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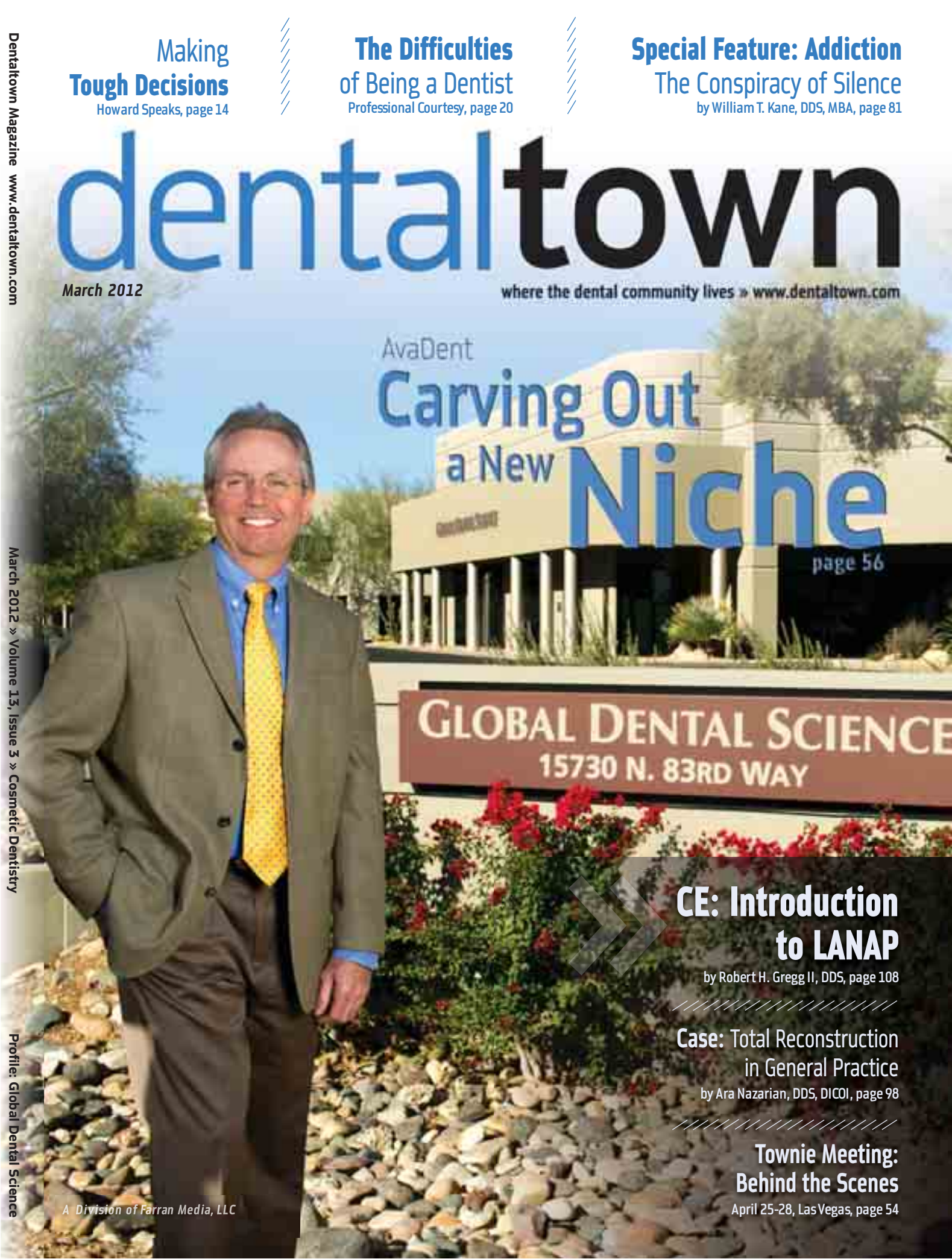

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CASEPRESENTATION

#30 Implant Size Selection

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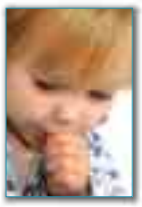

Monthly Poll

Charitable Dentistry

Do you provide volunteer dental services outside of your dental practice?

A. Yes **B.** No

Media Center

Webcast: Removable Prosthetics, Capture The Opportunity!

Dr. Frank Lauciello, Director of Removable Prosthodontics for Ivoclar Vivadent, explains four simple steps for success with denture placement.

Online CE

Minimally Invasive Ridge Augmentations: Maximizing Clinical Excellence Through Innovative Biologic Technologies – Anthony J. Reganato, DDS, MS

Creating longevity in implant dentistry is the summation of three main elements: 1) confidence in implant stability, position and angulation, 2) comfort level with the technique or approach employed and 3) a cornucopia of bone.

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Message from the Online Community Manager

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One of the best things about Dentaltown.com is the wealth of material you have at your fingertips. You can find information and join in conversations on everything from the latest implant techniques to staffing solutions to March Madness stats. With an average of more than 750 posts per day, keeping up with the discussions can be daunting. But it doesn't have to be. Customize your subscriptions to manage the topics you find most interesting and access them quickly and efficiently.

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VIDEOTUTORIAL

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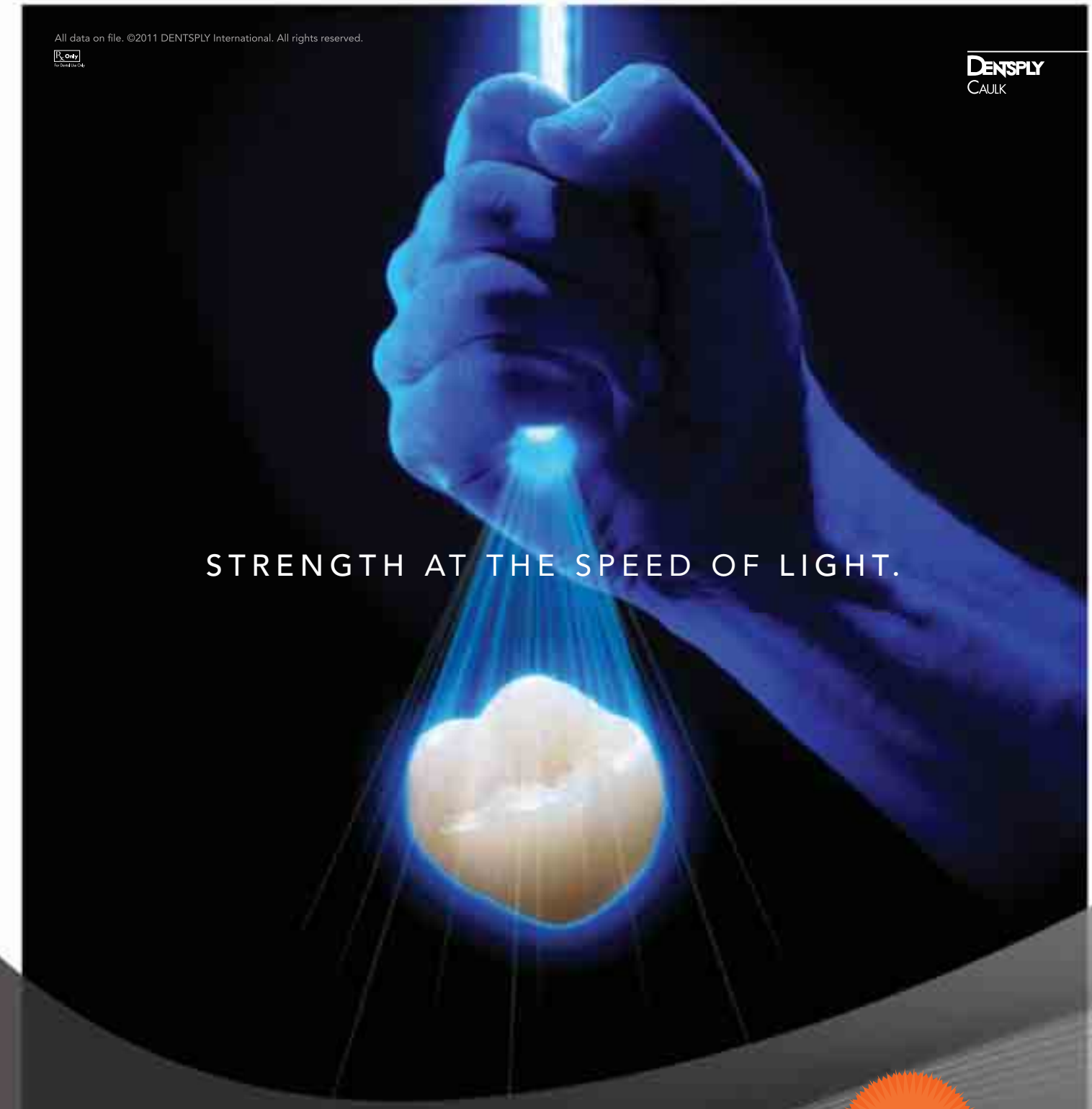

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What's New in Continuing Education?

by Howard M. Goldstein, DMD, Director of Continuing Education

The Tutorial for the New CEREC 4.0 Software
by Dr. Todd Ehrlich

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Cerec 4.0

Minimally Invasive Ridge Augmentations
by Dr. Anthony Reganato

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Ridge Augmentations

Treating Worn Smiles
Dr. John Nosti

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Worn Smiles

Welcome to Dentaltown's first continuing education update!

The way Dentaltown presents CE has changed for the better and our roster of courses and lecturers for 2012 is exciting!

This year we changed our format from the old PowerPoint and audio style to PowerPoint, clinical videos and video of the presenter speaking. This method of presenting helps engage a connection between presenter and listener. All of our courses from 2012 forward will be like this, thanks to your positive feedback. That being said, we do have many excellent courses from the past – some of which I'll refer to as the "golden oldies" – that have excellent information.

We are thrilled to educate dentists who have or are thinking of getting CEREC CAD/CAM milling units in their offices. Dr. Todd Ehrlich is one of the few dentists certified by Sirona and Patterson as an Advanced CEREC trainer. At the big meetings when they need someone to give a demonstration, he is their go-to guy. Todd has agreed to do a series of courses for us, the first of which is already up online – "The Tutorial for the New CEREC 4.0 Software." This course is a must for all CEREC users who want to get optimal results with the new software. This CE course is totally comprehensive and covers all aspects of the software from administration, to acquisition, to design and milling. No aspect of using 4.0 is untouched and every CEREC user will be totally competent and comfortable in using this software after viewing this course. This course can be found in the CAD/CAM section of our CE course listings.

Dentaltown is also proud to announce an implant surgical course presented by active Townie, Dr. Anthony Reganato titled, "Minimally Invasive Ridge Augmentations: Maximizing Clinical Excellence Through Innovative Biologic Technologies." This course goes through the ABCs of ridge augmentation and his use of guided bone regeneration is a must for all those who do or want to do implant surgery. This course can be found in the Implant section of our CE course listings.

Ever wondered how Dr. John Nosti turns those worn-down teeth back into a beautiful smile as he has shown so many times on our message boards? Dr. Nosti is quickly gaining the reputation of being one of the best at teaching dentists cosmetic dentistry without ignoring occlusion. Have you been worried about treating patients who show signs of occlusal breakdown? Join Dr. Nosti as he reviews the main causes of occlusal breakdown in patients. In this fast-pace course, he discusses ways to engage your patients and get them enrolled in their treatment, as well as reviews his treatment protocol from start to finish on these complex cases. This course, called "Treating Worn Smiles," can be found in the Cosmetic Dentistry section of our CE course listings. ■

To search for a course:

1. Go to the Dentaltown.com CE page at: http://dentaltown.com/onlinece
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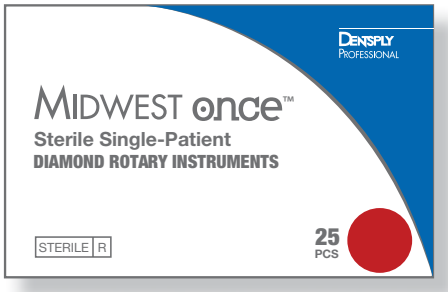

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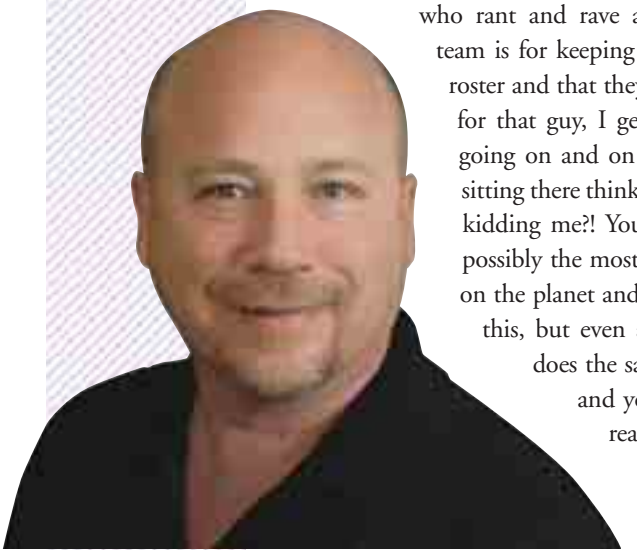
Tough Decisions

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

I find it extremely amusing how every dentist knows what the politicians on Capitol Hill should do to balance the budget and improve things for the USA. You say they need to cut overhead, scale back entitlements, raise taxes and deregulate. But, here's what you need to understand: our government is paralyzed. They've seen what happens to smart guys who made difficult and calculated decisions that focused more on our long-term sustainability – instead of short-term, ill-thought-out band-aids – and then lost the next election because of them. The government is not going to do what you know it needs to do to right the ship; the funny thing about all this is while the government isn't making the tough decisions you know it needs to make, you're not making any yourself. You all know how difficult it is to do effective dentistry, run a practice, keep paying your mortgage and keep food on the table these days. Do you really even need a reminder about this crappy economy? Here are a few things I see going on in dental practices around the country that make me think some of you need a wake-up call.

Get Your Staff in Gear

When I attend an Arizona Cardinals or Phoenix Suns game with certain dental colleagues who rant and rave about how stupid the team is for keeping certain players on the roster and that they should trade this guy for that guy, I get angry. While they're going on and on about pro sports, I'm sitting there thinking to myself, "Are you kidding me?! Your receptionist is quite possibly the most slothful human being on the planet and you are fully aware of this, but even after 10 years she still does the same awful job for you, and you let it continue. You really think you can run the Arizona Cardinals? You can't even run your own practice!"



Why is it some of you have the laziest, most unmotivated, dysfunctional staff in the world, but you hang onto them because of some emotional connection or because they've been with you for five years? Guys, listen up, it's time to make some tough decisions! You need to evaluate your teams. What have they done for you lately?!

It's tough out there, so it's time to get tough! Some of you give your staff a dollar raise every time the earth travels around the sun. Your entire pay structure is based on the zodiac. Doctor, if you work hard, you see more money because you're the dentist and you own the joint. Your bottom line directly correlates with your performance. Your staff doesn't care if it works hard or not because it keeps getting paid no matter what. They are trading time for cash! It's time to knock that off. Staff incentives need to be based on *production.* You need to make the decision and say, "I used to provide a 401(k). I used to provide health insurance. I used to give you a dollar raise every year but I am not doing any of that anymore until our collections reach this dollar amount." Get your team focused. Give them the same incentives you chase. If the practice does well, then everybody does well. Let your staff know you are only collecting $50,000 a month and until it gets up to $60,000 not a single raise or bonus will be given. That'll separate the wheat from the chaff pretty damn quick.

Get Personal

I tire of the complaints from doctors who say their practices are failing, but they drive a wicked sports car and live in a high-falootin' mansion in the ritzy part of town. If this is you, take a good look at yourself in the mirror, doc. Think you made some good decisions? Are you not making tough decisions because you're afraid how your wife is going to take it when you tell her it's time to rein in your household spending? Are you afraid of disappointing your oversized ego by downsizing your house and

continued on page 16

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trading in your BMW for a practical car? We hear over and over how important it is to market our practices to get more new patients, and I know a handful of dentists who say they can't afford to undertake a marketing campaign, yet they lease a Mercedes Benz at $1,000 a month! Are you kidding me?!

Maybe putting your Rolex up for auction on eBay is a good idea. Not just because you'll pick up a couple thousand dollars but because maybe you'll start to understand you're personally spending way too much. I'll borrow a line from the movie *Fight Club:* "the things you own end up owning *you."* You don't need the boat. You don't need the vacation condo. You don't need the fancy cars. You don't need a membership to the country club. You can't afford a stay-at-home spouse. You can't afford to go out to eat four nights a week. You need to sit down and figure out how to cut your personal expenses because they're also eating into your practice's bottom line. Seriously, how good does it feel that you bought your wife that Gucci purse? That's $5,000 that you could have reinvested in your dental practice. You could have bought two or three AMD Lasers for what you dropped on a handbag.

Maybe putting your Rolex up for auction on eBay is a good idea. Not just because you'll pick up a couple thousand dollars but because maybe you'll start to understand you're personally spending way too much.

You need to deploy some capital and do some serious investing in your office. I have written about investing in CAD/CAM until my fingers bled. We've got continuing education courses about cone beam computed tomography (CBCT) and how nobody wants to go back to using 2D X-rays like a pano or a PA after using 3D CBCT. Why can't you pull the trigger on these new technologies? Because you – just like your neutered congressmen – feel more comfortable kicking the can down the road another mile hoping things will change. Nothing is going to change until you start making some tough decisions.

Get Marketing

Every time you eat out for $100 that could have been $100 worth of Internet ads on Google or Facebook. My dental practice runs advertising on Google and Facebook and they cost us about a dollar a click. I would rather have 100 clicks to my dental office's Web site than a fancy dinner. You need higher patient flow, which equals more cash. Every time you are supposed to go out to dinner, go to the grocery store and buy a box of Kraft Mac & Cheese for a dollar instead. Then go home and buy $100 worth of advertising on Facebook. The smaller your market the more effective your ads will be. I live in an area of Phoenix, Arizona, called "Ahwatukee," and there are 3,600 people on Facebook that have Ahwatukee in their profile. Every time those 3,600 people log onto Facebook they see my ad. Most of the activity on Facebook is from women, and women make about 89 percent of all dental appointments. You can put two and two together…

Get Learning

We have 4,000 periodontists in the United States and every single one of them does a crown lengthening procedure every single day and you don't even know how to do it? Why don't you sell your Rolex watch, get on an airplane and fly to some pig jaw course that teaches you how to do crown lengthening especially because insurance pays 80 percent of it. Spend a little of your money wisely on new technologies or CE courses that make you better at dentistry in order to make *more* profit for yourself *and* your practice!

Get a Move On

I recently had some long, over-the-phone conversations with two despondent dentists. They are both from a town of 5,000, and the only factory in town – which employed all of the townsfolk – closed down a year ago. The town is drying up and 80 percent of their insured patients were people who worked at that factory. Now those people are not only

continued on page 18

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 continued from page 16

unemployed but they are leaving the city because there are no job opportunities in town, they have no money and they need to downsize. I listened to these two doctors tell me they were born in that town, married in that town and their kids were born in that town. I told them it was time to make a tough decision. I told them they needed to move, plain and simple. I said, "Look at your ancestors. Damn near every American immigrant made a tough decision 50, 100, 200 years ago when they were sick of living in the country they were in. Maybe they hated the king or the noble landlords. Maybe they were squatter peasants and despised their lives. They knew about the opportunity in America and left everything they had behind. With just the shirts on their backs they took a boat ride for six weeks and landed on the shores of America with nothing (if they survived the journey) just for the mere opportunity for a better life. And you are afraid to leave a ghost town that used to have 5,000 people and move an hour away or to a different state for better economic stability?"

Get 'em Out of Your Pocketbook

Another thing I hear all the time that continues to bother me is dentists telling me they are about to literally go broke by putting their kids through college. Here's what I say, "Doctor, did your dad pay for college? He didn't? OK, does your son in college even have a job? No? Does he have an iPad and an iPhone? Does he have a credit card? Are you paying his car insurance? Why don't you do your son a favor and tell him after this semester he is on his own. I was on my own, I made it, and I was a better person for it!" I would put all of my eggs in the basket of a self-made man any day over some daddy-did-it who was born with a silver spoon in his mouth.

Some of you have heard of the Five Ds. *Design* your plan. What do you have to do? What is your tough decision? Number two, *drop* everything that doesn't matter. This isn't the time to be in the Kiwanis Club, guys. This isn't the time to be coaching your kids' little league team. Get focused back on your business! Let's *delay* everything we can't drop. Let's *delegate* everything that can be delegated so you can *do* your plan. Guys, the feather in your cap is this – unlike your government, you don't have an election to worry about every four years. You can make the tough decisions to ensure your personal and professional success. Stop trying to make nice with everyone and start acting like a boss. If you and your practice fail because you didn't make the tough decisions, do you think they're going to help you out? No, because your staff is now out of a job and hates you for letting the practice tank; you were your family's bringer of bacon, and they know nothing but "spend." It's time to end this craziness. The buck starts and stops with you.

I'd love to hear from those of you who were recently faced with making a tough decision – whether in your practice or on the home front – and I want to know what the outcome was. Send me an e-mail at howard@dentaltown.com, or post your tough decision on the message boards of Dentaltown.com or in the comments section under this article on Dentaltown.com. ■

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.

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26 APR — **Townie Meeting**
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The Unbearable Lightness of Being (a Dentist)

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

I think it is safe to say if you have not earned a dental degree and practiced dentistry, you will never know what it is like to be a dentist. You might think nice teeth and plaid shorts can make you feel like a dentist, but there is much more to the full experience. My non-dental friends tell me they think dentistry looks easy. This month I'm providing you with a list that reaffirms all the reasons why life as a dentist is difficult. Mark the items that apply to your situation and share this with family and friends.

Dentistry is Demanding Because...

- ❑ I work in a small, dark, confined space – the mouth.
- ❑ I perform miniature surgeries on patients who are wide awake.
- ❑ Most people don't like coming to see me.
- ❑ I see my work every six months and there are some things that I would do differently.
- ❑ People expect everything I do to fix their mouths to last longer than anything else they buy.
- ❑ I send my impressions away to the lab and, no matter what mistake has been made, I must own it.
- ❑ People judge the quality of my dentistry by everything else except the quality of my dentistry.
- ❑ My staff doesn't always understand my frustrations.
- ❑ Dentists are rarely portrayed as heroes on TV or in the movies. If they are, they're bumbling idiots.
- ❑ My entire business is based on appointments, yet dental sales reps will continue to visit my office unannounced.
- ❑ When I see a patient who was the victim of an unscrupulous dentist, I get upset.
- ❑ Seeing people in pain is never fun. Even worse: causing people pain.
- ❑ Seeing people transfer their fear of dentistry to their innocent children is frustrating.
- ❑ Insurance companies make the delivery of treatment complicated and confusing for patients.
- ❑ Dentists are not great with demographics; we have too many in some places and not enough in others.
- ❑ Owning a business is great, except for when it's not.
- ❑ Time is your enemy and your friend.
- ❑ I am surrounded by technology but selecting the right things for my practice is difficult.
- ❑ Nobody knows how or why something is broken in the office, but we spend our days teaching patients to take care of things.
- ❑ People, materials and treatment don't always work the way you expect.
- ❑ Practicing dentistry takes a toll on my body that will not be fully realized until my retirement.
- ❑ Feelings of depression are very real and overwhelming.
- ❑ When I'm not working, my office is idle.
- ❑ Everything is more expensive when you add the word "dental."
- ❑ Hiring and firing staff is a huge responsibility.
- ❑ I enjoy being the master of my universe, but I do not enjoy managing a small business.
- ❑ _____

The last line is blank for you to add your own frustrations and challenges. In spite of my litany of self-pity, I can't think of anything else that I would rather do for a living. It is a privilege and honor to practice dentistry. Get out there and help somebody!

Send me an e-mail and let me know what it is that you love or hate about being a dentist: tom@dentaltown.com. ■

INTRODUCING

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Clear Aligners: Building Practices of GPs and Orthodontists

A hypothetical town hall meeting to discuss the considerations prior to adding clear aligners to a general dental practice.

by Dr. Rene Sterental

Technology has changed tools, processes and relationships in every industry, and dentistry is no exception. In general and orthodontic practices, the advent of clear aligner technology represents a disruptive technology with opinions differing widely on how and where it can and cannot be used most effectively. If we held a town hall meeting to answer questions about introducing orthodontics with clear aligners into a practice, the following topics are common concerns.

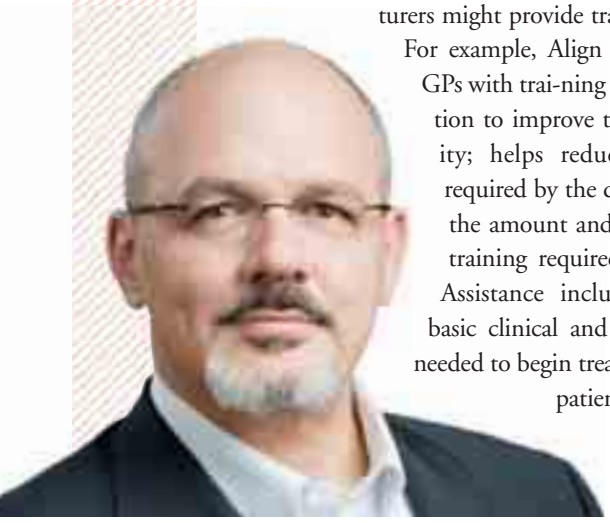
1. "I want to learn to use clear aligners, but how am I protected from failing?"

No doctor wants a case to fail. With varying degrees of comfort with orthodontic skills, many GPs are understandably cautious about extending their treatment offerings into unfamiliar territory.

Case Selection is Critical

When starting out with clear aligners, it is best to start with cases that are appropriate to your skill and experience level. These are often simpler cases, involving crowding, spacing or basic aesthetic concerns that do not require a change to the occlusion and typically have a projected treatment length of six to 12 months.

A Helping Hand Along the Way



For GPs new to clear aligner technology, manufacturers might provide training and assistance. For example, Align Technology provides GPs with trai-ning that covers case selection to improve treatment predictability; helps reduce time and effort required by the doctor and minimizes the amount and depth of specialized training required to use the system. Assistance includes such things as basic clinical and operational training needed to begin treating a broad range of patients with Invisalign; a comprehensive getting started kit; online connection to information and resources and an Invisalign Assist treatment option.

The Invisalign Assist treatment option provides procedural and technical support throughout the treatment process to help GPs achieve desired patient results. It includes a progress-tracking tool, detailed appointment plans for each patient, compliance indicators and ClinCheck setups created for each case by Invisalign technicians. As the GP becomes more comfortable with Invisalign, he or she can upgrade to Invisalign full treatment option, and extend capabilities to encompass more challenging cases.

Digital Treatment Delivers Visibility and Reassurance

Digital treatment plans for clear aligners enable doctors to see how teeth will move from diagnosis to completion – before and during the process. This high level of visibility allows doctors to see and plan tooth movements at every stage before treatment begins. Minor adjustments can be made at the end of treatment to reach the desired outcome. Digital treatment plans require thorough planning at the beginning of each case. If the patient is compliant and the treatment plan is correct, doctors gain enhanced predictability and minimize the risk of failure.

Establish A Relationship with A Local Orthodontist

Having an established relationship with a local orthodontist enables GPs to refer cases that exceed their comfort level. Ideally, the orthodontist would also offer clear aligner solutions, enabling both doctors to collaborate on case referral.

Additional Training

Additional training for doctors and staff is often available from aligner manufacturers. Continuing education (CE) credits often can be earned from live training courses, helping GPs and their staff to continue learning. Align Technology also provides information on a wide range of clinical topics online at www.aligntechinstitute.com.

continued on page 24

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 continued from page 22

2. "What is the role of clear aligner treatment versus brackets and wires in a GP office?"

Clear aligners and brackets and wires each have its place, and that place depends largely on the doctor's skills, comfort with technology and the patient's requirements. Brackets and wires are a proven orthodontic treatment approach and the preferred technique for many orthodontists.

Patients Who Won't Seek Orthodontic Treatment

Brackets and wires are obviously not for patients who are not likely to seek orthodontic treatment. They might be adults whose teeth have just "always been this way." They are not concerned about aesthetics. Or they might believe that they don't have problems that need correction.

However, many can benefit from clear aligner treatment from their GPs to improve their oral health. As the first point of contact for patients, the GP is the care provider most likely to identify issues and associated complications of crowding or spacing. Many patients do not realize that spacing, crowding and other malocclusions can lead to periodontal disease and create abnormal amounts of stress on teeth and jaws. Research has indicated that 74 percent of the U.S. population could benefit from straighter teeth.[1] When teeth are crowded, plaque with harmful bacteria can attach to the tooth surface down to the bottom of the pocket[2] and be difficult to remove. Bacteria can cause gum tissue surrounding the tooth to degrade, and if not treated, result in bone loss.[3] Poorly aligned teeth can also develop abfractions at the gum line. Premature wear can lead to poor root support, loose teeth and eventually, tooth loss. Clear aligners can be used effectively in these cases, especially when doctors educate patients about the consequences of malocclusion and choose cases appropriate for their skill level.

Adult Patient Preferences

Even patients who understand the benefits of straight teeth might object to wires and brackets or a two-to-three-year treatment plan. Adults in particular consider clear aligners more attractive and a short treatment easier to comply with. As long as the GP and patient understand and agree to the scope and deliverable outcome for a treatment regimen, then clear aligner treatment will be appropriate.

Continuity of Patient Relationship

Providing orthodontics with clear aligners in a GP office helps maintain patient relationships. Frequently, patients do not want to start a relationship with another care provider. If the GP can provide treatment with clear aligners for cases in which they feel comfortable, patients usually choose to remain with their familiar provider. Of course, complex cases will continue to be referred to local orthodontists.

Control over Comprehensive Treatment Plans

GPs can also use clear aligners to complement restorations. Restorative dentistry has frequently required teeth to be prepped prior to restorations. Clear aligners can help conserve patients' teeth by moving the teeth to the best position for occlusal forces to work, before restoration. By maintaining the patient relationship throughout a comprehensive treatment plan, GPs can reinforce the patient's decision and reassure him or her of progress toward the desired results. GPs can maintain control of the end-to-end treatment plan with the restorative results in mind.

Growing the Practice

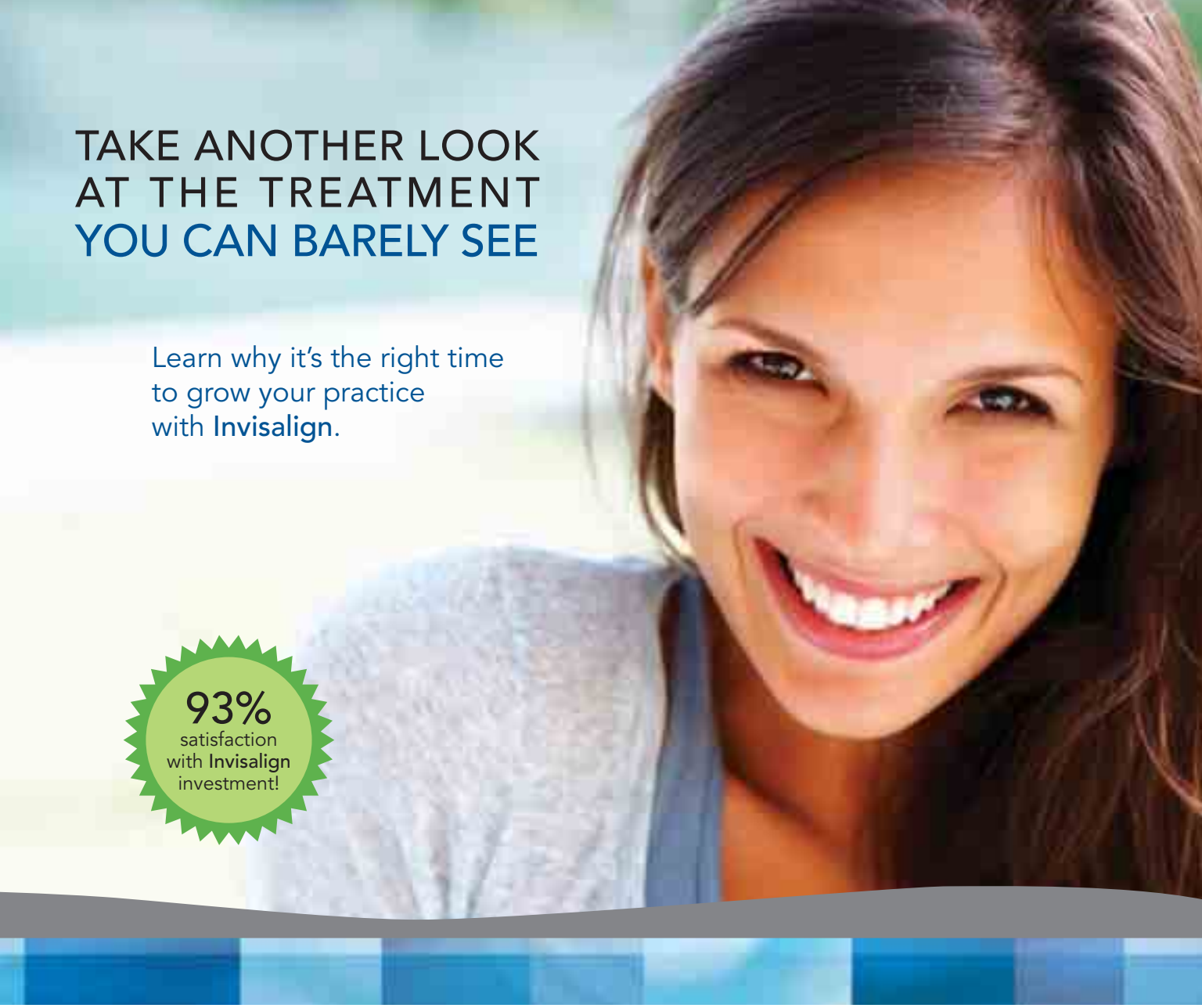
Incorporating orthodontics with clear aligners into a GP office is another way to grow the business. Patients are likely to refer friends and family, growing the patient base as well as offering new treatment options to existing patients.

Enhancing Skills

As GPs gain experience with clear aligners, they can take advantage of advanced technology and techniques to achieve even greater treatment precision and predictability. For example, advanced virtual modeling led to the introduction of Invisalign G4 SmartForce features. Based on biomechanical principles, SmartForce features are customized to address straight and rotational movement, as well as the path that a tooth must take to reach its final position. When combined with adjunct techniques, such as attachments or elastics, aligners can greatly enhance the scope of a doctor's capabilities and address more complex cases if he or she chooses.

1. *Brunelle, et. al. in Journal of Dental Research (2/96)*
2. *Chun-Hsi Chung, DMD, MS/Robert L. Vanarsdall, DDS/Elisabetta Ada Cavalcanti, DMD/Jill S. Baldinger, DMD/Chern-Hsiung Lai, DMD, PhD; International Journal of Adult Orthodontics and Orthognathic Surgery, 2000*
3. *Kirsten Staufer, Helga Landmesser; Journal of Orofacial Orthopedics, 2004*

continued on page 26



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 continued from page 24

3. "My local orthodontist provides clear aligner solutions, and I do not want to step on any toes. What will he or she think?"

GPs can use clear aligners very effectively to build their practices working with simpler cases while referring complex cases to the orthodontist. GPs and orthodontists have built synergistic relationships where both use clear aligner treatment, and both practices benefit from building new patient relationships. In fact, orthodontists can actually receive more referrals from GPs with the ability to offer their patients an attractive, more predictable treatment alternative to brackets and wires.

New Opportunity for New Business

Clear aligners offer an effective treatment option and assistance to both GPs and orthodontists. For GPs, clear aligners provide a way to improve overall oral health and address the needs of patients who would otherwise not seek to have their teeth straightened. For orthodontists, clear aligners offer a treatment alternative to brackets and wires to meet patients' preferences and improve treatment predictability. For GPs and orthodontists alike, clear aligner solutions can help build their practices, expand treatment options for patients and generate more referrals. ■

Author's Bio

Dr. Rene Sterental is the clinical director of New Product Development at Align Technology. He has been a staff orthodontist at Align Technology since 2003 and is also a member of the Align Speaker Bureau. Dr. Sterental received his orthodontic and dental degrees from Universidad Central de Venezuela, Caracas. Additionally, Dr. Sterental is an adjunct clinical assistant professor in the Invisalign undergraduate clinic at the University of the Pacific, San Francisco. Dr. Sterental is an international member of the AAO, the World Federation of Orthodontics and the Venezuelan Society of Orthodontics.

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Dentaltown.com Message Boards

Every month, our editorial team scours the message boards of Dentaltown.com for the most popular, poignant and pertinent threads of the past few months, edits them down to the most essential posts and shares them with readers of *Dentaltown Magazine*.

This month we chose message boards covering this issue's topics:

30 | **Veneer Case**

The title says veneer case but the patient photos tell a different story. Proceed with caution.

37 | **Microscope Learning Curve**

New equipment requires us to learn new skills, and the consensus on microscopes is that the effort is worth it.

44 | **Can't Figure Hygiene Schedule Out**

This conversation will lead us into the realm of pre-booking your hygiene appointments or not.

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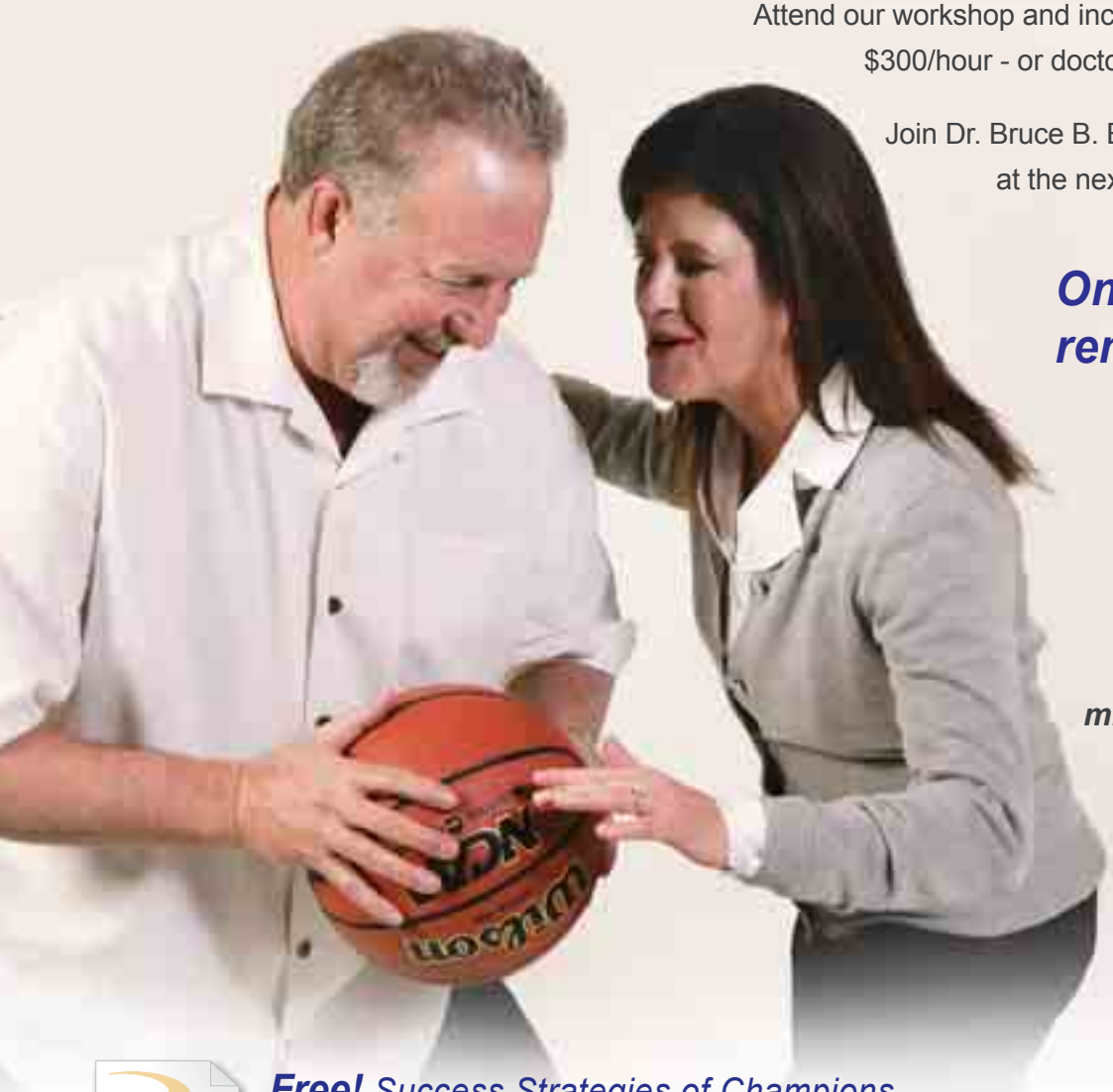

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Veneer Case

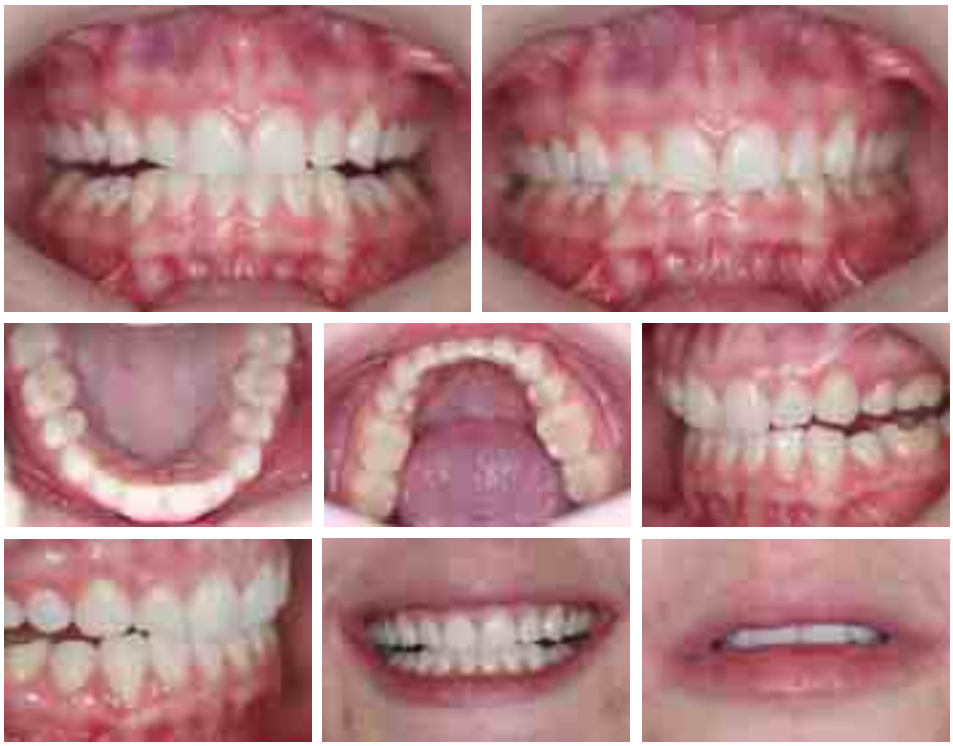
The title says veneer case but the patient photos tell a different story. Proceed with caution.

JKesling
Member Since: 08/29/04
Post: 1 of 38

Just wanted to get some feedback from some of you Townies regarding this case. A 22-year-old female is interested in getting porcelain veneers to improve her smile and repair the damage that has occurred from grinding. These pictures were taken about a year ago, so since then she has worn the incisal edges of the anterior teeth even more. I'd like to keep treatment as conservative as I can, but I'm concerned about her steep overbite. Right now, the plan is to proceed with porcelain veneers on #6-11 and then fabricate an appliance to protect everything.

Any suggestions or recommendations on this case? Would any of you consider direct veneers? What about margin placement?

Thanks! ■ Jeff



DEC 29 2011

Want to see more veneer cases? Then search for these other cases on Dentaltown.com.

My First Veneer Case
Search: My First Veneer Case

Anterior Veneer Case
Search: Anterior Veneer Case

skuzma2dds
Member Since: 08/06/07
Post: 3 of 38

You're right… that is some wear!

The looks of veneers would really enhance her smile, especially #6, #7 and #11 – they look like they belong on someone much older than 22.

Hoping the FMR/veneer guys chime in. ■

DEC 29 2011

The Chipster
Member Since: 07/08/03
Post: 4 of 38

Have you done any parafunctional analysis? Looking at that case off-the-cuff, I think six veneers alone is a plan for very expensive and frustrating disaster in broken porcelain. If you

continued on page 32

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 continued from page 30

don't change the bite in any way, what in the world makes you imagine that your porcelain will hold up any better than her enamel did?

It would be less expensive in the long run to just give her a check for $5,000-$7,000 and let her get the case done somewhere else. Seriously. Just doing veneers to make the teeth longer and hoping she'll wear a night guard? (Ask me how I know). ■

DEC 29 2011

JKesling
Member Since: 08/29/04
Post: 5 of 38

I see your point, Chip. That's why I'm a bit concerned about this case. It's relatively easy to prep and seat the case and then put her in a night guard and hope for the best. She's not interested in further ortho and is asymptomatic. Unfortunately, she started grinding her teeth at an early age and I want to help her. Just trying to figure out how to best treat her situation, without getting too aggressive.

I'm not trying to lengthen her teeth much at all. I have a diagnostic wax-up that keeps the teeth in proportion. Any other thoughts? ■ Jeff

DEC 30 2011

The Chipster
Member Since: 07/08/03
Post: 6 of 38

Nope, the only thought is that doing veneers without changing anything else is the wrong thing to do and a very bad idea, and if she asked me I would refuse. Just because it's easy and profitable (in the short term) doesn't mean you should do it, and in fact, you would only be making her worse off in the long run. ■

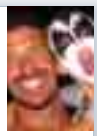
DEC 30 2011

elitey34
Member Since: 04/29/07
Post: 7 of 38

Too bad the ortho was probably planned and finished without restoratives in mind. And now that you need to restore, the teeth are not in the right position. Maybe you can get away with some recontouring and appliance. ■

DEC 30 2011

John Nosti
Member Since: 02/23/04
Post: 8 of 38



Jeff, I will chime in here and say that a good 50 percent of the cases I treat (or more) are done as "functionally" driven cosmetic dentistry like this, as opposed to people walking in off the streets asking me to treat their smile. I just completed a CE program for Dentaltown that is coming out in January that goes over cases just like this. The course is called "Treating Worn Smiles."

One of the most important pictures I think you are missing here is a profile shot. This will tell us if you can build out the smile or keep the teeth where they are facially. If you have the ability to bring them out 0.3-0.5mm, I would do that to be more conservative and hold on to what precious enamel you have. Unfortunately this means treating more teeth because if you are going to add to the canines facially you are going to create a negative buccal corridor and give her the Matthew Perry look.

I would consider using a lab that understands that the mock-up of the wax-up goes in first and then you prep through that. This ensures proper reduction and conservation of tooth structure.

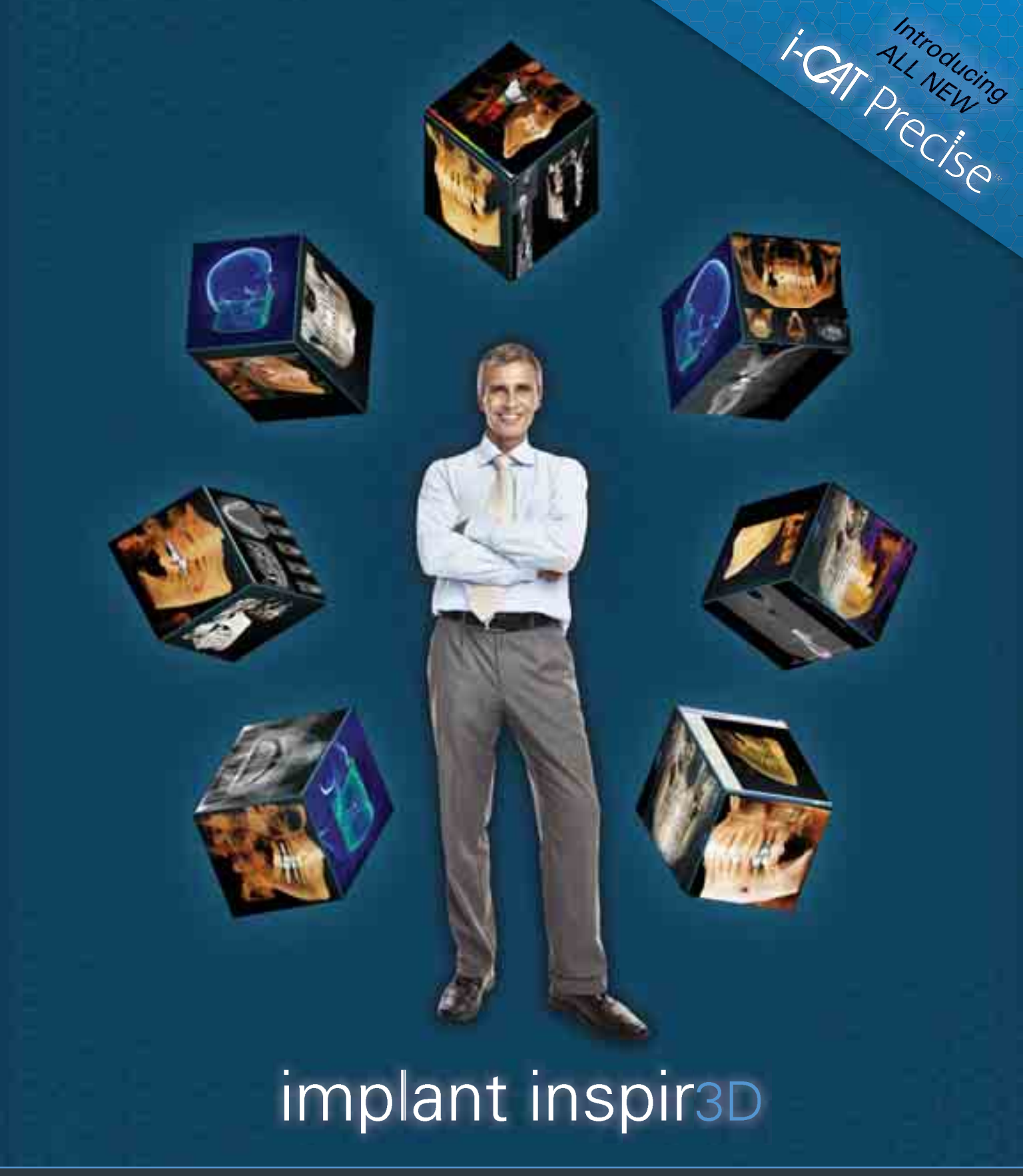
When you ordered your wax-up did you deprogram the patient ahead of time? Was the case mounted in CR? Did you plan to remove interferences and restore anterior guidance? If not, Chip is right… plan on failure. The first step in parafunctional control isn't hoping they wear their night guard, it is building the occlusion as a night guard they cannot take out (anterior guidance with no closure interferences)… then on top of that, it is a protective appliance.

Show us pictures of your wax-up.

Hope this helps. ■ John

DEC 30 2011

continued on page 34



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 continued from page 32

jasonsmithson
Member Since: 12/16/04
Post: 9 of 38

You need mounted models with a deprogrammed CR record and protrusive for this case.

I would use an NTI with Sharpie marks to deprogram… it will tell you a lot.

Basically the case is around 80 percent overbite with a stepped occlusal plane, so you have two choices.

1) Ortho and restore.

2) FMR and open vertical.

My instinct with this case would be to do direct or indirect composite Dahl on upper eight units and then monitor for a couple of years.

Low-risk approach.

You could then look at minimal prep ceramic or composite onlays on the posterior units and possibly minimal prep ceramics on the anteriors. ■

DEC 30 2011

JKesling
Member Since: 08/29/04
Post: 10 of 38

The patient is coming in next week with her father for consultation. I can take some more photos then. At the moment, I'm without an articulator, but I can see if I can borrow one. Jason, can you explain your deprogramming method? I know Miguel taught me how to do this before, but I think we were using a Pankey deprogrammer at the time.

Thanks! ■ Jeff

DEC 30 2011

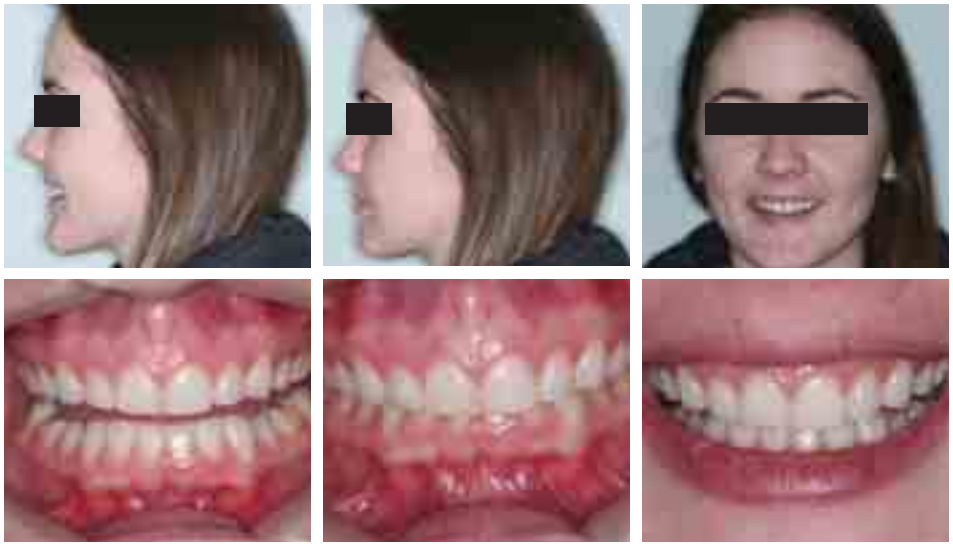
DrPaulG
Member Since: 04/02/03
Post: 11 of 38

Do you think the fact that her lower incisors appear to be so retroclined has anything to do with the fact that she has worn her teeth so much at such a young age? Is she trapped by such a deep overbite that she is trying to do anything to gain more freedom in her envelope of function? Also, not to hijack the thread – at what point do you go from treating the front 8-10 with veneers to lengthen and restore worn anterior teeth to converting to a FMR with an increase of the VDO? I mean, I see cases where eight veneers are done to lengthen and restore anterior teeth without touching the posterior occlusion. How successful are these considering what the patient did to his or her natural tooth structure? Or are the lower anteriors shortened to accommodate the increased length of the upper anteriors? ■ Paul

DEC 30 2011

JKesling
Member Since: 08/29/04
Post: 33 of 38

Here are some updated photos.



continued on page 36

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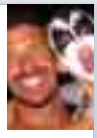
 continued from page 34

The patient was supposed to come in today to fabricate an NTI, but she cancelled. She was a bit upset when I brought up the need for ortho. Hopefully, if she agrees to proceed, the ortho won't take too long. Any additional thoughts after seeing the new pictures?

Thanks! ■ Jeff

JAN 5 2012

John Nosti
Member Since: 02/23/04
Post: 37 of 38



I know the consensus on this thread is ortho and conservative treatment, which I completely agree with as an option. But looking at these pictures, and especially the profile picture, I am thinking this case can be done with Emprethins. Of course, I am only going by photos. Models and such might paint a different picture… but in her smile picture I think 1mm can be added to her length, if they can thin them down to 0.5mm, that's even better. For sure her profile looks like her teeth need to be brought out.

This is a case I might want waxed and evaluated for no prep or super minimal prep. Of course deprogramming, equilibration and all that stuff still applies.

Just throwing that out there. ■

JAN 6 2012

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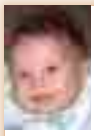
Microscope Learning Curve

New equipment requires us to learn new skills and the consensus on microscopes is that the effort is worth it.



mattyboy
Member Since: 07/02/09
Post: 1 of 21

Hey all, I got a chance to demo a Seiler scope yesterday (thanks to Stefan Luger, who is the man) and was absolutely amazed at what I could see. Microscopes are big investments, but I can get one for a pretty reasonable price. The issue that I have is "looking" through a scope and "working" through a scope are two totally different animals. I'm seriously worried about how the learning curve would affect me and was hoping to get some honest feedback from some of you who have already taken the plunge. Any help would be greatly appreciated.

Thanks. ■

AUG 9 2011

glennvanas
Member Since: 04/08/02
Post: 2 of 21

In general, you have to be committed to making it work. If you are and have a practice where it can succeed (in my opinion, some practices are better suited for success than others) then you can integrate it better by:

1. Taking a hands-on course (NCOFI, Wayne Remington, Stefan Luger, AMED, ESMD).
2. Go to a meeting (AMED, ESMD).
3. Read the microscope book. I can show you where to get it.
4. Order the DVD series from me.
5. Time and persistence and learning from Dentaltown posts (Aussiedentist had a great series of posts, as well as others). ■ Glenn

AUG 9 2011

smluger1
Member Since: 04/04/03
Post: 3 of 21

Hi Matt, I feel great that you are looking at the microscope section here on Dentaltown. You will be able to get some personal advice from a bunch of scope users.

Like we had discussed. Training is so important. I have met a good number of dentists who never had training and learned how to use it themselves and they took a long time to get proficient and many of them never got as good as they could be if they got trained.

Just commit yourself to learning it and the scope will take you to a level of performance that will surprise you. There is no other way of doing it as efficiently.

I really enjoyed working with you and loved the area you are in. Very impressive.

Good luck. ■ Stefan Luger

AUG 10 2011

aussiedentist
Member Since: 09/01/10
Posts: 4 & 6 of 21

The main problem you have at the moment is just your coordination, and you don't feel like your hands will ever be properly connected to your body. This is just because your eyes are no longer in your head; they are a foot away and at a different angle!

(If you don't believe me, then just set the scope up so it is in a straight line, and you can use it easily!)

I found it took a couple of weeks for me to be able to do an exam and cleaning as well as I used to. There is obviously going to be the initial drop off. No problem. Just go into the sur-

continued on page 38

 continued from page 37

gery room on your day off and butcher a few extracted teeth. Just practice moving things around, and in a short time you will wonder how you ever lived without the scope.

[Posted: 8/13/2011]

Make sure you get the metal halide light, It's unbelievable compared to cruddy halogens.

I'd also splurge and get the six-step – you will wind up using magnifications much higher than you ever initially imagined, and even if you don't, you might employ another dentist/endo who would appreciate it. ■

AUG 12 2011

mattyboy
Member Since: 07/02/09
Post: 7 of 21

I totally agree. Stefan brought out a Seiler six-step with a couple of nice add-ons… I'm sold. Got a lot going on right now, so unfortunately I'm going to have to hold off for a while. I do plan on getting some books and DVDs so when I do buy one and get trained, I'll be that much further ahead.

I feel so cheated looking through loupes now. Even the lowest magnification setting on the scope seemed higher than both pairs of my loupes. The most amazing part is the clarity too. It is like going from a 50-year-old tube TV to a high-def plasma. ■

AUG 13 2011

nxb8373
Member Since: 09/20/08
Post: 8 of 21

The learning curve is as short as you let it be. If you start using a scope for a procedure and then get frustrated and push it away because it is taking too long, you will take infinitely longer to get back to your normal speed. If you make yourself use it the entire time no matter what, you'll be amazed how quickly you get used to using it. I'm an endodontist who really uses his scope for the entire procedure, not just to pull it over and look. I'll tell you if I had to do molar endo without the scope, it would take me three times as long now.

My sister came home from dental school on break and asked me to clean her teeth. I started out just using my loupes and had to pull the scope over, I couldn't see, my back hurt, it was terrible.

My wife is an endodontist too and her best referral uses the scope for everything in her general practice, including cementing crowns.

And finally, don't let your assistants influence you by saying you are taking too long and "you were better without it" because I promise you aren't, none of us are. Show them what you can see under the scope and have them look through loupes – then ask if you were working on them, would they want the scope or the loupes?

You will do better work and your patients will benefit. ■ Nate

AUG 16 2011

O_B_one
Member Since: 09/25/08
Post: 9 of 21

With no training and very few microscope users in South Africa, I had no choice but to dive right into the deep end. I spent two hours doing scale and polish on my staff. I then did a few basic fillings. Before the end of the week I did preps and cementations.

The biggest and funniest adapting was that of my movements. With everything you see being massive, your hand movements are also. I ended up probing a nostril on the one patient, he was not happy. You will soon learn to glance down out of the eye piece to get your instruments in the mouth in full view of the scope. Then you just use it.

If you can get a hands-on go for it. But without it, it is possible. ■

SEP 23 2011

wrbirddog
Member Since: 04/11/07
Post: 11 of 21

I echo what the others have said. The use of the microscope makes you a better you – not better than everybody else, just a much better you as far as a clinical dentist.

continued on page 40

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Training will certainly make the transition easier and that is the beginning of your training. You must press on to do the rest every day you practice. I am constantly learning and I love it. I learn something with every class I teach (frequently from the new microscope participants).

As far as light source – the LED is the new standard. Unless your prime needs are photography in endodontic canals then you want Xenon, or LED and a ring flash with a DSLR. Metal halide is much better than halogen, but unfortunately (because I have seven metal halide light units) it is old technology already. ■

SEP 23 2011

mattyboy
Member Since: 07/02/09
Post: 12 of 21

Thanks for all of the feedback so far. I really appreciate it.

No scope for me yet… I did however, decide that I am a magnification junkie, and went up to 5.5x loupes with headlight for everything I'm doing. My thinking is that if I get used to working with higher mag loupes, it'll be less of a shock to me when I do get my scope (it has already been eye opening). It is definitely inspiring to know that there are plenty of GPs out there incorporating scopes into their practices, and I look forward to being a "scope doc." ■

SEP 23 2011

drrobjost
Member Since: 10/08/04
Post: 16 of 21

Hey Glenn, I have been doing my exams with 4.5 mag with a headlight and it's great how much I can see. Can't imagine what I am missing. I will move to the scope at some point… first I have to pay off all of the infection control stuff that was forced on us. Anyway, how do you do your recalls with a microscope logistically? Do you move them to another room with the microscope or do you have one in hygiene? How many scopes do you have? Thanks. ■ Rob

SEP 25 2011

glennvanas
Member Since: 04/08/02
Post: 17 of 21

Hi Rob. I am in my third office now. I have grown from two ops to four to six to now nine ops (I have two associates). Each op has a scope and why this happened is that more than once when I did only my restorative dentistry through the scope, what I thought I saw at the recall exam was in fact not the case when I opened it up with the scope.

For instance – decay was present on the adjacent tooth, the crack was larger than I thought, marginal decay under the crown was larger, etc.

So in the new office (built in 2008) I decided to have a scope available in all ops. I come into the operatory and I have the hygienist move the overhead light (she doesn't use the scope) and turn on the scope and turn the TV onto the scope so patients watch the hygiene exam.

On the Global G6 the lowest mag (2.1x mag) is right next to the 8x mag so I just literally flip between the two. Low mag for the overall view and a jump up to the higher mag if something is suspicious (cracked filling, marginal decay, cracks, occlusal decay). The turret is 0.33 at low mag and 1.25 at the higher mag for those who are using the Global scopes.

The difference in visual information between the two is that the higher mag is roughly 16 times that of the lower mag so it really works well for me.

Does that help? ■ Glenn

SEP 25 2011

drrobjost
Member Since: 10/08/04
Post: 18 of 21

Thanks Glenn. I am thinking about getting a scope at some time and I want to start budgeting for it. So I appreciate the info.

What is the cost of a good scope?

Would it be best for me to start with one in my main op?

The other concern I have is behaviorally feeling distanced from the patient. What is your experience with that? Thanks. ■ Rob

SEP 26 2011

continued on page 42

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glennvanas
Member Since: 04/08/02
Post: 19 of 21

No problem, Rob… after 14 years of using the scope I figure I know a few things about it. You will find it is a wonderful tool to work with in the office. For me it might be the number one thing I use for all patients.

There is a range from $13K or so to $25K depending on what you put on the scope (i.e. documentation, how many steps of magnification, etc.). You can start with a basic scope and then move up from there adding documentation, etc. when you are ready.

I think for most it is best to start with one main op scope and if you want you can buy two arms and have an LED light source joined to the scope. This will allow you to transfer the scope from one room to another and if you want you can eventually add the second optics and light source. The main cost of the scope is in the optics, so the arm is not that expensive.

To be honest I like that I don't see the patients' facial expressions. The assistant is there to tell me about the macro world and to be honest, I know when the patient is feeling the prep as their subtle flinch is magnified… I know when they are sore very quickly in the whole scheme of things. My attention is with the tooth, and the magnified view blocks out all the distractions and I can just focus on completing the task at hand. ■ Glenn

SEP 26 2011

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Can't Figure Hygiene Schedule Out

This conversation will lead us into the realm of pre-booking your hygiene appointments or not.

reccoso
Member Since: 05/06/08
Post: 1 of 63

I recently purchased a practice with around 3,000 active patients. There are three full-time hygienists (four days a week each, average appointment is 50 minutes) and the problem is that they're never booked out more than a week or so, and even then there are holes in the schedule. Plus, each hygienist books off 20 minutes before lunch and before the end of the day to clean up. Open time is 27 percent for two of them, and 20 percent for the other one.

I consider the hygiene program to be a good one, but there's something off about how patients are scheduled.

The way it works now, patients are sent a card about a month before their next hygiene appointment and then confirmed a week before.

Patients are only pre-booked for their next appointment in a minority of instances; majority of the time a contact is placed for the next hygiene appointment and then followed up with as time gets closer.

And hygiene books patients in their ops, while front desk follows up on any contacts, etc.

I just have a hard time believing that with this many patients hygiene is not booked out. I've tried to get patients pre-booked, but there's some resistance. Thanks for any advice. ■

NOV 14 2011

cmcalderwood
Member Since: 12/14/05
Post: 2 of 63

I haven't had very good results when I pre-book hygiene appointments. We have a lot of no-shows or last minute cancellations when we do that. My results have definitely improved when I have my girls call when the six-month recall approaches. Between that and the e-mails, we have seen an improvement. ■

NOV 14 2011

mopsy
Member Since: 11/22/02
Post: 3 of 63

I tried both ways and what I found is that majority of patients actually do like pre-booking. Hygienists schedule their next cleaning appointment in the operatories. We send a card or e-mail three weeks before to remind and then confirm two days before. Some people cancel or reschedule but most patients keep their appointments.

Those who don't pre-schedule get a postcard then a call from the front office. Then if they still don't schedule, they go on our past due hygiene list and we continue to contact them via e-mails, cards and calls. Note: when we call we block our number and never leave messages. That way we can call back and not appear like we are bothering them too much.

If you have trouble pre-appointing patients, you have to look at the verbal skills that your hygienists are using. I've been coming to the realization that our verbal skills are responsible for many of the things that either work or don't work in our practices. Whenever someone says "my patients just won't do it," I wonder if this is because the front office or another employee in the practice is not using the right verbal skills to guide patients toward making a good decision.

Also, just doing the math, 3,000 active patients require 6,000 hygiene hours (less any patients on irregular recall plus new patients). How many hygiene hours do you offer? Three hygienists full time would come out to 6,000 hours. So either your active patient numbers

are lower or your patients are not consistent in recall. Can you find out average recall time for your practice? That way you'll know whether you need to reduce the number of hygiene hours or start working with the hygienists on improving their verbal skills to both pre-appoint and to show patients the value of regular recall so that more of them go on the regular three to six months. ■

NOV 14 2011

gdersley
Member Since: 07/26/07
Post: 4 of 63

This is exactly what I was thinking. If your staff are telling you that "patients just don't like to pre-schedule," there is probably something going on with your staff. When I first purchased my practice, the patients weren't used to pre-scheduling so many of them would decline. However, when we changed the way we asked them, we had better success.

When we asked "would you like to schedule your next appointment now?" many of the patients would say "no."

When we started to say "let's go ahead and schedule your next appointment," most of the patients did not resist at all, and made his or her next appointment. You can emphasize the positives of scheduling in advance – mainly that the patient will get the time of their choice.

The staff also has to believe in it. If your receptionist secretly thinks that most patients hate pre-scheduling, it will show in her attitude and therefore most patients will not pre-schedule. ■

NOV 14 2011

msgdds
Member Since: 07/02/04
Post: 5 of 63

You said, "The way it works now, patients are sent a card about a month before their next hygiene appointment, and then confirmed a week before."

In my opinion, that is your issue… pre-book or not, make contact the day before the appointment, not a week.

I am working on this same thing. Fixing up an old hygiene program takes work but it's totally worth it.

I think pre-booking is an important way to make sure you don't lose patients because everyone leaves with a next visit.

It takes work but it sounds like you have a good solid base to work with, for sure.

Also, forget blocking before lunch and end of day, which is crazy. ■

NOV 14 2011

reccoso
Member Since: 05/06/08
Post: 7 of 63

Thanks for all the replies, especially the specific verbiage.

I've worked in offices that had fewer patients and hygiene was booked tighter. My staff, including hygienists, are all very experienced and set in their ways.

The one big constant conversation killer is "But we try! What can we do if patients don't want to pre-book?" I don't want these guys to feel like I'm asking of them

continued on page 46

 continued from page 45

something that's not doable and end up frustrating them. I think I'm going to recommend some of the verbal skills you guys offered.

For confirmation, however, what's the typical protocol for confirming a hygiene patient and a dental patient?

Thanks again. ■

NOV 14 2011

mopsy
Member Since: 11/22/02
Post: 8 of 63

We've experimented with this one quite a bit as well and this is what we ended up deciding on, "Hi, I am so and so calling to remind you that you are all confirmed for your appointment this Friday at 3 p.m. We are looking forward to seeing you soon." When a patient is coming in for something more extensive you can call with pre-operative instructions, "Hi, this is so and so calling to remind you to take your pre-medication and eat before your surgery on Friday at 3 p.m."

If you don't like the word remind you can say: "I am calling to let you know that we are looking forward to seeing you this Friday at 3."

We don't schedule tentative appointments. All of our appointments are confirmed when scheduled. So avoid telling them "I am calling to confirm…" ■

NOV 14 2011

shazammer1
Member Since: 12/20/00
Post: 10 of 63

I have worked in a lot of offices as a temp and for the most part they all book out recall appointments before the patient leaves. It is a given. Even the patients on shift work bring in their shift list so they know what times they will be free six months from now. They know to prepare for that question. As a last resort, set a tentative appointment, but set it. Don't make it sound like it is going to be easy to change it, just possible to change it.

I am sure when they first started doing this the patients balked or threw up lame excuses, but the truth becomes… if you don't book now, you will be months and months overdue because the book is filling up as we speak. You are making it too easy and convenient for your patients to book on a minute's notice.

Do not ask them if they can. Do not ask yes or no questions. Tell them the book is filling up and if they like the 11 a.m. appointment or 4 p.m. appointment they should put their name on it now because waiting will cause them to be on the wait list.

Most practice management seminars I have been to consider the unbooked patient a lost patient. Think of the chasing time you will save by at least having them in the book. Otherwise there are numerous phone calls and cards.

When your staff tells you that they can't, tell them "Well, I have talked to other offices and they all book out six months and we are going to do this too." It is like knowing you have a steady stream of patients coming in, how to order supplies, how to set vacations, how to plan your week, month, year.

continued on page 48

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Your front desk is giving up too easily and does not believe in the book-ahead club. You need some bulldog in there that is a firm believer in pre-booking and thinks a patient is a loose cannon when they don't. Attitude and verbiage and body language is everything. ■

NOV 14 2011

Rick Garofolo
Member Since: 10/06/11
Post: 12 of 63

I am so sorry to hear that your staff is telling you it can't be done. Ninety-nine percent of the dental offices in the country pre-book their hygiene appointments. Most people prefer it that way. In the offices that I have worked with (I am both a practice owner and a practice management consultant), we always pre-book hygiene appointments. In our office 98 percent leave their hygiene visit with their next scheduled and confirmed appointment. Note that when an appointment is made, it is confirmed. When we do our calls three days before, the message is always that "this is a reminder call for your confirmed appointment in our office."

We use a variety of methods for that reminder process that include sending postcards four weeks out, an e-mail and text message one week out (through which they can confirm, which is updated on our schedule immediately electronically) and then the reminder phone call three days out. If it is someone with a history of no-shows or last-minute cancels, we make sure to call them three days out and then again the day before and always leave a message reminding them of our cancellation policy and the fees associated with cancelling last minute or no-showing.

You stated that you just purchased the office. The important thing that you need to remember is to not take excuses from your staff for their lack of performance. If you start walking down that road now, you cannot expect it to get better, and have to assume it will carry over into other areas of performance as well. Excuses should never work. There should be a real conversation regarding the way it is going to be (state the goal) and then the discussion should be about how to get there, not if you can get there. Reaching your goal is not up for debate. You are the owner and you set the goals. The team's job (including you) is to figure out how to reach it.

Don't hesitate to contact me if you have any questions. I wish you the best of luck. ■

NOV 19 2011

Like what you are reading? Then check out these other message boards about hygiene schedules on Dentaltown.com.

Increasing Treatment Acceptance Out of Hygiene Chair
Search: Hygiene Chair

No-Show and Cancellation Proof Hygiene Schedule
Search: Cancellation Proof

debiallie
Member Since: 03/03/05
Post: 14 of 63

Our patients "reserve" their next recare appointment. Many realize that they might want a particular day, time or specific hygienist. I always encourage them to "reserve" their appointment so that our good patients get their choice of time or hygienist. The leftover appointments go to those who do not "reserve" their time or just call in when they finally want to come in. We have been doing this for a couple of years and patients make their next appointment at least 80 percent of the time. We do not encourage patients to pre-book who habitually cancel or no-show. They have to call us and take the open appointments. We are booked out for six months at the present time for five hygienists. Also, we have some patients who make their family members' appointments for the next 18 months so they can get desirable times for all their recall appointment. Patients who do not pre-schedule recare appointments are sent a text, e-mail or card depending on their choice of method. ■

NOV 19 2011

reccoso
Member Since: 05/06/08
Post: 16 of 63

I do think I'm overstaffed. I think what I really need is two and a half hygienists and not three. It is very difficult to ask someone to cut a day – but let's see. I'm hoping that future growth will allow for a busier hygiene schedule.

Believe it or not, this practice had four full-time hygienists. When I asked staff and the previous owners about this they said the schedule was "more spotty" with four hygienists, but they didn't mind because they could offer more 8 a.m. and afternoon appointments!

I couldn't believe it when I heard that they basically paid a hygienist for the whole day just so they could offer more appointments during the morning and afternoon times and I think that unfortunately that mentality is still there.

My hope is that with better scheduling and more growth the three hygienists can have a fuller schedule, but it's very frustrating to look at the hygiene schedule and see large holes and no one care about it but me – even front desk is gleefully resigned to the fact that that's how things are and it's normal! Frustrating!

I'm a little concerned though that the staff will implement the pre-booking thing in a haphazard way and come back to me with a "See! We told you! No one wants to pre-book!" ■

NOV 20 2011

Small point, but someone once said not to "remind" people implying they might have forgotten, but to "confirm" the appointment.

"I'm calling to *confirm* the appointment time that is reserved for you on [date]." ■

NOV 22 2011

jawbreaker
Member Since: 10/06/01
Post: 20 of 63

I have read so many great responses to this question.

If you have 3,000 patients and many of the adult patients are periodontal maintenance or if they are scheduled for scaling and root planing, you will need even more than 6,000

DPSDentalcoach
Member Since: 11/09/11
Post: 21 of 63

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hours. I agree that your active patient base is a lot less than 3,000 and possibly there are a lot of untreated perio patients. It is now the standard of care to prevent and intervene early rather than wait and watch. I always ask "What are we waiting for?"

One joke I heard from (I think) Esther Wilkins was: "Do you know what WNL means?" Answer: "We never look."

I think that verbal skills are the very important piece here. Many words used when speaking to dental patients can break down the importance of patient-centered, preventive care. I always use and suggest to other dental teams to say "Mrs. Johnson, I look forward to seeing you in X months to recheck that one area that is bleeding today (or insert what is appropriate) and I will do your annual X screening to prevent X. Is X day at X o'clock a time that will work?"

I have also found it works best to send an e-mail or text about two to three weeks prior (when applicable) then call a couple of days prior to the patient's appointment and say "Dr. Goodtooth is looking forward to seeing you for (type of appointment) on X day at X o'clock." There are several companies you can use to set up patient e-mails for appointment reminders and companies to call patients. It works well to continue follow-up between appointments. Examples of this are text messages and/or e-mails and the use of social media with posts about the office to keep patients informed.

I have also found people respond best when they are not "reminded" but you are calling with a positive reason, i.e. "Looking forward to seeing you for X."

When the verbiage is changed, it works well to add value to the patient appointment. It is a proven fact that when the entire dental team uses value-added terminology, patients will make dental appointments a priority. ■

NOV 23 2011

reccoso
Member Since: 05/06/08
Post: 23 of 63

I'm also still in a period of transition (about five months into this). I have made a few changes, and as recently as yesterday I asked the hygienists to switch up the schedule a bit so I wouldn't have three hygienists to check on a day where I'm the only doctor and my associate isn't there. This would mean that two of them would have to work Monday, Tuesday, Wednesday, and alternate between Thursday and Friday off. And the response from one (the one with the lowest hourly production and highest down time) was "I really don't like this because I'm at the cottage on Fridays blah, blah, blah…" They both want Fridays off. They both dislike each other. I would honestly love to get rid of cottage-girl, give the other hygienist the Fridays off and hire a part-time to work the Friday.

The third hygienist works Tuesday to Friday and can't work Mondays at all.

Our schedule is as follows right now:

Monday: one hygienist; Tuesday: three hygienists; Wednesday: three hygienists; Thursday: three hygienists; Friday: two hygienists.

I'm trying to go to:

Monday: two hygienists; Tuesday: three hygienists; Wednesday: three hygienists; Thursday: two hygienists; Friday: two hygienists.

I don't understand how they expect me to place their social calendar ahead of my personal and professional well being! It blows my mind that people can have such entitled attitudes. ■

NOV 24 2011

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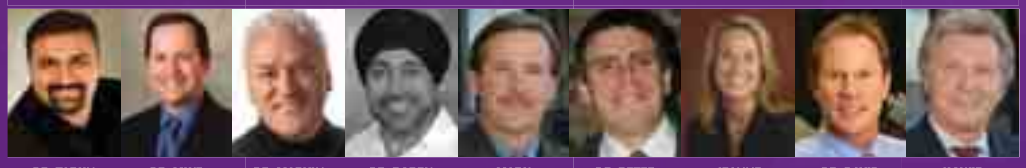

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New Products

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

www.dentaltown.com

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The Young Dental Elite Series line is made up of four prophy cups – the new Elite Flex and Elite Extend Flex, which join the Elite Original and the Pointed Polisher. The Elite Flex and Elite Extend Flex are 25 percent softer and more flexible than the Elite Original cup, which is optimal for improved cup flare and flexibility around the contours of the teeth. Also the Elite Extend Flex is 19 percent longer than the Elite Flex – ideal for clinicians who prefer to work with a longer prophy cup. For more information, visit www.youngdental.com.

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The Moses is an oral appliance that treats snoring and obstructive sleep apnea. The Moses is a custom-made appliance, manufactured in a certified medical device facility for each individual, ensuring a perfect fit and solution. The Moses was designed to improve the simple MAD (mandibular advancement device) design of the past by adding another dimension to oral appliance therapy – tongue position. The device stimulates the protrusive tongue reflexes, which guide the tongue into a forward position out of the airway. The unique open anterior acrylic design accommodates the forward tongue posture that results in patient comfort and efficacy. By combining tongue position and mandibular advancement you can be more conservative when advancing the mandible. No more patient discomfort or pain. Visit www.themoses.com for additional information.

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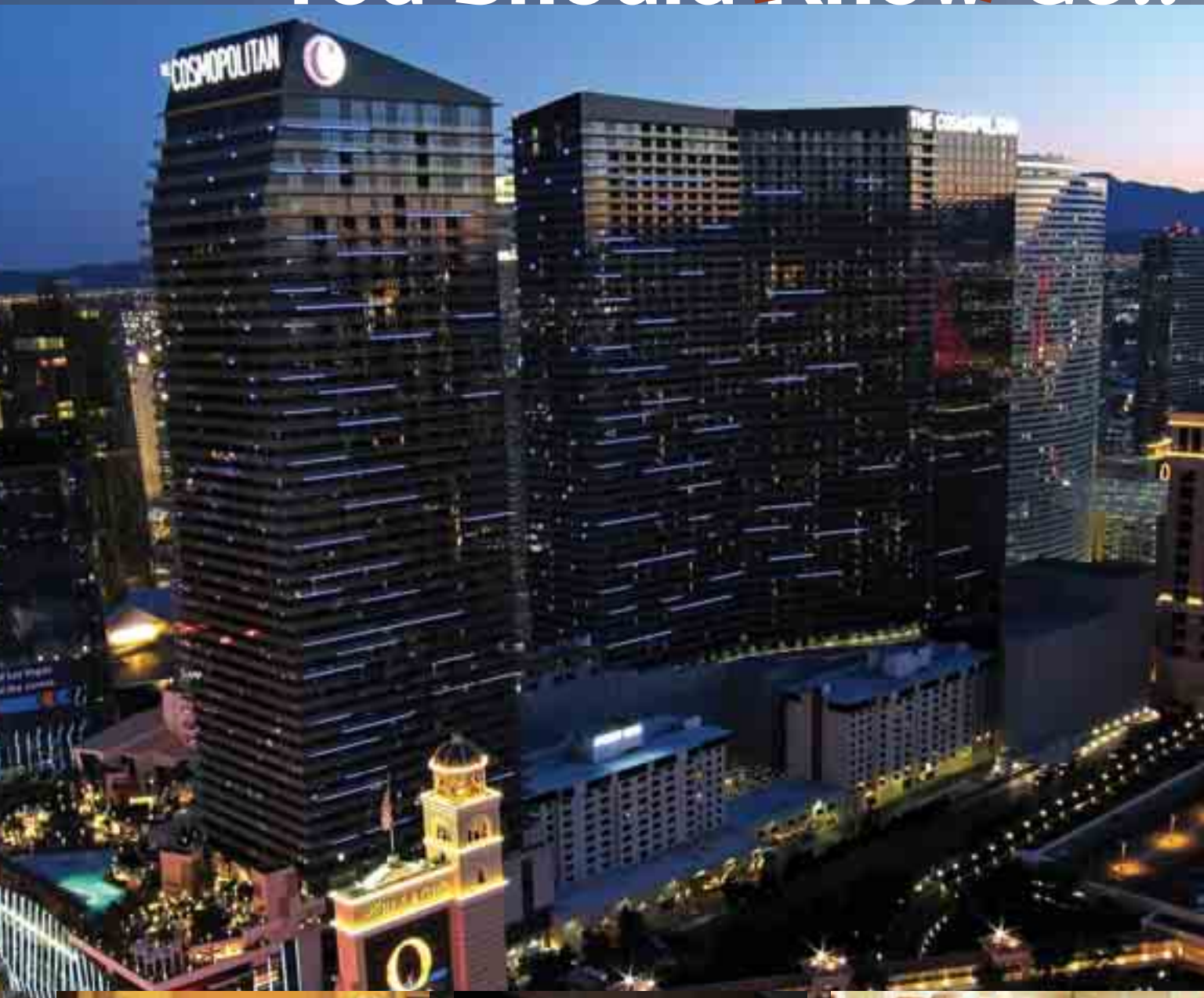

Townie Meeting

by Benjamin Lund, Editor, *Dentaltown Magazine*

Townie Meeting turns 10 this year! In case you even need a reason to get to Las Vegas next month to celebrate with Townies from all over the world, we spoke to Townie Meeting Coordinator Leslie Hollaway to get the inside scoop on how the meeting is put together and what we can all anticipate this year.

Leslie, tell us a little bit about your role as Townie Meeting coordinator.

Basically, I oversee all aspects of the meeting – from soup to nuts. Dr. Tarun "T-Bone" Agarwal and Dr. Sameer "socalsam" Puri are the visionaries and I just make it happen.

You're too modest, Leslie! So, this being the 10th annual Townie Meeting, what sort of special events do you have lined up?

We are very excited about celebrating the 10th year of Townie Meeting. There will be 10th anniversary giveaways for the attendees, some fun activities at the opening party and a drawing at the Closing Beer Bash for an exciting giveaway.

How long does it take for a Townie Meeting to come to fruition? Can you tell me about some of the logistics behind the scenes?

A Townie Meeting takes an average of 18 months to plan. It all starts with the hotel contract negotiation. Next is logo development and future Townie Meeting collateral to hand out at the current meeting, and Web site development.

After the current meeting concludes, Tarun, Sameer and I meet to tweak the meeting schedule, review suggestions, work on the curriculum, develop a marketing plan and argue about the party theme (we really *do* read all of the evaluations and suggestions). Then we get the ball rolling with the exhibit hall layout, exhibitor recruitment, attendee registrations and all the other details of planning.

The two weeks before the meeting starts is an entirely different story, in one word I would call it "mayhem." It's hard to see the finish line, but then everything starts falling into place. The goal is to make sure everything is organized by the time we arrive at the hotel so everyone can enjoy the weekend. We are also lucky to have an experienced registration staff who can handle any request and very fortunate for Dr. Glenn Hanf who organizes both the golf and poker tournaments.

During the meeting, "behind the scenes" is pretty relaxed. Since this is our 10th year, we don't have to re-invent the wheel. Logistics-wise, I meet with the hotel, then with the guys to review the entire weekend, give them their jobs and then pray Tarun doesn't offend anyone while on stage (laughs).

Tell us about some of the speaker highlights this year.

Well, it would not be a Townie Meeting without Dr. Howard Farran kicking off the meeting. We are also fortunate to have Dr. Mark Hyman, Dr. Gary DeWood, Drs. Rich and David Madow and Trisha O'Hehir from Hygienetown on the main stage. As far as continuing education, T-Bone and Sam take great pride in providing cutting-edge courses. This year the curriculum is extremely diverse. We have courses in implants, ceramics, bone grafting, ortho, team communication, perio, practice productivity, prosthetics, social media, Internet marketing, CEREC and AMD Laser courses to name a few.

What's the theme of the Townie party this year?

The Opening Party theme is James Bond. The Cosmopolitan Hotel lends itself well to this theme. There is even a bar called Bond in the hotel.

Do you have any cool costume suggestions for us?

The Dentaltown.com message boards have already been buzzing with some amusing costume suggestions. I think Jaws would definitely be appropriate, also Goldfinger, Odd Job, Q, M, a Bond girl or dress as though you will be playing baccarat at a Monte Carlo casino.

What is the number-one reason a dental professional should attend the Townie Meeting this year?

In addition to providing exceptional education that can be applied chairside Monday morning, the parties are fabulous and set in a relaxing environment that encourages socializing and the development of new and lasting friendships (I know that's two things but it's true).

Thanks for your time, Leslie! See you next month! The 2012 Townie Meeting takes place April 25-28 at The Cosmopolitan of Las Vegas in Las Vegas, Nevada. For more information, visit www.towniemeeting.com. ■

AvaDent: Carving Out a New Niche

Global Dental Science introduces the newest technology in denture manufacturing with AvaDent

by Benjamin Lund, Editor, *Dentaltown Magazine*

Think really hard: When was the last time "dentures" and "innovative" ever appeared in the same sentence? Probably when dentures were first introduced to the public, right? Well Global Dental Science (GDS) is changing that and has put innovation back into the manufacturing of dentures. This new company, headquartered in Scottsdale, Arizona, is revolutionizing dentures by automating the entire process and taking inconsistencies and human error out of the equation. The result? A true two-appointment, form-fitting denture. *Dentaltown Magazine* sat down with GDS President and CEO Tim Thompson to learn more about the company and it's game-changing technology.

Tim, thank you for spending some time with us. First off, can you tell me a little about Global Dental Science and how it was formed?

Thompson: Our mission at Global Dental Science is to be the premier dental innovations company, dedicated to improving dental out-

comes through process automation. Global Dental Science was formed in 2009 and we have spent the last few years creating AvaDent digital dentures based on a revolutionary, digital platform that is changing removable dentistry forever. The removable dentistry field has been largely unchanged in the last 50 years, but we are changing that. AvaDent incorporates 21st century measurement technology to capture a patient's digital record, with advanced CAD/CAM processing to bring precision, aesthetics, speed and profitability to removable dentistry. Now it is possible for dentists to offer their patients a precise fitting, aesthetic AvaDent in just two appointments while giving their patients a level of convenience, security and ongoing care never before possible.

What exactly is AvaDent?

Thompson: We have been kicking around the idea for automating denture design for the last seven years or so. The time was finally right to get it done. AvaDent is a digital platform for removable dentistry, which allows us to fabricate AvaDent digital dentures in a fully automated fashion. Unlike other so-called digital processes, with AvaDent we never pour a stone model or use other traditional removable procedures such as wax rims or hand packing, all of which create opportunities for errors. With AvaDent's procedure we can maintain digital CAD/CAM precision throughout the fabrication process. The missing piece of the puzzle up until now has been getting all the records in an initial appointment. We solved this with our patented Anatomical Measurement Device (AMD). The AMD is a clever piece of engineering developed by our team to capture all the necessary clinical measurements. Once the measurements are taken our process can create a final prosthesis to the doctor's precise specifications.

Tell me about the AvaDent process from start to finish. How do you go from impressions to a finished denture?

Thompson: The key to AvaDent being a two-appointment denture is capturing all the required clinical information in the first visit. To do that we have created a clinical process that can be completed with two easy steps in just one appointment.

The first step is to create a final impression. To do this we have refined a simple technique. Using AvaDent thermoplastic trays, border molding material and impression material, the doctor can now create a precise final impression at the first appointment. So, the final impression is actually the only impression the doctor needs to take!

Step two is to capture all of the measurements necessary to create an AvaDent using our AMD. After stabilizing the AMD with AvaDent bite registration material, the dentist is able to determine the correct vertical height, centric relation, lip support, bite plane, midline, smile line and central incisal line.

The clinician then specifies the tooth mold and shade, and sends the impressions, the AMD and the prescription. Using the shipping label provided, ships the impressions and AMD to our Scottsdale, Arizona, facility. There they are scanned into our proprietary AvaDent software and an AvaDent is digitally created. Within the AvaDent software, traditional setup principles are used, through complex algorithmic calculations, to provide optimal tooth selection, design and occlusion for each case. Based on the specific instructions provided on the prescription, AvaDent digital dental technicians are able to incorporate characteristics the dentist feels are necessary for clinical success.

Everything the doctor would need and want in a finished denture can be achieved through the AvaDent software. We have total control down to individual tooth position and arrangement and customized acrylic contouring. Following the design, a dentist might request a digital preview via e-mail or even on difficult case setups, he or she can actually arrange to participate in the design with one of our technicians via computer.

Once the digital design phase is complete, the permanent AvaDent digital design files are then uploaded into a milling machine and bases are precision milled from a base material of the doctor's choice of popular acrylics.

AvaDent's patented process for creating milling pucks from well-known acrylic manufacturers eliminates the possibility of any post-processing shrinkage or distortion. Additionally, this puck manufacturing process virtually eliminates the growth of fungus on the denture.




continued on page 58

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Through this precise milling process, the base will have perfect fit, tissue retention and accuracy. It re-creates precisely what is captured in the impression including the patient's natural rugae.

The next step is to bond the selected teeth into the precisely milled pockets of the bases. The completed AvaDent is then re-scanned and quality control checked for overall accuracy to the original digital design files. It is then polished and sent back to the dentist for insertion on the second appointment. All of this is completed in 10 days (this includes a total of four days shipping to/from our headquarters in Scottsdale, Arizona).

The complete digital process eliminates the room for error and inconsistency. AvaDent is the platform from which removable dentistry will evolve and make treating denture patients enjoyable and rewarding again. The process is simple and complete.

Compare an AvaDent denture to other dentures – where does it stand out?

Thompson: AvaDent digital dentures offer a number of benefits to both the patient and the dental office.

For the patient, AvaDent offers reduced chairtime, a superior fit, a permanent record (security, dentures for life) and a more bio-hygienic denture (no denture breath).

For the doctor, AvaDent offers a process that is easier, faster and more profitable. It is easier since there are no stone models or bite rims to deal with, and no more back and forth appointments with confusing high-tech procedures to learn. It's faster since it's delivered in two appointments and it's more profitable since there is no capital investment.

One of AvaDent's greatest benefits is a digital record is created and stored in a database. What this means is that in the event an AvaDent is lost or accidentally broken, we can quickly and easily produce another to its original clinical specification. The digital record also allows you to retain these patients and stores the information you need for treatment plans of future services, such as implant-supported AvaDent.

We stand out on several points:

1. We never make a stone model and therefore all the inaccuracies and error build-up of stone are eliminated.
2. We have a process of making our acrylic pucks that results in a zero porosity disk (fungus has been virtually eliminated in these dentures).
3. There is no material shrinkage since we mill a pre-shrunk disk, leading to better fit and increased comfort for the patient.
4. The denture is delivered in just two appointments.
5. We are using industry-accepted materials and teeth from leading manufacturers.
6. Our product is made exclusively in the USA at our Scottsdale, Arizona, facility.
7. We take no clinical shortcuts; all of our protocols have been developed by key prosthodontists.
8. Precision CAD/CAM results in exquisite quality and repeatability.
9. Using materials that are industry-proven and well-accepted, we have developed a tooth bonding process that exceeds all ADA standards.
10. All of our work is done without any of the traditional laboratory processes previously associated with making a denture.

Is there any training involved for customers when they decide to work with you?

Thompson: Yes, we require the dentist to be trained on the process, but the new process is very simple and uses conventional principles that all dentists know. In addition, we are encouraging the dentist's staff to attend the training since a significant percentage of the work can be easily delegated. We have several ways the dentist can learn the AvaDent system: hands-on seminar training, Webinars and in-office hands-on training. We currently offer a Webinar specifically for prosthodontists and are in the process of creating additional Web-based educational programs for all dentists.

What sort of support can an AvaDent customer expect during the process?

Thompson: We are committed to clinical excellence and have a very strong group of clinical support people on staff including Certified Dental Technicians (CDTs) and customer service representatives. In addition, we have a number of communication tools that we can use to give the doctor an up-close view of any issues we might have with the case, and allow the dentist to decide on the best outcome for the patient.

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What are you most proud of at GDS?

Thompson: We have a world-class set of people, very skilled in all aspects of this market. This has allowed us to quickly build our 27,000-square-foot facility in Arizona into a world-class dental laboratory. We have recently added an operatory for training and process validation, and have a CBCT on site to further our R&D of implant-supported and implant-retained dentures. This is not your father's lab; we have the systems in place to create a high-quality AvaDent every time.

What do you do to make your customers feel at ease?

Thompson: Being a young company in the marketplace we communicate with our customers often to try and ease any apprehension about who we are. We are also very pleased to have a strong team of key opinion leaders from the removable field working with us. We also have an incredible customer support group at the company and an elite outside sales organization focused on client satisfaction.

What do you find most appealing about working with dentists?

Thompson: I have worked directly with dentists for more than 15 years and I absolutely love it. They are a highly educated and talented group who generally embrace new ideas and are continuously focused on better outcomes for their patients. I have always considered the dental field the last of the true entrepreneurial small type of businesses that can make their business decisions quickly, which makes our job of helping to implement new technology and process improvements a lot easier.

The economy is on the mind of many clinicians. How does AvaDent alleviate any financial pressure for dentists?

Thompson: The timing couldn't be better for the introduction of our products. With one of the benefits of AvaDent being that we save the doctor a tremendous amount of time doing a case, dentists immediately see the benefit of switching to our product to improve their bottom line. We have had a lot of folks that had given up doing dentures return to the fold just because the business case is so compelling. Additionally, AvaDent offers the patient a superior product in less than half the chairtime of traditional dentures. This means less expense in terms of transportation and less time off from their work.

Tell me about your own global view of dentistry. How does AvaDent fit into that?

Thompson: The AvaDent platform is a very scalable system. We have big plans for extending our reach into other markets. Our laboratory is a 24/7 facility with fully automated operations. We will be launching outside the U.S. shortly.

Why should a dentist start offering AvaDent?

Thompson: This product is extremely easy to use, follows 100 percent of clinical-correctness, reduces chairtime and requires no capital equipment to begin using it. I think this is why we have had so many doctors join this revolution in dentistry.

What is the best way for a dentist to incorporate AvaDent into his or her practice?

Thompson: We are launching several ways that the dentist can begin using the AvaDent. First we have a seminar training program that is in 55 cities in 2012. Next we have a Web-based training system for prosthodontists that we have recently launched. Additionally, our sales team is well trained to provide hands on training in a dentist's office. We also have a "Can't Wait" training program that we run two weekends a month out of our new Scottsdale facility that has been wildly popular. Furthermore, once the dentist is trained, we have created an exclusive marketing campaign that AvaDent practices can use to increase patient awareness of its new offering.

What can we expect to see from AvaDent in the future?

Thompson: AvaDent is a platform for removable dentistry, and as such allows the dentist to further treat the patient through the digital record of the patient. This record is the cornerstone to all future procedures and allows the dentist (with very little effort) to create a timeline to recall the patient and provide the next level of care to the patient. We are really elevating removable dentistry. The dentist has the anatomical record in perfect occlusion and from there the next step is just a short one. We're excited that we introduced Single Arch AvaDent and AvaDent-Over-Implants at the Chicago Dental Society Midwinter Meeting and that's just the beginning of what is on the horizon. The future is here, it's true CAD/CAM dentures, and it's called AvaDent.

To learn more about Global Dental Science and AvaDent, visit www.avadent.com, call 855-282-3368 or e-mail info@globaldentalscience.com. ■

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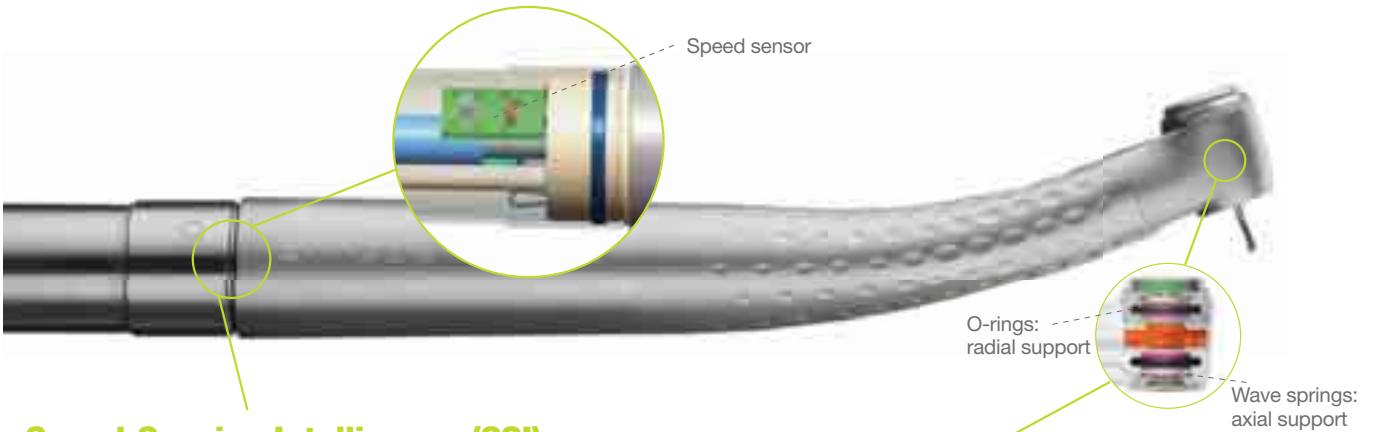

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Only Four Percent of Dentists Able to Retire at 65? Nonsense!

by Douglas Carlsen, DDS

Did you know that a private practice dentist, who has never saved a dime of his practice income and *never will,* could retire with $140,000 income at age 76? I'll explain later.

First of all, Dr. Will Guess has had it with all the financial freedom crap he's heard from various "gurus" out there.

In 2000 at age 45, Will had $1 million saved for retirement. He was on course to retire easily by 2010 at age 55. He'd been saving up to 10 percent of his income per year since his early 30s, with a portfolio consisting of a handful of large cap growth stocks, and, in recent years, all the hot "tech" and "dot com" stocks. Will was aware of academic warnings of his high-risk portfolio, but Will's Lehman Brothers broker was a genius. This time it was different!

We all remember what happened next. In fact, had it not been for Dr. Guess' ownership of large caps stocks, the situation would have been a total disaster. Nevertheless, in 2002 Will's portfolio was down to $300,000 and he and his broker retreated entirely from the market. Will stayed on the sidelines from 2003 through 2006, missing one of the best bull markets of all time. Will did get back in with small cap stocks, the darlings of the mid-2000s, in 2007. Of course, those stocks crashed soon after in 2008. By mid-2009, Dr. Guess' portfolio was down to $200,000. In 2011, after missing the next market run-up, he purchased $250,000 of gold. As of this article's writing, Dr. Guess has $300,000 saved, all in a gold bullion exchange traded fund (GLD).

Dr. Guess, now 57, would like to retire in nine years at age 66. Is it possible, and should Guess stay in gold?

For guidance, Wei Hu, the director of financial research at Financial Engines, a provider of asset allocation advice to large corporate and state 401(k) plans, states, "More savings and retiring later have much bigger effects than choosing to take more risk."[1] Hu also posits that the benefit of delayed retirement is magnified even more by delaying Social Security benefits until age 70. "Even a few years can make a huge difference."[2]

1. *Tom Lauricella, "How to Catch Up With Your Savings," The Wall Street Journal Sunday, Dec. 4, 2011.*
2. *Ibid.*

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[2] Bank of America Practice Solutions may prohibit use of an account to pay off or pay down another Bank of America account.

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I've used Financial Engines (FE), a user-friendly Monte Carlo software platform, to show dentists how different variables effect their savings plans for years. FE works with retirement plan providers such as Vanguard, Fidelity, J.P. Morgan and Mercer. Individuals can access FE services at www.financialengines.com for $150 per year.

For the examples below, Financial Engines online software was used.[3] It is assumed that the dentists below will spend the retirement average of $9,000 per month, with total income need of $140,000 per year before taxes.[4] It is also assumed that no mortgage will exist during retirement. They will sell their practices for $300,000 after all fees and taxes and expect a $200,000 inheritance (selling off parents' home) at age 72. They and their spouses will delay taking Social Security payments until retirement age and funds will be held in a discount brokerage with passively invested index funds.

If you are a lousy and late saver, working just a few more years around Social Security retirement age (66-67) and delaying Social Security benefits makes a huge difference in your retirement income!

Dr. Guess, age 57 and earning $250,000, can save 15 percent ($37,500) per year now that the kids are out of the nest. If he stays in a gold ETF (GLD), with historic growth trends, FE says he'll likely be able to pull out $115,000 per year at his retirement goal of 66 years. That's far below the $140,000 he will need. Also, due to gold's volatility, FE notes in a poor economy, Guess might receive only $93,000 per year. A 50/50 mix of stock and bond index funds would increase his income at age 66 to $125,000.

According to FE, with the 50/50 portfolio, Guess *will* be able to retire at 67 with $140,000 per year; with an all cash portfolio, age 68; with gold, possibly age 69. After retiring, Guess is advised by FE to have a broadly diversified mix of stock index funds and bond index funds with the majority in bonds. Gold is not advised.

Let's look at a young dentist, Dr. Anita Know, age 30, with an income that starts at $125,000, increasing to $170,000 at age 40, $230,000 at age 50, and $310,000 at age 60. These are fairly normal averages for dentists (four percent real increase per year). If she saves 10 percent per year, she will be able to retire with $140,000 income at age 63 using a 50/50 stock-bond portfolio throughout her career. Saving 15 percent per year will provide retirement at age 60.

If Dr. Know waits to start saving until age 35 at 10 percent per year, she will only have enough saved to provide $104,000 at age 63! If she saves 13 percent per year, she can retire at age 63. If she saves at the 10 percent rate until age 65, she *will* receive $140,000 retirement income.

If Dr. Know doesn't start saving until age 45 at 10 percent per year, she will be able to retire at age 69 with $140,000 per year. If she wishes to retire at age 63, though, she will have to save 21 percent per year.

Recap: saving 10 percent per year with a 50/50 mix held with a discount broker starting at age 30, a doctor's retirement is normally possible by age 63; starting at age 40, retirement might commence at age 67, starting at age 45, retirement delays to 69.

Bottom line: If you are a lousy and late saver, working just a few more years around Social Security retirement age (66-67) and delaying Social Security benefits makes a huge difference in your retirement income!

Let's now look at the worst possible scenario: Dr. Bill Mercedes is age 62 with no savings. His net income is $200,000 per year and he wants to "slow down" a bit, realizing that his income will not increase in the future. He doesn't count on ever saving any of his practice income, yet wants to know if he can ever retire. The assumptions for Dr. Mercedes are the same as our other two doctors.

According to Financial Engines, if he doesn't touch his and his spouse's Social Security income while working, and puts his practice sale and inheritance money into bonds, he can retire on an income of $140,000 at age 76. That's only nine years past Dr. Know, who saved diligently from age 40.

How does this magic work? If Mercedes delays his and his spouse's Social Security benefits to age 70 ($40K plus $20K spousal benefit per year) and doesn't touch it from age 70-76, he will have $360,000 saved, even without any growth. An additional $300,000 from the practice sale and $200,000 inheritance will give him $860,000. At age 76, longevity is muted tremendously compared to one in his mid-60s. With conservative investing, FE indicates near 10 percent withdrawal of the $860,000 is acceptable. Along with Social Security family benefits of $60,000 per year, he can enjoy an

3. *FE assumes 3.5% inflation and longevity to age 95 with all money spent at death. All figures are in 2012 dollars: no inflated dollars will be used. The illustrated 50/50 stock and bond portfolio used is 50% Vanguard Total Stock Market Index (VTSAX) and 50% Vanguard Total Bond Market Index (VBTLX). All calculations were crossed referenced for accuracy with Flexible Retirement Planner (www.flexibleretirementplanner.com).*
4. *Average dentist retiree income need from interviews is approximately $140K per year. Refer to "The Dentist's Number, Dentaltown, July 2009.*

income of more than $140,000 per year. The key for the Mercedes couple is to hide Social Security payments in the trunk for six years!

Final Thoughts: It is very difficult for a dentist to retire before age 60, due to high savings requirements and lack of Social Security benefits. It *is* possible for many dentists, even with poor saving histories, to retire by age 70 due to much higher Social Security payments and decreased longevity. Through numerous scenarios' calculations, I find that the bell curve of dentists' probable retirement ages is heavily weighted between ages 63-69. The statistic that says only four percent of dentists are able to retire at age 65 is nonsense! No citations or statistics exist to support the statement. It's financial-shark scare tactics!

**Note: The above FE calculations rely on investing with a fee-only advisor with funds held with a discount brokerage such as Vanguard or Schwab, using a passive investment strategy (buy and hold). Author Larry Swedroe warns that using active investment strategy (market timing), you will likely net one to two percent less per year over your career. If using a traditional broker or an insurance company, you will lose another one to two percent per year.[5] Adding an additional year to your retirement scenario using active management and another year for not using a fee-only advisor might be prudent.* ■

5. *Larry Swedroe, The Only Guide to a Winning Investment Strategy You'll Ever Need, Truman Talley Books, New York, 2005, pages 42, 242, 221.*

Next Month: **Obstacles to Savings**
Mistakes almost all dentists make with easy solutions provided to increase wealth and hasten retirement.

Author's Bio

Douglas Carlsen, DDS, owner of Golich Carlsen, retired at age 53 from private practice and clinical lecturing at UCLA School of Dentistry. He writes and lectures nationally on financial topics from the point of view of one that was able to retire early on his own terms. Carlsen consults with dentists, CPAs, and planners on business systems, personal finance and retirement scenarios. Visit his Web site: www.golichcarlsen.com; call 760-535-1621 or e-mail at drcarlsen@gmail.com.

NOT All Retirement Plans Are Created EQUAL

How a strategically designed retirement plan can increase your opportunities for a comfortable retirement.

by Tom Zgainer

While establishing a retirement plan for your company can provide a number of near and long-term benefits, it is wise to look at a number of factors to determine the plan that best suits your personal and corporate objectives. Oftentimes an employer implements a plan without considering that the employer might subject itself to unintended costs and liabilities. Retirement plans have specific requirements related to factors such as eligibility, employer contributions, vesting and compliance tests among many others. All these items should be part of a consultative discussion you have with the plan providers you are considering working with.

The initial question, however, is why do you want to set up a plan in the first place? Is it primarily to accelerate your personal retirement planning, or is it to provide an additional benefit to staff in order to attract and retain employees to help build a profitable practice, or is it some combination of these reasons?

While that might sound like a simple question, it can have a number of related answers. Getting to understand the various types of retirement plan options available to you will help guide you to the best type of plan for you, and the underlying design of the plan itself. SIMPLEs (Savings Incentive Match Plan for Employees of Small Employers), SEPs (Simplified Employee Pension Plans), 401(k) profit sharing plans, Defined Benefit and Cash Balance plans all have their place. And what might sound like the best fit for you today might not be a good fit in the future as your personal objectives and employee make-up change over time.

It is also important to be cognizant that setting up a retirement plan gives you some additional roles like plan fiduciary and trustee, along with new fee disclosure rules beginning next April that you need to understand. Spending some time to learn more about the points covered here will go a long way to helping you establish a successful retirement plan for you and your employees.

Comparing and Understanding Plan Types

Understanding which plan best fits your current personal and corporate objectives is important.

If you have a 401(k), Profit Sharing, SIMPLE or SEP retirement plan, this is a great time of year to review your plan to be sure that what you have in place today is what you will need in for the rest of this year and beyond. SIMPLE 401(k) plans are great when first starting out, but oftentimes business owners feel constrained by their lower contribution limits as compared to a 401(k), so now is the time to see if an alternative retirement plan might be part of your strategy going forward.

With a SIMPLE, due to a provision called the Exclusive Plan Rule, you can switch to a 401(k) plan only in January of the following year, so you'll want to be sure you are not limiting your contribution goals with the reduced limits within a SIMPLE as compared to a 401(k). Also, the 2012 deferral limits for a SIMPLE are $11,000 compared to $17,000 for a 401(k), a significant difference over time. With SEPs, oftentimes during the course of a year, employees become eligible for the same employer contribution percentage you might be paying yourself. This can become quite cost prohibitive for you. If you have a SEP, be sure to confirm with your provider/advisor/CPA as soon as possible what your contribution obligations will be to avoid any unpleasant surprises.

New Comparability Profit Sharing Plans

Business owners often ask how they can skew retirement plan benefits to themselves or to their key employees. The Internal Revenue Code restricts the ability of a sponsor of a tax-qualified retirement plan to do so: a plan will not be tax-qualified if it discriminates in favor of a "highly compensated" employees (HCE). In general, such an employee is either greater than a five percent owner of the employer or an employee that earned more than $115,000 in the prior plan year.

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A way for business owners to maximize the defined contribution benefits for them and their key employees is through the use of a "new comparability" contribution formula to help satisfy the onerous non-discrimination and top-heavy requirements of the Internal Revenue Code.

With respect to employer contributions to a defined contribution retirement plan, the "anti-discrimination" rule generally means that if an employer provides a contribution to a plan on behalf of an HCE as a certain percentage of the HCE's compensation, the employer must provide a contribution to the plan on behalf of a non-HCE in the same percentage of compensation. This is known as a "pro rata allocation."

Some exceptions to this rule exist, such as the doctrines of "integration" and "new comparability" (also known as "super-integration" or "tiered allocation"). The contribution doctrine of integration means that an employer must make disproportionately greater Social Security contributions on behalf of lower paid employees than on behalf of higher paid employees. Since Social Security is a type of retirement plan, the code permits an employer to offset the payment of greater Social Security contributions for lower-paid employees by allowing the employer to provide a disproportionately greater share of contributions to a retirement plan on behalf of higher compensated employees. If a plan is integrated, the employer need not provide a strict pro rata allocation contribution.

With regard to the doctrine of new comparability, discrimination is examined on a "benefits" (as opposed to "contributions") basis. Contribution amounts for all recipients are converted to a benefit at age 65. A benefit accrual rate for each is then determined and tested to ensure that it is not discriminatory. Since the select employees are often the business owner(s) and are usually older employees, they have less time to reach retirement age than do younger employees. An older employee needs to receive a disproportionately greater share of contributions than would a younger employee in order to receive an equal benefit at retirement age. That is why the select employees may receive a disproportionately greater share of contributions under this doctrine, the plan can be determined to be non-discriminatory and the tax-qualification rules of the code will be satisfied.

New comparability will often be more beneficial to the employer than integrated plans. This is because a new comparability plan provides a maximum benefit for the HCE's or select employee group, while providing the lowest possible contribution for the non-HCE's on non-key group allowed by law. Finally, it is often advantageous from an employer's perspective that the exceptions to the pro rata allocation formula can be used in a discretionary profit-sharing plan. This is because such a plan does not require that contributions be made to it year after year. Thus, if an employer has a poor year economically, the employer need not make a contribution to the plan unless it is top heavy.

Defined Benefit and Cash Balance Plans

High net-worth individuals have a constant need to maximize the bottom line. One effective way to accomplish this goal is to generate higher tax deductions by accelerating contributions. It's important to not overlook the role that a properly designed retirement plan can play in helping you shield more of your income from the tax collector while increasing your retirement savings.

Defined Benefit and Cash Balance enable successful business owners to keep more of their income while providing an improved retirement benefit. For the sole proprietor who requires a higher tax deduction than the 25 percent/$49,000/$54,500 found in a defined contribution plan, installing a traditional defined benefit plan can produce significant contribution and tax benefits.

A defined benefit plan promises a specified monthly benefit at retirement for life. The plan might state this promised benefit as an exact dollar amount, such as $100 per month at retirement. The annual benefit is defined as an accrual of a monthly benefit payable at retirement age, based on current and/or past compensation history. The maximum benefit is based on an annual benefit payable every year for life starting at age 62. That maximum is currently $195,000 (indexed).

The maximum contributions depend on the age and compensation of an individual with annual contributions for one individual as high as $200,000. The older the individual, the younger the assumed retirement age, the higher the potential limit. The ultimate benefit is totally dictated by plan terms with the employer responsible for all investment returns.

The maximum benefit limit of $195,000 at age 62 has an equivalent lump sum value of more than $2.4 million. A sole proprietor earning $500,000 at age 60 with a 25 percent SEP plan probably requires a higher tax deduction than the $49,000 with a defined contribution plan. Installing a traditional defined benefit plan can mean a new contribution of $200,000 that might more closely meet the needs of that individual.

Cash Balance Plans

For the owner of a successful company with two or more employees, a Cash Balance plan can allow the owner to pay less in overall pension benefits to the rank and file, while increasing their own retirement savings and obtaining a higher tax deduction. Cash Balance plans have several attractive features for small businesses. Contribution limits can be much higher than a defined contribution plan, the benefits formula for owners can be substantially higher than for non-owners (but only if non-discrimination testing is satisfied), and the owner can maximize discrimination and dollars by pairing a Cash Balance plan with a 401(k) profit sharing plan.

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A Cash Balance plan is a defined benefit retirement plan with an unusual contribution feature. It is used in cases where the owner wishes to benefit key employees and where the owner desires to have deductible contributions in an amount greater than the maximum contributions that can be made on behalf of a participant in a defined contribution plan (currently an annual $50,000 or $55,500 for an individual over 50).

Although a Cash Balance plan is classified as a defined benefit plan, it resembles a defined contribution plan from the perspective of a participant. In this regard, although the assets are commingled to provide benefits to all participants, a hypothetical account is maintained for each participant, the plan sponsor makes annual contributions, and interest is credited to each account.

The fictional contribution to the account is either a percentage of a participant's compensation or is a flat dollar amount. The interest credited is either a fixed rate (e.g., five percent) or tied to an index (e.g., the 30-year Treasury bond rate). Since a Cash Balance plan is a defined benefit plan, its benefits are based on the plan's benefits formula as opposed to the actual investment earnings on plan assets. In addition, actual investment earnings of the plan assets do not affect the amount of balances in plan accounts. That's why the plan sponsor, not participants, bears the investment risk.

At a minimum, it might be worth your time to see how each type of retirement plan might fit your own personal and business objectives. An experienced third-party administrator or actuary can gather your census information and run a number of illustrations to show you the various advantages and disadvantages which are a function of the amount of contributions you wish to make, and your employee demographics. Doing so will go a long way in helping you increase the odds that you will have a comfortable retirement to reward you for your years of active practice. ■

Author's Bio

Tom Zgainer is Sr. Vice President of Sales and Business Development for ExpertPlan, Inc. He has helped more than 2,300 small businesses establish a new or improved retirement plan over the past decade. Much of his focus has been on strategic plan designs for dentists, doctors and anesthesiologists. ExpertPlan, www.expertplan.com, is one of the country's largest independent retirement plan providers, with more than 18,000 clients. Mr. Zgainer can be reached at tzgainer@expertplan.com.

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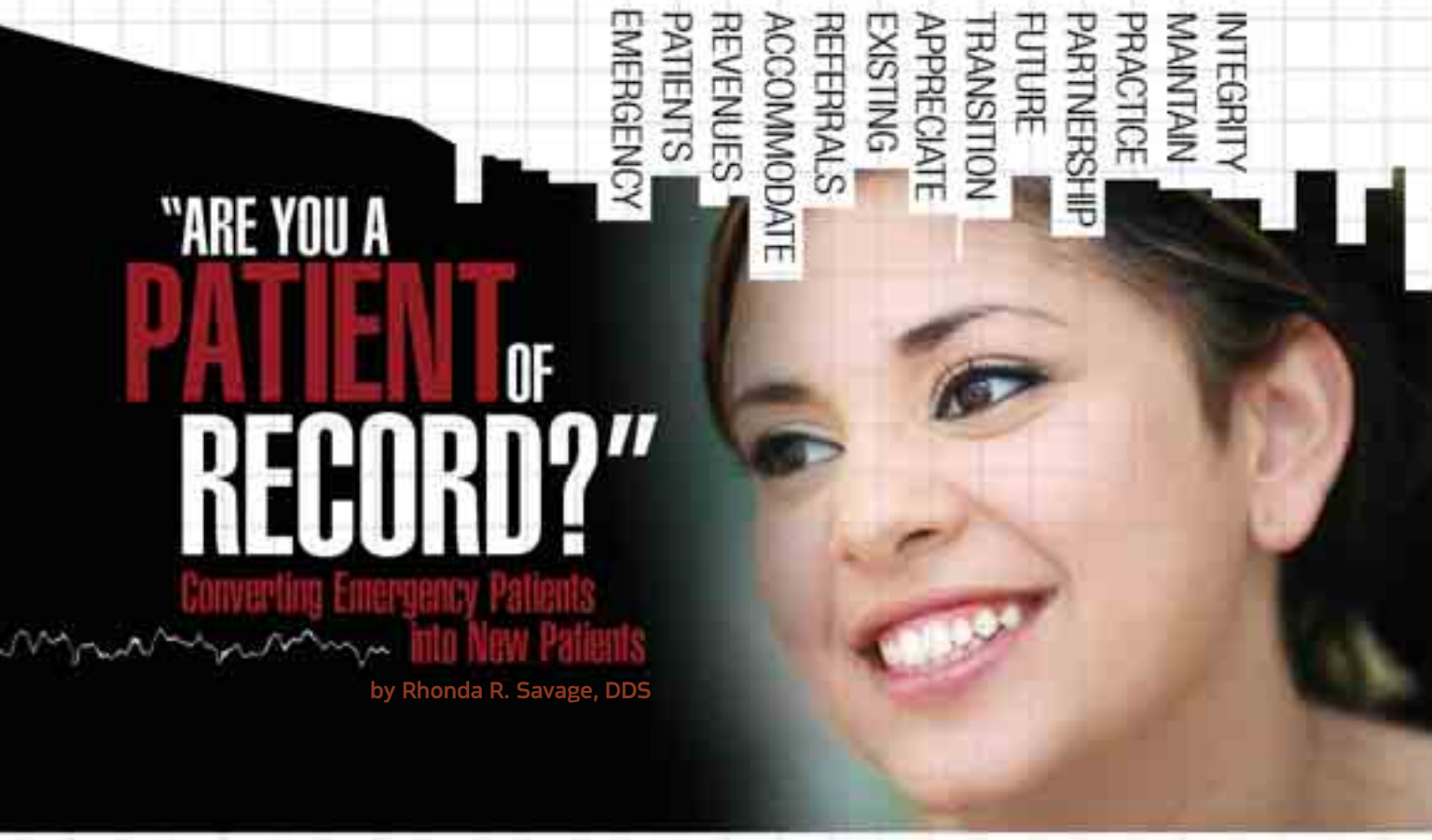

"ARE YOU A PATIENT OF RECORD?"

Converting Emergency Patients into New Patients

by Rhonda R. Savage, DDS

Emergency patients can be practice builders: more revenues, more referrals and, if handled well, more new patients. There are two types of emergency patients – new patients and existing patients. Both want empathy, a knowledgeable dental team, reassurance and they want it *right* now!

Why accommodate and appreciate emergencies? It depends on your need for new patients. What are the parameters that you need to consider for the future of your practice? Are you looking to transition, bring in an associate, partnership or sale? If not, do you have the patient base you need?

If your practice is located in a transient area, look at your active patient count as those who have been in for an appointment during the last 18 months. Stable areas can determine active patient count for the last 24 months. (You might need to call your software management company to put parameters into the system to get an accurate count.)

Most general dentists need 1,500 to 1,800 active patients for a full-time practice. If you provide more definitive dentistry, you might need more new patients who are willing to accept the dental care you offer. For most practices, in order to maintain your patient base, you need 10 to 20 new patients a month per doctor. If you have a need to grow your practice, you need 25 to 40 new patients a month per doctor.

Why would you need at least 10 new patients to maintain your base? Because some will leave due to insurance changes, others will go away for school; some will follow their spouse to the dentist he or she uses. And sadly, some die. However, most will leave because of a perception of a lack of customer service. If your practice receives less than 10 new patients per month, your practice is declining.

Emergency patients can build your patient base, if your team can convert them into a new patient and you earn the patient's trust. How do you earn trust? Honesty plus integrity leads to trust. The honesty part is pretty clear to most of us. But what does integrity mean?

Integrity means you follow through; do as you say you'll do and very importantly, you respect the patient's time. You diagnose with the patient's best interest in mind. Integrity means you train yourself and your team. Integrity means you're competent. Integrity is

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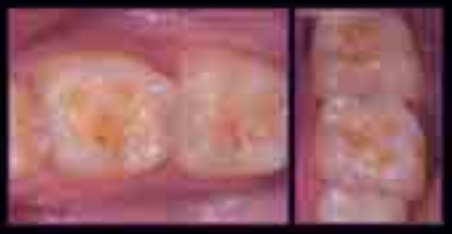
How many times have you restored cases like this and never knew how to address the underlying cause?

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one of those things that your patients will sense and feel; it's harder to define than honesty.

In order to gain trust, your team has to be competently trained to handle the emergency patient. In order to gain competency at any skill you must practice. The same goes for treating emergency patients. Verbal skills, customer service and great clinical skills come from practice. Converting the emergency patient into a new patient begins on the phone, and your team needs great phone skills. I'll mention a few tips in here regarding the phone, but you can also refer to the *Dentaltown Magazine* Archives to read my article: "Your Phones: A Joy or an Ouch?"

> *"In order to gain trust, your team has to be competently trained to handle the emergency patient."*

Verbal Skills

Let's go back to the title of this article, "Are You a Patient of Record?" Many times, people call and say, *"Hi, this is Sarah Stevens. I have a tooth bothering me and I need to see when I can get in."* If you have a newer front desk person, he or she might not recognize Sarah's name. The patient can be insulted if the team member says, *"I can help you with that. Are you a patient of record?"* Change this to say, *"Certainly. When was the last time you saw the doctor?"* The patient will either respond with, *"Oh, I haven't been in before"* or *"I was in about a year ago."* Now you know whether you have a new patient or an existing patient.

Essential Phone Skills

- All of your front desk team needs to be friendly and happy when answering the phone.
- They need to be knowledgeable.
- They need to express empathy by asking concerned questions.
- Be certain to "talk up" the doctor(s).
- Make sure they find out how the patient learned about your practice.
- Staff should begin by saying his or her own name: "Thank you for calling Dr. Savage's office. This is Kathy. How can I help you?"
- Staff should ask for the patient's name if it's not immediately offered.
- Staff should use the patient's first name throughout the phone call.

How to Deal with Insurance Questions

If you're not a participating provider or you're not in network, don't say, "We're not in network" or "We're not a Preferred Provider."

Instead say, *"We're not a contracted provider for your particular plan, but we do have a lot of patients who come here with your plan. They come because of the quality of care our doctors give our patients. You've chosen the right place to call. Our doctors believe in doing it right, not doing it over! You'll need to bring $100 with you to cover your deductible and your non-insurance balance. Will that be OK for you?"*

How to Deal with Money Questions

If they need to bring money, let them know and tell them how much, but be tactful. Ask, *"Will that be OK for you?"* If you don't ask, the patient might schedule but not show up. By asking, it gives the patient the "out" clause. They can say "no" without embarrassment.

Some practices, on the first visit, will not tell the patient about the difference in coverage, and instead, will only charge the amount that the patient would incur if they were seeing a participating provider. They want to get the patient in the door so the patient can experience the practice. However, this can be perceived as a bait-and-switch philosophy. You can anger the patient. It signals lack of honesty and lack of integrity. You'll create underlying resentment even if the patient continues with you. The relationship starts off on the wrong foot. I believe it's best to be honest and up front with the potential patient about participation or non-participation.

How to Deal with Scheduling

Build flexible time into the schedule to predictably accommodate emergencies. If you get three emergency patients on average a day, build in at least two time slots. These should be 30 minutes for triage: X-ray, exam and prescriptions, unless there is time to treat. The slots can be filled with restorative the day of if you don't need all the slots.

The emergency patient should only be treated if you do not keep an existing patient waiting. Also, make sure your team makes firm financial arrangements at the chair – pay at the time of service, use a third-party financing service or write a check. There are exceptions, of course, for trauma or emergency.

Your emergency flex-time should be mid-morning or mid-afternoon (or your slowest time of day). Offer the patient two options. About 75 percent of

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patients will take what you offer them. The remaining might need early morning or later afternoon. The worst time to schedule the emergency patient is just before lunch or in the last 45 minutes of the day. Flexible time can also be pinpointed at the morning huddle, due to changes in the schedule based upon phone messages.

Inviting the Emergency Patient to Become a New Patient

The best time to invite is when the patient is on the phone. The patient benefits tremendously if he or she choose a full exam versus an emergency exam.

An emergency new patient or an overdue existing patient calls with a toothache: The ability to diagnose is determined by the available X-rays and the doctor's time and focus. What if there's a lot of other decay that's not visible without a full set of X-rays? The patient might choose treatment differently if he or she knows about the other extensive needs. Also, if the patient needs an oral surgery referral, a limited exam and X-rays might not address the other oral surgery needs. You can save the patient time and money if the full diagnosis is done.

"Focus on verbal skills, timeliness, attention to customer service and you'll have more profit, more referrals and more new patients!"

Of course, this depends on the schedule and staffing, as well as the patient's willingness and financial ability. But if the patient has dental benefits, the full exam and X-rays will most likely be covered at nearly 100 percent. Make the suggestion on the phone and try to convert if you have the time in your schedule.

Converting the Emergency Patient into a New Patient

Offer to do a full exam/X-rays when the patient is in the chair, if you have time and the patient was interested during the phone call. If the patient isn't interested, don't try to talk the patient into coming back and scheduling for a new patient exam. Instead, say to the patient:

"Sarah, you do have a lot of dental needs. When you're ready, we can get you back for a new patient exam. You'd get necessary X-rays and then we'd sit and talk about your options. The good news is you do have options! It's a good thing to do. Emergency dentistry can be painful and expensive; preventive dentistry isn't. We can make your treatment fit your budget, your needs and your schedule. So when you're ready, give Kathy a call and she'll get you scheduled."

Notice the "You-You-You" focus It's all about the patient.

Also, about 50 percent of the time, the patient will say, "Well, can't I schedule that now?" Now it's the patient's idea, not yours! You'll have a higher show rate for this patient; you'll have a higher "no-show" rate if you try to talk her into scheduling a new patient exam.

Conclusion

Emergency patients can build your practice. Patients are postponing treatment due to finances more now than ever before! Focus on verbal skills, timeliness, attention to customer service and you'll have more profit, more referrals and more new patients! ■

Author's Bio

Rhonda Savage, DDS, a former dental assistant and front office staff, graduated with a B.S. in Biology, Cum Laude, Seattle University in 1985. She then graduated from the University of Washington, School of Dentistry in 1989, with numerous honors. She served on active duty as a dental officer in the U.S. Navy during Desert Shield/Desert Storm; awarded the Navy Achievement Medal, the National Defense Medal and an Expert Pistol Medal. Dr. Savage was in private practice for 16 years. She has authored many peer reviewed articles and has lectured internationally. She is a past president of the Washington State Dental Association and is an affiliate faculty member of the University of Washington, School of Dentistry. Dr. Savage is the CEO for Miles Global, an internationally known consulting business. A member of the National Speakers Association and the Institute of Management Consultants, Dr. Savage is a noted speaker on practice management, women's health issues and zoo dentistry. To speak with Dr. Savage about your practice concerns or to schedule her to speak at your dental society or study club, please e-mail rhonda@milesglobal.net, or call 877-343-0909.

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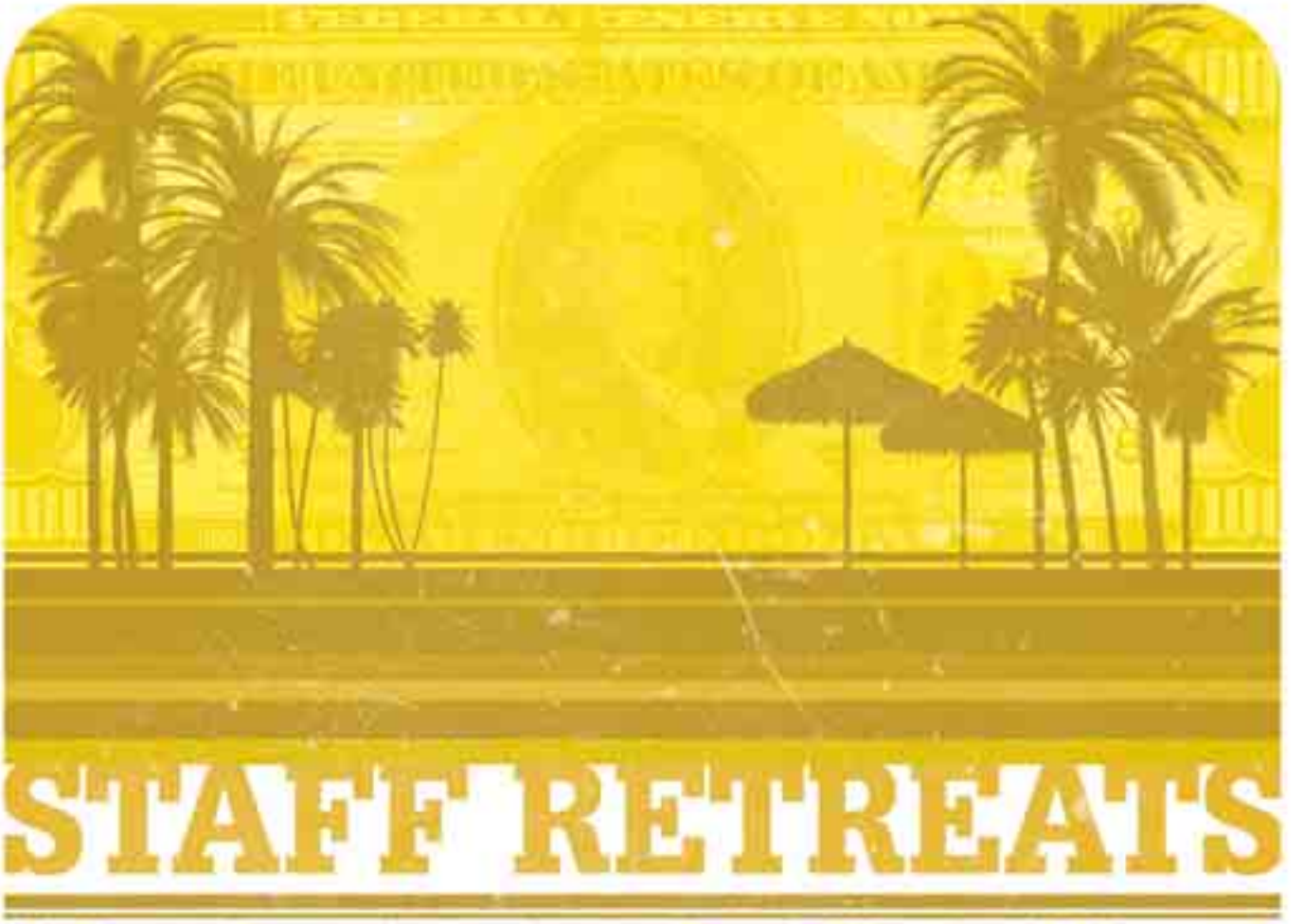

STAFF RETREATS

A Great Investment or a Great Waste of Money? The Choice is Yours.

by Richard Garofolo

Over the course of a year, I speak with literally tens of thousands of dentists, hygienists, assistants, office managers and front desk staff. One question that I am asked by many of them is, "Should I have a staff retreat, and why?" There are many important factors to take into account when thinking about having a staff retreat, and the first one is why you want to have it.

Many dentists tell me that they would like to have a staff retreat as a thank you to their staff for the great job they do all year long. That isn't a staff retreat, that's a staff appreciation week (or weekend or day). In our office, we take one day a year when we close the office, and we take the entire staff to New York City for the day. We walk around, shop, eat, sightsee and take in a Broadway show before taking the last train out of the city and back home. That is the "Thank You" for our staff, not a retreat. We do not discuss strategic planning, internal and external marketing or business at all.

A staff retreat can be used on a small scale as a reward for hitting their goals, or as an employee "Thank You," but staff retreats are really meant to reach a very specific set of goals that the business owner and management have decided are important to them. Without these clearly defined goals, there is no way to know if your retreat has been a success or not. You need a thermometer to measure things, and your goals are that thermometer. Doing the following activities *outside* of the office decreases the stress that your staff feels during regular staff meetings in the office and creates "outside" relationships that can grow in the office and improve staff moral and the teamwork attitude that every office needs and craves.

The location and duration of your staff retreat can have a very real affect on the productiveness and effectiveness of the retreat. You must take into consideration your budget for the staff retreat. If the weather is agreeable and money is tight, a local park with some picnic tables can work well. On the other side of the spectrum are the offices that will take the staff and spouses on a weeklong cruise. Most offices fall somewhere in the middle. A weekend away at a moderately priced (do not read cheap) hotel will tell your staff that you care and appreciate them, while providing a meeting room for the actual business and team building parts of the retreat. Take into account scheduling, budgets and desired outcomes as you consider the location for your staff retreat. The important thing is that people are relaxed and comfortable.

"Many dentists tell me that they would like to have a staff retreat as a thank you to their staff for the great job they do all year long. That isn't a staff retreat, that's a staff appreciation week (or weekend or day)."

Before deciding on a location, think about what type of retreat you would like to host. Are you going to concentrate on team building to increase moral in the office? Would you prefer a brainstorming session, talking about ways to increase production, effectiveness of the staff, ways to improve the patient experience in your office, starting from the first phone call to the minute the patient leaves the office for the first time? Strategic planning is important for any business. Try dividing your staff into teams, giving each team one project or problem to address, and define a clear amount of time when they come back to the whole team and present their three solutions or ideas. Let the entire team discuss these limited ideas, concentrating on finding the best possible solution or concept.

Training is one of the best reasons to have a staff retreat. Oftentimes, with the hustle and bustle of daily work life, we lose sight of the little things that make a big difference in our case acceptance percentages, integrating new technology or new concepts to the staff or just reiterating items that might have been discussed previously in one smooth, concise and well-planned

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lesson. Having a weekly staff meeting is a great start, but it is just not possible to fit all the important things into one or two hours. Look at the retreat as a refresher course. Your staff will retain much more when they aren't worried about the perio case coming in after lunch, or rushing to get home to their hungry children at the end of the day.

Once you know what type of retreat, how long you want it and where, you'll need to focus on who will run it. Often, the owner, manager, dentist or dental spouse will take this responsibility. It must be someone who will be at ease, who will be able to put the staff at ease. This person will be responsible for making sure everyone knows the ground rules of the retreat, the agenda and what the expectations are. These things must be either laid out in advance or at the very beginning of the retreat. Many owners prefer to have an outside moderator run the retreat for them. The staff might feel more comfortable speaking their mind if they know that the moderator has set the ground rules and that everyone is there for the betterment of the practice and the business. The entire staff must feel safe and secure enough to speak their mind for the improvement of the practice.

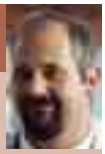
Whoever you choose to run the meeting must have a very clear understanding of what you want to get out of the retreat. Many practice management consultants offer this as one of their services, so consult with yours to see if it is something that they can offer or assist you with. Many will handle all the details from start to finish keeping in mind your budget and desired results.

No matter who, where, when or what, following these simple steps will let you be certain that your staff retreat is a great success.

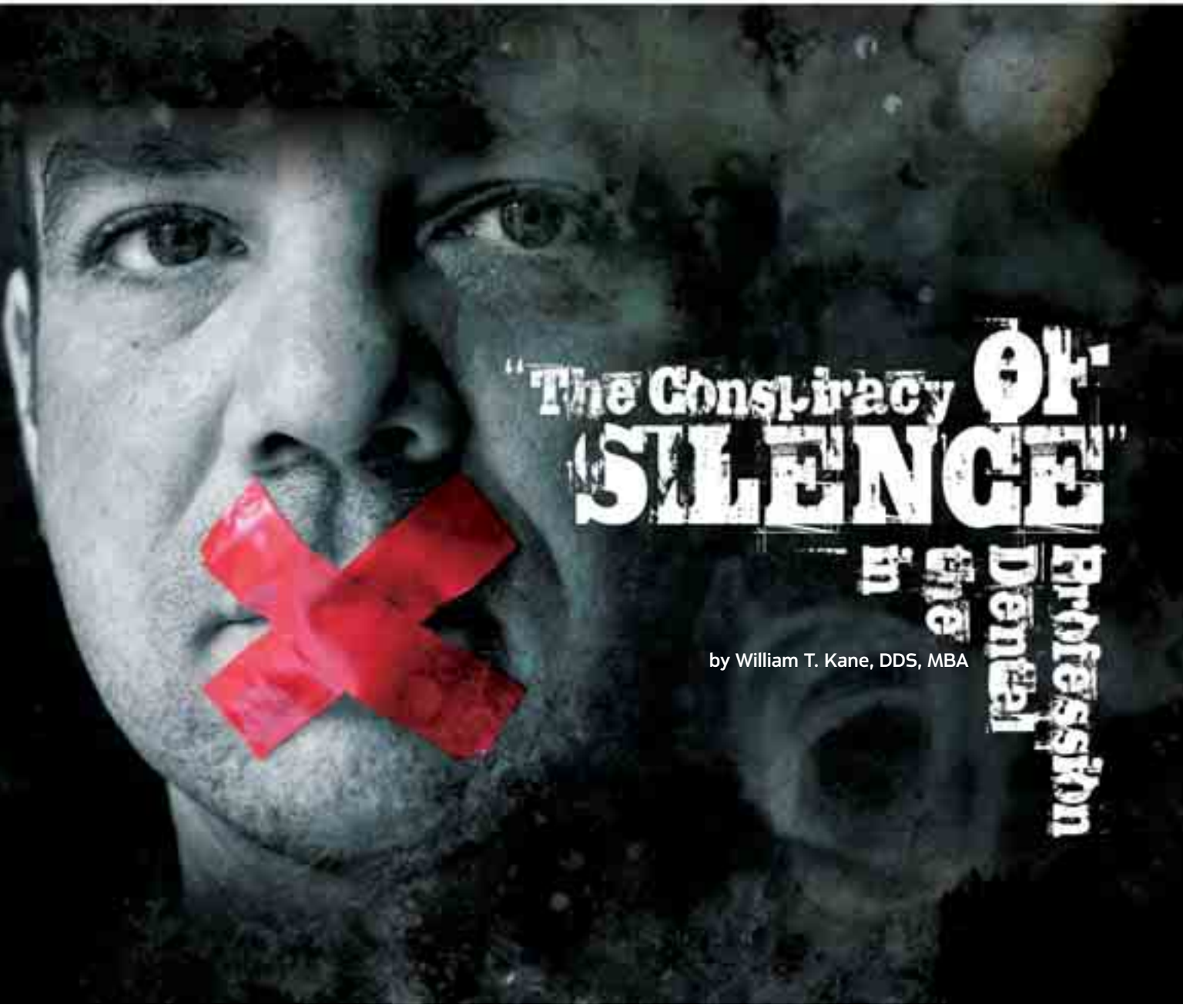
1. Have your expectations laid out in advance. Remember the thermometer!
2. Create an agenda and be sure to stick to it. Make sure that you have included time for relaxation. Down time is important and it is during these times that some great relationships can be created or repaired.
3. Be sure that any assignments are taken seriously and completed on time.
4. Know the ground rules and stick to them. Do not let personal feelings get in the way of productivity. Be honest and give everyone a chance to speak.
5. While coming up with all those great ideas, be sure to include how they are going to be implemented once you get back to the office. Great ideas do nothing but collect dust if they are shelved.
6. After you are back in the office, prepare a review form for each attendee. Be sure to ask for their complete and honest feedback on the retreat as a whole and for each individual session.

If you follow these simple steps, your retreat can be the great success that you want it to be, and can be the best investment that you make in your business this year. ■

Author's Bio



Rick Garofolo is the president and CEO of DentalSubs.com and The Practice Mechanic (a practice management consulting company). He has spent the past 20 years in marketing, management and consulting, working with hundreds of companies all over the world. He has been called the "Gordon Ramsey" of the dental world and has produced consistent results of 80 percent revenue growth in one year or less. You may contact Rick with any questions or comments at rick@practicemechanic.com.



"The Conspiracy of SILENCE" in the Dental Profession

by William T. Kane, DDS, MBA

The dental profession needs to be more diligent in identifying both its colleagues as well as patients who are suffering from addictive diseases and other well-being issues. We all know fellow dentists, dental team members and patients who are suffering from the disease of addiction. When we do not acknowledge and address these individuals we become part of "The Conspiracy of Silence" by allowing the suffering to continue.

Most, if not all, individuals with an addiction are unable to stop their addiction on their own. Most will need some type of professional assistance. Confronting an addicted person alone is very difficult depending on his or her state of denial. An intervention of some sort is perhaps the best way to begin to break the addicts denial. Sometimes an intervention takes the shape of an arrest for driving under the influence (DUI), or perhaps a visit from a state dental board investigator. Also, an intervention can be a more structured process carried out by someone trained in this area.

The disease of addiction is a complex primary, chronic progressive disease that if left untreated could lead to the person's death. Unfortunately, addiction is probably the only condition in which diagnostic and treatment procedures are delayed until the patient is in critical condition. In dentists, the disease of addiction is almost always in its advanced stages before signs and symptoms become obvious in the office or clinical setting.

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The dentist's mindset – one of perfectionism and focus; an individual who is knowledgeable about drugs – is perhaps the greatest impediment to getting help. Also, the dentist's status as undisputed master of his or her domain creates "The Conspiracy of Silence," in which family, staff and colleagues are wary of bringing the addicted dentist's problem to light.[1]

Dentists, similar to other professionals, frequently fail to confront addiction in colleagues, even when its presence is undeniable. Colleagues, family and staff might delay addressing the addicted dentist in an effort to protect him or her from adverse consequences such as shame, social stigmatization, income loss and licensure actions. Additionally, we are afraid of being wrong and fear retaliation.

However, failing to identify and address addiction because of its possible consequences is similar to failing to diagnose cancer because it will cause pain. We think out of loyalty and respect, we think we owe it to our colleagues and patients alike a chance to deal with their addiction on their own. Very often we believe they will be able to stop if they know they have a problem and that they can get the problem under control themselves.

Individuals with addictions develop denial; this convinces them that the disease of addiction is not present. Denial is an unconscious psychological defense mechanism that develops over time through repeated rationalization. Actual denial differs from lying in that it is not a conscious intent to deceive. It allows addicts to justify their behavior and to avoid painful knowledge of their actions.[2]

Taking denial out of the picture, the guilt and shame associated with addiction will cause dental professionals to avoid detection and resist treatment. Significant others, staff and family members who would not think of ignoring symptoms of diabetes in their loved one, tolerate signs of addiction or simply turn away in frustration.

The poor performance, deteriorating behavior, absenteeism and isolation of a dental professional, and patients as well, are frequently attributed to stress from a relationship, or financial or business difficulties, rather than the addiction that underlines them all. Unfortunately, addiction is a condition we really hate to look at except by the exclusion of all other possibilities. The fear of damaging the dental professional's reputation, particularly if you are uncertain the condition exists, causes concerned colleagues to rationalize their behavior, minimize difficulties and avoid confronting the addicted person.

When an addicted individual's behavior becomes so obvious to those around, two choices exist. One is to confront the individual or have an intervention concerning his or her behavior. If the intervention is adequately planned and carried out, often the addicted individual will receive appropriate treatment. This choice breaks "The Conspiracy of Silence" and the addicted individual begins the process of restoring his or her personal and professional lives.

The second choice is to do or say nothing, allowing "The Conspiracy of Silence" to continue. Dental colleagues, staff and family members simply let the natural progression of the disease of addiction take its toll on the individual with the addiction. It is so easy to rationalize, "it is really none of my business" or think, "I am not my brother's or sister's keeper."

The majority of dentists tend to work in solo practice or small groups. In these practice settings it is very easy to become isolated as a dentist or staff member's addiction progresses. The dentist and staff become a "highly dysfunctional family" creating and allowing "The Conspiracy of Silence" to grow and continue.

It would be correct to state that most dentists know a dental colleague who is currently suffering from an addiction. The suffering colleague might be in one's local area or even a dental school classmate in a different corner of the state or even a distant state. Dentists and dental specialists generally do not change practice locations frequently, so early identification and intervention might be somewhat easier. Indications that a dental colleague might have an addiction are generally not difficult to notice.

However, failing to identify and address addiction because of its possible consequences is similar to failing to diagnose cancer because it will cause pain.

Dental hygienists with an addiction may be more challenging to identify early. Since a dentist employs dental hygienists, it might be possible to move from practice to practice or change locations frequently. As an addiction progresses, absences from the practice becomes commonplace. This may cause friction in the practice and the dental hygienist might leave the practice. When a problematic dental hygienist leaves one practice, "The Conspiracy of Silence" generally follows him or her to the next practice. Dental hygienists, much like dentists, know a dental hygiene colleague who is suffering from addiction. Again, it could be someone close to home or in another part of the state.

Patients in our practices will present in both the active disease state as well as in recovery from these conditions. We need to treat these individuals in our practices just as we would treat those with other medical conditions. We need to address and break "The

1. *Peer Assistance Services Spring Dentists from Trap of Addiction. Nov 27, 2001. http://www.ed-dental.com/article/Peer-Assistance-Services-Spring-Dentists-Form-0001*
2. *McCall, S.V., West J Med 2001 January, 2001: 174(1): 50-54.*

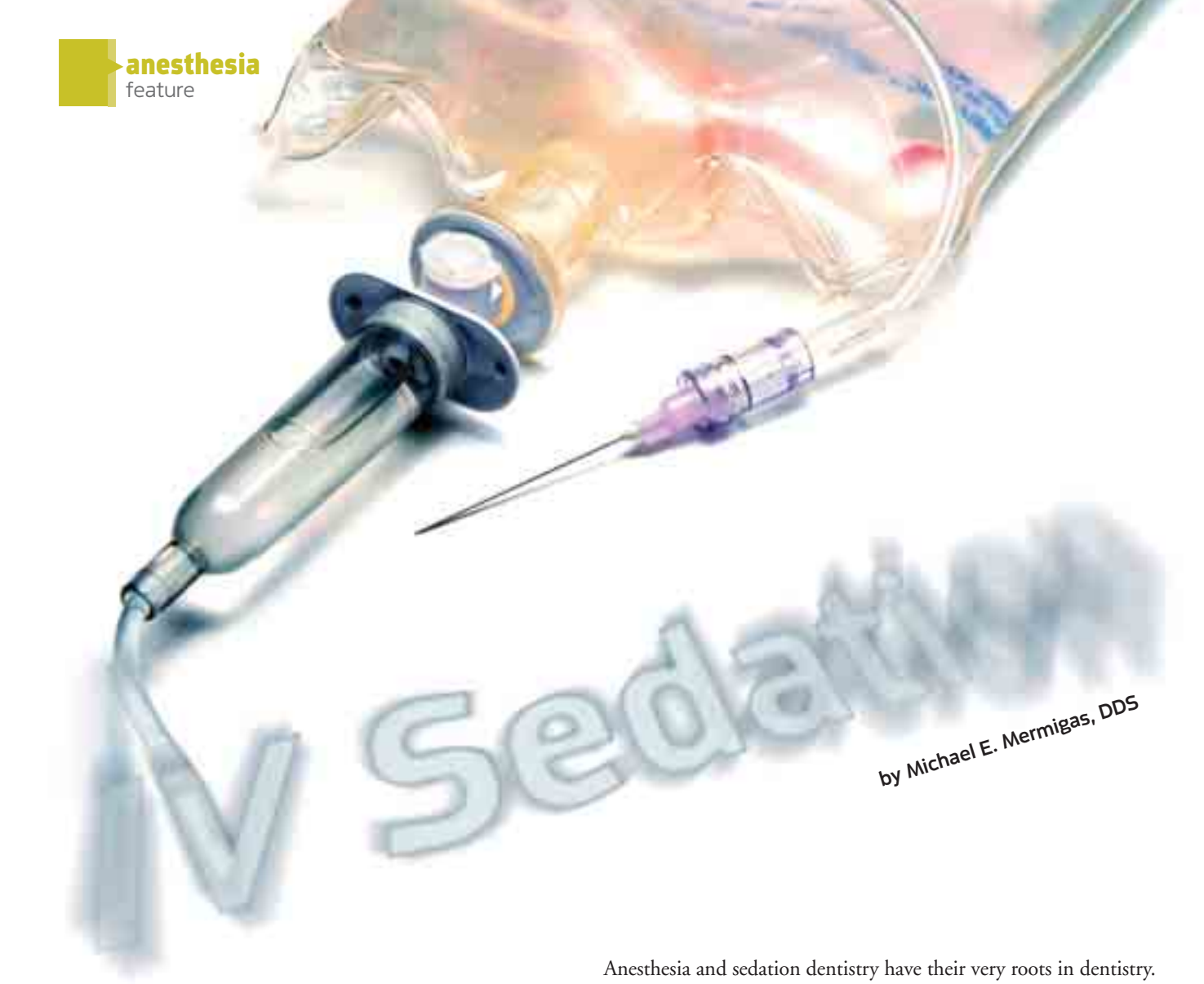
Conspiracy of Silence" in our patient populations as well. A place to start is with a call to the patient's physician expressing your concerns. The best source of information about addiction is patients who are in recovery. Through them you can become familiar with the resources in your own community; interventions, treatment and support for those with addictions. Another great source of information is a dental colleague who is in recovery. Additionally, employers in your area might have Employee Assistance Programs (EAP) designed to help these individuals.

The good news is "The Conspiracy of Silence" can be eliminated. Dentists and dental hygienists suffering from addictions respond very well to adequate treatment. Virtually every state has a peer assistance program for dental professionals generally through the state dental associations. These programs are not punitive, rather they are designed to assist the dentist or dental team member begin the journey toward recovery. Hundreds of dentists, dental hygienists and dental team members have been helped by these programs. Generally, these programs can assist you in identification, gathering information, planning and conducting an intervention and referral to treatment facilities.

An individual with an addiction is dying, struggling with a chronic progressive disease. If you are concerned about a colleague, break "The Conspiracy of Silence," pick up the phone and call the peer assistance program in your state. Several of these programs were listed in the article in the September 2011 issue of *Dentaltown Magazine,* and are available on the Web site. Your phone call might just save your colleague's life, both personally and professionally. I have seen this happen hundreds of times! ■

Author's Bio

William T, Kane, DDS, MBA, graduated from the University of Missouri – Kansas City School of Dentistry in 1980. He maintains a general practice in rural Dexter, Missouri. In addition to practicing dentistry, Dr. Kane's interest and passion have been in the area of recovery and wellness. Since 1987, Dr. Kane has been the Chairman of the Dentist Well–Being Committee for the Missouri Dental Association. Additionally, Dr. Kane served as a member of the Dental Wellness Advisory Committee (DWAC) with the American Dental Association. Dr. Kane is very familiar with issues facing patients with addictive diseases and has published and presented on these topics. He also completed an MBA in 1992 from Southeast Missouri State University. In the fall of 2010, Dr. Kane received his Fellowship in the American College of Dentists.



IV Sedation

by Michael E. Mermigas, DDS

It has been suggested that as much as five to 20 percent of the adult population in the United States avoid dental treatment because of dental anxiety.[1] It has also been demonstrated that a major cause of this anxiety involves conditioning from painful or other traumatic experiences.[2] These experiences can be traced back to an unpleasant childhood dental procedure, inadequate local anesthesia, resistance to local anesthesia or other similar factors.

Anesthesia and sedation dentistry have their very roots in dentistry. Only during the last half of the 20th century has the practice of sedation (enteral, inhalation and intravenous) and deep sedation/general anesthesia become more widely available in the dental office. Pioneers in anesthesia such as Drs. Leonard Monheim and Richard Bennett took the first steps in educating and training dentists to administer IV sedation. They developed the first undergraduate and postdoctoral training programs at the University of Pittsburgh School of Dental Medicine. Since this program was instituted, several other dental schools have followed and now offer undergraduate training in IV sedation.

IV sedation certification programs for dentists already practicing are now being offered as continuing education courses.

Dr. Bennett was the first to use the term "conscious sedation." This term implies that the patient remains fully conscious during the intraoperative period, but in a relaxed, anxiety-free state. By definition the protective reflexes remain intact. This implies that the airway is not compromised and that cardiovascular function is maintained by the patient's own physiologic mechanisms.

1. *Lindsay S, Jackson, C Fear of routine dental treatment in adults: its nature and management. Psych Health 1993; 8:135-53.*
2. *Kent G. Dental phobia. In: Davey, G, editor. Phobias. A handbook of theory and research. London: John Wiley and Sons; 1997.*

The term "conscious sedation" within the last decade has been supplanted by more specific terminology. Minimal, moderate, deep sedation and general anesthesia are the terms that are now in use to describe the various levels of anesthesia. Herein are the definitions of levels of sedation as defined and adopted by the American Society of Anesthesiologists (ASA).[3]

- **Minimal sedation:** Also known as anxiolysis. A drug-induced state during which the patient responds normally to verbal commands. Cognitive function and coordination might be impaired. Ventilatory and cardiovascular functions are unaffected.
- **Moderate sedation/analgesia (conscious sedation):** A drug-induced depression of consciousness during which the patient responds purposefully to verbal command, either alone or accompanied by light tactile stimulation. No interventions are necessary to maintain a patent airway. Spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- **Deep sedation/analgesia:** A drug-induced depression of consciousness during which the patient cannot be easily aroused, but responds purposefully following repeated or painful stimulation. Independent ventilatory function might be impaired. The patient might require assistance to maintain a patent airway. Spontaneous ventilation might be inadequate. Cardiovascular function is usually maintained.
- **General anesthesia:** A drug-induced loss of consciousness during which the patient is not arousable, even to painful stimuli. The ability to maintain independent ventilatory function is often impaired. Assistance is often required in maintaining a patent airway. Positive pressure ventilation might be required due to depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function might be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[4]

The vast majority of moderate to severely anxious dental patients can be easily and safely managed with moderate levels of sedation.

Advantages of Moderate Sedation:

- Relaxed patient, dentist and staff
- Increased access to care for those who would normally avoid treatment

The vast majority of moderate to severely anxious dental patients can be easily and safely managed with moderate levels of sedation.

- If benzodiazepines are employed there is an amnesic effect. The patient has little or no recall of unpleasant procedures.
- Diminishes extreme gag reflex
- Increases productivity

There are multiple modalities that may be employed to induce a state of moderate sedation. Among them are oral (enteral), inhalation (nitrous oxide/oxygen) and IV sedation. There are many advantages to offering the patient IV sedation.

Advantages of IV Sedation:

- Intravenous access to deliver medications
- Anesthetic agents, adjunctive agents (antibiotics, anti-inflammatory agents) and emergency drugs
- More predictable depth of sedation as the agents are easily titrated and have a rapid onset
- Anesthetic agents most often employed are short acting. This makes for a more rapid recovery.
- Reversal agents administered by the IV route have a more rapid onset and multiple dosing of these agents is less problematic as opposed to other routes such as intra-lingual or submucosal.
- Volume deficit replacement possible in the fasting patient

An emphasis should be made as to the safety of IV sedation. Intravenous access, electronic monitoring of vital signs, EKG, oxygen saturation of hemoglobin and end tidal CO_2 all enhance patient safety. The fact that the patient remains conscious and that the protective reflexes remain intact are also factors. Many liability insurance carriers do not surcharge the dentist for offering IV moderate sedation.

It is imperative for any dentist wishing to offer IV sedation to receive proper training and follow-up refresher training. Currently the American Dental Association Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students[5] recommend the following:

Moderate Parenteral Sedation Course Duration:

1. A minimum of 60 hours of instruction, plus management of at least 20 patients by the intravenous route per participant, is required to achieve competency in moderate sedation techniques.

3. *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. Anesthesiology: April 2002 - Volume 96 - Issue 4 - pp 1004-1017.*
4. *Excerpted from Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004, of the American Society of Anesthesiologists (ASA).*
5. *As adopted by the October 2007 ADA House of Delegates*

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2. Clinical experience in managing a compromised airway is critical to the prevention of emergencies.
3. Participants should be provided supervised opportunities for clinical experience to demonstrate competence in management of the airway.
4. Typically, clinical experience will be provided in managing healthy adult patients.
5. Additional supervised clinical experience is necessary to prepare participants to manage children (aged 12 and under) and medically compromised adults.
6. Successful completion of this course does result in clinical competency in moderate parenteral sedation.
7. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted.

Upon completion of moderate IV sedation training, the participant and staff are also trained in the area of patient evaluation, management of the medically compromised patient and management of dental office emergencies. These greatly enhance the dentist's ability to safely and effectively tailor treatment to a wide variety of patients with and without the need for sedation. ■

Author's Bio

Michael E. Mermigas, DDS, is director of the Duquesne University Center for Continuing Dental Education. He is a clinical assistant professor of pharmacology-toxicology at Duquesne's Mylan School of Pharmacy, and teaches several undergraduate as well as graduate courses. He is the director of continuing dental education at the university. Trained as both a general dentist and a registered pharmacist, Dr. Mermigas is a graduate of the Mylan School of Pharmacy and the West Virginia University School of Dentistry. He completed residency in hospital dentistry at the Department of Veteran's Affairs Medical Center in Pittsburgh, Pennsylvania, as well as an externship in oral implantology with the Midwest Implant Institute in Columbus, Ohio.

In addition to his teaching responsibilities, Dr. Mermigas maintains a private general and implant dentistry practice where he also provides anesthesia services. He has been providing sedation services to his patients and for other dental practices for more than 20 years. He also served for 15 years as an emergency medical technician. Dr. Mermigas has lectured extensively in the areas of pharmacology, anesthesia and pain control, medically compromised patients and microbiology.

LSK121 Chairside Shade Guide

Seasons of Life will eliminate guesswork.

A decade ago, Luke Kahng, CDT, a technician for more than 20 years, first began researching the difficulties of shade matching because re-makes are frustrating for everyone – the dentist, the patient and the lab. He came up with some interesting conclusions about natural dentition and how to properly re-create its appearance. His motivation was based on the realization that traditional shade tabs are merely a guide, limited when it comes to communicating natural dentition's characteristics and modifications. This led him to consider a more accurate method of communication between the patient, the clinician and the lab about color, the blueprint to successful restorations.

As a result, the concept of the Chairside Shade Guide came into production in 2009. In 2010, a debut of an updated version was presented. With continuous research toward improving the product, they are able to introduce the current ceramic shade tabs. The color formulas for these shade tabs have been researched, developed and carefully recorded by Mr. Kahng.

The Chairside Shade Guide Seasons of Life versions 3.0-5.0 are a series of porcelain ceramic shade tabs that match natural tooth colors as well as the existing dentition. In graduating from laminated commercial paper to ceramic shade tabs, it offers a more realistic color reproduction because the materials are equal. Guesswork regarding your final shade, including all modifications, is a thing of the past. And because these tabs are porcelain they can be sterilized after each use.

The Chairside Shade Guide ceramic shade tabs are divided into different categories, with 20 tabs in each grouping. It has taken into account the following preferences:

Chairside Shade Guide 3.0

Cosmetic (six colors), Young (14 colors)

Historically, precise cosmetic color guidelines have not been available. What is accessible is not what patients want. They prefer bright color with translucency, light with warm tones. The tabs are created with that in mind. The 3.0 categorization concentrates on a higher opacity and brightly colored appearance which translates into more dentin and less enamel in its content. The enamel color is bright (white) and medium-white, covered together in natural dentition's chemistry. There is also a higher composition of dentin with enamel overlay in this group. Opal, translucency, and variations of white calcification, different colors of mamelon and bright enamel with higher dentin are all included.

Chairside Shade Guide 4.0

Middle Years (20 colors) includes variation and 20-30 percent reduction of color in enamel.

Included are three white calcification possibilities and a variety of translucency with mamelon, demonstrating lower enamel and higher translucency color.

Cosmetic Shade Guide

Young Shade Guide

Middle Years Shade Guide

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Later Years Shade Guide

Chairside Shade Guide 5.0

Later Years (20 colors)

In this age group, the dentin color is intense in appearance, with transparency over the top. Brown, orange, gray and yellow are the color choices – subtle, moderate and heavy, with varying degrees of strength. These modifications and possible staining must be included if we are to have a matching restoration.

Communication is Key to Successful Restorations

Good communication improves case acceptance because patients value the time and effort that the dentist takes to educate them about their case. Natural color, translucency, transparency, bright color, cosmetic and rehabilitation cases are all difficult to discuss if they do not have the proper communication tools. These shade tabs can be used to help the clinician explain color variation with translucency. And the more a patient knows about his case, the better informed he feels, which leads to a sense of understanding and empowerment.

Complete Shade Guide

How The System Is Used

This revolutionary approach tracks different dentin and enamel colors by re-creating the layering thickness in order to mimic natural dentition, deep translucency, the mamelon effect, white calcification and opal blue coloring. The precise components and dentin/enamel combinations create incisal translucency with modifications, duplicated precisely according to the research conducted with natural dentition, and the appropriate age group it represents. This system incorporates modifications such as enamel overlay and dentin color, incisal edge, halo, translucency, transparency, bleaching color, mamelon and calcification and gives them to you in one shade tab. You will never have to guess which modifications to add to the restoration because everything is already included.

Enamel presents with many variations in color – orange, gray, brown and yellow are some of the more common possibilities. In order to mimic natural dentition, they have mixed the colors to create the complexity, tone and depth of color seen within natural teeth. Detailed attention has been paid to the internal dentin color, the incisal edge, the gingival-third staining and the translucency or transparency, as dictated by age, the in-depth research and what is seen in the patient's mouth. It is able to offer a true repetition of life-like enamel colors.

Consider your patients' natural dentition. There is not one set of teeth that looks exactly like another, but there are common modifications that we see from patient to patient. Frustration when it comes to discussing color is common, because we have not had the tools with which to work. The shade tabs are meant to help with patient/doctor/technician communication in a way that nothing else has before. These shade tabs are based completely on the theory behind custom shade matching and are each overlaid with different enamel colors so that they harmoniously match with natural teeth. The uniquely blended Chairside Shade Guide shade tabs take in-office custom shade matching to a whole new level! ■

Tetric EvoCeram Bulk Fill Simplifies Posterior Restorations

by Jason Olitsky, DMD, AAACD

Restoring cavity preparations is a main staple of dentistry, and although performed daily, the procedure is riddled with intricate complexities. Dentists most commonly face the potential for polymerization shrinkage, marginal leakage, caries, postoperative sensitivity and potential procedural failure due to the technique-sensitive protocol for placing composite restorations. Due to the multiple steps for proper placement and potentially numerous materials required, direct posterior restorations entail a long procedural time.

While direct composites are a more aesthetic and contemporary form of treatment, some are better suited for the anterior region because of their high polishability and optical characteristics. However, a significant disadvantage is their lack of strength, which precludes their use for posterior restorations. Other composites with enhanced strength and wear characteristics that are better suited for posterior restorations have fallen short in terms of aesthetic qualities.[1]

The need for more proficient techniques emerged, stimulated significant dental research, and has led to development of today's bulk-fill materials. Both highly effective and easy to use, dentists can use bulk-filled composites to place restorations faster, more efficiently and more confidently. Presently, bulk-fill composites diminish technique sensitivity, decrease shrinkage-induced failures[2-4] and demonstrate first-rate handling and adaptability, contributing to predictable and aesthetic posterior restorations.[5,6]

1. *Hervás-García A, Martinez-Lozano MA, Cabanes-Vila J, Barjau-Escribano A, Fos-Galve P. Composite resins. A review of the materials and clinical indications. Clinical Dentistry. Med Oral Patol Oral Cir Bucal. 2006 Mar 1;11(2):E215-20.*
2. *Roggendorf MJ, Krämer N, Appelt A, Naumann M, Frankenberger R. Marginal quality of flowable 4-mm base vs. conventionally layered resin composite. J Dent. 2011 Jul 27. (Epub ahead of print)*
3. *Kuijs RH, Fennis WM, Kreulen CM, Barink M, Verdonschot N. Does layering minimize shrinkage stresses in composite restorations? J Dent Res. 2003 Dec;82 (12):967-71.*
4. *Souza-Junior EJ, de Souza-Règis MR, Alonso RC, de Freitas AP, Sinhoreti MA, Cunha LG. Effect of the curing method and composite volume on marginal and internal adaptation of composite restoratives. Oper Dent. 2011 Mar-Apr;36(2):231-8. Epub 2011 June 24.*
5. *Idriss S, Habin C, Abduljabbar T, Omar R. Marginal adaptation of class ii resin composite restorations using incremental and bulk placement techniques: an ESEM study. J Oral Rehabil. 2003;30(10):1000-7.*
6. *Van Ende A, De Munck J, Mine A, Lambrechts P, Van Meerbeek B. Does a Low shrinking composite induce less stress at the adhesive interface? Dent Mater. 2010;26(3):215-22.*

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Tetric EvoCeram Bulk Fill

Tetric EvoCeram Bulk Fill composite (Ivoclar Vivadent, Amherst, New York) is a highly advanced material consisting of layered silicates for smooth consistency. As a result, it is effortless for filling cavity preparations of up to 4mm in a single-layer application. With Tetric EvoCeram Bulk Fill, dentists can use a flowable composite, but it is not necessary. Additionally, the material has a polymerization booster allowing for complete curing of 4mm thick increments in 10 seconds. The integrated shrinkage stress reliever decreases the shrinkage stress placed along cavity walls and surfaces, reducing the total shrinkage volume experienced during polymerization.

Tetric EvoCeram Bulk Fill enables a dentist to restore Class I and Class II restorations quickly. The material adapts to cavity walls and can be placed easily with conventional dental instruments. This material also displays an enamel-like translucency of 15 percent, and therefore blends seamlessly with a patient's natural dentition. Restorations are effortlessly polished to a high-gloss due to the material's nano-hybrid filler composition. The material is available in three universal shades (IVA for slightly reddish teeth; IVB for slightly yellowish teeth and IVW for quick deciduous fillings or light-colored teeth). Tetric EvoCeram Bulk Fill supplies the ideal mixture of simplicity, durability and aesthetics.[7]

Case Presentation

A 21-year-old man in excellent health presented with a failing occlusal buccal amalgam on tooth #30 and occlusal decay on tooth #31 (Fig. 1). After a thorough initial examination and consultation, the decision was made to restore the teeth with a tooth-colored posterior composite and remove the buccal amalgam on tooth #30 to create a more aesthetic result during the treatment. The material selected for this case was Tetric EvoCeram Bulk Fill.

Under rubber dam isolation (Hygienic Non-Latex Dental Dam, Coltène Whaledent), the amalgam and decay were removed entirely using a carbide bur, revealing preparations that were approximately 4mm deep. To improve isolation around the mesial facial of tooth #31, Liquidam material (Discus Dental) was used to complete isolation and prevent saliva contamination of the treatment area. Removal of the old amalgam and all decay in tooth #31 was successful (Fig. 2).

The cavosurface margins were smoothed with a fine grit diamond bur, followed by the total-etch technique. After disinfecting with 2% chlorhexadine gluconate, 35% phosphoric acid gel was applied to the enamel (Fig. 3), then to the dentin for 15 seconds before rinsing (Fig. 4). Etching of the enamel first ensures that the dentin is not over-etched.

In order to decrease the patient's sensitivity and re-wet dentin, the Telio CS Desensitizer (Ivoclar Vivadent) was used to help form protein plugs in the dentinal tubules. A single coat of desensitizer was scrubbed onto the preparation for 10 seconds (Fig. 5). Next, two coats of a fifth-generation adhesive (Excite F) were placed in each preparation for 10 seconds. The adhesive was air-dried with an A-dec drier to evaporate solvent, and light-

7. *Ivoclar Vivadent. Tetric EvoCeram bulk fill: The bulk composite without Compromises. Scientific Documentation. Amherst, NY: Ivoclar Vivadent.*

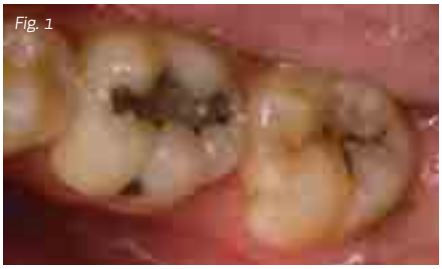

Fig. 1: Pre-operative view of the patient's failing occlusal buccal amalgam displayed on tooth #30 and occlusal decay shown on tooth #31.

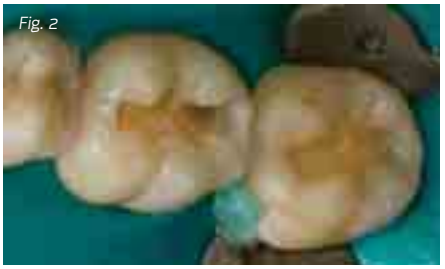

Fig. 2: Complete isolation was performed with a latex-free rubber dam and Liquidam material (Discus Dental) on tooth #31. Removal of the old amalgam and decay in both teeth was completed.

Fig. 3: The total-etch technique was performed. The etching of enamel was completed first.

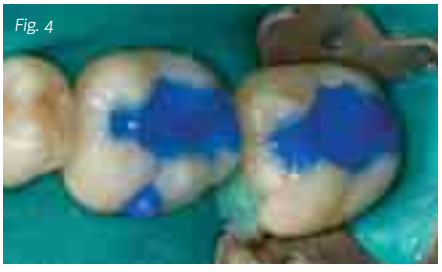

Fig. 4: The dentin was etched for 15 seconds before rinsing.

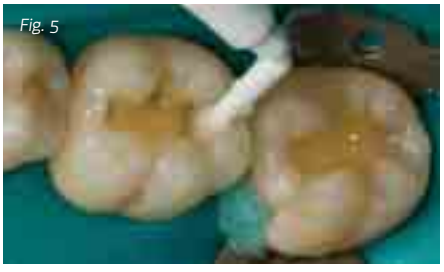

Fig. 5: Telio CS desensitizer was scrubbed onto preparation surfaces to decrease post-operative sensitivity.

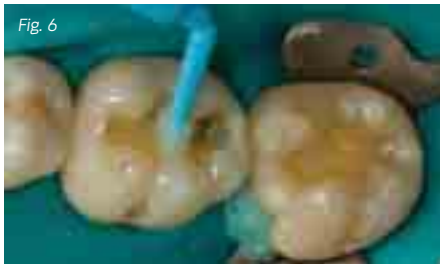

Fig. 6: Two coats of ExciTE F were placed and then air-dried.

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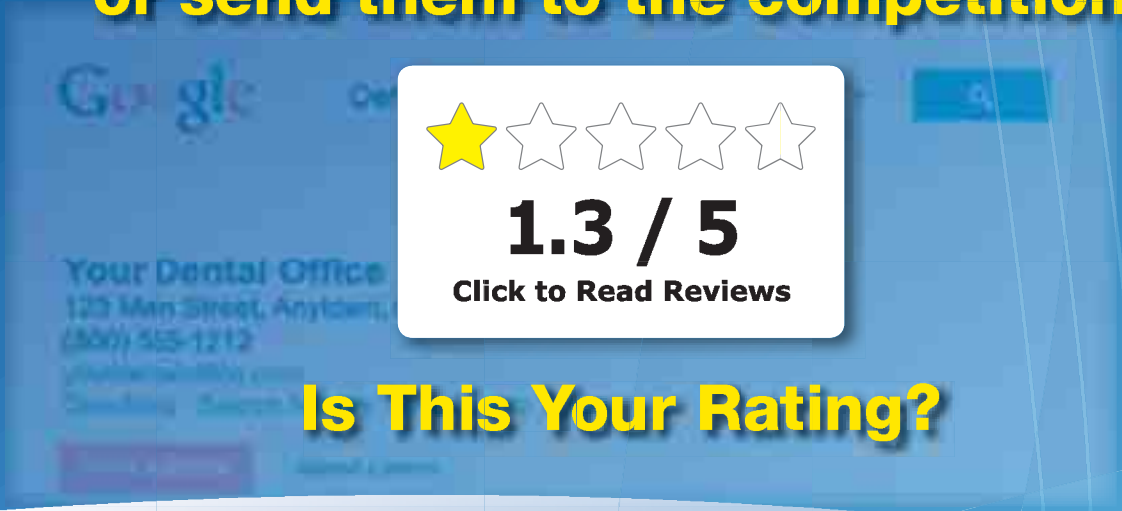
or send them to the competition.



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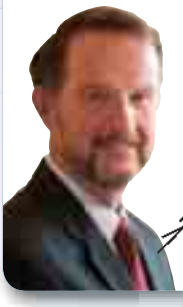

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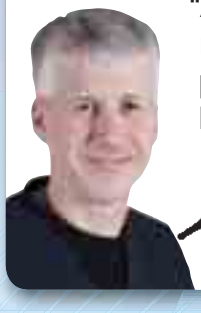
Dentist 30+ years,
Lecturer, Technology Columnist



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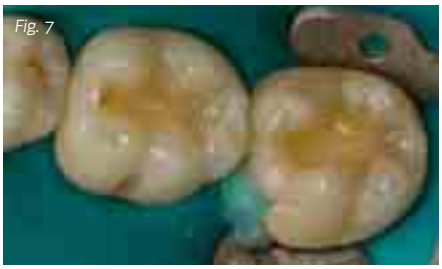
Fig. 7

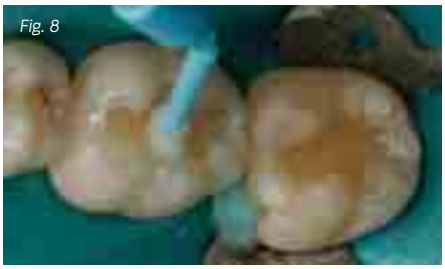
Fig. 8

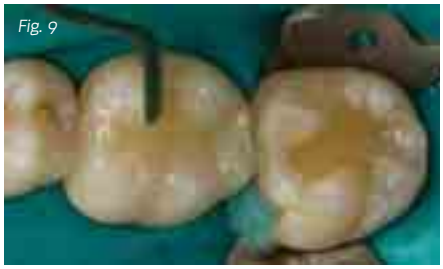
Fig. 9


Fig. 10

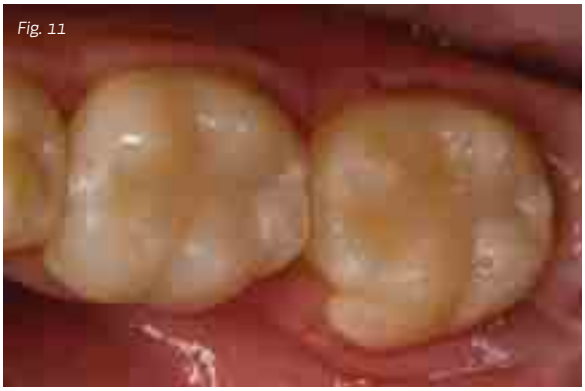
Fig. 11

Fig. 7: The Tetric EvoFlow layer was placed on the dentin, creating the desired adaptation to the pulpal floor.
Fig. 8: The unidose applicator brush was used to apply the bulk fill.
Fig. 9: An IPC-TTN instrument was used to sculpt the material.
Fig. 10: A view of the complete fill and adaptation of the composite restorative to the cavosurface margin of tooth #31. The material has still not been cured.
Fig. 11: The final restoration exhibiting excellent chameleon-like shade match and development of anatomical morphology.

cured with the bluephase 20i (Ivoclar Vivadent) for 10 seconds on low power (Fig.6).

An initial layer of flowable composite is believed to decrease sensitivity by also creating an elastic interface between dentin and the higher viscosity restorative materials. Therefore, a single .5mm thick increment of Tetric EvoFlow translucent was placed with a cavifil applicator on the pulpal floor of teeth #30 and #31. This was then light-cured for 10 seconds on high power (Fig. 7).

Shade IVA of Tetric EvoCeram Bulk Fill composite was chosen to achieve a natural shade blend. Choosing from the three available colors allowed for a simplified shade selection process. Beginning with tooth #30, 2mm of material was initially condensed into place with the soft-touch applicator brush, which was slightly moistened with adhesive. The remaining composite material was then placed in order to completely fill the cavity (Fig. 8). However, it is important to note that Tetric EvoCeram Bulk Fill can be placed in single-bulk increments of up to 4mm.

The restoration was then contoured with an IPC-TTN instrument to replicate natural occlusal and buccal morphology. The teeth were cured to a depth of 4mm, since curing between layers was not required (Fig. 9). The process was repeated for tooth #31, after which both restorations were cured on high power for five seconds each using the bluephase 20i curing light (Fig. 10).

With the rubber dam removed, the occlusion was checked with 40 micron articulating paper and adjusted with an OS1 carbide bur. The posterior restorations were then polished with Optrapol NG (Ivoclar Vivadent) for 30 seconds to achieve a natural-looking appearance and a high shine. With the ability to use one shade and cure one layer of Tetric EvoCeram Bulk Fill, a significant amount of time was saved and the shade of the final restorations matched perfectly with the rest of the patient's natural dentition. (Fig. 11).

Conclusion

Bulk-fill composites are an essential component for the easy and problem-free placement of predictable and aesthetic posterior restorations. Tetric EvoCeram Bulk Fill demonstrates many advantages, most notably decreased polymerization shrinkage, high-quality sculptability and premium aesthetics that allow dentists to create restorations that are virtually identical to the patient's natural dentition. ■

Author's Bio

Dr. Jason Olitsky, The Smile Stylist, is an accredited member of the AACD, as well as president for the Florida Academy of Cosmetic Dentistry. He was a clinical mentor with the Hornbrook Group and is currently faculty with the Gold Dust Clinical Mastery Series. Jason currently works three days a week with his wife and partner, where 80 percent of their production is based off large cosmetic cases. They started Wallsmiles.com, a site that sells wall art for the dental office and teaches dentists how to get their own patients' pictures on their walls. They created Smile Stylist, a brand committed to promoting, providing and maintaining beautiful smiles for the fashion-forward customer. He is also co-author of *The Naked Tooth: What Cosmetic Denists Don't Want to Know.* Check out Olitsky's technique via his OnDemand Webinar on Dentaltown.com.

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"Thin Is In"

Lab-assisted Minimal Prep Cases

by John Nosti, DDS, FAGD, FACE

Whether it is on the cover of *People Magazine,* discussed on network television shows or seen in banner ads on the Internet, ads for veneers are bombarding the population on a daily basis. The patients' knowledge about cosmetic dental procedures has changed dramatically in the past 10 years. In prior times, it would be pressed to find a patient who could tell you what a veneer was. Today patients are calling and asking for them by name: Lumineers, DaVinci Veneers, Durathin, Emprethin and Empress Veneers. Veneers have been used in dentistry for many years and their strength, durability and color stability have proven to withstand the test of time.[1,2]

Along with patients' knowledge, their aesthetic demands have increased as well. As dentists, we have found ourselves in a situation where patients are requesting "not to have their teeth drilled," while expecting the end result of a cut back and layered ceramic that typically requires removal of tooth structure.

In the past there have been very few options for dentists to provide ultra-thin minimal and no-preparation veneers. Powder and liquid or "stacked" veneers have been one of the original ultra-thin restorations available. Their advantages have been the ability to modify opacities within the same restoration, ability to add internal coloring and layering and working with an artistic ceramist to fabricate them. Disadvantages have been marginal integrity, wear compatibility, strength and the difficulty in fabrication.[2]

1. *Aristidis GA, Dimitra B, Five-Year clinical performance of porcelain laminate veneers. Quintessence Int. 2002 Mar; 33(3):185-9.*
2. *Qualtrough AJ, Burke FJ, The effect of different ceramic materials on the fracture resistance of dentin bonded crowns. Quintessence Int, 1997 March; 28(3): 197-203.*


Fig. 1

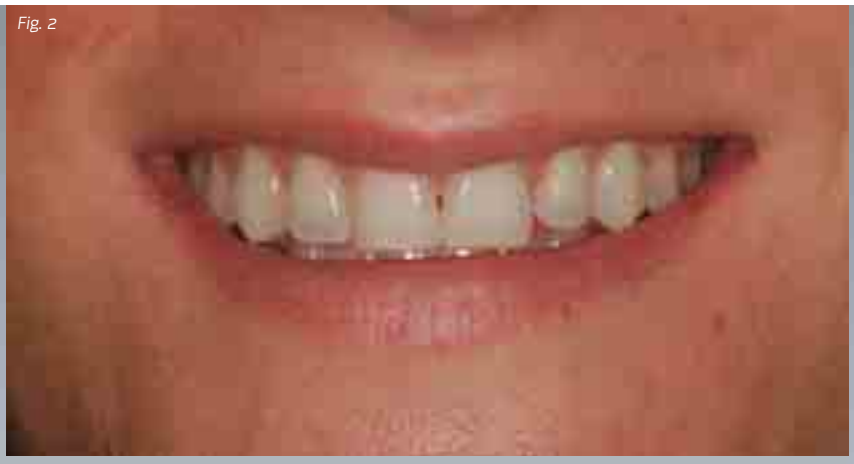
Fig. 2


Fig. 3

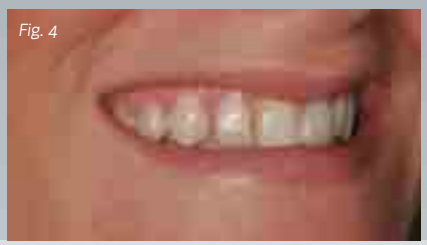
Fig. 4

Lumineers has had the market cornered in branding over the past few years and dentists have felt this is their only option to satisfy their patients' desires for minimally invasive dentistry. The advantages of Lumineers are name recognition and manufacturers marketing. The disadvantages in the past have been lack of doctor-ceramist interaction, no choice in ceramist and lack of vitality. With less than optimal results, dentists and ceramists alike have pushed to provide materials that will satisfy the patients' minimally invasive demands while providing the results dentists strive to achieve.

In the past four to five years, the ultra-thin pressed ceramic was born. The ceramist is able to press to full contour, cut back and layer, and finish down the restoration to .2-.3mm. The advantages of pressed ceramics are strength, the ability to design contours prior to becoming glass, the ability to measure the thickness throughout the lab process, marginal integrity, wear compatibility and the ability to work with an artistic ceramist. The disadvantages are, except for the incisal edge, there is a monochromatic shade present. It is difficult to cover gray teeth, and it is difficult to find a ceramist with the knowledge to fabricate them.

Guidelines and case selection for minimal to no-preparation veneers are as follows:

Proper pre-operative arch alignment required, color change, lengthening, closing small interproximal spaces, collapsed buccal corridor, wear (when knowledge of source is present) and direct resin bonding cases. Contraindications are rotation or crowding, buccally displaced teeth, severely lingualized teeth, bell-shaped or flared teeth, severely discolored teeth in relatively normal arch form.[3,4,5]

Case Presentation

A 26-year-old female, (Figs. 1-4) presented to the office with the desire for a more attractive and more feminine smile. Her dental history: peg laterals with direct resin bonding.

Upon the clinical exam it was noted that her teeth had a straight vertical position. This is an ideal situation for conservative treatment, considering teeth should have an inclination to them facially. This also allows the teeth to appear darker since they do not reflect light properly. She had spacing present, narrow buccal corridor, disliked the color of her teeth, as well as had a few teeth that were rotated facially. Teeth facially placed are a contraindication for "no-prep" veneers.

A complete examination was performed including a full-mouth series of radiographs, periodontal charting, occlusal analysis with T-scan III and joint vibration analysis to verify the health of the temporomandibular joint. Upon the completion of the examination, aesthetic options were discussed, including minimal to no-preparation veneers.

3. *Hornbrook, DS. Minimal Preparation Veneers. Clinical Mastery Series, July 2009.*
4. *Hornbrook, DS. Porcelain Veneers: optimizing esthetics while reestablishing canine guindance. Compend. Contin. Educ. Dent. 1995 Dec;16(12):1190-1194.*
5. *Strassler, HE. Minimally Invasive porcelain veneers: indications for a conservative esthetic dentistry treatment modality. Gen. Dent. 2007, Nov;55(7):686-694.*

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To communicate the desired length and position of her teeth for the final restorations, a mock-up was done by adding Accolade flowable composite to the incisal edges of the anterior six teeth. To communicate the buccal corridor position, flowable composite was added to the facial of the premolars and molars.

Polyvinyl siloxane impressions were taken of the mock-up and of her teeth pre-operatively. A facebow transfer was completed using the Kois Dento-Facial Analyzer, and a centric relation bite was taken to communicate proper jaw position and facilitate mounting to the articulator. Photos were taken of the patient pre-operatively of the mock-up and with shade tabs of her existing dentition.

A diagnostic wax-up was completed to determine proper length, width and facial position of the teeth, as well as determine adequate thickness for the final restorative material. It was determined that slight preparation was required to achieve the results the patient desired (Fig. 5). A reduction tray was fabricated (Fig. 6), similar to reduction copings, to allow minimal reduction to achieve the proper result. This allows the exact minimal reduction to be completed to achieve the desired outcome. This lab-assisted preparation tray takes the guesswork out of removing too much facially placed tooth structure for the desired result.

From here on the dentist has two options. 1) Have the ceramics fabricated to the reduction position and to prep and seat the final restorations at the next visit. This is a viable option because the only reduction is in the body of the tooth structure. There is no change of structure where the margins are planned. 2) Prepare the tooth structure using the reduction guide and take another impression following the completed enamel reduction.

During the second consult appointment, the reduction tray was seated (Fig. 7), and the minimal reduction that was required was completed (Fig. 8). No anesthesia was required during this enamel-reduction process. A new final impression was taken once the enamel reduction process was complete. The cosmetic wax-up was transferred to the patient's mouth to communicate the final planned position of the restorations. A siltech putty matrix was lined with Luxatemp Bleach shade and placed to position over the patient's unprepared and prepared teeth and let to set for 1.5 minutes. The excess was trimmed and polished with carbide finishing burs, and Ivoclar Astropol polishing points. The occlusion was verified, and final positions communicated with the patient. A final shade was determined. Impressions were taken of the temporaries in place, a facebow transfer was repeated and bite records repeated. Photographs were taken of the temporaries (Fig. 3) with shade tabs to communicate the desired final shade to the laboratory.

Emprethin minimal and no-preparation ultra-thin veneers were fabricated (Fig. 9). Emprethins are pressed ceramics,


Fig. 5


Fig. 6

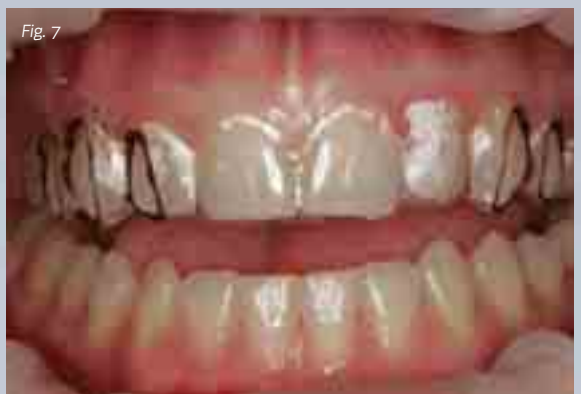


Fig. 7

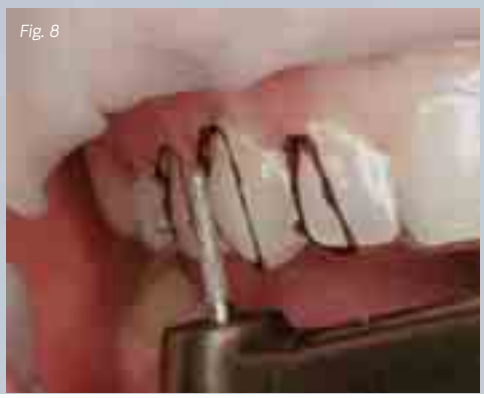


Fig. 8


Fig. 9


Fig. 10

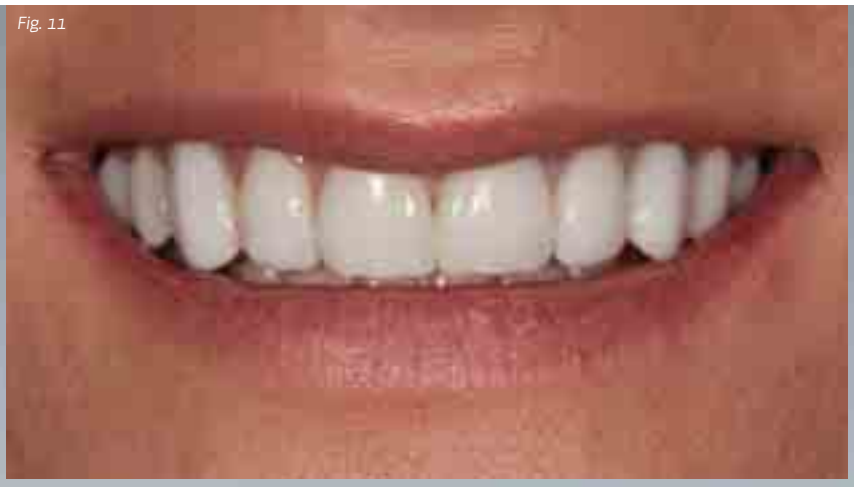


Fig. 11


Fig. 12


Fig. 13

which despite their ultra-thin final result, are cut back and layered to provide a more realistic natural appearance and incisal characteristics unlike many monochromatic counterparts. The strength of pressed ceramics has proven to be superior to that of powder liquid in many studies.

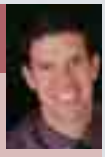
At her third visit, the restorations were tried in with Variolink Veneer try-in paste and she was allowed to view what the final result would be prior to insertion. Once approved, the restorations were etched with phosphoric acid, silanated, and the internal aspect painted with excite bonding agent, and Variolink veneer cement. Each tooth was etched for 30 seconds due to uncut enamel, and bonding agent was placed in two to three coats. The veneers were placed and cured for 60 seconds. The occlusion was verified and adjustments made with the T-Scan III occlusal analysis system in all excursive movements, centric, and the final polish was completed.

The patient is extremely happy with the final result (Figs. 10-13) and her overall treatment sequence. She is a practicing dental assistant and was told by other practitioners that her only option for a more attractive smile would be aggressive veneer preparation or return into orthodontic treatment. She was aware of other no-preparation veneer materials on the market and was extremely happy with the vitality the Emprethins provided.

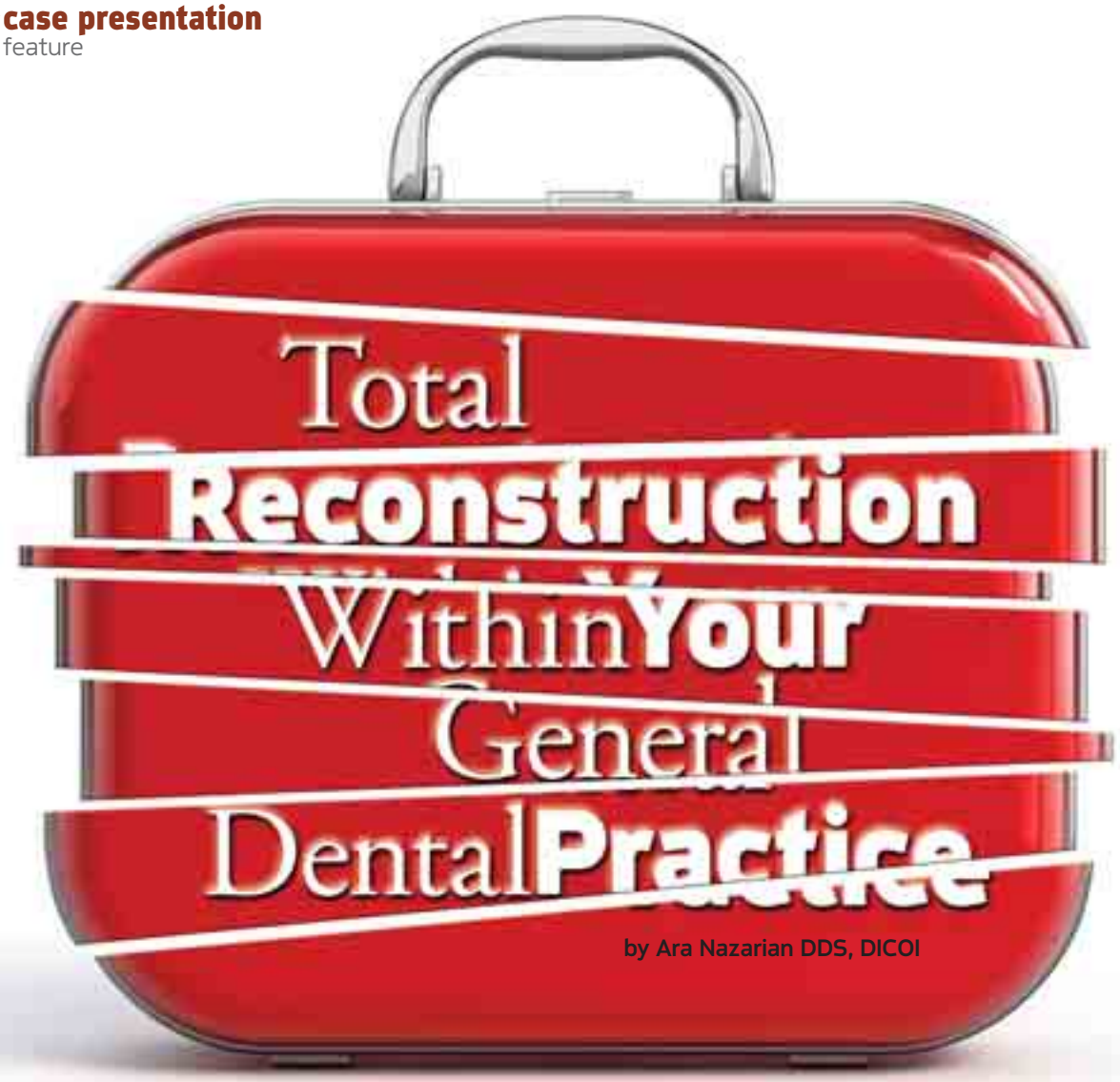
Minimally invasive dentistry can be a viable option whether you are attempting to rebuild a worn dentition to optimum function and anterior guidance, or providing your patient with an outstanding smile. With both the doctor and lab having sound knowledge of guidelines, materials and case selection, your patient will be happy with the results for many years to come. ■

*Emprethins are a trademark of GoldDust Dental Lab

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.



Total Reconstruction Within Your General Dental Practice

by Ara Nazarian DDS, DICOI

"Reconstructive dentistry" is probably the broadest and most inclusive term used to describe the concept of replacing, rebuilding or creating the elements and relationships between teeth, the upper and lower jaws and overall facial structures. In order to provide this type of reconstructive dental treatment, the goal of the provider is to utilize a wide variety of dental services, such as restorative, endodontic, periodontic, implant and prosthetic care to produce the precise outcome desired by the patient. In fact, I recently started the Reconstructive Dentistry Institute in Michigan, where general dentists come to train in the various services necessary to rebuild a dentition to proper form and function. For those dentists who do not want to incorporate this type of service, specialists would be involved to provide a team approach for this type of patient care.

Many patients have put off treatment due to the economy. When they finally return to the dentist, they have a variety of multiple problems that need attention and care. These problems might require root canals, scaling and root planing, extractions, grafting, fillings or implant placement. In my practice, we are able to address all these concerns utilizing oral or IV sedation within a couple of appointments, whereas before they would be referred out to various specialties and have taken more time or multiple visits. In other words, patients who have the least amount of time for what seems to be a considerable amount of dentistry (multiple implants or reconstructive procedures) are accommodated with special appoint-

"Many patients have put off treatment due to the economy. When they finally return to the dentist, they have a variety of multiple problems that need attention and care."

ments. Our office's ability to schedule these appointment blocks enables patients with overflowing work schedules or active lifestyles to obtain needed treatments with the least amount of visits and the least inconvenience.

This article describes a case where the patient needed several dental services within the various disciplines of dentistry to fulfill his demands for an aesthetic and functional smile. In my practice and dental lectures, I have described this treatment as the "Ultimate Dental Treatment." This article will illustrate an efficient and effective approach in preparation, bonding, implants, prosthetics and more!

Case Presentation

A man in his late 50s presented to the practice dissatisfied with the appearance of his smile (Fig. 1). He commented that he felt that his existing teeth and restorations were unattractive because of size, shape and color. He also mentioned that he could feel some chips in his restorations as well as broken portions of tooth structure causing occasional discomfort.

Initial diagnostic evaluation consisted of a series of digital images with study models, a panoramic X-ray and full set of radiographs. Upon clinical examination, it was very evident that the patient had some failing composite and amalgam restorations with recurrent decay (Fig. 2). According to the patient, these restorations had been placed about 10 to 15 years prior. Overall marginal integrity appeared to be compromised with these restorations. Examining these restorations from the occlusal view, one could see multiple cracks and craze lines. In the posterior maxillary and mandibular regions, there were several teeth the patient had complained of discomfort to hot and cold as well as to biting.

Planning

To develop a treatment plan and determine if the vertical dimension could be increased, a diagnostic wax-up was fabricated (Fig. 3). Based on information gathered from the initial consult, it was determined that all the remaining teeth should be cleaned of any caries, cored if necessary and crowned, and the edentulous area of #29 restored with a dental implant. For the areas of #30 and #31 the patient did not desire to undergo block grafting for the deficient amount of bone. All risks, benefits and alternatives to various treatments were clearly reviewed with the patient.

As a result of the information gathered from the diagnostic wax-up and the patient's desires for treatment, it was determined that restoring the entire upper and lower dentition would enhance aesthetics and function. The final treatment plan would consist of Noritake Katana crowns (teeth #2-15 and teeth #18-28), core restorations where needed and implant placement of tooth #29 with corresponding abutment and crown.

Preparation

Using a coarse grit chamfer diamond bur 856 (Axis), the teeth were prepared for all-ceramic Noritake Katana crowns. Utilizing Expasyl (Kerr) we not only

Fig. 1: Pre-operative facial shot

Fig. 2: Pre-operative retracted view

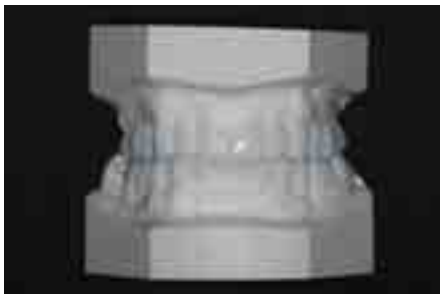


Fig. 3: Wax-up

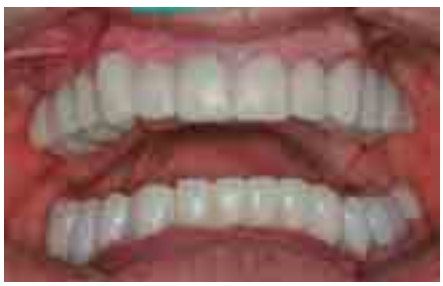


Fig. 4: Retracted view of temporaries

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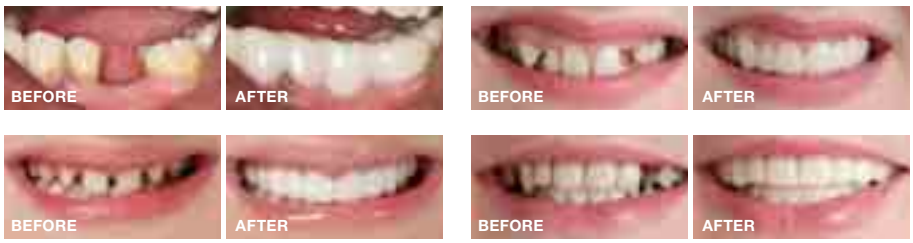

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Fig. 5: Full face shot of temporaries


Fig. 6: Lab work of zirconia copings


Fig. 7: Close up of crowns seated


Fig. 8: OCO Biomedical TSI Implant (9080)

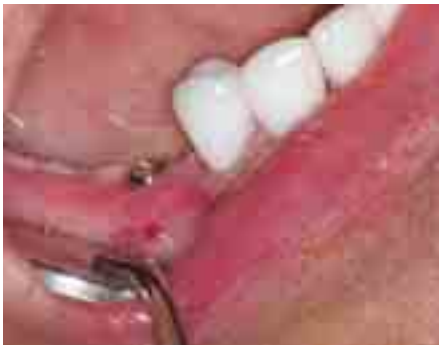
Fig. 9: Implant placed in the #29 area.

controlled hemorrhaging, but also achieved gingival retraction. After approximately two minutes in the sulcus, the Expasyl was rinsed off with copious amounts of water. Utilizing a full-arch tray (Pentron) and fast-set impression material (Take One Advance, Kerr) an impression was taken for the final restorations. The same materials and steps were utilized for the mandibular arch.

Provisionalization

A provisional restoration, which would aid in determining the best size, shape, color and position, was made from a Siltec (Ivoclar Vivadent) impression of the diagnostic wax-up. Using Temphase (Kerr) temporary material, this mold was quickly filled and placed on the patient's prepared dentition (Fig. 4). Within minutes, the temporary was fabricated and the margins trimmed with fine trimming burs (Axis). The next day, the patient returned for evaluation of aesthetics, phonetics and bite. Already the patient exhibited excitement and confidence with his provisional restorations (Fig. 5); however, he selected a whiter shade (010 Bleach Shade) for his final restorations. Information was recorded and the patient was informed to rinse with Oris (Dentsply) chlorhexidine gluconate rinse to keep his gingival tissues healthy.

Cementation

Before try-in of the definitive restorations to verify fit and shade, the provisional restorations were removed sequentially starting from the maxillary anterior region. Any remaining cement was cleaned off the prepared teeth and bleeding from the gingival tissues controlled with Expasyl (Kerr) paste. After the patient was shown the retracted view for acceptance, the cementation process was initiated. The prepared dentition was cleaned with chlorohexidine 2% (Consepsis, Ultradent Products, Inc.) for 15 seconds and rinsed to remove any contamination during the temporary phase. The preparations were then desensitized (Gluma, Heraeus Kulzer), and the final Katana (Noritake) crown restorations were tried in to verify marginal fit, contour, contacts, shade and accuracy. The patient was very satisfied with the look of his new restorations and approved them for final cementation.

The crown restorations (Dental Arts Lab) were seated utilizing self-etching, self-adhesive resin cement (Maxcem Elite, Kerr). Excess cement was easily removed from the margins and accomplished within a short amount of time before final curing with the curing light (DEMI, Kerr) for 20 seconds. No finishing of the cement was necessary along the margins. Any adjustments to the occlusion were achieved using the Zir-Cut Polishing Set (Axis Dental). The overall health and structure of the soft tissue and restorations was very good (Fig. 7). The patient was very pleased with the restorations and was now eager to start treatment on the edentulous area of #29.

Before the surgical appointment, a CBCT scan was taken to accurately treatment plan this case to make certain that no complications would arise from the conservative non-flap approach. SimPlant software (Materialise Dental, Glen Burnie, Maryland) was used through 3D Diagnostix virtual assistance to precisely plan the placement of a 4mm x 12mm TSI (OCO Biomedical) dental implant (#29).

The area was anesthetized using 1.8ml 4% Septocaine (Septodent) with 1:100,000 epinephrine. Using the surgical guide provided by 3D Diagnostix, the site for the implant was begun with a #8 surgical bur (Axis) in a high-speed handpiece through the soft tissue extending approximately a millimeter into bone.

A 2.0mm pilot drill was placed into the site and advanced to a depth of 14mm measuring from the tissue surface. This additional 2mm was the same depth of the tissue height to bone. A paralleling pin was placed in the site of the osteotomy and an X-ray taken to check the angulations of the pin within the mandible. Using a rotary tissue punch, provided in the kit (OCO Biomedical), an outline was created over the initial osteotomy and the tissue plug removed with a curette. Since there was unevenness in the ridge of bone, a countersink drill was used to countersink the implant collar. Intermediate drills were sequentially used in this system to work up to the final drill size due to the dense cortical bone that was present. Once the osteotomy was completed, an implant finger driver was used to place the dental implant until increased torque was necessary (Fig. 8). The ratchet wrench was then connected to the adapter and the implant torqued to final depth reaching a torque level of 55Ncm (Fig. 9). A healing cap was hand-tightened to the implant. A post-operative radiograph was made of the implant and the healing cap to ensure complete seating. The implant was evaluated clinically after one week. The patient stated he had no post-operative discomfort or swelling.

Four months later, the healing cap was removed and the implant tested with the ISQ meter (Osstell) to ensure osseointegration. An impression was taken of the implant using an impression post from OCO Biomedical. The impression was captured using a full-arch tray and fast-set polyvinylsiloxane impression material (Take One Advance, Kerr).

When the patient returned for the seating appointment the Katana (Noritake) crown (Fig. 10) was placed on the implant/corresponding abutment and another X-ray was taken to verify an accurate fit. Since there were no open margins and the contacts and occlusion were good, the crown restoration was then seated using Maxcem Elite (Kerr) cement. Once the cement reached its gel stage, it was quickly cleaned off and any excess removed.

The patient was very pleased with the end result (Figs. 11&12) and was surprised at how atraumatically the dental implant was placed through the gingiva and that the whole process of his dental reconstruction was accomplished "under one roof."

Today, patients like to get all their services under one roof. They know, trust and feel comfortable with their general dentist and usually prefer him/her to perform dental procedures necessary to reach optimum dental health. I am not advocating general dentists offer procedures they are not comfortable with or not properly trained for. However, it is my opinion that general dentists should implement a multi-disciplinary approach into their practices – "Ultimate Dental Treatment." Because of time constraints, fear of going to multiple offices and increasing costs, patients will seek providers who are reconstructive in nature. ■

Fig. 10: Implant crown

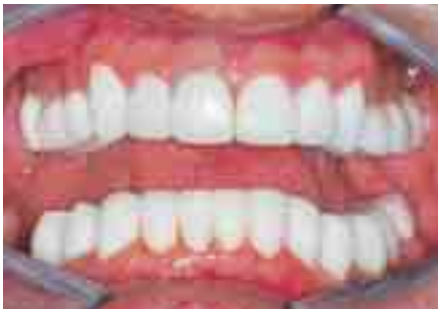

Fig. 11: Post-operative retracted view

Fig. 12: Post-operative facial shot

Author's Bio

Dr. Nazarian maintains a private practice in Troy, Michigan, with an emphasis on comprehensive and restorative care. He is a diplomate in the International Congress of Oral Implantologists (ICOI). His articles have been published in many of today's popular dental publications. Dr. Nazarian is the director of the Reconstructive Dentistry Institute. He has conducted lectures and hands-on workshops on aesthetic materials and dental implants throughout the United States, Europe, New Zealand and Australia. Dr. Nazarian is also the creator of the DemoDent patient education model system. He can be reached at 248-457-0500 or at the Web site www.aranazariandds.com.

OCF Sponsors 13th Annual Oral Cancer Awareness Month

The Oral Cancer Foundation (OCF) is encouraging the dental community to get involved in Oral Cancer Awareness Month this April 2012 by offering free oral cancer screenings to the public in a national effort to raise awareness of this silent killer. By implementing a public awareness campaign, OCF wants to educate the public about the risk factors, early signs and symptoms of the disease, as well as the need for all adults to undergo an annual oral cancer screening. For more information on how to get involved, visit www.oralcancerfoundation.org/events/oral-cancer-awareness-month.html.

Industry News

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

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Kool Smiles to Bring PBS Kids' Award-winning Content to Dental Patients

Marking the first national initiative of its kind in the industry, Kool Smiles now provides children and their parents access to PBS Kids' award-winning content within their offices and online. This includes links to PBS Kids' educational videos, online games and PBS Parents articles, tips and blogs, on Kool Smiles' Web site and social media presences. Additionally, printed activities will be available in Kool Smiles offices for kids and parents to take home. These educational materials will be available at more than 125 Kool Smiles locations, serving more than 100 low-income communities across the United States. For additional information, visit www.mykoolsmiles.com.

CEREC Announces Its Next Anniversary Celebration Ahead of Schedule

Sirona is celebrating the 27-and-a-half-year anniversary of its CEREC dental CAD/CAM system with a three-day extravaganza at the Venetian Casino and Resort in Las Vegas, Nevada, August 16-18, 2012. The event will be geared toward all dental and laboratory professionals and enables participants to earn up to 18 CE credits across a comprehensive spectrum of topics and tracks. There will also be an exhibit hall showcasing top dental companies and their products and services. For additional information, visit www.cerec27andahalf.com or call 855-237-3248.

Dr. Rhonda Savage and John Christensen to Headline at World Dental Forum 2012

Modern Dental Laboratory USA announces the addition of three key opinion leaders to the World Dental Forum 2012, Dr. Rhonda Savage, Dr. Howard Farran and Mr. John Christensen. The biennial World Dental Forum will be held in Hong Kong, China, from May 31 to June 3, 2012, and is open to all dentists. The World Dental Forum gives U.S. dentists an opportunity to meet with world-renowned dentists, opinion leaders and suppliers from around the world, and will also be able to earn up to 16 AGD PACE CE credits. For more information, visit www.moderndentalusa.com/wdf.

ADM Rolls Out All Points Multi-targeted Direct Mail Service

AIM Dental Marketing (ADM) introduces the All Points direct mail service. All Points direct mail service has the ability to communicate a unique message, offer and imagery to an address based on that household's characteristics. With All Points, dental offices can simultaneously target up to five distinct audiences with a message that is unique to them. ADM will help identify your ideal target audiences, design and print your mailers, then manage and monitor your program. To learn more, visit www.aimdentalmarketing.com/all-points.

ClearCorrect Launches New Phase Out Project

ClearCorrect introduces the Phase Out project. The Phase Out project is centered around a patient's leftover phases. When doctors prescribe ClearCorrect, their lab fee covers a maximum number of phases. When everything goes smoothly, a few phases are often left unused at the end of treatment. For each leftover phase, $20 will go toward phasing out life-impacting issues for people in need. ClearCorrect is partnering with charity: water. Now every time a phase is left over at the end of treatment, $20 goes toward building wells and other water projects in developing nations. To learn more about this endeavor, visit www.clearcorrect.com/phaseout.

phase out

TerraCycle Offers Marketing Support To Dental Offices That Sign Up For Oral Care Brigade

In an effort to divert more waste from landfills and help businesses engage local communities, TerraCycle is encouraging dental offices to sign up for the Oral Care Brigade, a free recycling program for oral care products, by offering free local marketing campaigns to offices that sign up. By joining the Brigade, dental offices can offer their existing customers and the local community an easy way to earn extra funding for local schools or charities, while also creating free marketing and consumer engagement opportunities. Any dentist office employee can sign up for the Oral Care Brigade at www.terracycle.net to send in toothbrushes, toothpaste tubes, toothpaste caps and floss containers, regardless of brand.

MARKETING

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. 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 January 13, 2012 to February 10, 2012 on Dentaltown.com.

Does your practice participate with Groupon or a similar site?

NO 91%

YES 9%

Do you send a thank-you gift to patients who refer other patients?

- 48% Yes
- 52% No

Do you send a newsletter (print or electronic) to your patients?

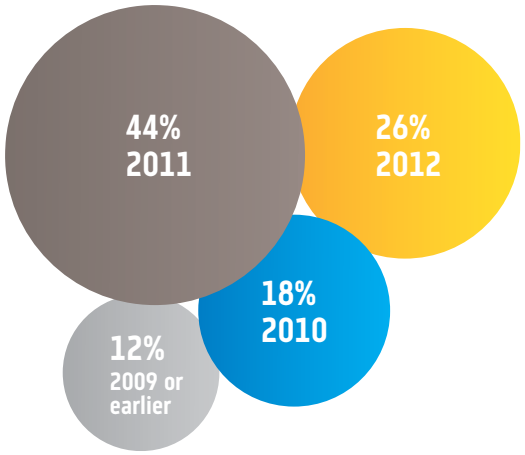
- 25% Yes
- 75% No

Your most successful marketing strategies include:

1. Word of mouth/patient referrals
2. Web site
3. Direct mail
4. Social media
5. External ads (radio, TV, billboards, movie theater)

SEO Search Engine Optimization is the process of improving a Web site's visibility in a search engine's results.

When was the last time you adjusted fees in your practice?



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Introduction to the Laser-assisted New Attachment Procedure for the Treatment of Periodontitis

by Robert H. Gregg II, DDS

The breakthrough Laser-assisted New Attachment Procedure (LANAP) offers many advantages over conventional flap periodontal surgery or scaling and root planing for the treatment of periodontitis. This no-cut, no-sew technique is bringing revolutionary outcomes into the treatment rooms of general dentists and periodontists alike, allowing the profession to battle against a disease that threatens the health of more than 80 percent of Americans. This overview explains what the Laser-assisted New Attachment Procedure (LANAP) is, how it works and what clinical trials are showing about the exciting results this strict protocol can achieve for patients with gingivitis, "garden variety" periodontitis, and even the most extremely severe forms of gum disease.

After reading this article, the reader should be able to:

- appreciate the proportion of American patients who suffer from moderate to severe gum disease.
- summarize the steps and components of the LANAP protocol for treating periodontitis.
- understand the differences between conventional flap surgery and laser-assisted new attachment procedures.
- have an awareness of the percentage of general practitioners who perform probe examinations and the need for more.

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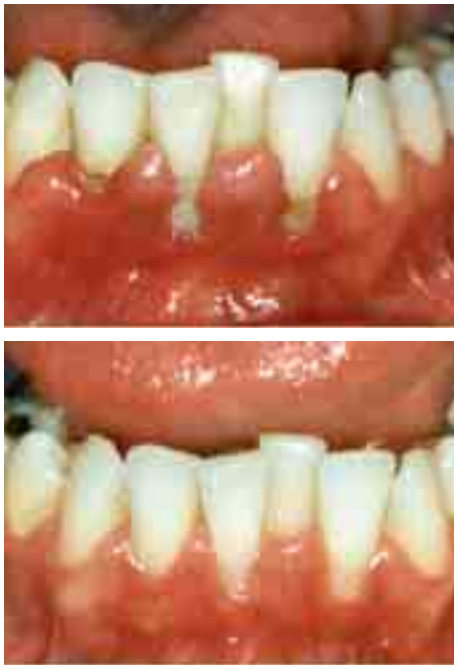
Most Americans – about 80 percent – suffer with gum disease on some level, according to the U.S. Surgeon General. Michael Newman, DDS, PhD, says that only three percent of the 100 million-plus Americans with moderate to severe periodontal disease are treated each year, which means an increasing number of worsening cases appear in general dental practices across the country every day.[1] The growing threat requires a greater number of general dentists to take the lead in properly performing a periodontal probing exam. Still, for many offices, the challenge lies in persuading the patient to seek treatment via referral to a periodontist.

A growing number of general practitioners have reached a frustration threshold, seeing one patient after another who either continues with poor gum health or seeks treatment from a periodontist and achieves results that ultimately leave much to be desired. Some of these dentists have discovered a treatment protocol that allows them to take action and provide patients with improved care, without even referring them out of the practice. The treatment is achieving unsurpassed results not otherwise attainable with conventional techniques.

Widely known to be closely linked with heart disease and strokes, periodontitis has now been fingered as the cause in a full-term baby's death.[2] It is believed that the mother's gum disease introduced fatal bacteria to her womb. In an age of burgeoning technology, the news stories linking gum disease to more disastrous results are inevitable. As the dangerous consequences of gum disease become increasingly clear, more dental clinicians must take the reins in educating patients and ensuring their successful treatment.

Dental practitioners have used free-running (FR) pulsed Nd:YAG lasers for more than 20 years, but only recently has the laser been combined with a specific, successful protocol and research-proven operating parameters to achieve FDA clearance and a track record of success in university-based clinical studies for its efficacy at "cementum-mediated new PDL attachment to the tooth root surface in the absence of long junctional epithelium."[3,4] The protocol has shown consistent probe depth reduction, histological and clinical new attachment and radiographic bone growth for periodontally involved teeth with no elevation of the periosteum and minimal patient discomfort.[5-7]

Its greatest potential may lie in patients' willingness to accept treatment and comply. With 97 percent refusing current protocols, a no-cut, no-sew solution has meant a flock of new patients willing to seek treatment for their gum disease from those dentists who choose to offer the LANAP protocol.



Top: Before
Bottom: Nine days after LANAP

What is the LANAP Protocol?

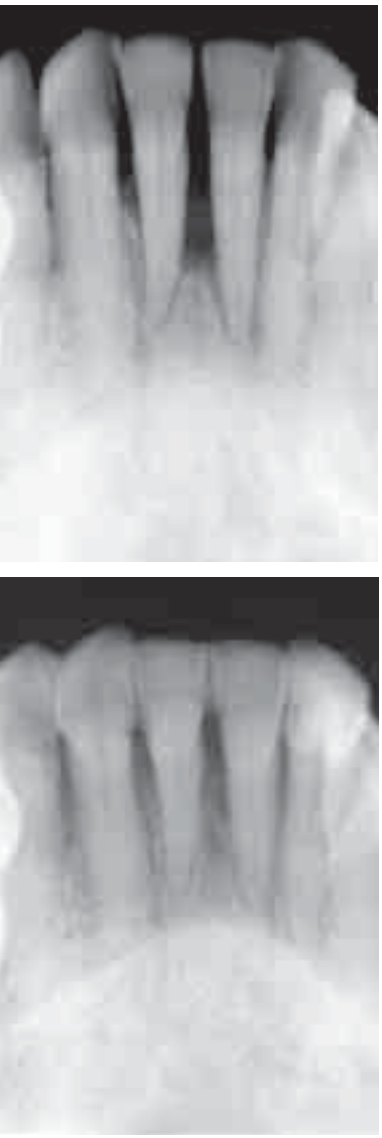
The procedure combines the PerioLase MVP-7 free-running (FR) pulsed Nd:YAG laser with a strict, specific, research-proven protocol that has achieved FDA clearance for the treatment of all forms of gum disease – from early detection to so-called "hopeless" teeth. The breakthrough is called Laser-assisted New Attachment Procedure, and it has left a trail of healthy patients in its wake for the inventors of the protocol, Drs. Robert H. Gregg II and Delwin K. McCarthy, as well as more than a thousand dentists and specialists who have learned the procedure from the Institute for Advanced Laser Dentistry (IALD).

Drs. Gregg and McCarthy pioneered the use of the FR pulsed Nd:YAG laser in treating gum disease in the 1990s. They were astounded by their ability to regenerate bone growth (routine 50 percent defect fill) and stimulate new attachment for their own patients with severe gum disease. The results were too good to keep to themselves.

1. *Faculty Bio pages. UCLA School of Dentistry Web site. Michael G. Newman, BA, DDS, FACD, http://www.dent.ucla.edu/bio/bio.asp?id=277. Accessed on March 13, 2008.*
2. *Carroll, Linda. Mother's gum disease linked to infant's death. http://www.msnbc.msn.com/id/34979552/. Accessed February 25, 2010.*
3. *Myers TD, Myers WD, Stone RM. First soft tissue study utilizing a pulsed Nd:YAG dental laser. Northwest Dent. 1989;68: 14-17.*
4. *White JM, Goodis HE, Rose CL. Use of the pulsed Nd:YAG laser for intraoral soft tissue surgery. Lasers Surg Med. 1991;11:455-461.*
5. *Gregg RH II, McCarthy D. Laser periodontal therapy: case reports. Dent Today. Oct 2001;20:74-81.*
6. *Gregg RH II, McCarthy D. Laser periodontal therapy for bone regeneration. Dent Today. May 2002;21:54-59.*
7. *501(k)s final decisions rendered for July 2004 (PerioLase MPV-7, 510(k) number K030290). US FDA Center for Devices and radiological Health Web site. http://www.fda.gov/cdrh/510k/sumjul04.html. Updated August 9, 2004. Accessed January 2, 2008.*

continued on page 110

The pair continued to fine-tune the procedure after patenting it so that they could share it with their peers and set a goal for the new gold standard for the treatment of gum disease across the country.



Top: Pre-LANAP
Bottom: Post-LANAP

Designed and refined over 10 years, the LANAP technique's specific clinical steps must be performed properly and in precise order to achieve consistent positive outcomes. The key steps, in order, make up the patented portion of the technique and are the crux of why the LANAP protocol is so successful. The procedure may be performed in all four quadrants in a single appointment, but for patient comfort and case control, laser treatment is typically limited to no more than two non-adjacent quadrants per visit, with several days between visits.

First, the patient is profoundly anesthetized with local anesthetic so that the patient's pocket depths can be probed down to the level of intra-osseous defects (bone sounding). The thin optic fiber is then used parallel to the root surface, to affect the pocket wall. Next, an EMS ultrasonic scaler removes calcified plaque and calculus adherent to the root surface. The first pass with the laser, called laser troughing, is accomplished with the short duration pulse. The FR pulsed Nd:YAG laser is used to achieve optimal reduction of microbiotic pathogens (antisepsis) within the periodontal sulcus and surrounding tissues. Perio pathogens and pathologic proteins are selectively destroyed by the laser's light energy, providing an antiseptic surgical environment that allows healing following the laser hemostasis step.[8-15]

The technique uses selective photothermolysis to remove the diseased, infected and inflamed pocket epithelium while preserving healthy connective tissue, literally separating the tissue layers at the level of the rete pegs and ridges.[8-11] The practitioner is able to achieve both tissue ablation and antiseptic hemostasis with extreme precision by varying the laser's energy density, pulse duration and rate of repetition. The laser assists in the destruction of perio pathogens while preserving the healthy tissue, allowing for less post-operative discomfort and a much shorter post-surgical recovery perception for the patient.

At this point, a second pass is completed to finish debriding the pocket and achieve hemostasis with a thermal fibrin clot. Gingival tissue is compressed against the root surface as necessary to close the pocket and aid with formation and stabilization of the fibrin clot. No sutures or surgical glue is needed. Mobile teeth above Class II mobility are splinted. Occlusal adjustments are performed to remove interferences, minimize trauma and provide balance to long axis forces and are considered an essential component of the LANAP protocol.

Finally, post-operative instructions specific to the LANAP protocol, diet guidelines and oral hygiene instructions are explained and their importance is stressed, and continued periodontal maintenance is scheduled. Patients are monitored at one week, 30 days and then every three months for periodontal maintenance. No subsequent probing is performed for at least six months to a year to allow sufficient healing time for the cementum-fiber PDL interface.

Harnessing the LANAP Protocol's Results

The availability of a procedure that eliminates cutting and sewing without gum recession is changing the standard of care for periodontitis treatment. Not only is there a treatment protocol that is universally accepted by patients, but it also

8. *Yukna RA, Evans GH, Vastardis S, et al. Human periodontal regeneration following the laser assisted new attachment procedure. Paper presented at: IADR/AADR/CADR 82nd General Session; March 10-13, 2004; Honolulu, HI. Abstract 2411. http://iadr.confex.com/iadr/2004Hawaii/techprogram/abstract_47642.htm. Accessed January 2, 2008.*
9. *Neill ME, Mellonig JT. Clinical efficacy of the Nd:YAG laser for combination periodontitis therapy. Pract Periodontics Aesthet Dent. 1997;9(suppl):1-5.*
10. *Gregg RH, McCarthy DK. Laser ENAP for periodontal ligament regeneration. Dent Today. 1998;17:86-89.*
11. *Gregg RH, McCarthy DK, Laser ENAP for periodontal bone regeneration. Dent Today. 1998;17:88-91.*
12. *Midda M, Renton-Harper P. Lasers in dentistry. Br Dent J. 1991;170:343-346.*
13. *Moritz A, Schoop U, Goharkhay K, et al. The bactericidal effect of Nd:YAG, Ho:YAG, and Er:YAG laser irradiation in the root canal: an in vitro comparison. J Clin Laser Med Surg. 1999;17:161-164.*
14. *Whitters CJ, Macfarlane TW, MacKenzie D, et al. The bactericidal activity of pulsed Nd:YAG laser radiation in vitro. Lasers Med Sci. 1994;9:297-303.*
15. *Harris DM. Ablation of Porphyromonas gingivalis in vitro with pulsed dental lasers. Paper presented at: 32nd Annual Meeting and Exhibition of the AADR; March 12-15, 2003; San Antonio, TX. Abstract 855. http://iadr.confex.com/iadr/2003SanAnton/techprogram/abstract_27983.htm. Accessed January 2, 2008.*



Live patient clinical hands-on training with direct instructor supervision

represents an option that includes both specialists and general practitioners in the solution. A general practitioner who might be reluctant to perform invasive surgery might welcome the opportunity to treat such an overwhelming health issue without referring patients elsewhere. Alternatively, the LANAP protocol practiced by periodontal specialists becomes a more attractive referral for general practitioners and their patients.

Those who choose to embrace the LANAP protocol do so with an extensive support system in place. Clinicians are required to undergo extensive training and adhere to the protocols that have proven successful before performing the LANAP technique. Millennium Dental Technologies, the manufacturer of the PerioLase MVP-7, requires that clinicians first satisfactorily complete a three-day lecture course and live, hands-on patient treatment and patient response before the company will even ship the laser and all the essential elements of the protocol. Additional study follows the initial training.

The Science Behind the LANAP Protocol

Early LANAP protocol research showed consistent mean pocket depth reduction (nearly 50 percent) and improved bone density (38 percent) in an eight-year retrospective study of the protocol's earliest clinical results. The Emago imaging system demonstrated that 100 percent of these cases showed bone density increases. The procedure has also proven effective at reducing pocket depth without gingival recession over a six-month period.[16,17]

In the fourth-largest human histological study in the perio regeneration literature (with a control group), the LANAP protocol using the PerioLase MPV-7 was compared to a blinded examiner (clinical) conventional scaling and root planing without laser assistance. Twelve teeth were removed *en bloc* and examined by a blinded histologist. When the blinded code was broken, all teeth treated with the LANAP protocol demonstrated 100 percent cementum-mediated new periodontal ligament attachment to the previously periodontally affected tooth roots in all six of the LANAP-treated teeth and in the absence of long junctional epithelium.[8-11] These results are unique in the perio literature.

Given its unique, predictably regenerative results, it should come as no surprise that the LANAP protocol has inspired its share of imitators. As yet, those copycat protocols have no science to support their continued use. The patented LANAP protocol is the only peer-reviewed and FDA-cleared approach that is proven successful at treating mild, moderate and especially severe periodontitis.

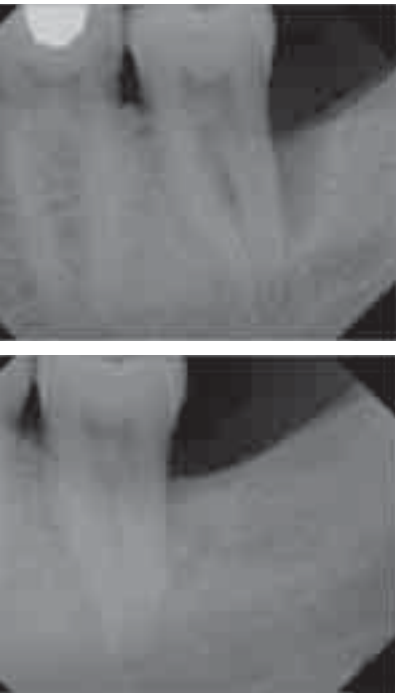
LANAP Protocol vs. Cut-and-Sew Procedures

The successful treatment of periodontal disease requires thorough debridement of the root surface. Pockets of 5mm or greater depth make it difficult to remove subgingival plaque and calculus. Surgical intervention allows access and visualization for scaling and root planing in these deep pockets.[18] While scalpel surgery can accomplish such access and visualization, it can also result in

16. *Harris DM. Dosimetry for laser sulcular debridement. Laser Surg Med. 2003;33:217-218.*
17. *Harris DM, Gregg RH II, McCarthy DK, et al. Laser-assisted new attachment procedure in private practice. Gen Dent. 2004;52:396-403.*
16. *Harris DM. Dosimetry for laser sulcular debridement. Laser Surg Med. 2003;33:217-218.*

continued on page 112

attachment loss, gingival cratering and gingival recession.[19-22] Additionally, the associated pain and discomfort can be deterrents.[23] In any case, many general practitioners would never consider performing conventional flap surgery because of its invasive nature.



Top: Pre-LANAP, April 2009
Bottom: Post-LANAP, May 2010

LANAP treatment, while an exceptional alternative, is not without its drawbacks. The predominant issues involve cost and time. The initial financial outlay for the laser equipment can be cost-prohibitive for some practices. Similarly, dental clinicians must be willing and able to take time away from the office to undergo procedural training and learn LANAP treatment with live patients. Following the training, and as with anything new, there can be a learning curve as clinicians grow comfortable and begin to excel at treating patients with LANAP.

For now, cut-and-sew techniques remain the standard of care and additional study will be required to persuade many professionals that any laser system provides clinical value surpassing scaling and root planing techniques and conventional surgical treatment.[24] Cautious experts warn that the improper use of the Nd:YAG laser can have detrimental effects on the root surface ranging from heat cracking to charring, cementum meltdown and crater formation.[25] These negative outcomes are not typical with adherence to current LANAP protocols and thus appear to result from improper laser settings. Studies continue, and most researchers agree that laser or laser-assisted pocket therapy is expected to become a new technical modality in periodontics.[26]

The LANAP treatment protocol achieves the same access to the problem that root planing and scaling or conventional flap surgery does, but it achieves its success differently. The practitioner uses a quartz fiber in place of a scalpel to achieve both tissue ablation and antibiotic properties. No cutting means a significantly more comfortable recovery. Patients typically remain on a soft diet for several days to a week following LANAP treatment and are instructed to avoid brushing at the surgical site for that period.

Conclusion

Whereas treatment outcomes with conventional modalities might be variable; in stark contrast, the LANAP protocol allows clinicians to achieve predictable, positive results – including the three-dimensional regeneration of bone. Also, the comfort levels associated with this minimally invasive treatment are substantially increasing patient acceptance rates. Ongoing additional studies are expected to continue to underscore the LANAP protocol advantages and pave the way for its acceptance as a standard of care in treating patients with moderate to severe gum disease. ■

19. *Becker W, Becker BE, Ochsenbein C, Kerry G, Caffesse R, Morrison EC, Prichard J. A longitudinal study comparing scaling, osseous surgery, and modified Widman procedures. Results after one year. J Periodontol 1988;59:351-365.*
20. *Pihlstrom BL, Ortiz-Campos C, McHugh RB. A randomized four-years study of periodontal therapy. J Periodontol 1981;52:227-242.*
21. *Kaldahl WB, Kalkwarf KL, Patil KD, Dyer JK, Bates RE Jr. Evaluation of four modalities of periodontal therapy. Mean probing depth, probing attachment level, and recession changes. J Periodontol 1988;59:783-793.*
22. *Hill RW, Ramfjord SP, Morrison EC, Appleberry EA, Caffesse RG, Kerry GJ, Nissle RR. Four types of periodontal treatment compared over two years. J Periodontol 1981;52:655-662.*
23. *Curtis JW Jr, McLain JB, Hutchinson RA. The incidence and severity of complications and pain following periodontal surgery. J Periodontol 1985;56:597-601.*
24. *Matthews, Debora C. The truth about soft tissue lasers and nonsurgical periodontal therapy. JCDA 2010.*
25. *Chanthaboury, Rachel, Irinakis, Tassos. The use of lasers for periodontal debridement: marketing tool or proven therapy? JCDA Oct 2005.*
26. *Ishikawa, Isao; Aoki, Akira; Takasaki, Aristeo A.; Mizutani, Koji; Sasaki, Katia M; Izumi, Yuichi. Periodontology 2000 May 2009.*

Author's Bio

Dr. Robert Gregg is a former faculty member at UCLA School of Dentistry. He has been using lasers clinically since August 1990, including CO_2, free-running pulsed (FRP) Nd:YAG, both single and variable pulsed; FRP Ho:YAG, surgical Argon, CW diodes and Er:YAG. He has given lectures nationally and internationally on the subject of clinical laser applications, and has conducted seminars for the UCLA Department of Continuing Education. Dr. Gregg, along with Delwin K. McCarthy, DDS, formed The Institute for Advanced Laser Dentistry (IALD) in 2001.

Post-test

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1. What is "laser troughing"?
   a. Debridement of the calculus with the laser
   b. The first pass with the laser, accomplished with long pulses
   c. The second pass with the laser, accomplished with short pulses
   d. The first pass with the laser, accomplished with short pulses

2. How many Americans are estimated to have moderate to severe periodontitis?
   a. 80 percent
   b. More than 100 million
   c. Fewer than 80 million
   d. 50 percent

3. Which of the following is *not* linked to gum disease?
   a. Diabetes
   b. Fatal pregnancy complications
   c. Bleeding gums
   d. Heart disease

4. Which of the following are drawbacks of conventional flap surgery?
   a. Pain and discomfort of recovery
   b. Attachment loss
   c. Gingival cratering and recession
   d. All of the above

5. Which of the following was shown about the LANAP protocol in a human histological study?
   a. More than half the treated teeth formed new attachments at the gum line
   b. 100 percent decrease in bleeding gums
   c. 100 percent frequency of cementum-mediated new attachment
   d. 100 percent frequency of hemostasis in deep pockets

6. Who can perform the LANAP protocol?
   a. Certified LANAP practitioners, who may be general dentists or specialists
   b. Specially trained dentists and dental hygienists
   c. Only periodontists with special advanced coursework
   d. Dental laser specialists

7. Which of the following is considered an important part of the LANAP procedure?
   a. 100 percent antisepsis in 5mm pockets
   b. Occlusal adjustments to remove interferences, minimize trauma and provide balance to long axis forces
   c. Removal of all subgingival calculus
   d. Eradication of healthy tissue

8. What is the maximum treatment per visit?
   a. All four quadrants may be treated in a single visit
   b. Only a single quadrant at a time
   c. Two non-adjacent quadrants may be treated
   d. No more than two adjacent quadrants may be treated

9. What is the recommended treatment per visit, for the sake of patient comfort and case control?
   a. All four quadrants may be treated in a single visit
   b. Only a single quadrant at a time
   c. Two non-adjacent quadrants may be treated
   d. No more than two adjacent quadrants may be treated

10. Which technology does the LANAP protocol utilize?
    a. A CO_2 laser
    b. Any laser set to the correct frequency may be used
    c. The PerioLase MPV-7 laser (Nd:YAG)
    d. Short-pulse lasers

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- ❑ Orthodontics
- ❑ Orthodontic Resident
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- ❑ Pediatric Resident
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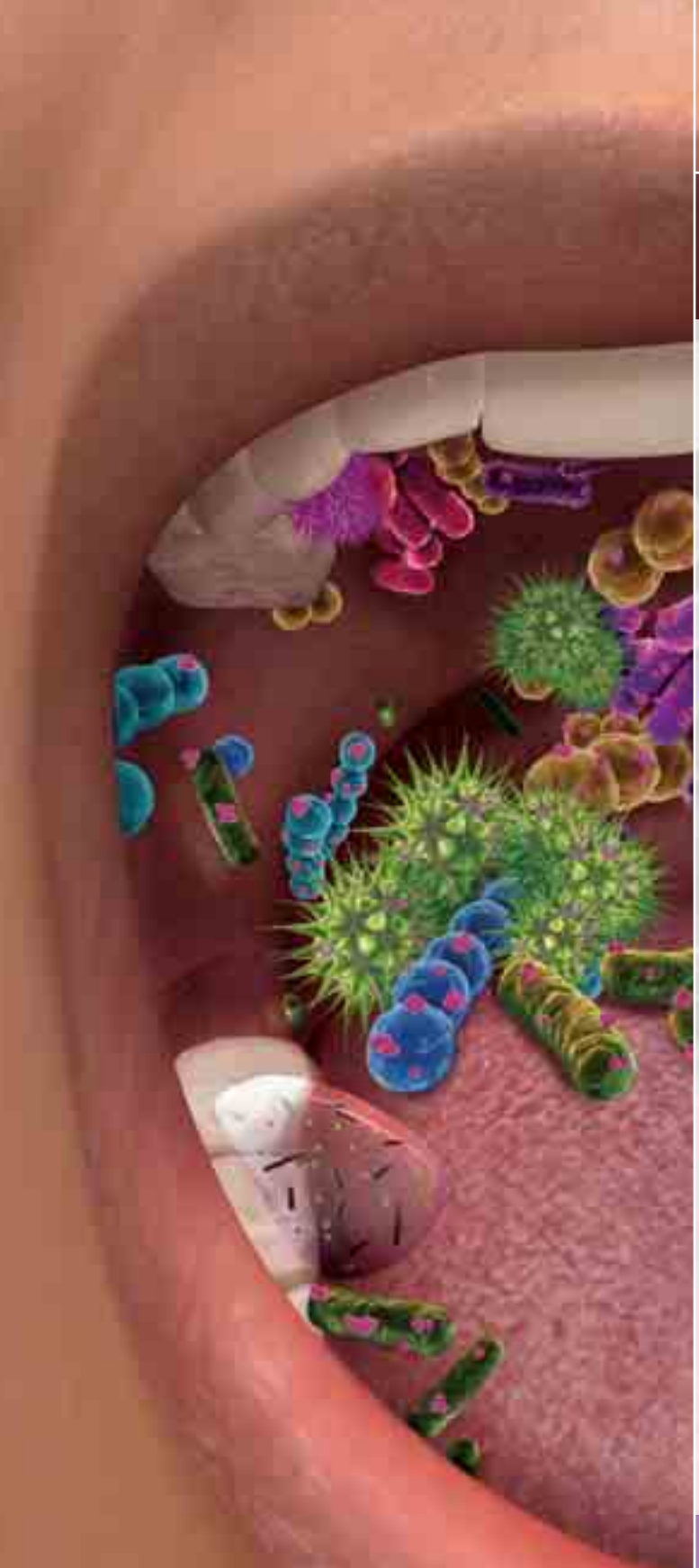

Is Tooth Decay Inevitable?

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

My childhood experience with the dentist was not asking "if" I had a cavity, but rather "how many" cavities I had at each visit. Are carious lesions inevitable? Will everyone, except maybe the children of hygienists, have to deal with dental caries one day?

In my travels I often ask the person next to me on a plane if they think tooth decay is inevitable. Do they think everyone will eventually have cavities? Invariably, the answer is yes. The adults have had tooth decay, their parents did and they fully expect their children will also have tooth decay one day. Hopefully not as many cavities as they had, but cavities nonetheless.

What do you think? Ask your friends, people you see at church or at your kid's after-school functions if they think dental disease is inevitable. It's even worse when your own family members in fields other than dentistry fully expect their kids to experience tooth decay someday. No one I've talked to outside dentistry actually believed that tooth decay was preventable. Surprisingly, many dental professionals surrounded by dental disease all day also believe it's inevitable.

In the past, tooth decay was diagnosed when the explorer dropped into a hole on the tooth surface. Those frank cavitations can now be prevented through early intervention and identification of risk factors. Knowing more about the quality and pH of saliva and the kind and number of bacteria in the mouth provides valuable information before tooth decay occurs.

Kids in the future will no longer wait to find out if they have cavities. New technologies are available to monitor risk factors that can predict caries activity before it breaks through the enamel and requires a restoration. The new question is – What is my risk for future tooth decay and what can I do to reduce that risk? ■

Inside This Section

116 Perio Reports
120 Profile in Oral Health: Technologies for Caries Risk Assessment and Prevention
124 Message Board: 19-year-old Female – What Are Your Thoughts on the Cause?

ATP Test for Oral Bacteria

When large numbers of cariogenic bacteria adhere to the teeth in plaque biofilm, ingested sugars are converted to acids that demineralize the enamel. Saliva will remineralize the surfaces, but too much exposure to this acid will tip the balance in favor of demineralization and eventually cavitation of the surface. A measure of the number of bacteria in the biofilm provides valuable information when determining a person's risk for future caries.

Researchers at Oregon Health and Sciences University in Portland, Oregon, compared laboratory methods of measuring bacteria to a chairside version. Laboratory cultures of plaque samples were grown to determine numbers and specific oral bacteria present. A laboratory assay and CariScreen, the chairside test, both measure ATP production by the bacteria using bioluminescence. This approach measures release of visible light by the bacteria. Measuring the energy potential of bacteria in the biofilm is reflective of actual cell numbers.

A total of 33 children ages seven to 12 years participated in the study. Plaque and caries were measured and a saliva sample was also collected. Plaque biofilm samples were taken from one tooth surface in each quadrant and parallel testing was done using the laboratory and chairside techniques. The chairside technique uses a swab to collect plaque biofilm. The swab is returned to its sheath and a bulb is opened on the opposite end releasing extraction components that drain over the biofilm swab. The closed sheath is then inserted into a handheld device for reading.

Both the laboratory and the chairside bioluminescence readings were comparable. Culture counts of bacteria reflected similar readings to the chairside test. Clinical indications of active caries also correlated highly with the chairside test scores.

Clinical Implications: These findings confirm the value of ATP bioluminescence chairside testing to determine the caries risk based on bacterial numbers and biofilm load. ■

Fazilat, S., Sauerwein, R., McLeod, J., Finlayson, T., Adam, E., Engle, J., Gagneja, P., Maier, T., Machida, C.: Application of Adenosine Triphosphate-Driven Bioluminescence for Quantification of Plaque Bacteria and Assessment of Oral Hygiene in Children. Pediatric Dent 32: (10) 195-204, 2010.

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pH Scale

Alkaline pH			Neutral	Acidic pH			
10	9.0	8.0	7.0	6.0	5.0	4.0	3.0
High Alkaline	Olive Oil	Apples	Water	Milk	Cooked Beans	Coffee	Lamb
Ionized Water	Green Tea	Almonds		Fruit Juices	Chicken	White Bread	Shellfish
Artichokes	Lettuce	Avocados		Most Grains	Beer	Peanuts	Pastries
Cucumbers	Celery	Tomatoes		Eggs	Sugar	Beef	Pasta
Onions	Beets	Grapefruit		Fish	White Rice	Blackberries	Cheese
Lemons	Figs	Bananas		Tea	Molasses	Popcorn	Soda

Plaque pH Drops When Exposed to Sugar

This classic study, published in 1944, is referenced by many subsequent researchers. Prior to this study, Dr. W.D. Miller postulated in 1890 that decalcification of enamel was due to acids produced by bacteria metabolizing carbohydrates – something we still believe today. However, the acid-producing bacteria were found in the mouths of those with and without caries, leading to the concept of caries-susceptible and caries-immune people. Evidence was offered showing that the pH of a carious lesion was acidic by placing litmus paper on the open carious lesion, but resting saliva was not found to be in the dangerous acid range.

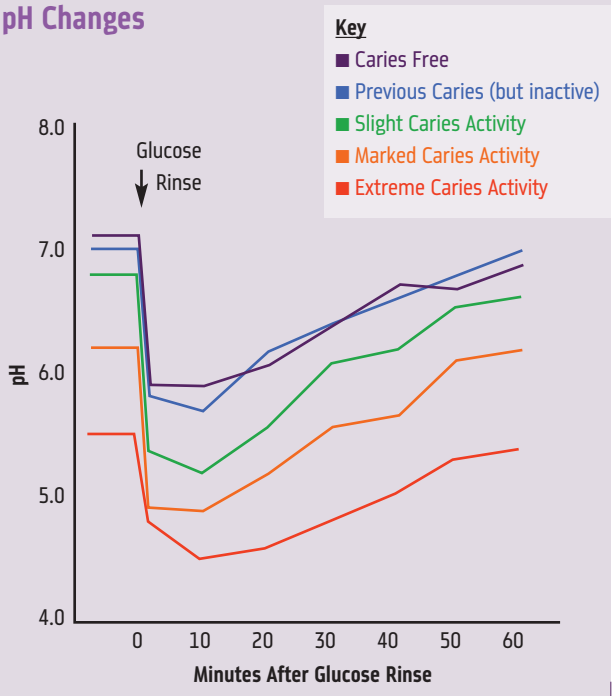
This study was undertaken to determine if plaque pH changes after a sugar rinse were the same in those with and those without caries. Five groups were tested: caries free, caries inactive, slight caries activity, marked caries activity and extreme caries activity. They were instructed to refrain from oral hygiene for three to four days before the test. Plaque pH was measured on the facial surfaces of maxillary and mandibular anterior teeth. Additional pH measurements were made on the gingival tissues, cheeks near parotid ducts, floor of the mouth near sub-maxillary ducts and the dorsum of the tongue. After baseline readings, subjects swished with a 10 percent glucose solution for two minutes. The pH reading was repeated after the rinse and every 10 minutes for an hour.

The drop in plaque pH and duration was greater in those with the most caries activity compare to those without caries activity. The plaque pH dropped below five only in those with caries activity. Interproximal surfaces might have lower pH and for longer times, due to the inaccessibility of saliva to flush the area, thus trapping carbohydrate food particles there longer.

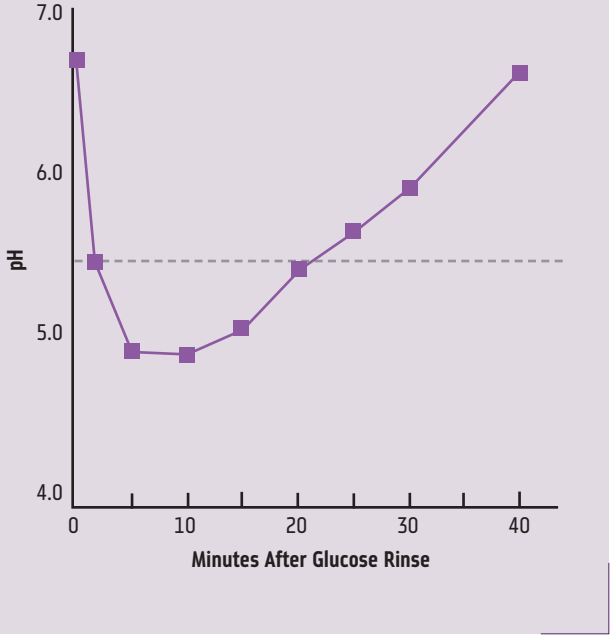
Clinical Implications: These findings are referred to as the Stephan Curve, describing the impact of sucrose on the pH of bacterial plaque. ■

Stephan, R.M.: Intra-Oral Hydrogen Ion Concentrations Associated with Dental Caries Activity. J Dent Res 23: 257-266, 1944.

pH Changes



The Stephan Curve



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Saliva and Dental Caries

Saliva protects the teeth through antimicrobial functions, mechanically clearing bacteria from the mouth and buffering the acids, thus elevating the pH. Saliva is the primary host defense system against the bacteria and acids associated with caries. Saliva provides the balance between demineralization and remineralization.

The most important functions of saliva regarding caries are flushing and neutralizing. The higher the salivary flow rate, the better the oral clearance capacity. In general, those with reduced saliva often have a high caries incidence.

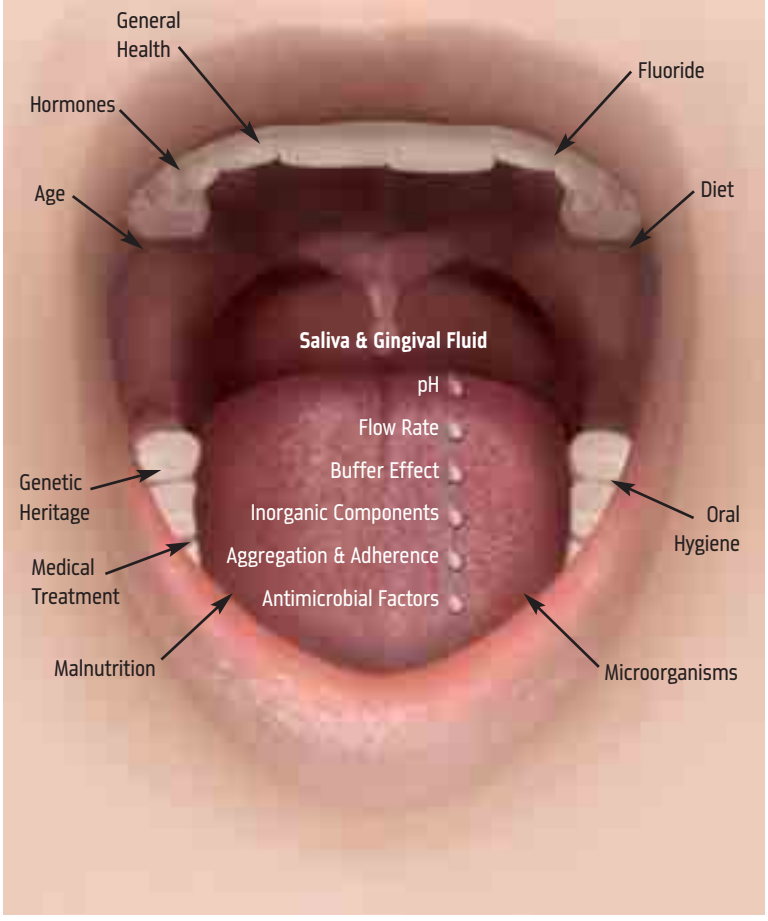
The buffering action of saliva is due to three buffering systems: bicarbonate, phosphate and protein. Reduced flow rate and reduced buffering capacity mean poor resistance to an acid attack. This is especially true among the elderly with xerostomia. Hormones, metabolic changes in the body and general health also influence the buffering capacity of saliva. Interestingly, as the flow rate decreases with malnutrition, the buffering capacity increases.

Proteins in saliva can either help or hinder the situation. Proteins are important in the formation of pellicle on tooth surfaces, providing protection from acids. However, some proteins assist bacteria in adhering to the pellicle-covered tooth surfaces. In the protective mode, the proteins cause oral bacteria to stick together and be flushed from the mouth.

The mucin protein, MG1, is higher in those susceptible to caries while MG2 is higher in those resistant to caries. One study shows MG2 to be four-times higher in caries-resistant people.

Immunoglobulins also influence the incidence of caries – some helping prevent caries while others hinder the preventive process. Differences in saliva between caries-susceptible and caries-resistant people suggest a host derived genetic influence.

Factors Affecting the Development of Dental Caries



Clinical Implications: Saliva is an amazing, multifactorial substance that can encourage the caries process in some and prevent it in others, depending on many factors. The more you know about a person's saliva, the more effective your preventive plan will be. ■

Lenander-Lumikari, M., Loimaranta, V.: Saliva and Dental Caries. Adv Dent Res 14: 40-47, 2000.

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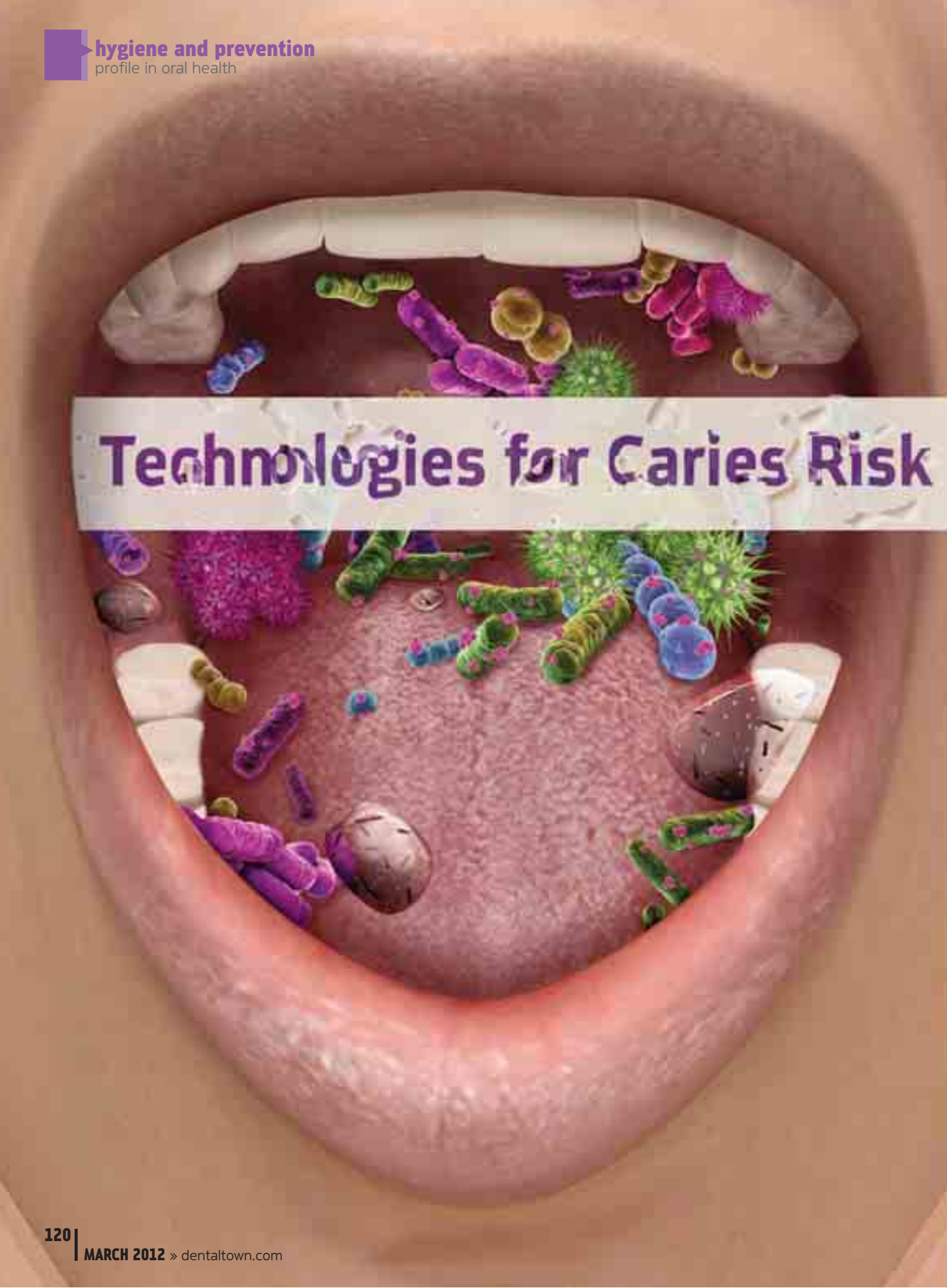

Technologies for Caries Risk

The implementation of caries risk assessment (CRA) and caries risk management (CRM) is more than simply filling out a risk assessment form. The challenge now is to discover the agents, materials and technologies that best complement both CRA and caries prevention. Interventions are based on the concept of altering the caries balance in favor of health by identifying and treating pathological (risk) factors such as pathogenic bacteria, unhealthy saliva and poor dietary habits (i.e. frequent ingestion of fermentable carbohydrates) and promoting protective factors including saliva, sealants, antimicrobials, fluoride, oral probiotics and a healthy diet.

by Tim Ives, RDH

Assessment and Prevention

Technologies for Caries Risk Assessment

Screening systems or "caries activity tests" are available today and should be simple, inexpensive, rapid and accurate. They complement the risk assessment and assist the clinician in determining treatment management priorities. These tests are also helpful in patient education and motivation. Current tests provide information about saliva and bacteria present. Saliva tests measure hydration, flow, viscosity, pH and buffering capacity. Bacterial testing measures the presence of significant numbers of *S. mutans* or levels of bacteria that would put a patient at risk for caries.

1. Saliva hydration, flow and viscosity
2. Saliva pH
3. Saliva buffering
4. Specific bacterial quantity and activity

Saliva Testing

Caries is basically a pH disease, so the level of acid in the saliva is critical. Saliva plays a significant role in maintaining a healthy oral environment by neutralizing acids and flushing away food and bacteria. Saliva acts as a lubricant and delivers calcium, phosphate and fluoride to tooth surfaces. When saliva pH flow and buffering capacity are not within normal limits, demineralization occurs. Understanding these aspects of a patient's saliva provides the clinician valuable information needed to determine treatment choices and preventive strategies.

The Saliva-Check Buffer test kit from GC America provides instruction to the clinician for evaluating hydration, salivary consistency, resting saliva pH, stimulated saliva flow, stimulated saliva pH and saliva buffering capacity. These six tests can be completed within 10 minutes.

Hydration is measured visually by watching saliva flow from minor salivary ducts on the inside of the lower lip. Beginning with a dry inner lip surface, droplets of saliva will appear in less than 60 seconds for a normal flow rate. Taking longer than 60 seconds for droplets to appear indicates a low flow rate.

Saliva consistency is determined by observing resting saliva in the mouth. Normal viscosity of saliva is clear and watery. Frothy bubbly saliva indicates increased viscosity and viscosity increases more as it becomes sticky.

Testing for pH is easily done with a piece of litmus paper or a specific pH testing strip. The patient expectorates any pooled saliva into a small collection cup and the strip is placed in the saliva for 10 seconds. Comparing the color change of the strip to the testing color chart will determine pH.

Saliva quantity is tested over a period of five minutes as the patient chews a piece of wax and expectorates all saliva into a small collection cup with markings. Normal salivary flow varies between 1ml and 1.6ml per minute. After five minutes the quantity of saliva collected should be 5ml or more. Less than 3.5ml collected over five minutes is considered very low.

Buffering capacity is tested with a buffer test strip. A small plastic pipette is used to draw saliva from the collection cup and dispense one drop onto each of three test pads on the buffer test strip. The test strip colors begin to change immediately and after two minutes the final colors will be variations of green, blue and red, with greens and blues indicating greater buffering capacity and blues and reds, less buffering capacity.

Bacterial Testing

Estimates now suggest the number of bacterial species identified in the mouth is as high as 800. Other researchers studying

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DNA implications suggest the numbers are actually 3,600 to 6,800, while still other researchers suggest the number of different oral bacteria is as high as 19,000. No matter the number, only a few hundred can actually be cultured in the laboratory. The new genetic variations of oral bacteria recently reported cannot be measured in clinical practice. Despite these new findings, the primary species associated with cavitated lesions is *Streptococcus mutans.* In-office testing of *S. mutans* is available and easy to do. GC America sells Saliva-Check-Mutans, a 15-minute test to identify or monitor the presence of *S. mutans.*

The patient is given a piece of wax to chew that stimulates salivary flow. Saliva is expectorated into a small receptacle to which a drop of Reagent 1 is added, the container is tapped 15 times and then four drops of Reagent 2 are added. Shaking the container disperses the reagent and the color changes to green. A sample of the saliva is then dispensed onto the window on the testing card and 15 minutes later, if the bacterial count for *S. mutans* is over a threshold level, a red line appears under the T for test, next to the red line of the control or C.

> "Behavioral interventions focus on counseling with the patient for both oral hygiene needs and dietary modifications."

Another chairside test for oral bacteria measures the production of ATP by bacteria, giving an indication of the number of bacteria present. The CariScreen Caries Susceptibility Test by CariFree uses a swab, a reagent and a meter for reading the outcome. The swab comes in a protective tube that becomes the test device. The cotton swab is removed from the protective tube and used to collect a sample of bacterial biofilm from the lingual surface of the lower anterior teeth, careful not to touch lips, tongue or gingiva. The swab is returned to the protective tube and the reagent is released from a bulb on the end of the swab case. A reaction is created that is then measured using the meter. Scores given by the meter range from 0 to 9,999. A score under 1,500 is considered healthy, while scores above that are considered at risk for caries.

Plaque pH Testing

GC America provides a plaque indicator kit, which is a simple plaque pH test. Plaque is collected from maxillary and mandibular teeth on two small plastic probes. These probes are then dipped for one second into a solution and allowed to stand for five minutes at room temperature. Acidic strains of bacteria will cause a color change on the probe that can be measured against a supplied color chart.

Developing a Preventive Protocol

Results from the various screening tests and additional information regarding dental history, medical history, lifestyle, age and socio-economic status will be taken into account when designing an individualized preventive protocol. The overall preventive protocol includes four specific areas: reparative, therapeutic, behavioral and non-modifiable aspects.

Reparative interventions include both restorative treatments and remineralization protocols. Lesions through the enamel and into the dentin will need to be repaired with a dental restoration. Demineralized lesions that have not yet broken though the enamel can often be remineralized by products that stimulate salivary flow or provide minerals necessary for remineralization. Many products containing amorphous calcium phosphate, tricalcium phosphate, xylitol or fluoride are now available for remineralization therapy.

Therapeutic interventions target the bacteria, the salivary pH and support remineralization. Products include antimicrobial rinses and xylitol containing products. For those with high levels of oral *S mutans* and/or an acidic resting pH, antimicrobial mouthrinses containing stabilized chlorine dioxide can be used in combination with a xylitol rinse twice daily for three months prior to re-testing. Professional topical iodine treatments every three months will also address high bacterial counts. Use of xylitol products will interfere with bacterial communication and acid production leading to a decrease in the number of bacteria in the mouth. Xylitol will also stimulate salivary flow and elevate the pH. To be most effective, these products should be sweetened with 100 percent xylitol. The Spry Dental Defense products fit this criteria and are available in toothpaste, gel, mouthrinse, chewing gum, candy, mints and a dry mouth spray. Xylitol has a slight cooling sensation that is responsible for stimulation of salivary flow. Low salivary pH levels can be elevated quickly with a rinse made with a teaspoon of baking soda in a glass of water. Patients should be encouraged to drink more water. A professional rinse is available from CariFree to elevate the oral pH.

Behavioral interventions focus on counseling with the patient for both oral hygiene needs and dietary modifications. Many options are available today to control bacterial biofilm, so limiting oral hygiene instructions to brushing and flossing is a thing of the past. Dietary modifications take into account the frequency of sugar and fermentable carbohydrate ingestion, limiting soda, juice and sugars to mealtime. Motivational interviewing focuses on communication between patient and clinician to decide a plan of action that the patient can and wants to accomplish.

Non-modifiable issues that need to be addressed include special needs, xerostomia, medicines being taken and general health issues. While these cannot easily be changes, the preventive plan can be adapted to take these conditions into consideration.

Summary

A variety of products are now available to complement the risk assessment process, providing the clinician with valuable information. Each positive or negative result within the testing sequence will guide the clinician into altering the patient's oral balance in favor of health. With the right combination of products, instructions and guidance, caries can be prevented and eradicated.

Curing Caries – The Book!

These two articles really only scratch at the surface of caries management and provide a taster for a book, *Curing Caries,* which is being launched this Spring. This will provide the essential scientific theory but more importantly act as a pictorial step-by-step guide to the process of risk assessment including saliva and bacterial testing within the dental office. There will be a section on product options recommend for each specific testing result. These recommendations are based on several years of clinical experience in which many patients have successfully been cured of caries. In addition, there will be advice and guidance on incorporating a caries management system into your current practice setting. Don't miss the 2012 Townie Meeting, featuring Tim Ives presenting a lecture/hands-on program in the Hygiene Track.

Caries Management Consulting

During July and August 2012 Tim Ives and Dave Bridges, co-author of *Curing Caries,* will be visiting the U.S. providing one-day, in-office caries management training sessions. Brochure and scheduling information is available in the message board titled: Curing Caries – The Book at: www.dentalvillage.co.uk. ■

Author's Bio

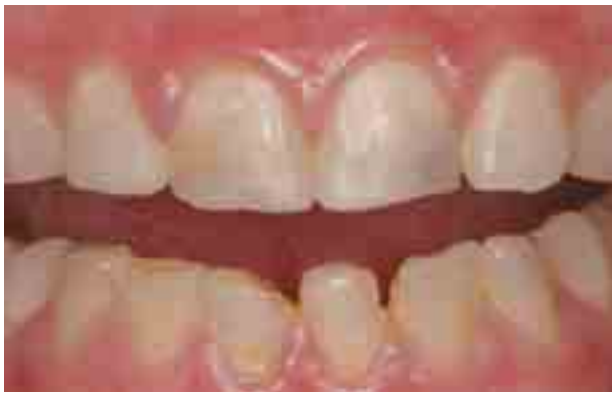
Timothy Ives, RDH, spent 22 years in the Royal Air Force, much of that time providing dental hygiene services. His tours of duty included Hong Kong, Cyprus, Germany, New Zealand, Holland and the U.K. Besides clinical practice, he also has a certificate in appraisal of dental practices. He has a passion for minimally invasive dentistry (MID) and co-runs an MID-based Web site with his friend, Dave Bridges, RDH: www.dentalvillage.co.uk. Tim is an active Townie, member of the Hygienetown.com Advisory Board and available for in-office CAMBRA training.

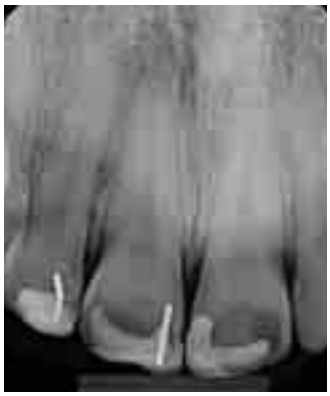
19-year-old Female – What Are Your Thoughts on the Cause?

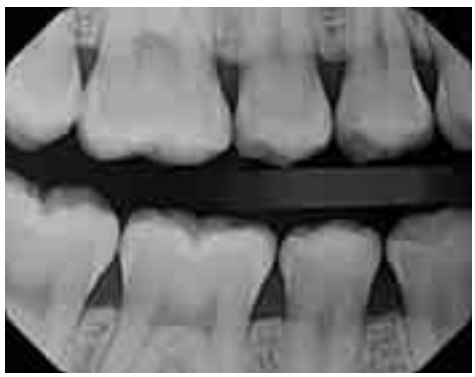
Looking for a second opinion on a case treatment planned for periodontal surgery. Patient presents with severe enamel erosion, moderate to severe caries and no obvious periodontal disease.

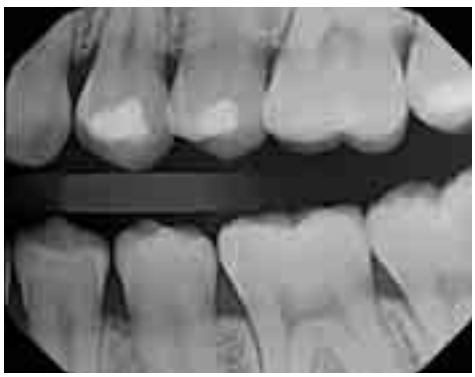
khess248
Member Since: 12/02/08
Post: 1 of 21

Introduction: A 19-year-old female presented in our office last week for a second opinion. Her previous dentists had recommended gum surgery. We are currently putting together a treatment plan but my concern is what has caused this damage to her teeth? Patient is not on any medications, no allergies. She claims she doesn't have any GERD issues and denies any drug abuse or bulimia. We also were not able to identify any dietary issues (pop drinking, gummy bear addiction, etc.). Obviously we are missing something or she isn't being truthful (my bet is on the second one). I would appreciate any opinions. ■



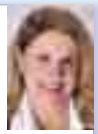






DEC 13 2011

joymoeller
Member Since: 09/16/08
Post: 2 of 21



I would say she might have a bacterial problem that is causing all the decay or she is not telling the truth about drug addiction or diet. Also, I do not agree with the previous dentist recommending gum surgery. I would get the caries under control first. Does she grind her teeth? ■

DEC 15 2011

continued on page 126

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THE XYLITOL EXPERTS

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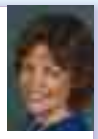
Trisha O'Hehir
Member Since: 05/22/03
Post: 3 of 21



I wonder what the previous dentists thought he would accomplish with gum surgery? Looks like the puffy tissue is primarily in the anterior region. Is she a mouth breather?

You're right – something else is going on. Perhaps she doesn't consider herself bulimic now, but ask about the past. Any vomiting history? When was the last time she vomited – for any reason? You're a good detective. Keep asking questions, you'll discover the cause. ■

DEC 15 2011

timothyives
Member Since: 12/13/08
Post: 4 of 21

I agree, it doesn't add up. There is extensive loss of tooth surface and caries for a 19-year-old with a good diet and no stomach and/or acidic issues. Your real problem is how to get her to be honest with you in order for you to come up with a good prevention plan. My advice would be to take it slowly and build up her trust and not to challenge her too much. Once someone has been imaginative with the truth, it's difficult for he or she to reverse. Make it as easy for her as you can. ■

DEC 16 2011

shazammer1
Member Since: 12/20/00
Post: 5 of 21

My thought would be that many people have GERD and are symptomless. Do her molars have cusp damage, kind of a gouged out look to the cusp? GERD will manifest as sore throat, hoarseness, posterior decay, chest pressure, actual heart burn or nothing. People even go so far as to develop esophageal cancer having shown no symptoms, so I would think maybe reflux that she is not aware of. ■

DEC 16 2011

alidia
Member Since: 09/18/06
Post: 6 of 21

Any history of previous ortho treatment? Poor hygiene while on braces could have caused this type of damage to her teeth. ■

DEC 16 2011

dboncbr1100xx
Member Since: 10/14/06
Post: 7 of 21

This is not a caries case per se as the damage is mainly anterior and secondary to tooth structure loss. The damage is mainly incisal/occlusal. The lesions appear arrested/low activity as they are clean, smooth with dark dentine. This is an erosion case. The labial damage suggests more acid in than out but there might be some out also. The fact that there's little stain/calculus lingually suggests this together with the incisal edge/tip cupping. I don't think this is occlusion per se as radiographs show cusps on molars. The fillings on the left might also lead one to suggest some acid out.

My hunch is she's a young alcoholic who vomits regularly afterward and sleeps it off, on her left side mainly. I don't think it's bulimia as this would present with more palatal/lingual damage and perhaps bilateral posterior fillings, but I did consider it. She isn't going to tell you any of this – especially if the state drinking age is 21. It's just a hunch but an educated one. I think it fits the limited information here.

Or, it could be entirely innocent. Something low or no sugar but acidic – diet soda? Maybe she wakes in the night with dry mouth from mouth breathing, has a quick sip of something and drops back off to sleep on her left side? Thoughts? ■

DEC 18 2011

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A man is visiting his aunt in the nursing home. However, it turns out that she is taking a nap, so he just sits down in a chair in her room, flips through a few magazines, and munches on some peanuts sitting in a bowl on the table.

Eventually, the aunt wakes up, and her nephew realizes he's absentmindedly finished the entire bowl.

"I'm so sorry, auntie, I've eaten all of your peanuts!"

"That's okay, dearie," the aunt replied. "After I've sucked the chocolate off, I don't care for them anyway." ■

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Short Term Ortho System

Straight Teeth. Less Time. Clear Braces.

WHAT'S ALL THE BUZZ ABOUT?

IT'S EASY...

No previous orthodontic experience needed. Expertly positioned clear brackets come set in custom **bonding trays - *ready for 1-step seating.***

EFFECTIVE...

Braces are by far the most reliable and efficient appliances for moving teeth. Six Month Smiles **award- winning clear braces** are specifically engineered for optimum and controlled short-term orthodontic results.

AND PATIENTS WANT IT.

Unique, **clear brackets and tooth-colored wires** gives patients the smiles they want **quickly.**

Course Schedule:

San Diego	Mar. 23-24
Orlando	Apr. 13-14
New York City	Apr. 20-21
Atlanta	May 4-5
Boston	May 18-19
Chicago	Jun. 1-2
Seattle	Jul. 26-27
New York City	Jul. 26-27
Denver	Aug. 10-11
Philadelphia	Aug. 24-25
Chicago	Sep. 14-15
San Francisco	Sep. 28-29
Indianapolis	Oct. 12-13
Washington, DC	Oct. 26-27
Las Vegas	Nov. 2-3
Miami	Nov.9-10
Phoenix	Nov. 16-17
Houston	Nov. 30-Dec. 1
Los Angeles	Dec. 7-8

- **Your first case is FREE ($518 Value!)**
- **Register 6 weeks in advance, and bring a team member for FREE! ($325 Value)**

The World Class Six Month Smiles 2 Day Hands On Course provides general dentists, like you, with the knowledge and confidence needed to start using this award winning system to improve the lives of your patients while simultaneously growing your practice and your services. The ongoing support from Six Month Smiles, Inc. gives you peace of mind as you help your patients smile with confidence.

To Register or Learn More,

Visit www.SixMonthSmilesTownies.com or Call (585) 571-4729

Go beyond “open wide”...

“Open wide” is merely the opening line of an engaging story between you and your patients.

From there, the conversation moves to how much they love skateboarding, eating vanilla swirl ice cream, or family picnics.

By delivering great oral care in the office, your patient’s journey to a healthier mouth and more fulfilling mindset has begun. Our at-home patient-based solutions help them continue a great oral health routine after they leave. We share your passion for helping patients more fully engage in their lives, whether it’s acing that job interview or making plans for that white wedding. Stories you’ll hear more about at their next visit.

To see the compelling solutions tailored for your patients, please visit dentalcare.com.

Crest + Oral-B

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continuing the care that starts in your chair Crest + Oral-B