia, and South America, extraction and removable is Cadillac dentistry, and you are a, you are, not only a legend in the United States, but you are a legend in Africa and Asia and South America, and I've seen it. Um, I want to…and then in saying that, so, we need more basic oral surgeon, I mean, more…

Jay Reznick: Well, it's on its way, and as you may have noticed, about a year ago, I completely revised my Online Oral Surgery website, and um, I've been absolutely blown away by how many dentists in how many countries around the world have subscribed. I mean, I never would have thought that I would have subscribers in China and Japan and Australia and New Zealand and Trinidad and Tobagos and, I mean, you name the country and I've got subscribers there. But, I look at the Google analytics and look at the map of where subscribers are coming from, it's just amazing how may dentists around the world, um, are, you know…we take CE for granted here in the United States. There are so many CE course available to dentists in every city, every weekend, yet, if you know, for the dentists who are practicing in some of these countries, especially in third world countries, they just don't have the CE opportunities, uh, in their areas that we do, and that's where, you know, they, they need Dentaltown, they need Online Oral Surgery, they need online education because that's the only way they can keep up with the times, that's they only way they can stay as current as they possibly can in their countries with the resources they have is with these online resources, and it's just incredible that, um, you know, when you think about when we were in dental school, uh, the internet didn't even exist. And you know, I'm a year or two older than you, and when I think about that, it doesn't seem that long ago. Um, where we've come, uh, with the internet and technology, 3D CAD-CAM, uh, technology, things we didn't even think of when we were in school, uh, it's just changed everything. The way that we do dentistry today is not even close to, uh, what we were practicing when we started dental school, and twenty-five years from now, you know, who knows. It's going to be, it's going to be just mindboggling, it'll blow us away.

Howard Farran: You know, it was Guttenberg's press that ended the dark ages because for the first time ever, you could write down everything you learned before you died and give it to the next generation or a guy in the next city or in another country. In 500 years after Guttenberg's press, we landed on the moon, and the internet is the printing press at the speed of light and it is going to absolutely flatten the learning curve, so all two million dentists are going to grow towards a very rapid mean…I was blown away in Tanzania a couple of weeks ago at what some of those dentists were actually doing, and um, amazing…so, I want to get to, um, I want to get to um, the hottest topic in oral surgery to this day, and that is, um, so when we got out of school, it was two-dimensional radiographs

and panos, and then came out with the big 3D CBCT cone beam technology, and then we were all told that we would be able to take a 3D image and then we would email that to Glidewell and they would make a surgically-guided stent and we would, um, just be able to give local, pop in that stent and drill the hole and the, um, the implantology would be far more easier, more successful, avoid mental foramens in fear of the nerves and sinuses, and fantastic. And now, the breaking news is that Sirona actually owns all the patents for this, and has launched, um, lawsuits…um, Glidewell now no longer offers a surgical-guided stent…

Jay Reznick: Oh really, okay.

Howard Farran: …and, um, and so my first question is, um, my first question is, is a general dentist who wants to get into beginners implantology and pulls #30 and wants to play still, is a surgical-guided stent something, is it overkill…how often does a guy like you use a surgical-guided stent?

Jay Reznick: Yeah, I would say, I can tell you that I do 99.99% of my implants with guided surgery. And when I tell especially some of my…

Howard Farran: With guided stents?

Jay Reznick: Well, I did surgical stents because, you know, you think about…well, first of all, we're working not on a two-dimensional patient – we're working on a 3D patient. We're providing care. Working makes it sound like we're working on a car. But, we're treating patients who exist in 3D, and when we're doing what we do, if we're doing implants, we're relying on a lot of our senses to place the implants in the proper position, angulation to the proper depth, and I will tell you that no matter how experienced you are, no matter how long you've been doing this, no matter how many cases you've done, no matter how complicated, that when you're in the mouth and you've got that hand piece back there, and you're trying to line it up correctly so that it's equally spaced between the tooth in front and the tooth in back, perfectly parallel to them, and perfectly positioned mesiodistally and buccolingually, and you've got to drill that drill up and down in a straight line multiple times in a row before you place that implant, I don't care who you are, you can't do that with 100% accuracy at all. You, the best that you can do, and I've talked to, you know, I've been privileged to rub shoulders with some of the biggest names in implantology in the world, and we've sat down over a cocktail…

Howard Farran: You mean, with yourself in the shower.

Jay Reznick: (Laughs) I can't sit in my shower, it's too small.

Howard Farran: Okay.

Jay Reznick: Uh, but we've sat down over cocktails when people are relaxed and will be honest with you, and there isn't an implant surgeon alive, no matter whether they're a specialist or a general dentist with tons of experience, who will tell you that they are any better than about 85% accurate. As far as placing the implant precisely where they plan it to be. It's always, or, 15% of the time it's a little bit off, it's a little too lingual, it's angulated a little bit, um…

Howard Farran: And that's with the surgical guide?

Jay Reznick: That's without a surgical guide.

Howard Farran: Without a surgical guide. Okay.

Jay Reznick: So, without a surgical guide, we're 85, maybe, maybe 90% accurate, okay?

Howard Farran: And those are guys that have sunk 10,000 implants?

Jay Reznick: Right. So that means, flip side, if we're 90% accurate, then 10% of the time we're not accurate. Now, if I'm doing 500 implants a year in my practice, let's say, okay, and 10% of those are little bit off, that's 50 implants. And hopefully some, most of them are still restorable, but that's 50 implants that are not exactly where I wanted them to be in a span of a year. Now, you know, is that acceptable? Well, you know, we're all, we're all dentists, we're all perfections. We like, we like, um, our results to be what we intended them to be. And if we're off 10% of the time, and especially if you're a specialist who relies on referrals to send you patients, you know, if all 10% of those errors, or 10% of those inaccuracies are with the same referral, you probably aren't going to see anything else from that dentist again, as far as implants go. So, our goal is to be, is to be 100% accurate. Now, I don't think we can ever get 100%. You know, I've learned in medical school there's never an always and there's never a never, okay? So, we want to be as accurate as we can placing implants. So, there's no such thing as a simple case. So, if you've got a premolar, you've got 29, you've #31 and you're trying to put an implant at #30, you've got one spot, one angle, one position where that implant needs to be. Do you want that implant placement to be 99.9% accurately placed or do you want it to be 90% accurately placed? And in my book, I want 99.9% accuracy. And so that's why I do every single case with guided surgery, with a guided surgical stent. And you know, I do have, I do have Galileos in my practice and I do have CEREC in my practice, and I use them together to create my, uh, planning, my surgical plans and to generate the surgical guides.

Howard Farran: Okay, now for our listeners, uh, Galileos and CEREC, those are both owned by Sirona…

Jay Reznick: Correct.

Howard Farran: So, like Apple, it's a closed system that's been designed together as opposed to an open system where people got all these different parts and pieces and they're trying to get them to network together, which in my observation has basically been a disaster.

Jay Reznick: Yeah. Um, and I, you know, I, we would like, as clinicians, for everything to work. Just like with our, you know, PCs, we want all the different components to work together no matter who makes them, but I think what's different about computers is your market is huge. When it comes to cone beam, the market is smaller, and these companies have invested millions and millions of dollars into these products and into these technologies are for them to work together, for CEREC and Galileos to work together, and so as much as we would love everything to be shared, um, you know, I think it's going to be a while before they're going to be willing to do that because they've invested an awful lot in the technology and, um, you know, they want their system to be exclusive. I think, I think, um, that's

perfectly understandable. So, eventually, all these different systems will probably talk to each other, will be able to exchange data back and forth, but at least for right now, if you want to truly integrate a CAD-CAM cone beam system, um, Galileos, you know, and CEREC from Sirona are really your only option. But, you know, I've been using them for a long time. I was one of the first Galileos owners in the U.S…

Howard Farran: What year was that?

Jay Reznick: Um, 19…no wait, 2007? 2006?

Howard Farran: Okay.

Jay Reznick: Okay. Um…

Howard Farran: I was in grammar school at that time.

Jay Reznick: (Laughs) I remember. I helped you across the street. Um, and I did the very first guided, or Galileos guided implant surgery that was ever done, like on stage at the Scottsdale. I can't remember if you were there or not. Um, so I've been, my history, you know, with Sirona goes way back. In fact, I've done more Galileos-guided surgeries than anyone else in the world. And…

Howard Farran: Yeah.

Jay Reznick: You know, I do a lot of these, and I do probably two or three implant cases in a typical day, and they're all guided.

Howard Farran: Yeah, now for our listeners, um, Sirona used to be the dental division of Seamons, right?

Jay Reznick: Correct, yeah.

Howard Farran: And then it was spun off, and I've been to their headquarters and I mean, that's a lot of Ph.Ds in white coats for one thing, and I've been in a lot of other factories, and you have a programmer trying to program a bridge between this other company's deal and this other company's deal, and it's just like if you've ever had software and you had it dumped into a _____, like a lot of dentists my age used to have another software and they uploaded it into Eaglesoft or Dentrix of SoftDent, and you lose half your data, that was always tough. So, so, so what we've learned so far is that you're recommending the only, um, company that, um, makes the 3D radiograph, Galileos, and the uh, CAD-CAM, the Galileos, CBCT, Omnicam I suppose, so we've got that. Um, so for a young person getting into it, um, you know, it's been a horrible economy since Leemans day, uh, cracked up August 15, 2008. Um, the only way you can describe this economy is its just flat, it's just…

Jay Reznick: Oh, totally.

Howard Farran: It's malaise, there's no boom, there's just…flat. So, you're talking about two machines…I mean, how much does a CEREC machine cost these days? How much does a Galileos cost, and is that a justifiable return on investment for everyone listening today?

Jay Reznick: I think if you're brand new into practice, it's a huge investment. I think you're looking at about $150,000 let's say for a Galileos and about another $100,000 for the CEREC. It's a big investment. It's a…when you think about the number, it's huge, um, if you're right brand new into practice. But, if you've got money behind you, that's one thing. But, if you're like most of us, um, starting practice from scratch, it's a lot to put out at first. Um, I think you really need to get established a little bit first before you make that investment. Um…

Howard Farran: Okay, well, first thing, my MBA from ASU I want to say is, the $250,000 you just stated is a balance sheet number…

Jay Reznick: But, I'm not done, Howard. I'm not done.

Howard Farran: But, but what would the cost be on a statement of cash flow, what would the monthly payment be?

Jay Reznick: Well, what I was going to get to, and I'll give you my example of when I first bought Galileos, okay, um, Galileos at the time was about $185,000 – I did get a little bit of a discount, um, but it ended up costing me about $3,500 a month on a lease, five-year lease-to-own. So, I said, okay, if I can do a dozen scans at $300 apiece for the next, you know, five years, that's going to pay for the machine. That's going to cover my lease, and anything above that is gravy.

Howard Farran: And if you did what = how many scans?

Jay Reznick: Uh, I figure if I do 12, let's see, 12 at $300 apiece, that's $3.600, right?

Howard Farran: Twelve at $300 is $3,600…

Jay Reznick: Okay.

Howard Farran: And your lease payment was $3,500.

Jay Reznick: $3,500. So, if I do…

Howard Farran: So, we're positive on a statement of cash flow.

Jay Reznick: So, if I do a dozen scans a month, of at least breaking even on it. Well, what I found was that as I got the technology to the practice, I used it more and more. And now, I actually probably get about 50, 60 or sometimes even 70 scans a month because I'm doing implants, I'm doing impacted wisdom teeth, looking at the nerve relationship with the impacted or the roots of the teeth, I'm looking at the sinuses, I am having patients come in with trauma, patients coming in with pathology with impacted canines, with perioendo lesions with pins that's unclear where it's coming from, um, you know, my twelve cases that I had to generate to pay for the technology was the tip of the iceberg, so the, the long answer to your question is, you've got to think about how you're going to use this technology in your office, and don't think of it as $150,000, $250,000 investment, but as you said, the MBA way of looking at it is look at your monthly cash flow, your output of what it's going to cost you per month, and can you generate that much dentistry per month from having the technology in your office,

and what I've learned talking to a number of general dentists who have the technology is not only do the use the technology for, yeah, as it was, as you think it was intended, like for implants for Galileos and crowns for…and inlays for CEREC, but the amount of dentistry, for example, uh, that it finds you to do. So, endolesions that were occult, you're now discovering them on routine exam, and treating them before they become symptomatic, uh, you're having patients come to your office, see the technology, being blown away by how high-tech your office is, and referring friends.

Howard Farran: Okay, so what is the, uh, now you're a DDS and an MD, so are you billing these out medical or are you billing these dental, does dental insurance pay for these?

Jay Reznick: It depends what we're doing it for. Now, there are some, there are some services out there that, that will bill, um, pretty much every scan under medical, okay?

Howard Farran: There are services for dentistry that…

Jay Reznick: There are services for dentists that, um, that will assist you in learning the billing codes and the techniques for billing cone beam at under the patient's medical insurance.

Howard Farran: And what is that company? You got a www for me?

Jay Reznick: Uh, I'll have to, uh, let's see…um, I'll have you give you the information. I don't have it at the top of my head. But, um…

Howard Farran: Well, I'll be the only guy who ever lived that knew something that asked a question that Jay didn't have the answer.

Jay Reznick: (Laughs) Uh, I can find it real quickly, but, uh…I'll get it to you. But, there are…there is a few people that do this. The one guy that I know is, his name is Hoo-tan, and I know you can reach him through Patterson, everyone with Patterson knows Hoo-tan. Um, so um…

Howard Farran: Actually, on my podcast, we have a transcript of all these notes, so we'll just have all these in the notes, yeah. I do that so the dentists can multi-task and do laundry and wash dishes and do lab work and not have to stop and write down notes…

Jay Reznick: Perfect.

Howard Farran: …so all this will be in the transcripts.

Jay Reznick: Great, so what I do for my practice is, if it's a dental indication, so it's for wisdom teeth, it's for impacted canines, anything like that, we generally either bill it under the patient's dental insurance as a panoramic plus a ceph, because that's really what it is, uh, except that it's 3D when you put them together, um, or if it's for TMJ, if it's for pathology, if it's for sleep apnea, then we do bill it under the patient's medical insurance as a 3D scan. Now, the difference between billing under dental insurance and with medical insurance is medical insurance always requires a dictated report, a written report, of the indications for the scan and what the findings were. So, that's one difference that you, what's one thing you need to know if you're billing for cone beam under medical insurance.

Howard Farran: Okay, so a pan, so you bill out a panon 7 if it's wisdom teeth, but for, uh, medical, you said sleep apnea and what else?

Jay Reznick: Sleep apnea, TMJ, trauma, pathology…

Howard Farran: Okay. And I was amazed that you said TMJ because on Dentaltown, if you call TMJ, some people throw you under a bus that it's got to be TMD, but do you think TMJ is still the accepted term?

Jay Reznick: Well, you know, I don't go on the forums, but you know, I think…um, well, TMD includes, in my mind, TMJ. TMJ is nothing more than temporomandibular joint. So, when patients tell me, oh, I have TMJ, I say, oh, that's just like saying I have knee or elbow or shoulder, okay? What they have is TMJ dysfunction or myofascial pain or temporomandibular dysfunction. But, when I speak about TMJ, I'm speaking about bony or joint pathology, uh, which is what you're going to image with cone beam. You're going to see if there are arthritic changes in the joint, decreases in joint space, changes in, uh, joint position, changes in conular morphology. So, when I'm saying TMJ, I'm really specifically saying what bony changes you'll see on the CT scan.

Howard Farran: And I don't want to get into a big TMJ discussion, but um…

Jay Reznick: I don't either, Howard.

Howard Farran: Well what percent of temporomandibular joint disorder pain is, um, do you think is psychosomatic from the brain, stress, grrr…versus actually something, um, wrong?

Jay Reznick: Well, I think, uh, I mean, you've got your patients that have organic joint disease, like patients with arthritis, rheumatoid arthritis, uh, and that type of disease, um, that's probably a small percentage, maybe 10%. The rest of patients, most of the symptoms they have, whether they're TMJ being joint symptoms versus TMD, more joint and/or muscle, uh, has to do with stress and clinching, bruxism, uh, putting an extra excess load on the joints that they're not accustomed to handling, and resulting in joint pain resulting in muscular pain, and I'll , I'll tell patients that, you know, what causes this, because they say, well, I'm only, you know, I only grind my teeth maybe for ten minutes a night. You know, they don't really know, but they'll tell me, that you don't really know how much your grinding, and I don't…even if it is only ten minutes, it's putting a lot of stress on that joint and on that system. And so, just as if you've got, you know, you walk, you have someone walking around with a backpack with fifteen pounds of rocks on your back, okay? For a long time, they may not have any issues. But, over time, they're going to start developing back pain, knee pain, hip pain; it's the same thing with TMD or TMJ. Everyone has their own threshold of what's going to make them symptomatic, and some patients it just takes a little bit of insult and they're going to have symptoms, some patients it takes a lot. But, um, I would say probably, you know, to answer your question again, probably 90% of the patients, uh, out there, uh, can attribute some or most of their symptoms to stress or the results of stress like Bruxism.

Howard Farran: Okay, so let's get, so we've talked about the fact that you do 99.99% of surgical-guided, we've talked about that you really like the closed, integrated system under one Sirona umbrella, the CAD-CAM and the, uh, the Galileos, um, and yeah, you're milling it…are you milling out your own surgical-guided stents?

Jay Reznick: Uh, occasionally. Um, I do have, I have done a number of the CEREC guides. Um, most of the time when my patients come in, um, they've had the tooth missing for, you know, for a little while – we maybe took the tooth out a little while ago or they've been edentulous in this site for a while. Uh, for those cases, you know, I don't need to bill out a guide and have it ready this afternoon, um, I have the luxury of being able to send it off to Germany and getting it back next week. For…

Howard Farran: So you're…so you're emailing your CBCT file…

Jay Reznick: Correct.

Howard Farran: …and a lot of dentists believe that the file's too big to, um, to email, so are you doing this through a Dropbox or are you…

Jay Reznick: Yeah, exactly. It's an upload through SICAT, it goes to their Dropbox, um, and uh, they have…the system, actually the whole technique or the whole sequence is integrated into the implant planning software so it allows you to automatically upload the data as the final step in the process. And, you know, you just basically click a couple of buttons, you let it go, go have some coffee, come back, see a couple of patients, and it's done. Uh, so…

Howard Farran: And this is going…so, you're going to give me the names of, uh, in a later email that I'll put the transcript of all the people that can bill out CBCT to medical, and then you can get me the, uh, the names of this, uh, this uh, place you're sending it to, you said it's in Germany. I want to get it….is it Sirona…

Jay Reznick: _____ it's a SICAT, S-I-C-A-T, which is the, uh, a, uh, a company that's owned by Sirona that developed the implant planning software and who makes the surgical guides.

Howard Farran: Okay, and so you email that to them and how long does it take you to get the surgical guide and uh…where in California are ya…

Jay Reznick: I'm in, I'm in Tarzana, which is a suburb of Los Angeles.

Howard Farran: Tarzana. Okay, you're in Tarzana. I just went to Tan, Tan, Tan, I just went to Tazania…no, where did I go?

Jay Reznick: Tanzania?

Howard Farran: Tanzania.

Jay Reznick: Not even close.

Howard Farran: Tanzania, and you're in Tarzania?

Jay Reznick: Tarzana. Just think of Tarzan with an A on the end. In fact…

Howard Farran: Okay, Tarzana.

Jay Reznick: The reason it's called Tarzana is in the, in the hills, about a half a mile up the street from my office, is where they filmed the original Tarzan movie.

Howard Farran: Seriously?

Jay Reznick: Yeah.

Howard Farran: Oh, that is…uh…and Samir's from Chatsworth?

Jay Reznick: Samir lives in Chatsworth. He actually used to practice in my building until he moved to Phoenix. Scottsdale.

Howard Farran: Yeah, so, so, you're going to email that to, uh, Germany, Sirona, and then when are you going to get it back in Tazania, Aftica, LA, Tarzanville?

Jay Reznick: I send it out and generally, um, I will get it back, if I upload it, I can get it, usually get it back, uh, five working days later.

Howard Farran: Okay, and what is that going to cost you?

Jay Reznick: Uh, it's, uh, I think 30…well, the surgical guide itself is about $300. Uh, if I'm doing multiple sites, then maybe $350 or $400, and then I think about 30, 30 bucks shipping.

Howard Farran: Thirty bucks shipping?

Jay Reznick: Yeah.

Howard Farran: Okay, and uh…

Jay Reznick: And it comes back FedEx.

Howard Farran: FedEx? Okay, and so, here you are, and again, when we're talking, you know, not only are these podcasts downloaded all over the world, it's a, you know, 2 million dentists around the world, the United States is also a huge, vast country.

Jay Reznick: Yeah.

Howard Farran: You just…people oversimplify the United States. It's funny how when you go around the world they all think of New York, as New York City is America, and the United States is the same size as China, and half of them are spread out in a hundred…half the dentists are in 117 cities and the other half are in 19,000 cities, and like you say, if you can't do oral surgery or you can't do basic stuff in these towns of 5,000, you can't really, um raise the oral health…

Jay Reznick: You can't practice dentistry.

Howard Farran: Yeah, you can't practice and you can't raise the oral health of your community.

Jay Reznick: Not at all.

Howard Farran: I mean, we've all got to be public health dentists, so, so, I'm a dentist, I'm a…I want to get into this, I've got to do…I've got to do, um, 10-12 scans a month to make this cash flow for the Galileos, um, what…talk…walk through what a, what a newbie , a beginner could do. I mean, could he replace…the most common missing tooth in America is going to be a first molar. Uh, where, we're told there's four different implant sites – there's the, um, the anterior maxilla which is Styrofoam, the posterior maxilla is all sinuses, uh, the posterior mandible's got that big inferior _____ nerve or mental foramen and a loop coming out of there, and then you've got the, uh, the easy section, the lower anterior which is hard as oak wood, you have no sinuses or nerves…

Jay Reznick: Yeah, there's hardly any _____ foam.

Howard Farran: What…yeah, yeah, so walk through the beginner. What, what could you expect to do? What, how would you, um, wade into the placing your first implant. What percent of the general dentists would you say have never placed their first implant _____?

Jay Reznick: I would say it's probably something like 80% of dentists have never placed an implant. Um…

Howard Farran: See, I would have said, I would have said 90.

Jay Reznick: It could be.

Howard Farran: But, my friends…

Jay Reznick: And you know more than…

Howard Farran: ..aren't as smart as yours. My friends aren't as smart as yours.

Jay Reznick: That's being conservative. But…

Howard Farran: Okay, so, so, so four…so 80-90% of everybody listening to you is a virgin. They've never done one. So, tell, talk to me like I was your, uh, your only son who just graduated from dental school – how would I wade into this process?

Jay Reznick: Well, I would start off with simpler cases, and what I mean is in a nonaesthetic area where you've got lots of bone, you've got, uh, a little bit of room, a little bit of wiggle room for placing the implant, so if it's a little bit off angle, a little off position, you're still going to be okay, in a healthy patient with lots of _____ tissue, um, and um, uh, no, a nonsmoker, uh someone who's in good health, okay? Start off with a simple, easy…

Howard Farran: Nonaesthetic, nonsmoker, what were the other ones?

Jay Reznick: Uh, no significant medical problems, so not a diabetic, um, you know, just basically a healthy patient. Young, healthy patient.

Howard Farran: Yeah. Young, health patient, not where I'm going to see it.

Jay Reznick: Right, exactly. Good potential for healing…

Howard Farran: Okay, Now we're…

Jay Reznick: Is not going to, not going to give you any trouble when it comes to healing.

Howard Farran: So, a healthy, young, nonsmoker…what's are we talking – second bi back or first bi back?

Jay Reznick: Uh, second bite, first molar, first bi are good places to place implants.

Howard Farran: Okay, let's start…let's start with the, uh, with the most common missing tooth in America – the first molar.

Jay Reznick: Okay…

Howard Farran: So, now I'm…

Jay Reznick: That's a great one. But, but I want to tell you is that, you know, that you have to keep in mind that as simple as people like to make this sound, you're still doing surgery. You're still cutting through tissue on somebody. You're still drilling into bone, okay? So, don't take that lightly. You learn in surgical residency that you have a big responsibility; it's a big privilege to be able to operate on somebody, okay? So, you know, in dental school, we sometimes, we tend to not really make light of some of the procedures, but we kind of think that they're simple and, you know, they're noninvasive, you know, class, class one amalgam, um, you know, it's got a few complications, you know, if you hit, uh, if you…pulp out, you can get a root canal done. Uh, it's not as invasive, more reversible. Surgery for the most part is not reversible. If you don't do good surgery, okay, then it's very hard to redeem yourself from that. So, what I tell newbie dentists who are newbie implantologists is that you need to learn implantology to the standard of someone who has been fully trained at implants, the same standard as a periodontist, as an oral surgeon, so that you understand what you're doing. You understand the principles of bone healing, of soft tissue healing, um, soft tissue management, bone management, so that you are prepared to deal with the things that will come up in surgery. Because there's not, you know, there's not a surgeon alive who has never had a complication, okay? Complications are part of doing any surgical procedure, and what separates the men from the boys, so to speak, is knowing how to anticipate those complications, how to avoid those complications, and how to manage them if they do occur, okay? And that's where a lot of people get themselves in trouble is they see that empty edentulous space and they see the drill in their hand, and they see the titanium implant, and they just without thinking about what they're doing, go to place the implant and something happens, okay? And they're not prepared to manage, to avoid the complication, to recognize it, or to, um, to treat it, and so that's where, you know, you can really get yourself in trouble. So, take…if you're going to be placing

implants, if you're going to be doing any surgery – we talk about any surgery whether, you know…we talk about this a lot in the oral surgery courses that I teach, is know what you're doing, think about it like a surgeon, be prepared for, um, what may happen, know how to manage the common complications, so that you can, you know, your self-assured you are providing the best care for the patient. Because what it comes down to is really doing what's best for the patient.

Howard Farran: I just realized you've got to write a series for Dentaltown, um, losing your implant virginity. And I'm not…I'll ask you right now, um, go through what the top complications you're seeing newbies getting into that they were over their head that _____...

Jay Reznick: Implants or in general?

Howard Farran: With implants.

Jay Reznick: Um…

Howard Farran: Or in general. Or in general.

Jay Reznick: Well, uh, one of the big things that I'm seeing is not properly evaluating the surgical site. And placing an implant where it shouldn't have been placed. And a good example is the case that I just did right before I came to, came here, is um, a patient was missing a lateral incisor, um, and congenitally missing a lateral incisor. Uh, the dentist, uh, took a panoramic radiograph, did a clinical exam, um, there was fibrous tissue in the area of the ridge, because you know, the patient had been congenitally missing tooth #7, and so the ridge resorbed over time, okay? It was hard to appreciate that clinically because there was some fibrous tissue in there, and so the ridge felt like it was adequately wide. The dentist placed the implant, uh, using a flapless technique because there was adequate kerious tissue, and the implant went into the bone and two weeks later, the implant was lose. Now, we go back and we do a 3D CT scan, and we see that the implant was half in bone, half out, because of resorption of the ridge, okay? So, the mistake here was, was not recognizing that in a patient who's got a congenitally missing tooth, that you're going to have ridge resorption nine times out of ten, and anticipating that, evaluating for that with a 3D scan and then managing it appropriately either by grafting or referring to a specialist who can graft and prepare the ridge, for the implant placement. So, that's one thing we're seeing is not adequately working up the case. The other is…

Howard Farran: So, that person, this wouldn't have happened if they would have had a CBCT and they would've got a surgical=guided stent.

Jay Reznick: It would have seen that the ridge was narrow and they would've augmented the ridge first and not even attempted to place the implant right away.

Howard Farran: Now, now, would the, um, now when you send these CBCTs, they're also diagnosing and telling you the width and length of the implant, correct?

Jay Reznick: Correct, so you're seeing on screen, uh, in 3D and various cross sections the height and the width of the bone and the density, and then you have the opportunity using implant planning software

within, uh, within the scan to bring in a 3D image, an STL file, a stereolithographic file, of the implant that you want to place no matter which, or whatever system it may be in the various diameters _____ lens, and you actually place that virtually in to the patient's jaw. So you can see do you have enough width of ridge, do you have enough, uh, height of bone, uh, before it goes into the sinus or above the nerve or the nasal cavity, to be able to place the implant. Um, in, you know, the old days, if I was placing, let's say a lower first molar implant at tooth #30, I would have a 5-mm diameter implant that, my guestimate was that I was going to need a 10-mm long fixture. I would also have an 8-1/2, and I'd also have a 12, and I'd also have a 6, and I'd also have a 4 diameter, because I knew that sometimes I would flap it open and the bone wouldn't be as wide as it looked on the panoramic or I would start drilling and realize that, you know, I need a shorter implant or I can go with a longer implant. And with cone….

Howard Farran: I know.

Jay Reznick: …with cone beam technology and 3D scanning and treatment planning, I don't need to do that anymore. I know exactly what implant I'm going to place and, um, and then I plan the exact angle that it needs to be placed, the exact position and depth so that its coming out exactly with the central axis of the restoration, and using my surgical guide that was created from the CT data, I now have a guide that allows me to place that implant with high degree of accuracy, with a 1% variation in angle and about a 500 micron maximal variation in positioning.

Howard Farran: Yeah, and some of these young kids showing off their implant cases on Dentaltown, sometimes I've just wanted to log on and say, do you realize 27 years ago when I went to the _____, got my fellowship of the _____ and got my dental international _____ implantology that we didn't have any of this fancy stuff, and you had panos and until you flapped it open, you never knew what you had. So, this guy going into a first molar, what percent of the time could he place a stent and not lay a flat?

Jay Reznick: Well, you know, I get this question asked all the time when I'm, when I'm lecturing and I get emails from dentists…uh, they say, well, I have a surgical guide – does that mean I don't need to flap it open, I can do a flapless technique or a punch, and that, you know, that in a sense shows me what I was talking about is not having that fundamental understanding, not having that fundamental knowledge of basic implantology. Because what determines whether or not you need to lay a flap versus being able to do a punch technique is not having a surgical guide, it's the amount of keratinized tissue that's present on the ridge and whether or not you need to do any bony augmentation or bony contouring. That's what determines it.

Howard Farran: So, in your practice, you're doing 500 implants a year – what percent of the time do you lay a flap or not have to lay a flap for a simple, one-implant root form replacing a molar, first molar?

Jay Reznick: I probably do those flapless 90% of the time. But, also keep in mind…

Howard Farran: Wow.

Jay Reznick: …that I'm developing that site, um, using a ridge preservation technique and keratinized tissue regeneration from the time that I took that tooth out three to four months prior. So, I'm pr…

Howard Farran: Okay, and then for the other dentist who's thinking about, again, losing his dental…should we name this, this podcast Losing your…

Jay Reznick: Losing our virginity, sure.

Howard Farran: Losing your virginity? Um, so what scar...what would be higher risk – a lower first molar with that injury all over the nerve, you hit that, that's not good, or a maxillary first molar and hitting a sinus. What is the bigger, the bigger risk…what…

Jay Reznick: Well, I think…

Howard Farran: Let's, let's talk about the difference between those two, the mandible and the maxilla.

Jay Reznick: I think the chance, the chances of impacting the sinus, uh, maxillary first molar, are much greater than the chance of impacting the nerve. Um, so if you're doing, let's say you don't have cone beam, um, you're just using a panoramic only, okay? You can get a pretty good estimate of where that inferior alveolar nerve is, and though…most of the time, you're going to be safe with a 10 mm or 10-12 mm implant, okay? If you have to, you can go a little bit shorter like a nine or maybe an 8 – I wouldn't go any shorter than that, um, but you can get, let's say on average, a 10 mm implant in that site without a problem, okay? In the maxilla, if, especially if the tooth has been gone for as little as four months, you can get pneumatization of the sinus where the sinus now starts to dip down and you may only have, even if you did ridge preservation grafting, you may only have about 6 mm of bone left, okay? So, that the ridge shrinks because it's expanding from the sinus side, and so um, you know, I'm finding that even when I do really careful ridge preservation technique on a first molar site and I build up the ridge and overbuild it, I'm still having to go back probably 30% of the time and doing an indirect sinus lift at the time I place those upper first molar implants. And so, if you're going to be doing those, then you also need to know the technique for doing an indirect sinus lift. So again, you know, so to answer, in answer to your question, I think the lower first molar is a safer bet of a first case to work on, or first case to tackle, than an upper first molar, for that reason.

Howard Farran: And so, how would a dentist learn this sinus step?

Jay Reznick: Well, there just happens to be a lot of courses out there, there's a lot of, uh, they're, and the range from weekend courses given all over the country, uh, or even, you know, abroad in resorts, to, uh, fellowships where you go one weekend a month, you know, for two years to really learn, uh, everything you possibly can about, uh, implantology. So, there are a lot of opportunities out there, I mean, a Arun Garg gives some great courses, um, you know, Misch Institute is a, you know, if you want to get really involved in implants is fantastic, so there are a lot of opportunity out there for education. There's a number, there are a number of, uh, implant institutes in California, uh, by various clinicians that are available. There's…all you have to do is get on the internet and Google dental implant, you know, live surgical training, um, hands-on training and there's a lot out there.

Howard Farran: Okay, I want to completely switch gears because I know, of the two million dentists on earth, uh, you know, 80, 90, uh…on earth, probably 95% of the dentists have never placed an implant…

Jay Reznick: Yeah.

Howard Farran: …but the next hardest thing would be a wisdom tooth. So, I got you for 13 minutes left, um, what, tell dentists your thoughts on what you think the problems are with a general dentist when they're pulling out a wisdom tooth, and , what, what do you see them doing wrong and what advice would you give them?

Jay Reznick: Well, I think, um, you know, going back to what I said earlier about, uh, the implants, uh, it's the same thing, and that's not evaluating the clinical situation in the eyes of a surgeon, okay? Uh, and what I mean by that, and when I give my courses, I talk about this right up front, say, you know, there is a big difference in my training versus yours, okay, that we will never equalize, okay? Um, but what we can equalize is our thought process, okay? When a general dentist is doing a crown prep, they visualize what that prep is going to look like when they're done. And so they know what burrs they're going to need, they know what hand instruments they're going to need, they know everything they're going to need to complete that crown prop efficiently. They know what they're going to do if they get a pulp exposure, they know, you know, for example, if you know, if there is too much kerious tooth tissue and they need to build up, uh, they need to do a post and build-up, they've got all this in the back of their mind before they pick up the hand piece. Yet, when they take out a tooth, they go in there with a forceps and they wiggle it, and when it breaks, they get in there and start digging and become frustrated after a half hour of not doing anything. So, one of the biggest pitfalls that dentists get into, um, with doing surgical extractions or impactions, is not mentally walking through what they are going to be doing and having the right instruments available to them, and knowing what to do to do that efficiently, okay? Um, when I do my typical case of four partial or fully bony impacted wisdom teeth, okay…and granted, my patients are under general anesthesia, so I can work a little bit faster, but my typical case is 12-16 minutes for all four wisdom teeth, okay? And I don't do it in 12-16 minutes for four wisdom teeth because my hands are moving this fast, I do it because I'm efficient, okay? I'm efficient with my movements and because my staff has been with me for a long time and I have them trained, and they know they can anticipate what instrument I'm going to need next, and they have it ready in my hand, okay? And that comes with doing the same thing over and over again the same way, okay? But again, we have that plan, we know what we're going to do. So, you know, I would say if you're going to do impactions, if you're going to do surgical extractions, okay, anything beyond a tooth that's flapping in the breeze, get yourself some education in not only the technical aspects of oral surgery, but also the thought processes of oral surgery so you can start thinking more like an oral surgeon, because it will really help you. It's what keeps you out of trouble and what gets you out of trouble. What I see most commonly usually, the, uh, when a dentist gets into trouble taking out a wisdom tooth, is they didn't make an adequate enough flap to get access and see what they're doing, they didn't remove enough bone for the tooth to come out or to get the roots out, they didn't section the tooth properly, or just flat out they didn't have the right instruments, and you know, there's what…no way they could complete the case because they didn't have the right instruments. If all I had was a straight elevator and a 62

forceps, I couldn't do what I do the way I do it. You've got to have the right, you've got to have the right instruments also.

Howard Farran: And to our viewers, I've been in your office and it's like watching a Wolfgang Amadeus Mozart play the piano, or would you say you're more of a Chopin and a Warsaw, but um, but I want to back you up a little further, um, you and I have a very good friend that we love hold and dear truly, who removed a canine on a person and the infection went back into the head and they died in the hospital three days later of a brain abscess…um, we've, and, he didn't put him on antibiotics afterwards…we also, um, how often do you hear of a Ludwig's angina case, so I want you to go through, because a lot of dentists, um, are asking on Dentaltown, you know, can you pull a hot tooth or do you got to put them on antibiotics and let that settle down – go over the worst case scenarios, and what, what do you call, what do you call canine-to-canine, because there are no valves from the veins going back into the head. So, lets…I've only got you for eight more minutes, so let's go over the worst case scenario which is, someone dies from pulling a tooth. Just…

Jay Reznick: Well, I mean, first of all, it's pretty rare to actually kill someone from pulling a tooth. Um, usually if the patient dies a few days after you take out the tooth, it wasn't because you took out the tooth, it was because the patient had that infection there for weeks, and the infection made its way to the blood system and into the brain, and you just happen to take out the tooth three days before it killed him, okay? Um…

Howard Farran: So, you're talking about Ludwig's angina and maxillary incisors.

Jay Reznick: What's essentially a brain abscess. So, that brain abscess was probably well on its way to occurring before the tooth was taken out.

Howard Farran: So you think that person would have died whether or not they had the tooth removed or not?

Jay Reznick: Probably, yeah, yeah. Now, it's possible that by going in and manipulating the tooth, it may have pushed some bacteria through those, you know, valveless veins, uh, towards the cavernous sinus, you know, that, towards the center of the brain, but you know, it's hard… you know, it's hard to know for sure. But, most likely if something like that happens in a scenario like that, it's because that infection was long standing and it was going to go to the brain soon anyway. Now…

Howard Farran: And are those the two main things, incisors back into the brain in Ludwig's angina and the second molars?

Jay Reznick: Well, I'll tell you…I've been doing this for now for, what, almost 25 years, and I have yet to see, I think I've seen one case of a dental infection, uh, from the anterior that actually went to the brain, uh, that you could associate with, uh, with an abscessed tooth. Uh, it's very rate, okay? Um, most of the time the patient's going to have external swelling and pain and they're going to seek care before it ever gets to that. Um, now, but going back to, you know, thought…

Howard Farran: What about Ludwig's angina?

Jay Reznick: Okay, Ludwig's angina is a little different because you can have a, um, a lower molar, which is usually the cause, uh, that has an abscess. And that, the patient will have tooth pain, but what will happen is the reason they're having pain is that the swelling and the edema is within the periodontal ligament space pressing on the nerves in the PDL, and that's what's causing the pain, okay? Eventually, that infectious process will erode through the bone via the path of least resistance, and a lot of times, that gets to the lingual aspect of the mandible, and when it does, releases some pressure and the patient will have some pain relief, but unfortunately, then the infection will start to spread, uh, into the fascial spaces of the neck. And again, it's, it's not a common occurrence. When I was in residency in LA County Hospital, we saw it a lot. Um, but you know, in private practice, we don't see it all that often, maybe only once or twice a year. Um…

Howard Farran: But, but, but what's the short, simple rules for a general dentist in an office and it's a hot #2…

Jay Reznick: Here's what I do…

Howard Farran: …uh, do I, do I antibiotics first or pull it and antibiotics…or give them a gram and preoperative clearance?

Jay Reznick: Okay, here's how I look at it. Um, there are two different types of dental infections. There is a tru…there's a dental perioithical pathology, and there is pericoronitis, which is inflammation or infection of the soft tissue around a wisdom tooth. With pericoronitis, the infection is in the soft tissue, not in the tooth. And if you go in and take out the tooth, in the face of that, you definitely will push bacteria, you'll push the infection into the fascial space. So, you want to make sure absolutely that the patient is on antibiotics before you touch them, and you calm that down before you go in there and do surgery. With peri…

Howard Farran: Is it a gram, is it a gram now and pull it an hour later enough or are you talking about 24 hours, 48 hours, three days…

Jay Reznick: With pericoronitis, I usually give it 24 hours, I put them also on chlorhexidine rinse and warm salt water rinses every one to two hours to bring the swelling down, okay? For perioithical infection, uh, it's a little, it's different, but there's a lot of room for, for clinical experience and clinical experience. An abscessed tooth is like a splinter in your finger, okay? That infection is not going to get better until you take the splinter out, okay? So, a dental abscess of a tooth is not going to get better until you take out the source of the infection which is either by extracting the tooth or doing endodontic treatment, okay? So, that's the primary thing that you've got to do, is you've got to get that tooth out ASAP because that's the source of the infection. Now, is that, you know, always a practical thing to do? Well, if the patient's got a little bit of swelling, I don't think you necessarily need to…well, if the infection has gotten into the tissues, then I definitely will premed them, let's say a gram of cephalexin or two grams of amoxicillin, something along those lines, about 30 minutes before I take the tooth out, okay? Um, because you want to get an adequate blood level of antibiotics before you, uh, take the tooth out.

Howard Farran: One gram…you said one gram of cephalexin, Keflex, or two grams of amoxicillin?

Jay Reznick: _____ use.

Howard Farran: And what do you think of the guy still using MDK?

Jay Reznick: You know, it works. I don't think there's anything wrong with it. Uh, it's an old drug, it's been around forever, and it's still fairly effective for dental pathology. Um, now if the patient comes in and they're really swollen, okay, um, again, I'll do the same thing – I'll get them on, you know, I'll give them a loading dose of antibiotics, but the key is to get that tooth ASAP, okay? If someone comes in and they've got a lower molar that's abscessed and they've got a little bit of swelling, okay, I know from experience that trying to numb up that lower first molar, especially if it's been root canalled, and get that tooth out, and the patient to like me afterwards is pretty difficult. Lower molars, lower second molars, first molars that are infected are really hard to get numb. So, I will put that patient on antibiotics, chlorhexidine rinse, saline rinses, load them up on antibiotics, let that infection cool down a little bit, and then bring them back to the office in one to two days to take out the tooth.

Howard Farran: Okay, now I only gotcha for one minute, and in one minute, when you travel, when you lecture from Poland, all these different countries, some people think you've got to use hydrogen peroxide because it's going to oxidize and erode. Some like salt warm water, some like, um, _____...

Jay Reznick: And baking soda.

Howard Farran: …yeah, and baking soda. So, you keep saying chlorhexidine gluconate and salt water rinses, what is the killing mechanism of a salt water rinse? Are you, are you thinking the warm water disassociates sodium from chlorine and it's basically a chlorine rinse?

Jay Reznick: No, basically what the chlorine water does is the, it agitates, um, if you've got...essentially with pericoronitis, the warm salt water, um, will agitate the site, just physically, but the warmth causes vasodilation and causes, um, more blood flow to the area, which would help the antibiotics get into the tissues and bring down the swelling. The other thing that does _____ (Audio cuts out) And then the salt…

Howard Farran: So the salt, the salt, sodium chloride acts…okay…

Jay Reznick: And then the salt is hypertonic, so, compared to the cells, so when you're rinsing with the salt, what it does is it draws, because of fluid shifts, draws the edema out of the tissues and reduces the swelling. So, you've got the physical action of just the rinsing, the warmth of the rinse that increases blood flow a little bit, and you've got the osmotic action of the salt which reduced the edema.

Howard Farran: And I just want to end in this note, because we are out of time, that um, your right – you can't numb up that tooth, um, because it will be sensitive, but the caveat on that is if they've ever been married, then they're already used to pain and suffering, and it's no big deal. You just can't do it on a single person. Hey Jay, it has been amazing. Tell them your website they can go to to learn all the surgery…I love your website.

Jay Reznick: It's call onlineoralsurgery.com, and…

Howard Farran: And how many hours do you have on there?

Jay Reznick: I've got about thirteen hours of content, uh, the last five hours or pretty close to that are in high definition, uh, we're adding new content all the time, it's on everything about basic office oral surgery, I&D, infections, surgical extractions, root retrieval, management of bleeding, management of infections, impactions, uh, biopsies, you name it, whatever will increase your competence and confidence in office-based oral surgery, it's on the website and it's growing all the time.

Howard Farran: And I'll tell you what – there's nothing cooler than sitting in your La-Z-Boy, watching that on the big screen, listening to Jay on surround sound, and you feel like you're literally sitting on the person's incisors watching the whole thing, I mean, it is world class, unbelievable, and a lot of dentists are thinking, oh, I can't watch that in my front room, you know, my family would kill me.

Jay Reznick: They love it.

Howard Farran: Are you kidding me? Two-year-olds…

Jay Reznick: My kids love it.

Howard Farran: They love it. I once sat with my two-year-old granddaughter and she was mesmerized and, I mean, it's just amazing. Jay, I want to thank you not only for all that you do for your patients and all that you do for dentistry, but you are just, I can't think of a more important person on Dentaltown…

Jay Reznick: Well, thanks Howard. Thank you.

Howard Farran: …and on behalf of 180,000 townies, thank you for all that you do for Dentaltown, and if you ever want to do this again, if you ever want to come back for another hour…

Jay Reznick: You got it. I want to thank you for everything that you've done for dentistry. And it's just, uh, amazing. You are a towering figure in dentistry. Everyone knows who you are, all over the…

Howard Farran: Uh, next time you're at the Scottsdale Center where you're _____

Jay Reznick: Sounds good.

Howard Farran: …let's do sushi.

Jay Reznick: You got it. _____.

Howard Farran: Okay buddy, thanks.

Jay Reznick: Okay.

Howard Farran: Howard Farran: Okay, thank you. Bye-bye.