Help

Click to display a thumbnail listing of pages.

Click to print this PDF file or pages from it.

Click to save this PDF file to your computer.

Click to go to the next or previous page of the PDF.

Click to decrease or increase the magnification of current page. May have to use horizontal scrollbar to view right hand page.

dentaltown

Subscribe to Dentaltown Email to a friend Email for help

Dentaltown Magazine www.dentaltown.com November 2010 » Volume 11, Issue 11 » Implant Dentistry Profile: Officite

Drs. Carl & Craig Misch: **Bone Augmentation by Deficit Six & Topography** page 54

November 2010 » Volume 11, Issue 11

dentaltown

Officite

Officite

Leaders of Their Domain

page 46

Mobile Dentistry:
Bringing Back the House Call
page 74

Case Report:
CBCT & Dental Implants
page 82

Marketing:
The Power of Mom's Purse
page 64

Periodical Publications Mail Agreement No. 40902037 *A Division of Farran Media, LLC* **www.dentaltown.com**

Is this the first 8th Generation bond?

THE DENTAL ADVISOR
Editors' Choice
★★★★★

Futurabond DC

Dual-Cured

- It is dual-cured and works with all light-, self- or dual-cured resins
- It works in a self-cured mode without any light – great for endo
- It takes only 35 sec. from start to finish
- It needs only one coat
- It does not need to be refrigerated or shaken before use
- It comes in unit dose providing the freshest chemistry each time

... and it has everything you expect from a great self-etch bond

- Virtually no sensitivity
- Over 30 MPa bond strength to dentin and enamel

Learn more and order your FREE SAMPLE www.vocoamerica.com

Whatever generation you call Futurabond DC, it will replace all of your existing bonding systems. Futurabond DC is the only bonding agent you will ever need for all of your adhesive dentistry.

AVAILABLE FROM PATTERSON AND HENRY SCHEIN.

Call toll-free 1-888-658-2584 FREE FACTS, circle 38 on card

VOCO
THE DENTALISTS

VOCO America, Inc. · 555 Pleasantville Rd Suite 120 NB · Briarcliff Manor, NY 10510 · www.vocoamerica.com · mfouts@voco.com

AMD LASERS™

Effective. Practical. Affordable. World Class Lasers.

The Fine Art of Laser Dentistry

"revolutionary, easy-to-use"
George Freedman, D.D.S.
International Lecturer, Author
Toronto, Canada

"impressive, every dentist should own one"
Ross Nash, D.D.S.
Nash Institute
Charlotte, North Carolina

"this laser can do it all"
Ron Kemmer, D.D.S.
International Lecturer
Albany, New York

"laser leader, superior products"
Larry Rosenthal, D.D.S.
Director, Aesthetic Advantage
New York, New York

Picasso

3-Year Warranty

$4,995 Multi-Lingual Menu 8 Custom Presets 7.0 Watts

Priced to put a laser in Every **Operatory** & Every **Office**

NEW Bleaching Tip Now Included

Preloaded with the new AMD LASERS app (set-up & how to videos, certification, articles and more) with every Accessory Kit purchase.

#1 Lasers in the World

Picasso Lite

3-Year Warranty

$2,495 Universal Icon Menu 3 Custom Presets 2.5 Watts

"Designed for you, simple to use, great looking and affordable. Your patients want it and you need it. Welcome to the 21st Century and to *the* standard of care – a laser for every office and every operatory."

Alan Miller
President/CEO
AMD LASERS™, LLC

Visit us on YouTube

the future of dentistry
now at your fingertips...

AMD LASERS™, LLC.
www.amdlasers.com

7405 Westfield Blvd.
Indianapolis, IN 46240, USA

866.**WWW.AMDL**
866.**999.2635**
FREE FACTS, circle 47 on card

TEL: 317.202.9530
FAX: 678.868.4108
sales@amdlasers.com

FDA CE
ISO 13485

Anita Aminoshariae, D.D.S., M.S.

CLEVELAND, OHIO
11 years in practice

DENTSPLY
TULSA DENTAL
SPECIALTIES

TRUST.

We're here for you with scientifically proven products and knowledgeable support, including our experienced, on-staff Clinicians on Call. DENTSPLY Tulsa Dental Specialties. *Trust comes from experience.*

TRUSTED PERFORMANCE.

ProTaper® Universal rotary files offer a patented progressive taper design that provides a unique blend of efficiency and simplicity. Trusted by more clinicians worldwide than any other NiTi instrument.

Call 1-800-662-1202 to speak with our trusted Clinicians on Call.

ENDODONTICS AND IMPLANTS ▪ CONTINUING EDUCATION ▪ CLINICIANS ON CALL ▪ KNOWLEDGEABLE SERVICE ▪ PREDICTABLE SUCCESS

DENTSPLY Tulsa Dental Specialties / DENTSPLY International, Inc. / 5100 E. Skelly Drive, Suite 300 / Tulsa, OK 74135 / 1-800-662-1202 / 1-800-597-2779 (fax) / www.tulsadentalspecialties.com

CONSULT INSTRUCTIONS FOR USE

FREE FACTS, circle 19 on card

Rx Only For Dental Use Only

Manufactured Under U.S. Patent Numbers: 5,658,145; 5,746,597; 5,544,950; 5,762,541; 5,628,674; 5,527,205; 5,941,760; 5,464,362; 4,934,934; 6,106,296.

CEREC® AC Connect. Impress Everyone.

Please visit us at the GNY Dental Meeting at Sirona Booth #4625 or Patterson Booth #4601

Sirona's New Toll-Free Digital Highway

Put yourself on the road to success with the new CEREC® AC Connect chairside digital impression system. Delivering the fastest acquisition speeds on the market, the CEREC AC Connect now brings the fastest return on investment. And only Sirona offers you the ability to upgrade your digital impressioning unit to connect to an in-office milling unit.

- **No scan fees**
- **Fastest acquisition speeds**
- **Superior Bluecam precision**
- **Fully upgradable to provide in-office milling capabilities**

Call 800.873.7683 or visit us at www.cereconline.com

FREE FACTS, circle 27 on card

CEREC 25th Anniversary Special:

$25,995*

*Only in the US. Offer limited to the first 250 units purchased. Prices are subject to change without notice and do not include sales tax and freight, where applicable.

Contact your Patterson representative for more information

Exclusive Distributor | PATTERSON DENTAL

Sirona.
The Dental Company

Articles

continued on page 8

Brasseler USA Brings Bioceramic Nanotechnology to Endodontics!

DENTISTRY TODAY TOP 100 PRODUCTS 2009

EndoSequence BC Sealer

townie choice awards 2009

Modern material science has finally allowed us to bring you a root canal sealer worthy of bearing the EndoSequence name. With its outstanding features and convenient delivery, EndoSequence BC Sealer is truly Revolutionary!

Can Your Current Endodontic Sealer Make All of These Claims?

User-Friendly, Non-Technique Sensitive Formula
No mix. No mess. Our premixed syringes allow you to deliver a consistent, homogeneous product every application.

Zero Shrinkage
No base. No catalyst. No heating/cooling. No shrinkage. The outstanding gap-free seal you create during application is never compromised by the setting reaction of the material.

Monobloc Seal:
Endosequence BC Sealer forms hydroxyapatite upon setting and chemically and micromechanically bonds to both dentin and to our silicate coated gutta percha, creating a true, gap-free monobloc seal.

Excellent Flow:
Nano-sized particles and an ideal viscosity give Endosequence BC Sealer outstanding flow characteristics...completely filling and sealing every aspect throughout the canal.

Hydrophillic:
Endosequence BC Sealer's bio-active chemistry actually employs the natural moisture present in the dentinal tubules to activate and complete its setting reaction.

Biocompatible:
Endosequence BC Sealer's calcium silicate/calcium phosphate composition is highly biocompatible. Unlike many other sealers, in the event of an overfill, no inflammatory reaction will occur.

Anti-Bacterial:
Tests show Endosequence BC Sealer killed all *Enterococcus faecalis* within 2 minutes of contact*.

Highly Radiopaque:
No worries about identifying Endosequence BC Sealer on post-op radiographs!

"This stuff was sent straight down from the top of Mount Olympus!"
Henry Pond DMD,
(General Practitioner)
Salt Lake City, Utah

"Hands down the best sealer/technique I have ever used...and I've used them all!"
Brad Trotter DDS,
(Endodontist)
Baltimore, MD

FREE FACTS, circle 10 on card

Introductory Special! SAVE 20%!
Retail: $130.00
Special Price: $104.00

EXPECT THE BEST • BUY DIRECT

Your Expertise. Our Instrumentation. Outstanding Results.

To order call 800.841.4522 or fax 888.610.1937.
Visit our web site: www.BrasselerUSA.com

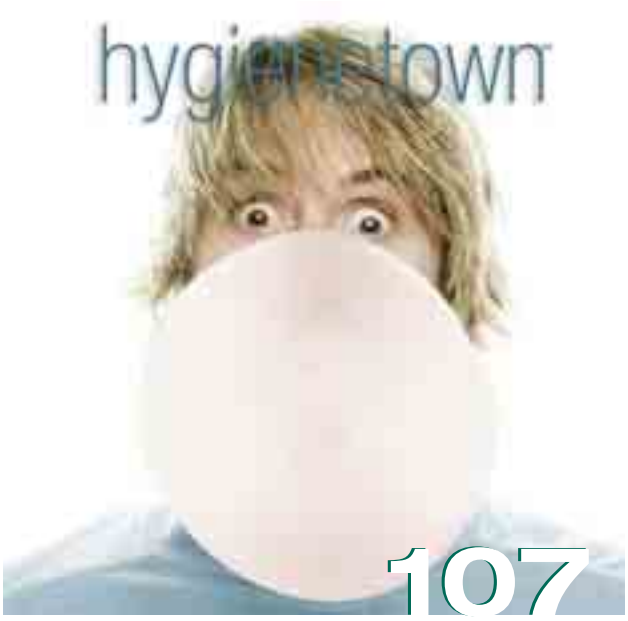
BRASSELER USA
DENTAL INSTRUMENTATION

*JOE-Volume 35, Number 7, July 2009, Pg 1051-1055

B-3326-TOWN-08.10

continued from page 6

Townie Clinicals



Hygienetown Section

Product Profiles

In This Issue

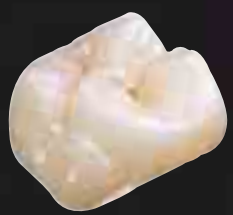
Dentaltown (ISSN 1555-404X) is published monthly on a controlled/complimentary basis by Dentaltown.com, LLC, 10850 S. 48th St., Phoenix, AZ 85044. Tel. (480) 598-0001. Fax (480) 598-3450.
USPS# 023-324 Periodical Postage Paid in Phoenix, Arizona and additional mailing offices.
POSTMASTER: Send address changes to: Dentaltown.com, LLC, 10850 S. 48th St., Phoenix, AZ 85044

Publications Mail Agreement #40902037 Return undeliverable Canadian addresses to Station A, P.O. Box 54, Windsor ON N9A 6J e-mail: cpcreturns@wdsmail.com

3M ESPE Lava™ DVS

Digital Veneering System

A new generation of Lava™ is here... now your patients can experience the strength and beauty of a Lava™ restoration that is more esthetic than other ceramics. Lava™ DVS is digitally made with three precisely controlled layers - the zirconia coping, the fusion porcelain and the glass ceramic material - all with different shades and translucencies. With this type of digital precision, manual adjustments are minimized.



Lava™ DVS

Full Contour Digital Crown

- **Strongest All-Ceramic** with a precise digital fit
- For posterior and anterior restorations
- Conservative prep and conventional cementation
- Single crowns only

Regular Price	With Coupon
~~$145~~	$85
Single Unit Only	Single Unit Only

Take $60 Off!

Lava™ DVS
Full Contour Crown

For new accounts only.
Offer expires: 12-31-10
CODE - DVS60DT

Made in the USA

We Accept C.O.S. Scans

Lava™ All-Ceramic System is a registered trademark of 3M ESPE

CELEBRATING 40 YEARS Of Service 1970-2010

Call: (800) 443-8048

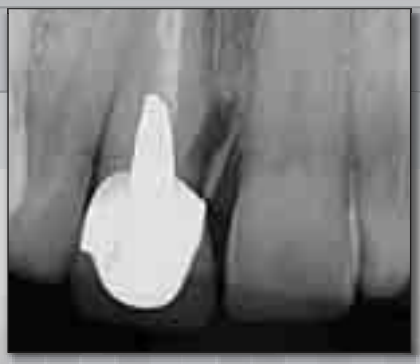
FREE FACTS, circle 34 on card

www.continentaldental.com

CONTINENTAL Dental Laboratories of California

Authorized Milling Center

Case Presentation



Replacing a Fractured #8 Cast/Post and Crown

Hint: the tooth is gone and replaced with an implant.

Fractured #8 Search

Message Boards

Counteracting a Terrible Consumer Web site Posting About My Office

These are powerful sites in some cases and we will be forced to pay more attention to these sites in the coming years.

Consumer Web site Posting Search

How Much Are You Paying for Facebook Ads?

If you just asked, "Dentists are advertising their practice on Facebook?" you need this thread.

Facebook Ads Search

Connect with Dentaltown Magazine

Become a *Dentaltown Magazine* Friend and Fan on Facebook
www.facebook.com/dentaltown

Follow *Dentaltown Magazine* on Twitter
www.twitter.com/dentaltown

Subscribe to *Dentaltown Magazine*
www.towniecentral.com/dentaltown/subscriptions.aspx

Receive *Dentaltown Magazine* e-newsletters
www.towniecentral.com/dentaltown/myprofile.aspx

Gettag

Throughout *Dentaltown Magazine,* you can scan tag codes to access information directly from your smartphone. To scan these codes, visit http://gettag.mobi/ to download the free barcode reader to your mobile device. You can then scan every code you see in *Dentaltown Magazine* to access additional information, enter contests, link to message boards, comment on articles and more!

OCO BIOMEDICAL

DESIGNED AND MANUFACTURED IN THE U.S.A

Presents:

"Simple implant placement in a complex economy"

The 2010
Greater New York
Dental Meeting
Nov 26th-Dec 1st, 2010

On Tuesday, November 30th; Ara Nazarian DDS will perform implant placement surgery at this LIVE program. Two procedures will be presented placing our I-Mini, ISI and ERI Implants. Dr. Nazarian is an energetic and knowledgeable presenter so if you're attending the GNYDM, don't miss this presentation

WHAT MAKES THE OCO IMPLANT SYSTEM SUPERIOR?

- True Immediate Load Capable
- Over 99% reported success rate
- Dual Stabilization™ Design
- One Proven Implant Body
- Simple Placement Procedure
- Flexible & Progressive System
- Multiple Restorative Options
- Cost Effective Pricing

Proven, reliable and versatile, OCO dental implants can be easily deployed in virtually any implant case. With our universal Dual Stabilizing implant body you can easily progress from mini, to full size one-piece, to two-piece implants for either immediate or delayed loading needs. Our cost effective system also allows you to place larger diameter and longer implants without significantly changing technique or instrumentation.

OCO BIOMEDICAL PRODUCTS ARE NOW CERTIFIED FOR SALE IN THE EUROPEAN UNION

REGISTERED COMPANY • ISO CERTIFIED • 13485:2003

Learn more about the unique OCO Biomedical dental implant system:

Visit www.ocobiomedical.com or call (800) 228-0477

FREE FACTS, circle 28 on card

LEARN HOW EASY IMPLANTS CAN BE

In just a few hours learn how to place both mini and standard one or two piece dental implants and restore both dentures and crown & bridge cases. Earn 7 CE Credits.

2010 DATES & LOCATIONS:

November 13th - Manhattan, NY
December 11th - Hollywood, FL

2011 DATES & LOCATIONS:

January 8th - Orlando, FL
January 22nd - Dallas, TX
February 26th - San Antonio, TX
March 12th - New Orleans, LA
March 19th - Las Vegas, NV
April 2nd - Vancouver, BC
April 16th - Atlanta, GA
April 23rd - San Francisco, CA
May 21st - Toronto, BC
May 28th - Cleveland, OH
More 2011 Dates at
www.ocobiomedical.com/training

Academy of General Dentistry

PACE Program Approval for Continuing Education

Dental Secret Seminars is an Approved PACE Program Provider FAGD/MAGD Credit
8/1/2009 - 7/31/2011

dentaltown
a Farran Media interactive healthcare community | www.dentaltown.com

Editorial Advisory Board

Benco Dental
We deliver success smile after smile.®
800.GO.BENCO • benco.com

NORTH AMERICA'S LARGEST DENTAL EQUIPMENT SHOWROOM

THE CENTERPOINT EXPERIENCE

The CenterPoint Experience means choice. Choice in equipment, choice in technology, choice in interior and office design. Benco Dental has long offered dentists more equipment options than any national dental company. Now, we introduce CenterPoint, an industry first: every major equipment line and category, side by side, under one roof. From chairs to digital imaging, sterilization to computer networks, CenterPoint has options for every style and price point in a single location, where experienced, knowledgeable Equipment Specialists are available to help you develop an office solution that achieves your goals.

- 25 working operatories and 14 digital X-ray units on display.
- A complete array of fully operational digital imaging choices, from large-field-of-view 3D cone beam and intraoral sensors, to digital impressioning machines. We are your source for digital imaging.
- On-site design team to convert your ideas into a reality.

Benco Dental CenterPoint is your source and destination for the latest in dental technology and equipment. Contact your Friendly Benco Rep to schedule a visit today.

BENCO DENTAL • 295 CENTERPOINT BOULEVARD • PITTSTON, PA 18640

INTEREST-FREE FINANCING
0%
FOR 10 MONTHS*

HI-TECH FINANCING
4.99%
36 months

go digital!

LIMITED TIME OFFER
EXPIRES 12.31.10

For year-end deals and special financing on the latest digital equipment, visit benco.com/godigital

FREE FACTS, circle 31 on card
*Details at benco.com/godigital

How's the Reception in Here?

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

How does the owner of an NBA team win a championship? Take a look at Jerry Buss, the owner of the Los Angeles Lakers. Does he get out and sprint up and down the court every night? Does he dive into the stands after errant balls? Does he dunk the ball after a fast break? No way! Jerry Buss couldn't dunk a basketball if he were jumping on a trampoline underneath the basket. Any dentist can see, if Jerry Buss wants to win, he delegates the basket making and rebound getting to talented players who can do it. Makes sense, right?

Now, thinking along the same lines, how does a dentist make his or her practice successful? Does the dentist answer the phones? Does the dentist schedule patients? Does the dentist prep the operatory before every procedure? Does the dentist check patients in and out? No. Like Jerry Buss, you have to delegate to talented people!

When I'm doing a root canal, I'm in the zone. A nuclear bomb could go off in the next town over and I'd never know it – that's how focused I get. If the phone were to ring next to me and I'm in the middle of a procedure – I don't care if it's a new patient or my lab or the president of the United States – the last thing I'm going to do is answer it. I'm too busy doing dentistry. That's why I have a front desk.

But how is your front desk performing? A couple months ago I wrote about the necessity of having a good team (*Editor's note: See "Win Like George" on page 10 of the September issue of* Dentaltown Magazine). If you can't trust your employees to do a good job, maybe they need better training (or maybe you need new employees). But what if you're satisfied with your front desk? Does your front desk have enough time to spend with someone on the phone or check someone out – the *right* way? And by "the right way" I mean with care, calm and understanding. I've visited many dental practices that only have one person manning the front desk. She's answering the phone, putting everyone on hold, asking the person checking in to fill out necessary paperwork and asking the three people at the window behind her to wait in line before she checks them out. She might be busting her butt, trying to ensure everyone gets filed through, with all of their questions answered and follow-up appointments scheduled, but while she's checking out one person, the two people on the phone who have been on hold for the last 10 minutes hang up and call the dental office down the street, meanwhile the third guy in the check-out line just leaves, even though he's been told he needs two fillings (and when the front desk person calls after him to say she'll call him later to schedule a follow-up appointment, she never does because she can't find the time). That's how dental offices end up with 4,000 or 5,000 inactive charts and wonder why nobody comes back.

You can have the most talented person working your front desk, but once she has to choose between the new patient on the phone and the person checking out, you've got a problem. She might be a superstar, but she can't do everything at once.

It is time to stop thinking of your front desk as *overhead.*

The dentists who show up to team-building seminars without their staff are the same people who think of their support staff as burdens who are only there to take care of the filing and answer the phones, so they're not bothered while they're working on their patients in the operatory. You can't win doing this – in fact, you're not even in the *game.*

I love my front office staff. Know why? They are a productive and motivated team! They didn't get there overnight; it took proper training and close scrutiny of each employee's job description – two key elements for a successful front office. Let's take a quick look at both of these in detail.

Areas of training to evaluate in your front office are:

1. How well does your staff know your practice management software? Are they able to efficiently schedule a patient when they call? Can they produce, for their needs and for yours, the necessary reports from the system? If not, get a qualified trainer into your office ASAP! Practice management software has come a long way and if used properly can manage your recall, treatment planning, billing and outstanding insurance. But remember, it is only a tool and it is up to your properly trained staff to utilize the information to generate production.
2. Have you invested in phone training? We use Jay Geier's Scheduling Institute training program and have found it to be awesome. Whichever program you choose be sure your staff is recorded and evaluated on a regular basis. Your staff will develop a system to answer your phones efficiently and effectively. Add that to a productive templated schedule and you are on your way!

continued on page 16

Count on Keller

IPS e.max lithium disilicate

- CAD/CAM Accuracy & Fit
- Cement or Bond
- Pressed Strength

BruxZir
Total Zirconia Crowns

- CAD/CAM Consistency
- Ideal for Clenchers & Grinders
- Conservative Prep

$109 EVERYDAY

FREE SHIPPING
When You Bundle 2 or More Cases
in 1 Shipping Box

FREE FACTS, circle 6 on card

Keller Laboratories, Inc.
160 Larkin Williams Industrial Court
Fenton, MO 63026

Call Today For Your Case Pick-Up!
800-325-3056

keller
www.kellerlab.com

continued from page 14

Let's look at job descriptions. I don't have one person manning my front desk; I have three and an office manager. Each member of my team has a defined job description. What's great about that is each person is an important piece of the puzzle and when it all comes together it's complete and it works. There's no double work and nothing gets lost in the black hole.

Take a look at Thomas Watson Jr. He was the president of IBM from 1952 to 1971, and dominated the computer market. If you were to ask him how to go about doubling your sales, do you know what he would tell you in one sentence? *Double your sales force.* Simple, right? If you want to double your sales, double the amount of people selling your stuff. Your front desk should be selling your practice, and if you want to sell your practice more than you already are, you need to add to your team.

There are a lot of people out there trying to teach practice management. I can't tell you how many times I've heard someone tell us that in order to keep costs down, you need to reduce your staff labor. Why is it that in baseball, whoever spends the most money on the best players always ends up in the World Series? And why is it thar whenever I meet a dentist whose practice nets (not gross) more than $550,000 a year, he or she always has a high labor cost?

I get belittled all the time when I tell other dentists that I pay my staff 27 percent production. They say, "Oh, Howard, that's not right. You should be paying your staff something closer to 20 percent." Well, sure, I can go ahead and make it five percent if I wanted to. I'll just walk into Today's Dental tomorrow, fire my three amazing receptionists and office manager, fire my three outstanding hygienists, and get rid of my four awesome assistants and fill all their positions with the cheapest labor I can find. I'll just put an ad out there on Craigslist for a receptionist. I'll pay minimum wage, no benefits, no 401(k) and no vacation time – the cheapest staff possible. Still think I'm going to pull in several million dollars next year? Think I'll net even one new patient next month?

You get what you pay for, guys. The world's greatest receptionist can turn one phone call into four appointments. The world's greatest receptionist attends every single practice management class she can find. Docs, get your front desk on Dentaltown.com and make them start taking a *free* practice management continuing education course each *week.*

Stop treating your staff like overhead. Start treating them like professionals. Start treating them like practice builders. Start taking them to practice management classes with you. Hire an office manager to take you to the next level. Stop trying to manage everything and start delegating. Loosen up on the reins and let your team focus on the business of your practice while you worry about doing good dentistry. But remember, you can't have one without the other. ■

National Ad Campaign

Dentistry and Oral Health Needs a National Ad Campaign! Scan this MS Tag with your phone to read Howard's appeal and click the "I'm In!" button on the home page of Dentaltown.com to let the ADA know you want to raise your membership fees for a national ad campaign!

Howard Live

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

Dr. Farran's next speaking engagement is **November 29 through December 1, 2010, at the Greater New York Dental Meeting in New York, New York.** For more information, please call Colleen at 480-445-9712.

Seminars 2010-2011

Nov. 29 – Dec. 1 ▪ New York, NY
Greater New York Dental Meeting
www.gnydm.com

January 14 ▪ South Sioux City, NE
Sioux City Dental Society
president@scdentalsociety.com

February 18 ▪ Seattle, WA
Washington AGD
Valbartoli@comcast.net
washingtonagd@yahoo.com
Val Bartoli-253-306-0730

The Moses™

Designed to comfortably and effectively
ELIMINATE SNORING

$269
Introductory Price

The Moses™ The only appliance that incorporates *all 3* attributes of a successful anti-snore appliance.

1. **Mandibular Advancement:** This popular feature is at the heart of the best appliances offered today. Compared to other MADs, TMJ issues are reduced because The Moses™ also advances the tongue.
2. **Tongue Management:** The device stimulates protrusive tongue reflexes and the open anterior design allows the tongue to advance which enlarges the cross sectional area of the airway. All without the uncomfortable issues of tongue retention devices.
3. **Patient Compliance:** The Moses™ is comfortable and easy to wear. When wearing the appliance, the patient can talk, drink, open wide and close their lips. Eliminated are the claustrophobic locked jaw and mouth breather designs of earlier MADs.

Dr. Moses chose the only certified Medical Device Manufacturer available to the US dentist as the exclusive manufacturer of The Moses™. This insures consistent high quality and meets the most stringent quality standards in the world.

MODERN
Dental Laboratory USA
a certified Medical Device Manufacturer

moderndentalUSA.com
themoses.com
877-711-8778

FREE FACTS, circle 45 on card

What Did You Miss at the ADA Meeting?

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

As of this writing, I have just left the 151st ADA meeting in Orlando. Attendance numbers were relatively low for an ADA meeting and the common explanation seems to be the economy. While some trade shows are struggling with sagging attendance numbers, most expected better attendance this year since the last meeting was held in Hawaii. Next year, the show will be in Las Vegas, October 10-13. Mark your calendars now and enjoy the highlights in the meantime.

Philips Sonicare has just made moves on both the business and clinical front. They just purchased Discus Dental for an undisclosed sum of money. It will be interesting to see how this acquisition will progress in the marketplace over the next 12 months. Clinically, they are working to promote a new Webinar "Using Motivational Interviewing Strategies for Impactful Patient Communication." Motivational Interviewing is a technique developed by Stephen Rollnick, PhD, and William R. Miller, PhD, which uses client-centered counseling to explore and resolve ambivalence. This translates to a teachable technique for communicating with our patients so they can be motivated to improve their dental health. To find the course, visit www.sonicare.com/dp and look in the Education & Resources section.

I have been using **3M ESPE** fluoride varnish on my patients for a couple of years now and I love the concept. You can deliver a high dose of fluoride in less than a minute and the patient does not have to wait 30 minutes before their next meal. We recently posted a short technique video from 3M ESPE that reviews the application of fluoride varnish on the teeth. Take a moment to visit our Media Center on Dentaltown.com and watch the video. I also suggest that the dentist apply the fluoride right after they finish the patient exam. This is more efficient than having the hygienist reglove and move back into the chair to finish the appointment.

My visit to the **CareCredit** booth proved to be one of the most educational meetings on the exhibit floor. I visited with George, who took the time to review my practice performance report, which provided me with specific numbers related to use of CareCredit in my practice. While I'm not the financial coordinator in my practice, I learned a few valuable tips for the coordinators reading this column. First, describe your patient financing options to your patient as a "payment plan." You are not offering the patient CareCredit or ChaseHealthAdvance… you are asking them if they want to pay for their treatment with cash, check, credit card or a payment plan. Second, let the patient decide which method will work the best for them and I promise you will have fewer patients that leave the office without scheduling an appointment.

In other business news, the company formerly known as Matsco has just completed a three year process to rebrand themselves as **Wells Fargo Practice Finance**. This acquisition promises to deliver many advantages to clients via the multitude of services offered by Wells Fargo, as well as a continuation of knowledgeable lending that was a hallmark of Matsco.

The Greater New York Dental Meeting is up next and I have already heard about a few great surprises on the horizon. Stay tuned and send me a note if you have a question: tom@dentaltown.com ■

Darby
Dental Supply, LLC

SUPER "MIX+MATCH" DEAL

on all SuperDent PVS Impression and Bite Registration Materials!

**SuperDent is manufactured by the maker of a leading brand of impression material—
we can't tell you who, but this is a great opportunity to try, buy, and earn a great gift.**

Spend $249
get the new 2GB iPod shuffle®

Spend $499
get the new Apple TV®

Spend $699
get the new 8GB iPod nano®

Spend $999
get the new 8GB iPod touch®

Take the SuperDent Challenge:
If our impression material isn't as good as or better than what you're using today, return all unused material for a full refund. No questions asked. We guarantee you'll be extremely impressed!

800.886.1952

Offer expires December 15, 2010

www.darbydentalsupply.com

Limit one offer per practice location. New SuperDent PVS Impression Material and Bite Registration users only. Cannot be combined with any other promotion or discount. Other restrictions may apply. Spend levels are per order. Must be on one invoice. Mix and Match all SuperDent impression material and impression material accessories. Free Rewards items must be returned unopened if purchased product is returned.

FREE FACTS, circle 24 on card

For over 500 other great rewards, call for your FREE Darby Rewards Guide: 800.886.1952

Risk Assessment and Minimally Invasive-based Care

The Case for CAMBRA and CariFree

by V. Kim Kutsch, DMD

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

Until now, dentists have spent the majority of their time actively treating and restoring the real damages caused by dental caries. The caries infection, which is responsible for chronic cavities in patients, is a bacterial-mediated disease involving the two primary pathogens *Mutans streptococci* and *Lactobacillus.* However, recent biofilm science has expanded this disease model to include numerous pathogens in a biofilm community. Studies regarding biofilm suggest caries is a pH dysfunction of the biofilm. Prolonged periods of low pH in the mouth select for cariogenic pathogens and also lead to demineralization and net mineral loss from the teeth. In order to effectively treat dental caries, not only must the teeth be restored to function, but the dental biofilm needs to be restored to health. The intention of the CariFree system is to regulate the mouth's pH levels, as well as strengthen teeth in a process to correct the actual caries disease, as opposed to simply repairing the signs and symptoms.

Caries management by risk assessment or CAMBRA is a standard of care that includes early risk assessment and diagnosis of the disease process and then also treatment with minimally invasive procedures. Within all of health care, minimally invasive care is preferred by practitioners and patients. CariFree is an entire system that allows practices to diagnose and treat the caries infection, and support minimally invasive procedures. The traditional pick-and-stick method for cavity identification, followed by the drill-and-fill surgical model for treating cavities has become outdated. They are not only uncomfortable for patients; they are ineffective in maintaining oral health for high-risk patients, as the restorative measures have no beneficial effect on the dental biofilm. Frequently, dental caries is a life-long chronic disease for patients, a condition that leads to ongoing restorative therapy, which continues until they run out of teeth or die. The way to significantly lower the potential decay rate for a patient is to effectively treat the underlying cause of cavities.

While new research indicates there might be genetic components and gender differences for dental caries, all members of the population might be at risk for the disease since it does not discriminate by age. In addition the disease might be transmitted horizontally and vertically within a family structure. Multiple risk factors exist for the disease and have been studied and validated. Dental caries is a complex biofilm disease, and the risk factors need to be addressed to effectively treat it. Previous attempts at treating chronic decay with improved oral hygiene, brushing and flossing, have had only limited results as it doesn't change the content or behavior of the biofilm. Reducing the plaque temporarily reduces the overall bacterial load, but the nature of the biofilm and the pH dysfunction remain the same. Even the use of fluoride has limitations.While fluoride has been demonstrated repeatedly to have beneficial effects at treating the disease in children, few studies demonstrate any significant benefit in adults. Fluoride does improve remineralization results, but increasing levels and frequency of fluoride use in treatment therapies have not been effective at reducing the decay rate. At this point, good oral hygiene and fluoride therapy might not be enough to provide effective treatment outcomes for all patients. The CariFree system focuses on correcting the pH dysfunction of the biofilm and combines the therapeutic effects of fluoride and xylitol. This revolutionary approach to treating dental caries offers significant hope to patients and predictable treatment outcomes for the practices responsible for their care.

continued on page 22

Esthetic anchors for your core material

A metal anchor may be perfect for your boat, but not for your patients' teeth. If retention and esthetics with minimized instances of root fractures are what you're looking for then the choice is **FibreKleer®**. ***FibreKleer* Posts** are engineered to securely anchor your core build-ups without sacrificing the natural esthetics that your patients demand.

***FibreKleer* Posts** deliver:

- Tenacious core retention
- Minimized instances of root fracture†
- Natural esthetics
- Dentin-like flexural properties
- 3 different geometric shapes each in 3 sizes

2010 REALITY ★★★★

To anchor your cores with one of dentistry's most trusted fiber posts

call 800-551-0283 or visit www.pentron.com today!

† When compared to metal posts. Data available upon request.

FREE Offer*

FibreKleer®

Buy 3 Post Refills, Get 1 FREE!*

(10 packs & 30 packs)

– or –

Buy a FibreKleer Post Kit, Get a Breeze® Cement Refill FREE!

Order Today!

Promo Code: DTWPOST

FREE FACTS, circle 26 on card

800.551.0283 | 203.265.7397 | www.pentron.com

Build-it® FR™ | FibreKleer® | FibreKor® Crown & Bridge

** Free item must be of equal or lesser value. * Offer expires November 30, 2010. Additional shipping charges will apply. Subject to change or cancellation without notice. Orders subject to credit approval.

Pentron Clinical
Sybron Dental Specialties

continued from page 20

The CariFree system allows practices to begin with caries risk assessment and caries susceptibility screening. The CariFree caries risk assessment helps dentists identify which patients are at high-risk for dental caries by identifying specific known risk factors, which leads to individual-specific treatment protocols, rather than a "one-size-fits-all" surgical approach to the disease after it already exists. The CariFree CariScreen biometric measures the biofilm activity, and is diagnostic for the caries potential of the biofilm. The CariScreen is a chairside real-time test, which only takes seconds to administer and get results. The screening utilizes a light-sensitive meter and swab combination, based on ATP bioluminescence technology. The CariScreen biometric has been demonstrated in multiple independent university-based studies to correlate directly to the potential caries biofilm activity and patients' caries risk. This procedure is extremely simple, provided at a low-cost, and allows practices to effectively monitor their patients' risk levels. The biometric provides both a baseline and a therapeutic treatment endpoint so that practices can better design appropriate individualized treatment therapies and monitor their effectiveness and outcomes.

Cariogenic bacteria are both acidogenic and aciduric by nature. They all share adaptive mechanisms that allow them to exist and thrive in low pH conditions. While most people consider sugar to be the main culprit responsible for tooth decay, it is actually the acids produced when the biofilm bacteria metabolize the sugar, which becomes the basis for the disease. The low pH selects for bacteria that are acidogenic or aciduric and at the same time dissolves the calcium and phosphate from the teeth. By therapeutically raising the pH of the biofilm, the selection pressure is reversed and calcium and phosphate ions re-enter the enamel. Raising the pH encourages the growth of healthy bacteria and also drives remineralization. Xylitol has been demonstrated in multiple studies as an effective anti-caries agent. It reduces the transmission of cariogenic bacteria between individuals, as well as impedes bacteria's ability to stick to teeth. In addition xylitol has a synergistic effect on even low levels of fluoride. The CariFree oral products combine pH strategies with xylitol and fluoride to provide effective treatment for the biofilm component of dental caries, and significantly drive remineralization of the teeth. The CariFree line of products can be bought online or sold directly from the dental practice. With products ranging from rinses, sprays, and nonabrasive gels to lollipops for children, cavity prevention is made easy.

The dental profession is experiencing a rapid shift from the traditional surgical model to a risk-assessment-based medical model in treating dental caries. This shift is taking place in the dental schools as CAMBRA is now becoming a required part of the curriculum. The change is being driven in private practice as more professionals look for effective prevention measures, minimally-invasive-based care, reduced restorative risks and greater predictability in treatment outcomes. And finally, patients are aiding progress as they become better educated about dental disease and the options of minimally invasive care. Too many people have suffered from this disease for too long. What we've been doing isn't acceptable anymore. With our increased understanding of the biofilm pH dysfunction of this disease, it's time for us to take a bold new approach. G.V. Black dreamed of a profession that was truly prevention-oriented, where we understood dental caries so well that we could prevent its pathogenic effects. Bob Barkley admonished us to become education centers rather than surgical centers, where we teach our patients about prevention. Dr. John Kois teaches a system that incorporates risk-assessment-based diagnosis and minimally invasive procedures to provide greater predictability in treatment outcomes. It's time for us to eliminate this disease. It's time to stop the suffering in our youngest children and our oldest seniors. We can create a future where we spend our time focusing on wellness, creating the healthy, beautiful, confident and long-lasting smiles that all of our patients desire. It's time! ■

Author's Bio

Dr. V. Kim Kutsch received his undergraduate degree from Westminster College in Utah and then completed his DMD at University of Oregon School of Dentistry in 1979. He is an inventor holding numerous patents in dentistry, product consultant, internationally recognized speaker, is past president of the Academy of Laser Dentistry, and the WCMID. He also has served on the board of directors for the WCLI and the AACD. As an author, Dr. Kutsch has published dozens of articles and abstracts on minimally invasive dentistry, caries risk assessment, digital radiography and other technologies in both dental and medical journals and contributed to several textbooks. He also acts as a reviewer for several journals. Dr. Kutsch also serves as CEO of Oral Biotech, As a clinician he is a graduate and mentor in the prestigious Kois Center and maintains a private practice in Albany Oregon.

"Bye-bye, Flipper!"

snap it!™

The Flipper Replacement

Brought to you by Snap-On Smile™ Dentistry's Biggest TV Launch since LUMINEERS®

Esthetic • Comfortable • Efficient

The Flipper Replacement

No More Flippers!

The Better Choice for Partial Dentures.

Snap-It! is the ideal replacement for uncomfortable partial dentures or bulky flippers that make eating a chore. Finally, no more coverage of palate and gums with uncomfortable flipper appliances!

Snap-It! is surprisingly flexible yet incredibly strong and simply snaps into place over the patient's existing dentition, with NO prepping, NO injections and NO adhesives.

"Finally, a temporary partial replacement for a missing tooth that works! *My patients love it! Snap-It! feels secure so they can speak and eat with it without worrying about it becoming loose and falling out. It's simple and literally snaps into place. Snap-It! is a great solution to no more flippers!"*

—**Dr. Terri Alani, Houston, Texas**

Snap-It! is part of the Snap-On Smile product line, which includes patents and patents pending domestically and internationally.

Exclusively distributed by HENRY SCHEIN® DENTAL

To prescribe Snap-It! for your next implant or partial denture case **call 800/445-0345**

www.denmat.com/snapit

DenMat

FREE FACTS, circle 22 on card

Dental News in Brief

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

Discus Dental Acquired by Philips

Discus Holdings, Inc., announced that it has entered into a definitive merger agreement with Royal Philips Electronics. Through this acquisition Philips expands its oral healthcare portfolio. Upon closing of the transaction, pending regulatory approvals and expected in the fourth quarter of 2010, Discus will become part of Philips' Consumer Lifestyle sector's Health and Wellness business. For more information visit www.discusdental.com and www.philips.com.

Michigan Dentist Becomes American Dental Association President

Raymond F. Gist, DDS, a Flint, Michigan, general dentist was inducted at the ADA's 151st Annual Session in Orlando, Florida as the 2010-2011 president of the American Dental Association. Dr. Gist is the first African-American president of the 157,000 dentist member organization. During his one-year term, Dr. Gist plans to focus on membership outreach and advocacy efforts that will have special appeal to young dentists. For more information visit the Association's Web site at www.ada.org.

Matsco Becomes Wells Fargo Practice Finance

Wells Fargo announces the unveiling of the Wells Fargo Practice Finance brand, from its previous Matsco identity. Wells Fargo acquired Matsco more than three years ago as part of its acquisition of Greater Bay Bancorp. This transition articulates a singular resource for finance and support for healthcare professionals that aspire to start, grow or purchase a private practice. As a part of Wells Fargo Practice Finance, current clients will enjoy greater access to the full range of products and services. More information can be found at www.wellsfargo.com/practicefinance.

New Research Supports the Efficacy of MI Paste Plus in Orthodontic Patients

Research presented at the 2010 International Association for Dental Research meeting in Barcelona, Spain supports the use of MI Paste Plus with Recaldent containing casein phosphopeptide – amorphous calcium phosphate and fluoride (CPP-ACPF) for the prevention of decalcification in orthodontic patients. A four-week study, conducted by Dr. Chung How Kau and associates compared the use of MI Paste Plus versus a fluoride-containing dentifrice as the control. MI Paste Plus, which contains 900ppm fluoride, was found in this study to significantly reduce orthodontic decalcification, a condition that affects up to half of all orthodontic patients.

continued on page 26

YANKEE Dental Congress® 36

Boston Convention & Exhibition Center

JANUARY 26–30, 2011
EXHIBITS: JANUARY 27–29, 2011

Your Dental Connection

INNOVATION

450+ Exhibitors, High-Tech Playground, and Dental Office Design Pavilion

EDUCATION

Over 300 Courses Featuring Live Patient Demonstrations, Endodontic and Periodontic Fast Tracks, Hands-on Courses, and More

COLLABORATION

Networking Lounge, Receptions Galore, and Fat Thursday Carnival

NEW REGISTRATION GROUP DISCOUNT

Your Entire Dental Team Can Get Connected

Register 4 dental professionals from the same office and the 5th goes FREE*

*SOME RESTRICTIONS APPLY

Get Connected - Registration is Now Open!

yankeedental.com ✦ 877-515-9071

FREE FACTS, circle 18 on card

continued from page 24

PracticeWorks Announces Company Name Change to Carestream Dental

PracticeWorks Systems, LLC, a subsidiary of Carestream Health, Inc., and the exclusive manufacturer of Kodak Dental Systems, announces its corporate name change to Carestream Dental, LLC, effective September 1, 2010. The company's headquarters will remain in Atlanta, Georgia. This name change is part of the larger rebranding of the global dental businesses of Carestream Health, all of which will adopt the Carestream Dental brand. For more information visit www.kodakdental.com.

Sybron Dental Specialties Unveils State-of-the-art Continuing Education Center

Sybron Dental Specialties, Inc., announces the official opening of the Sybron Learning Center, a state-of-the-art continuing education center. The 15,000 square foot facility, located directly adjacent to the Disneyland Resort Theme Parks in Anaheim, California is equipped with the latest laboratory and multimedia technologies, including: full film and broadcast capability, a primary surgery suite, a 200-seat auditorium and a 50-person bench laboratory with adjoining observation room, four fully functional operatories and an X-ray room equipped with 3D panoramic, pan/ceph, and intraoral X-ray imaging. To learn more, visit www.sybronlearningcenter.com.

UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation (Requester Publications Only)

Dentaltown	0 2 3 . 3 2 4	10/1/2010
Monthly	12	

9633 S. 48th Street, Suite 200 Phoenix, Maricopa County, AZ 85044-8603

9633 S. 48th Street, Suite 200 Phoenix, Maricopa County, AZ 85044-8603

Howard Farran, 9633 S. 48th Street, Suite 200 Phoenix, AZ 85044-8603

Bert Lund, 9633 S. 48th Street, Suite 200 Phoenix, AZ 85044-8603

Dr. Tom Giacobbi, 9633 S. 48th Street, Suite 200 Phoenix, AZ 85044-8603

Farran Media, LLC	9633 S. 48th Street, Suite 200
	Phoenix, AZ 85044-8603

Howard Farran	9633 S. 48th Street, Suite 200
	Phoenix, AZ 85044-8603

Dentaltown	September 2010	
	118,875	119,500
	115,907	115,845
	—	—
	1,071	1,198
	—	—
	116,978	117,043
	—	—
	—	—
	—	—
	1,644	2,213
	1,644	2,213
	118,622	119,256
	253	244
	118,875	119,500
	98.61%	98.14%

November 2010

President — 10/1/2010

More brawn than beauty!

BruxZir®

SOLID ZIRCONIA CROWNS & BRIDGES

$99/unit*

- Ideal for bruxers and grinders who have destroyed other restorations thanks to its virtually chip-proof durability.
- An esthetic alternative to metals with CAD/CAM consistency of contacts and occlusion.
- Conservatively prepare as thin as 0.5 mm with feather edge margins, much like you would cast gold.

CEREC® users who send digital files will save $17 per case when prescribing restorations without modelwork.

This patient fractured a porcelain all-ceramic crown on the second molar and chipped the first molar. Both crowns were replaced with BruxZir.

This patient presented with a predominantly cast-metal bridge and desired a more esthetic option. A high-strength BruxZir bridge was prescribed.

For more information, visit bruxzir.com.

BruxZir is made from translucent Prismatik Clinical Zirconia™.
BruxZir and Prismatik Clinical Zirconia are trademarks of Glidewell Laboratories.

FREE FACTS, circle 23 on card

*Price does not include $14 round-trip overnight shipping.

Call for case pickup

800•854•7256

glidewelldental.com

GLIDEWELL LABORATORIES

"The Standard of Care"

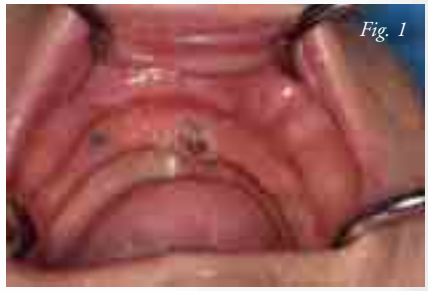
Lower Four One-Piece Implant Overdenture

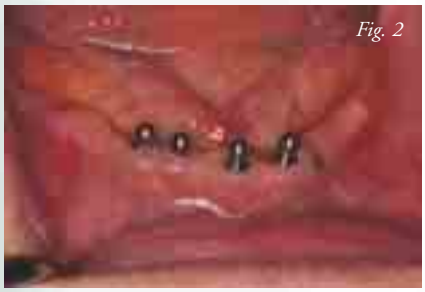
Small diameter implants can do wonders for a lower full denture. This case provides a great example.

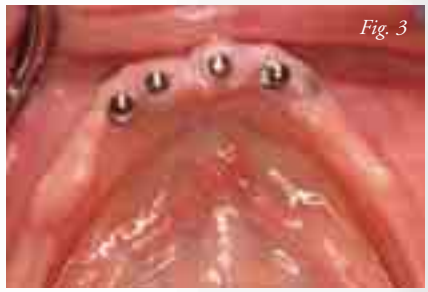
RLang
Posted: 9/2/2010
Post: 1 of 11

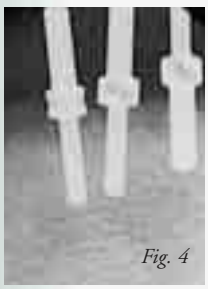
A 76-year-old patient presented with an old poor fitting denture, deficient ridge, and not a lot of attached gingiva. She desired more retention with her lower denture. She elected a more economical treatment plan of four one-piece 3x12 Biohorizons implants.

Fig. 1: Preop lower mandible









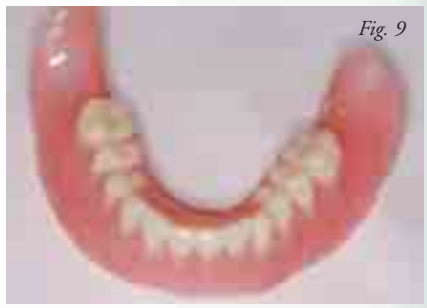


Fig. 2: Postop three months healing
Fig. 3: Postop mandible three months healing
Figs. 4-5: Positioning pins
Figs. 6-7: Final X-rays
Fig. 8: New denture with attachments
Fig. 9: Lower denture

Looking for more overdenture cases? Why not check out these message boards on Dentaltown.com:

Implant Placement for Lower Overdenture Using Cone Beam for Treatment Planning
Search: *Implant Placement for Lower*

Staged Mandibular Implant Overdenture Treatment.
Search: *Staged Mandibular*

Simple Lower Overdenture
Search: *Simple Lower Overdenture*

or... Scan this tag with your mobile phone to view this message board.

continued on page 30

New Lightweight Nike®
Skylon Ace Frame available
in Black and Varsity Red.

DESIGNS FOR VISION®

Vision Magnified

The ONLY Magnification Custom Manufactured to your measurements *(never off the shelf)* for TRUE Ergonomics

The Lightest
LED DayLite™ Mini

Just See It Today
with our 45 Day,
NO Obligation Trial.

DESIGNS FOR VISION®

760 Koehler Avenue | Ronkonkoma, NY 11779 | 1.631.585.3300 | **1.800.345.4009**
info@DesignsForVision.com | **www.DesignsForVision.com**

 FREE FACTS, circle 21 on card

continued from page 28


Fig. 10


Fig. 11

Fig. 10: Final retracted

Fig. 10: Final smile.

This was a great indication for use of these implants. The 3mm one-piece implants were narrow enough to use on her ridge and much stronger than a mini. The lab fees are less because you do not have to buy an additional attachment to place in the implant. The disadvantage of this is if an attachment wears you cannot easily fix it, replacing the implant is needed. Another disadvantage is that during the healing stage the patient must be very careful to not function on the implants. Her old lower was relined with a soft liner and the implant areas were aggressively ground out. The ridge was so narrow I had to perform an alveoloplasty to obtain enough width to place these implants. Due to her age and delicate bite, this treatment should serve her well. If she had a stronger bite I would be concerned long term as it is opposing upper crowned teeth. Thanks for any comments. ■

Jordan "skibum" Pilling
Posted: 9/2/2010
Post: 2 of 11

I bet she is so happy. I recommend this treatment to many of my patients but often have difficulty with case acceptance for the overdenture. Is there any reason why you placed them all so close and anterior instead of placing two a little further back? I am assuming that is just where you had the bone to do it. ■

utdental
Posted: 9/2/2010
Post: 3 of 11

What advantage does the patient receive by doing four instead of just two – especially if they are all anterior to the mental foramen like these? The only advantage I see is this sets them up to transition to a fixed appliance in the future with a few more implants. Is there really a big change in retention when they are this close? ■

sensei
Posted: 9/2/2010
Post: 4 of 11

These implants are one-piece so there is no transitioning to fixed. I have the same questions though. Would it have been almost as cost effective to place 2x3.0

continued on page 32

i Am Your Service Lab

Dental Laboratories Inc.

i Solid Zirconia *

* No porcelain, recommend for posterior

$ 59.00 Per Unit

Porcelain to Metal*

* Metal price extra

$ 59.00 Per Unit

i Zirconia Layered $ 79.00 Per Unit

Framework Only $ 59.00 Per Arch

Metal Free Partial $ 99.00 Per Arch

Full Denture $ 99.00 Per Arch

Transparent Framework $ 99.00 Per Arch

i Dental Laboratories Inc.
info@i-dentallabs.com

50% off
First Shipment
Unlimited cases per shipment
Prepaid only
One coupon per dentist only
Please send it within cases

Please call 877-592-9301 for more promotions

FREE FACTS, circle 14 on card

continued from page 30

implants with locators? Wouldn't this make it possible to change the abutments later if they wear or convert to a fixed/removable hybrid? I do see the advantage of the case being overengineered. If you happen to lose one, the case is still successful. I took an IMTEC course and they really pushed the idea of placing four to five minis so the case is not a flop if one fails. Definitely a nice case. I'm sure your patient is very happy. ■

mandm_sudz
Posted: 9/2/2010
Post: 6 of 11

You could and should have placed the distal-most implants way more distal, or just placed three implants instead of four tightly spaced ones. Two regular implants with locators would have done the trick and are upgradeable, as someone correctly mentioned earlier. In my opinion, if you are going to place minis, true minis would be better. These are 3mm implants and the case should be flapped to visualize bone architecture so they can be correctly placed. ■

RLang
Posted: 9/2/2010
Posts: 8,10 & 11 of 11

Thanks for your comments.

Jordan, the mandible was very thin and after alveoloplasty this was all I could place. I did want to place two further back but was unable to. There are three reasons to place four implants. 1. The case is more retentive even though the ap spreads is not ideal. 2. Implants retain bone and this will keep the anterior ridge from further atrophy especially against the upper natural crowned teeth. 3. This case will not fail if one implant is lost, it is overengineered.

These are one-piece implants and cannot be transitioned over. This is a dead end case and all that can be done without extensive bone grafting.

[Posted: 9/2/2010]

Martin, This case was flapped and the ridge-reduced to allow for placement of 3mm diameter implants. I could not place anything wider. There was not a lot to work with distal to these implants. I could have done three I guess, but did want to put in four and they did a little close. The case is very retentive and the patient was very pleased. It was not ideal and the reason I posted this case for discussion.

[Posted: 9/2/2010]

Sensei, There are no other plans for this case. Using two 3mm implants with locators is another way to go. The problem with the one-piece implants is they can wear and not be swapped out. But the advantage is they are much stronger. I have done other cases and placed two so it could be changed in the future or added to. This treatment was a simple economical solution to this patient's problem, however not so flashy. ■

Find it online at www.dentaltown.com

One-Piece Implant Overdenture Search

Chilling

to see your website on a mobile?? We can help!!!

Available NOW! for your Practice

INCREASE your exposure 6X

- Testimonials
- Appears automatically
- Nothing to download
- Works on all mobile phones
- Increase web presence up to 6x
- Tremendous SEO advantage
- Works on "all" websites
- 1 touch features such as:
  - Call
  - Email
  - GPS directions
  - Full screen video
  - Smile Gallery

Before

After

Text "practice" to 69302 for an instant "live" demo

Get a custom mobile app for your practice TODAY!

ProMedDevs

"Excellent patient builder..."

www.promeddevs.com 888.846.2515 FREE FACTS, circle 7 on card

Immediate Implant #9 Failed

Sometimes great intentions can fail when the case is not designed properly.

kwalia
Posted: 8/31/2010
Post: 1 of 45

Patient had presented to our office as #9 was broken by a surgeon during surgery. Patient is healthy 52-year-old female, but is a heavy smoker.

Went over all the options. Patient opted for an implant and the surgeon's office said they would cover the full fee. Surgery was performed in March, implant had torqued to 30Ncm. No pain was present and tissues were healing well.

After restoring the tooth (I took extra care to make sure it had minimal occlusion), patient kept complaining of pain. I had recommended removing the abutment and crown, and going back to a healing abutment to see if things would settle down. Patient had trips planned and wanted the crown for the trips

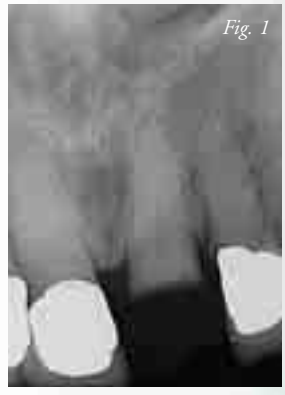


Fig. 1

Fast forward to today, she comes in to have the abutment and crown removed and the whole implant is loose. I remove the implant/abut/crown in one piece with my hands. I ended up placing a dPTFE membrane and Oragraft from Salvin after curretting the site.

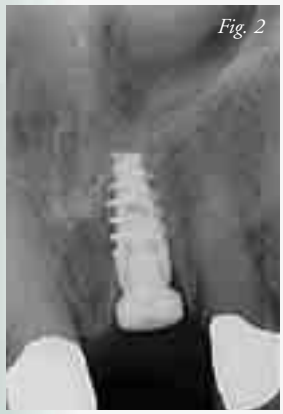


Fig. 2

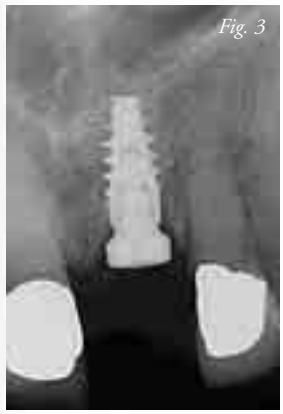


Fig. 3

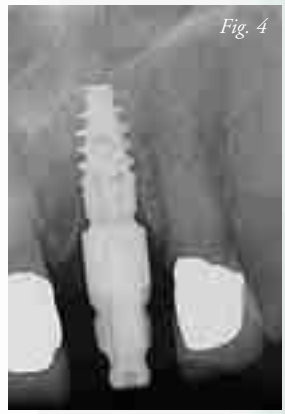


Fig. 4

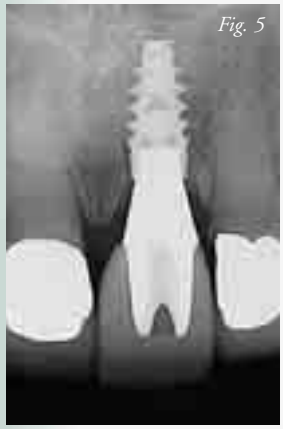


Fig. 5

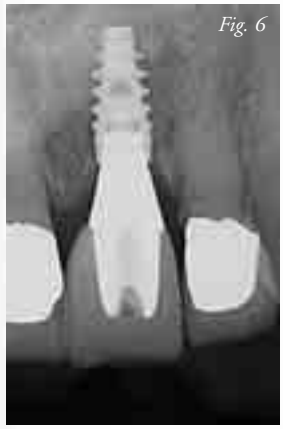


Fig. 6

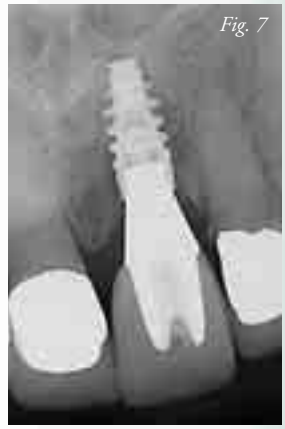


Fig. 7

If you would like to read what Townies are saying in similar message boards, check out...

Failing Implant Help Needed
Search: *Failing Help Needed*

Implant Failed After 2 Months
Search: *After 2 Months*

Failed Immediate Molar Implant and Then… Ah Success!
Search: *Failed Molar Implant*

or... Scan this tag with your mobile phone to view this message board.

What would you have done differently? What do you think caused the failure? Smoking?

Fig. 1: Initial preop
Fig. 2: At time of placement, March 2010
Fig. 3: One month postop
Fig. 4: Three months postop
Fig. 5: Initial try-in, not cemented yet
Fig. 6: Patient complaining of pain, July 2010
Fig. 7: Implant loose, August 2010
What are your thoughts? ■

caseypete1
Posted: 8/31/2010
Posts: 2 & 3 of 45

The crown root ratio is excessive. It is possible it was placed in an infected site. Also was the implant loaded immediately? If so, that should be done with a temp on the day of surgery. That temp should be totally out of occlusion. You cannot wait a few weeks for lab work and load it. It's either in the beginning or not at all. Did the implant obturate the extraction site? Most of these fail because of load or infection. Some fail because of compromised health (i.e., diabetes).

[Posted: 8/31/2010]

Just looking back at the three-month radiograph, it looks like there is some radiolucency on the mesial part of that implant. If the bone wasn't formed yet this could mean a major crown root ratio problem. That implant might have been moving after the crown was placed (no good for bone formation). Maybe three months is a little too soon to load. I always wait six months in the anterior maxilla. ■

kwalia
Posted: 8/31/2010
Post: 4 of 45

The case wasn't an immediate load. The impression was taken at three and a half months and the restoration was placed four months after placement. The site was cleaned prior to placement, but I guess there could have been some lingering infection. The implant did obturate the extraction site. ■

drlister
Posted: 8/31/2010
Post: 5 of 45

I have to agree with crown-to-root ratio (ask me how I know). Unlike posterior teeth with most forces directed along the long axis of the tooth, in the anterior forces are exerted at an angle. If the implant had the same tooth-to-root ratio as the original tooth you might have a better chance. You are looking at a bone graft from hell or a bridge. ■

continued on page 36

continued from page 35

kwalia
Posted: 8/31/2010
Post: 7 of 45

Again I just want to get more opinions so I can learn and not make the same mistakes again.

At this point I've grafted and we've discussed doing another implant in four to six months or doing a bridge. Patient wanted to pursue the implant option again, so now we wait and see how things heal. ■ Kunal

Skku90
Posted: 8/31/2010
Post: 8 of 45

What was the dimension of the implant? Which brand? How was the bone quality? Longer and wider implant with more threads (I see only six on the implant presented here) equals more surface area. Also it will improve crown-to-root ratio. ■

caseypete1
Posted: 8/31/2010
Post: 9 of 45

It looks like #10 is going to end up the same way. Maybe two implants after grafting (longer ones). Wait six to eight months then restore with splinted crowns. It might end up being an aesthetic nightmare if not done right. ■

kwalia
Posted: 8/31/2010
Post: 10 of 45

The heavy smoking is what keeps coming back to me. Yes it is NobelActive. I tried to keep the platform 3mm below the adjacent CEJ/gingival margin, but I think about 4-4.5mm below. ■

pjmop
Posted: 8/31/2010
Post: 11 of 45

Crown-implant ratio had nothing to do with it, in my opinion. Did you torque test the implant before impressing? My guess, based on past experiences with implants in smokers, is the implant was never integrated. A two-stage approach is indicated in smokers. Bury that dude and tell them to try their best to not smoke until after the incision over the implant is closed. If they have to smoke the first week, ask them to put gauze over the surgical site. In general I find a near 100 percent success rate when two-staging. I've gone to it almost exclusively, even in non-smokers. ■

Jonathan Abenaim DMD FICOI DICOI
Posted: 8/31/2010
Post: 12 of 45

Implants don't fail that quickly. You probably never had full osseointegration. Look into this... will make your life way more predictable. No more guessing when the implant is ready, as X-rays are useless. ■

Fig. 8a

Fig. 8b

Fig. 8c

Fig. 9a

Fig. 9b

kwalia
Posted: 8/31/2010
Post: 13 of 45

I've looked into that before. However, the price was near $3,000. Is that about right? I believe NeOss is the distributor for it.

Lack of osseointegration from the start…so I should have waited longer for healing? I'm just wondering about next time. So far I'm thinking to just wait four to six months prior to placing the implant and then six months covered with a cover screw. ■

pjmop
Posted: 8/31/2010
Post: 14 of 45

Your plan should work, but another option if you have enough bone width, is to go up one implant size (about .5mm) and place another implant immediately. Curette the socket walls of any epithelial tissue and place a slightly larger implant with cover screw. ■

continued on page 38

TAKE THE DSG **ALL-CERAMIC** LINE TO A MORE SUCCESSFUL PRACTICE

The rising value of gold is making many dentists rethink PFMs and full cast restorations. With all-ceramic solutions from the DSG Network, you can satisfy your patients with unparalleled strength and esthetics with these leading restorations: IPS e.max® CAD and Press, 3M™ ESPE™ Lava™, DSz™ zirconia, and DSmz™ — DSG's new monolithic zirconia. You save on material costs, while delivering your patients a restoration replete with strength, esthetics and precise fit.

GET YOUR FREE STARTER KIT TODAY AND ENJOY
20% OFF YOUR FIRST ALL-CERAMIC CASE.

dentalservices.net/kit
877.870.6189

DSG Dental Services Group™
The Laboratory Network

FREE FACTS, circle 37 on card

continued from page 36

cletus THE slack jawed DDS
Posted: 8/31/2010
Post: 15 of 45

Smoker equals poor protoplasm environment for healing. One stage surgery equals chance of poor integration in a poor host. Looked like an infected extraction equaled impossibility for immediate placement – not a good place for healing.

You had two or three strikes against you from the beginning. It's time to fade back and punt. Graft the site, get primary closure and let it sit six months. Place another at that time, get primary closure, and let it heal six months. Explain to the patient that this is because you have had one failure and they smoke; extra precautions need to be taken for success.

If you try to place a new implant in the same site moving up in diameter, you risk hitting nearby roots and the site is still not well from the previous failure and you are not going to get primary closure. This is not the surgeon's skills at fault; it is the surgeon's judgment that is at fault.

I had a woman who fractured off an anterior bridge and lost two teeth. She had smoked like a chimney for more than 40 years, but had recently quit cold turkey. Being a trusting individual, I placed the implants, one-stage surgery. Three weeks later she calls with a lot of pain, comes in and they are infected. We start one course of amoxicillin. She calls back at the end of the week still in pain, we switch to clindamycin. We call her at the end of that week, it is much better.

Patient calls back a month later, pain is back and they feel loose. She comes in two days later with both implants in her hand, bone looks like crap, and the gingiva looks like a slaughterhouse. I can't believe it. Upon investigation, she admits that she went back to smoking the week after we placed the implants. Refunded her money. She went to the surgeon for grafting and implants and to the prosthodontist for crowns. She is no longer a patient, my choice. Lesson learned.

I now only place implants on smokers after three months or more of healing postextraction and only with primary closure. They are also prewarned that if the implant fails, they get to pay a second time full price. They get pretty motivated and want Chantix at that point. ■

NewKid
Posted: 8/31/2010
Post: 16 of 45

Although it makes sense that crown-to-root ratio could be an issue, there is no evidence in the literature to support this for sure. Drill a hole through the crown. Remove the crown and abutment. Close it back up. Blast him with antibiotic, chlorhexidine, and Chantix (warn about suicide). Wait three more months and re-evaluate every four weeks. If more evidence of failure, don't waste time. Trephine the implant and graft. One reason (if this is failing) is fracture of buccal plate of bone during extraction. What was your torque during implant placement? ■

docaz
Posted: 8/31/2010
Post: 17 of 45

First of all, do not beat yourself up too much because I do not think that this was a major screw up and asking for opinions from others is a great way to learn from problems.

I agree with sdcrog, that I would have picked a 2mm or so longer implant with the neck not that far below the crest. Particularly with conical connections and platform switched implants, you have a good chance to end up with nice bone at the crest, but I do not think that this was the reason for the failure.

More likely the implant was not fully integrated when it was restored and even light masticatory force can kill it in that case. In general, after immediate placement, I wait a little longer because we have to wait for the bone to grow toward the implant from the walls of the extraction site. With this particular implant it is even more important to do so because it is designed to be placed in an undersized osteotomy and the core of

continued on page 40

A Beautiful Custom Website
Shouldn't Cost You Thousands!

$0 Setup Fee
&
$39.95 /month

No Contract
No Obligation
Unlimited Support

"I got more new patients in 6 months using your service than I did in 4 yrs with my other company. I just landed a $10,000 case from one new patient who saw and liked my website!"

Dr. Thomas Volck - http://www.vandaliacosmeticdentist.com

Every Website Features:

Beautiful Designs – A huge selection of stylish, high-end designs customized to your specific practice.

Practice Specific – Over 40 pages of content written for your general or specialist practice. Change it all at the click of a button.

Fully Customizable – Unlimited content, pictures, video and links for your practice.

Patient Interaction – Online storefront, Google maps, music, smile gallery, member section, online forms and site statistics.

Patient Education Center – Printable patient forms, appointment requests, educational spotlight on your practice specialty and testimonials.

Get Top Local Search Results

Google msn AOL YAHOO!

There Were Over One Million Local Searches for a Dentist Last Month!

Was Your Practice Found?

Custom Patient Education Videos

Cosmetics
Implants
Orthodontics
Prosthodontics
Periodontics
Pedodontics
Endodontics
Technology

Absolutely Free With Your Website

FREE FACTS, circle 36 on card

THE ONLINE PRACTICE

Call Today! We'll Walk You Through It!
1-888-932-5560
www.TheOnlinePractice.com

continued from page 38

the implant is very narrow. The interesting thing is that this particular type of implant is marketed for improved initial stability because of the thread pattern, but in my opinion, this is only valid in a healed site, not in immediate extraction sites. In immediate extraction sites I suspect that there is no advantage and possibly a disadvantage and I have experienced that myself, but at this time I have only placed a few of them (and I had exactly this problem, but I was fortunate to realize at the time when I wanted to remove the healing abutment and let the implant sit for another two months).

The question is if one could have predicted the problems when it was restored and my opinion is that often it is not that easy when the implant is stable. This happens when part of the implant is integrated and part of it is not. I suspect that even in the best hands that could have happened. I wonder if there is anybody in the group who is using an Ostell Mentor or a Periotest and if they feel that these devices would have been helpful.

In general, particularly in anterior cases or if an expensive custom abutment is used, I suggest to go through a temporary phase. This will allow adequate time for soft tissue maturation which can take six months and while it can not avoid a failure, it can at least lower the cost associated with it, in case it happens. Best. ■ Albert

Dan Haghighi, DDS
Posted: 8/31/2010
Post: 19 of 45

Was this a flapless surgery? If so, was the apex of the implant body lingual to the apex of the socket? One possibility given the very thin buccal alveolar walls was that you had a partial or complete buccal fenestration which then might have caused failure upon loading.

Another thought would be failure due to occlusal interferences or nonimplant-protected occlusion. My guess is as others have surmised – that the implant was probably never fully integrated to begin with. Good luck. Cheers. ■ Dan

kwalia
Posted: 9/1/2010
Post: 20 of 45

Thanks everyone for the comments. I guess this is a lesson learned on smokers to wait much longer and on everyone else to wait a bit longer for anterior cases.

The surgery was not done flapless. So I could see exactly where the bone was and there was quite a bit of buccal bone present and the implant was lingual.

As far as the Ostell Mentor or Periotest, do you guys use these on every case? What's the cost of the unit? ■

utdental
Posted: 9/2/2010
Post: 27 of 45

How does one torque test? Just dial in 35Ncm on your ratchet and see if the implant holds still? I heard you never want to reverse torque test because this could indeed break osseintegration, is this true? That might have been in Misch's textbook. ■

pjmop
Posted: 9/2/2010
Post: 28 of 45

I put about 20-25Ncm of torque on it. It doesn't have to be in reverse. If there's pain, let it integrate another month or so. If it spins, it's not integrated and should be removed. The Osstell is probably a better alternative. I just ordered one from Hiossen for less than $2,000. ■

FREE iPAD WHEN YOU SWITCH*

We're giving away an iPad to the first 97 doctors that switch before Christmas 2010, PLUS a FREE patient medical history app to download. Restrictions apply. Call for details.

Helpful Hint: Call ASAP to get one of these bad boys for Christmas.

Time for New Software?

Are you hounded by pesky servers? Do you stress over data backups? Do you lose time and money to useless upgrades? Then make a change to a fresh, web-based alternative to dental software. A simple phone call will get you started. But hurry: The first 97 doctors to make the switch before Christmas 2010 get a free iPad and medical history app. Call now for the exciting details. Very cool!

Call 888-910-4376
or visit www.curvedental.com/ipad

curvedental®

FREE FACTS, circle 35 on card

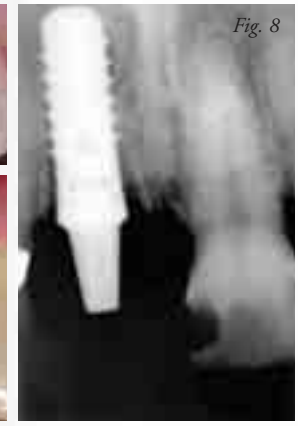
Another Immediate with Temp at One Year

Immediate implants satisfy our desire for immediate gratification and this example demonstrates success.

emilverban
Posted: 8/27/2007
Post: 1 of 11

Number 8 fracture of endodontically treated tooth. Extraction immediate placement and one-year follow-up. Placement of 4.1x12 Straumann.

Fig. 1: Number 8 old crown with fracture of tooth structure
Fig. 2: Extraction
Fig. 3: Note erosion of root tip
Fig. 4: Extraction socket
Fig. 5: Placement of 4.1x12 with solid abutment; implant placed with a 2mm horizontal space to labial plate
Fig. 6: Use of premade coping for temp and jell-temp



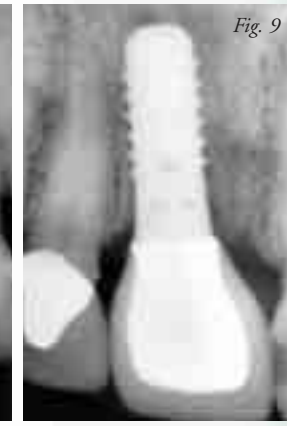


Fig. 7: Finished temp – cemented with zinc phosphate for 12 weeks before removal and impression
Fig. 8: Day one – note the vertical level of platform and the void of bone on mesial and distal
Fig. 9: One-year follow-up with permanent crown
Fig. 10: Final crown at one year

Want to know what your peers have to say about immediate implants? Check out these other message boards on Dentaltown.com.

Immediate Placement in the Anterior - Why to the Lingual!
Search: *Placement Anterior*

Immediate Post-Extraction Implants
Search: *Post-extraction implants*

Planned on Immediate Implants...
Search: *Planned on Immediate*

or... Scan this tag with your mobile phone to view this message board.


Fig. 11

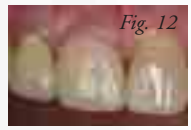


Fig. 12

Fig. 11: Patient in on maintenance and an X-ray at 18 months postop – slightly elongated

Fig. 12: Intraoral photo postop at 18 months – immediate placement and correct placement of platform will allow aesthetic results even with the 1.8mm collar. In this case a custom abutment was not needed. ■

docaz
Posted: 8/28/2007
Post: 2 of 11

This is a great case showing that in good hands a one-stage implant can be very aesthetic and have great tissue response. The solid abutment that you have used is much narrower than abutments that have a screw hole through them allowing for increased thickness of the restoration and resulting in increased translucency. Obviously not all ceramics can handle a certain thickness and we are now considering endorsing Lava restorations for situations like these to take advantage of that and eliminate the need for zirconia abutments.

Thanks for posting. ■ Albert

Julio 1
Posted: 8/28/2007
Post: 4 of 11

Nice case showing interproximal bone regeneration, but I will bet you anything that there is dehiscence of the facial bone. I think this case would benefit from a connective tissue graft, don't you? ■

continued on page 44

continued from page 43

m_a_fouda
Posted: 2/5/2008
Post: 8 of 11

This case shows again that the gap between implant and bone in extraction sockets doesn't require any grafts (provided that buccal plate is intact). It is a great result. I like the case and you don't need a CT graft or anything. Keep up the good work. ■

emilverban
Posted: 2/5/2008
Posts: 10 & 11 of 11

The gauge will aid in placing the platform in the proper position. The photos illustrate.


Fig. 13


Fig. 14


Fig. 15


Fig. 16


Fig. 17

Fig. 13: In this case the gauge is at the apex of the socket. This tells me that I can drill directly through the socket and have my 2mm of buccal space needed not to encroach on the plate.

Figs. 14-15: Note the contour of the labial at abutment placement. No grafting was used.

Fig. 16: Final crown.

[Posted: 9/10/2010]

Fig. 17: Now over three years. ■

Find it online at www.dentaltown.com

Another Immediate Search


Burbank Dental Laboratory Inc.
Providing the most durable single-unit restorations available...
veneers
thin veneers
inlays/onlays
crowns
IPS e.max
all ceramic all you need
e.max (full contour monolithic - press and stain)
· 4 levels of opacity - 90% Block out or translucent - chameleon effect
· Ideal wear on opposing natural teeth
· Years of clinical evidence
· Best fitting all ceramic restoration available
· Monolithic crown (one material throughout the entire restoration)
· Stronger than layered zirconia restorations
· Outstanding esthetics
· Conventionally cementable
· Efficiently produced providing rapid turn around
FREE FACTS, circle 42 on card
IPS e.max
$ 25.00 Off Per Unit
First e.max Case Only
Monolithic Restoration (press & stain)
Maximum 4 Unit - One Case
Offer Expires 1-15-2011
Proudly Made In The USA
Burbank
Dental Laboratory Inc.
800-336-3053
Burbank
Dental Laboratory

Leaders of Their Domain

Officite delivers all-encompassing Internet strategies to the dental profession.

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

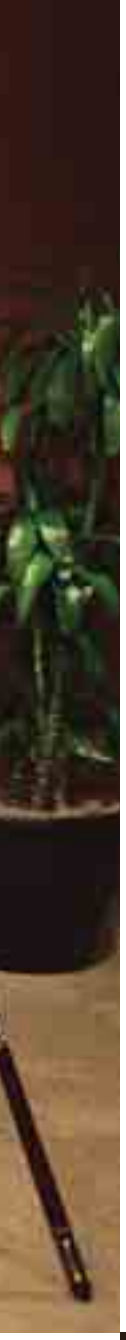
Practice Web sites are more than a commodity; they are in many cases, a new patient's introduction to your practice. How someone perceives your Web site may determine how they perceive your overall practice… and you never get a second chance to make a first impression. It's rare for a dentist or an office manager to be able to set aside time to develop and manage a practice Web site. Fortunately, there's help. Since 2002, Officite has taken the reins of more than 5,000 medical practices' Web sites and has become integral in helping grow those practices with online customization and practical marketing solutions. *Dentaltown Magazine* sat down with Officite President, CEO and Co-founder Glenn Lombardi to learn more.

What is your current business philosophy? In other words, if you were to meet a dentist on the street, how would you describe how Officite can help dentists succeed?

Glenn Lombardi: Officite can provide dentists with a full turnkey, easy-to-use Internet strategy to set up their entire online presence and new patient solution. From premium Web site designs and patient education to search engine marketing, social networking, and patient reviews optimization and management – we've got it all. Our sites are designed with all of the information a patient would ever need, including new patient registration forms, doctor bios, service descriptions and appointment scheduling, making an Officite Web site a 24/7 storefront for the practice and a patient's portal to the practice even when the office is closed.

Glenn, when we showcase companies on the cover of *Dentaltown Magazine*, we typically feature a cover photo of the company's executive team. Why did you prefer we use the photograph of three of your dental clients instead?

Lombardi: As the leading dental Web site provider, Officite has experienced tremendous growth and success since its inception in 2002. The success stories of Grove Dental Associates, Dr. Lou Graham and Dr. Mary Sue Stonisch are just a small representation of the thousands of dental practices we have worked with in the past decade. To put it simply, their stories are our success (**see sidebar testimonials**).



What key innovations has Officite brought to the dental profession?

Lombardi: We've made getting on the Internet and managing your entire online presence easy for any dental professional. We take a comprehensive approach to Internet marketing, seamlessly integrating a client's Web site with print materials, search marketing strategies and social networking so that it can all be managed from one central location – the Doctor Portal.

Can you tell us more about the Doctor Portal?

Lombardi: From making changes to your Web site and tracking new patient appointments to reviewing your search marketing campaign, we've integrated it all. The Doctor Portal gives dentists one easy, seamless dashboard for managing and reviewing their entire Internet strategy, including e-mail, Web stats and Google applications and reports. From the Doctor Portal, clients also have access to a full array of support resources including video tutorials, marketing articles and valuable tips for improving a Web site's performance.

How do your Web sites generate new patients differently than the average site?

Lombardi: An Officite Web site delivers results. We customize a new patient strategy that's unique for each dental practice based on their goals, local competitors and market. This might include a call-to-action campaign, a demographic focused search engine optimization strategy or a targeted paid advertising campaign specific to service electives, like veneers, implants, snoring or sedation dentistry. But most importantly, we track our clients' progress and performance, providing results so the dentist can instantly update and measure their return on investment (ROI). Clients always have the ability to easily monitor and measure their Web site's performance when teamed with Officite.

What changes have you seen in the Internet since you started creating sites in 2002?

Lombardi: One of the most significant changes has been the switch from dial-up to broadband. This transition greatly enhanced the number of people using the Web, including the number of current and potential patients searching for local dentists. As a result, a Web site has become a critical marketing tool for dentists looking to generate new patients. In fact, the search term "dentist" is searched for more than two million times a month on Google.

The second major change was the emergence of Google and other major search engines. Officite harnesses the power of search engines to increase Web site visibility for our clients, as seen with our current full service Internet marketing programs, such as search engine optimization, pay-per-click advertising and local maps optimization.

A third change has been the incredible growth of social networking. When we first started in 2002, everyone was buying a Web site to have an online brochure. These sites offered only basic information about the practice with little value and limited ability for a patient to interact with the practice. With the integration of our social networking and blog technology with a dental practice's Web site, these platforms have become powerful vehicles to communicate not only with new patients, but more importantly with current patients to build retention and referrals.

continued on page 48

Spotlight on Officite Client: Mary Sue Stonisch, DDS, FAGD

www.smileenhancementstudio.com • www.yoursmilenow.com
Officite Client Since: 2004 • Location: Grosse Pointe Woods, MI

Dr. Stonisch was one of Officite's first Search Engine Optimization clients and currently holds the top position on Google, Yahoo and Bing.

Stonisch: Not only does Officite make it affordable, but they are always three steps ahead in terms of marketing and technology. They know what trends are coming and they know how to execute a strategy that works for every individual practice – big and small. Officite currently manages my search engine optimization program. I always know where I show up on search engines, and I'm always near the top.

On Officite's ability to manage and integrate all aspects of the site:

Stonisch: It's not just about a Web site, it's about utilizing every new technology source that's out there from Facebook to Twitter to blogging to SEO, and Officite is able to do that for me, and do it well. They have placed everything under one umbrella for my practice making it easy for me to participate in various programs that are the most beneficial to my practice needs. They research my practice needs to determine my ROI and then deliver a solution that works. They do what they do best so that I can spend my time doing what I do best! I make one phone call and they do the rest.

continued from page 47

Explain your strategy and goals with search engine optimization. Is it true that once a dentist goes down this road he/she must constantly chase more optimization?

Lombardi: Once you start search engine optimization (SEO) you need to continue it if you want to maintain a high ranking in the search engine search results. But you also need to choose the right partner with a proven track record of an ROI before signing up for the program in the first place. A lot of companies will offer very expensive SEO strategies and after six months if it doesn't work they will offer the service for free. If a company wasn't able to improve your ranking and performance in the first six months, how effective are they going to be in the following months? With that said, you can't invest in SEO unless you're certain you're going to work with an expert who has a proven track record working with and providing an ROI for their clients. If we don't think SEO can be successfully maintained for the long-term after researching a client's competitive market, then we don't recommend it. We typically would offer other strategies based on our clients' needs, including pay-per-click advertising, local maps and direct mail that also deliver results.

How does Officite set itself apart from competitors?

Lombardi: We deliver results. We have facilitated more than 275,000 new patient appointment requests for our clients and we know that because we continually track, maintain and monitor new patient activity for each of our clients' Web sites.

We have built a highly innovative and easy-to-use site building and editing tool in the market space – the "point and click" site editor. It is built with the latest and most innovative technologies, which gives our clients the greatest flexibility and ease of use.

We offer a comprehensive turnkey marketing solution for any dental practice. From Web sites and search marketing to social media, patients' reviews optimization and management, print marketing, and direct mail, Officite can manage the entire marketing process for a practice.

Do you write the blog entries for your dental clients? How does this process work?

Lombardi: Dentists can either blog for themselves with our integrated blog technology from our easy-to-access Doctor Portal. Or, Officite can manage the client's blog for them

continued on page 50

Spotlight on Officite Client: Grove Dental Associates
Greg Shubat, DDS, Partner & Darla Scheidt, Marketing Director

www.grovedental.com • Officite Client Since: 2005 • Location: Bolingbrook, Downers Grove, Lombard and Wheaton, IL

More than 2,000 new patients generated since launch of site; 400 new patients generated from the Internet through July of this year

Shubat: Every day we get a new patient who found us on our Web site.

Officite makes managing Grove Dental's entire marketing strategy (custom designed website, print advertising, e-mail marketing, search engine marketing, social media, blogs) effortless for the practice.

Scheidt: Even in a large group practice with a robust marketing budget, one single person can't possibly handle the intricacies involved with marketing our practice. We need an expert to assure the most productivity and efficiency out of all of the specialized areas of marketing. Officite has proven to be the expert source we've needed to succeed for the last six years.

Shubat: We've learned that tracking is most important to evaluate our marketing efforts' success. Officite has set up our site so that we can easily measure it's performance. Now we always know what is working. We want a good ROI.

On Officite's management of Grove's entire social networking and blog campaign:

Scheidt: It's no longer just about patient education; it's no longer self-diagnosis; today it's about building relationships. Patients have to feel good about who you are and start to build that trust. I think that's especially true with a specialty practice. Social media makes it easy to cultivate and maintain these relationships, and Officite makes it even easier to build, engage and manage these platforms.

Shubat: Yellow page usage has been replaced by Internet searches. A Web site tied to effective search engine optimization and social media sites is the new way to attract new patients.

Are you attending
the Greater New York Dental Meeting?

We are!

Stop by the Dentaltown booth #5602
for exciting giveaways and prizes
like NEW iPod Nanos,
Starbucks gift cards and more!

See you there!

Don't miss Dr. Howard Farran's lecture
"The Virtues of Profitable Dentistry"

Monday, Nov. 29 • 2-5 p.m.
Tuesday, Nov. 30 • 2-5 p.m.
Wednesday, Dec. 1 • 2-5 p.m.

dentaltown®
a Farran Media interactive healthcare community | www.dentaltown.com

continued from page 48

through our blog management program. Through a partnership with *Dear Doctor* – the leading patient magazine – clients can choose up to five prewritten, customized blog articles per month generated from the *Dear Doctor Digital Library* of almost a thousand patient-specific articles. Then Officite will automate the entire process of customizing and posting the articles to the client's blog and social media sites so their entire network is updated continuously on a monthly basis. The process requires no effort on behalf of the dentist because we take care of the content creation and postings.

Aside from a Web site, what is the best "bang for your buck" when it comes to marketing?

Lombardi: An integrated Internet marketing strategy is easily the best "bang-for-your-buck" marketing today. This includes search marketing, social media, local maps and reviews optimization and management. Tying all these search solutions together is really what makes the Web site an effective marketing tool.

What are your thoughts on online reviews? How do you manage online reviews for your clients?

Lombardi: Online patient reviews are the number-one new opportunity for dentists right now, even bigger than social media. Patients now have the ability to go online and review any local dentist at any time through numerous online directory resources, such as Google, Yahoo, Yelp, City Search and more. Let's face it, patients trust other patients more than any other form of marketing, so it's important that dentists take control of this increasingly popular review process. We offer our clients exclusive access to our review toolkit service, which they can use to encourage reviews about their practice. And we help our clients manage and audit their online presence through numerous tools, including our new reputation auditing service. Today, most dentists have only a small number of reviews, and in most cases these reviews are negative as these patients are the most motivated to leave a review in the first place. The best way to combat negative reviews is to increase the number of positive reviews about your practice. By using our reviews optimization and management program, we give you the tools and resources to streamline the process for patients to post reviews about your practice online so that six months to a year from now you can expect 100 and even 200 positive reviews that will offset the two or three negative ones. Online reviews are one of the newest and biggest opportunities today for dentists to move forward.

How do you see dentistry changing in the future and how will Officite contribute?

Lombardi: From CEREC to digital X-rays, technology in the practice is constantly growing and evolving. And with the recent mandate from the government for electronic medical records (EMR) systems, practice management will further be driven by online processes. Officite is constantly staying abreast of the latest trends and we continue to innovate faster, easier and more efficient ways for our clients and their patients, including our mobile ready Web pages, site editing technology and online performance tracking. We can integrate a client's entire Web site and Internet strategy with their current practice management processes. An integrated approach with a Web site functioning as the foundation of all practice marketing is where the future is going to happen, and you can count on Officite to be at the forefront of these latest innovations.

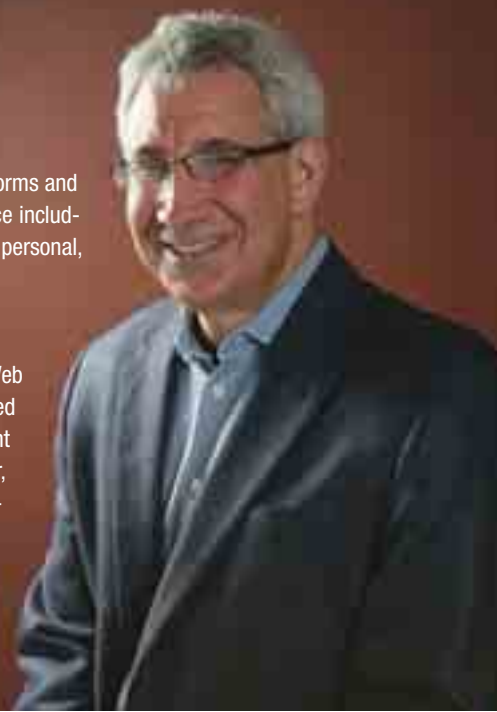
For more information about Officite, visit www.officite.com or call 888-749-3779. n

Spotlight on Officite Client: Lou Graham, DDS

www.udpdentistry.com
Officite Client since: 2006 • Location: Chicago, IL

Officite has created a dynamic, fully-functional website with customized videos for Dr. Graham.
Graham: I wanted to differentiate my practice beyond the basic information of the Web site like new patient forms and education in order to highlight my true passion for dentistry. Officite coordinated a video shoot for my practice including patient testimonials, which have been powerful tools in showing patients who we are; they are warm and personal, and it helps make patients comfortable to pick up the phone and call us where print can't do that.

Dentists without an Internet strategy won't survive.
Graham: When I graduated dental school there were no cell phones, no texts, no Facebook, no Google and Web sites weren't even a thought. But today, every new patient that comes into our office under 50 has embraced this digital wave as a part of their entire social structure. Patients want 24/7 access to information; they want social media; and they want to search online for a dentist to learn more about the practice. As a practitioner, even if it's not familiar to you, you have to go with the times. I've entrusted my entire online marketing strategy to Officite so it's not overwhelming.



It's the end of the year,
and you know what that means...

You need CE credits for your upcoming license renewal!

146+ courses to meet all of your requirements
Convenient system organizes all of your certificates
Earn credits anytime, anywhere

Recently released courses:

The WOW factor - Delivering exceptional cosmetic dentistry and increasing profitability using the diode soft tissue laser
Speaker: Todd Meeks, DDS

Composite: The Ultimate Material for Minimally Invasive Dentistry
Speaker: Brian LeSage, DDS, FAGD, FAACD
Sponsored by: Heraeus

Go to Dentaltown.com today and get the credits you need

dentaltown
continuing education

ADA CERP and/or AGD PACE approved courses are valued at two CE credits. For more information, visit www.towniecentral.com/dentaltown/onlinece.aspx

ADA C·E·R·P® | Continuing Education Recognition Program

Farran Media is an ADA CERP Recognized provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.

Academy of General Dentistry
PACE Program Approval for Continuing Education

Approved PACE Program Provider
FAGD/MAGD Credit
Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement.
12/01/2004 to 12/31/2012

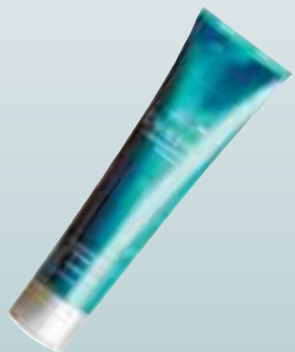
You are invited to visit Dentaltown.com to ask questions or post comments about the following New Product Profiles. If you would like to submit a new product for consideration to appear in this section, please send your press releases to Assistant Editor Marie Leland at marie@farranmedia.com. All material is subject to editing and space availability.

Dentisse Natural Reflection Toothpaste

Dentisse Natural Reflection is a new brand of premium oral care toothpaste using a special refined kaolin (a natural white clay) cleaning and polishing agent to produce a healthier looking smile. The kaolin clay is highly purified and specially refined to produce flat-surfaced particles with microscopic ridges that polish teeth to a micro-smooth luster and its bold mint flavor comes from pure, natural peppermint oil. Visit www.dentisse.com for more information.

Dentisse Natural Reflection Toothpaste

FREE FACTS, circle 50 on card



My Social Practice

My Social Practice provides an innovative social media marketing solution for dental practices. Social media is word-of-mouth marketing online. It increases the loyalty of current patients and is a powerful tool in acquiring new referrals. My Social Practice designs, programs and creates integrated tools including a customized blog site, Facebook micro site, Twitter platform, YouTube channel and printed promotional materials. Visit www.mysocialpractice.com or call 877-316-7516 for additional information.

My Social Practice

FREE FACTS, circle 51 on card

MySocialPractice.com

TePe Implant Kit

The TePe Implant Kit contains three professionally selected brushes. TePe Implant Care has an angled neck and a slim brush head for easy access to the lingual and palatal surfaces of the implants. The TePe Implant Brush, with an extra narrow brush head and a long thin neck makes it easier to clean the buccal surfaces. The Interdental Brush, which is plastic-coated, efficiently cleans the approximal surfaces of the implants. For more information visit www.tepe.com/implantcare.

TePe Implant Kit

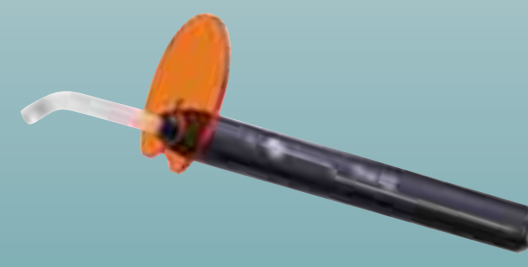
FREE FACTS, circle 52 on card

MiniLED Black

MiniLED Black is the first and only cordless LED curing light in the world powered by three AA batteries. The MiniLED Black possesses a 10 second fast cure mode and has a power output of 1,250mW/cm^2. This high power output combined with a wide spectrum of light emitted (420-480nm) make it able to efficiently cure virtually any composite on the market. For more information visit www.acteongroup.com.

MiniLED Black

FREE FACTS, circle 53 on card



DEFEND Micro Applicators

DEFEND Micro Applicators offer precise, no-drip, no-spill application of agents and solutions. Designed with a bendable, "stay put" neck, DEFEND Micro Applicators are constructed with non-absorbent, non-linting fibers that leave no residue. Offered in three sizes (super fine, fine and regular) they can suspend solutions as small as 1/8 of a drop without dripping or spilling. Call 800-275-0020 or visit www.defend.com for more information.

DEFEND Micro Applicators FREE FACTS, circle 54 on card

Pro-fix Precision Fixation System

The Pro-fix system includes self-drilling membrane fixation screws, self-drilling tenting screws, and self-tapping bone fixation screws. Pro-fix features a locking-taper cruciform drive system that allows easy pickup and safe transport of the screw to the surgical site. Osteogenics will first introduce the 3mm self-drilling membrane fixation screws designed to engage bone without the need of a predrilled pilot hole. Visit www.osteogenics.com for more information.

Pro-fix Precision Fixation System FREE FACTS, circle 55 on card

Ridge Splitting Chisels

Ridge Splitting Chisels are used for lateral ridge augmentation to increase bone support for implant insertion. They enable the insertion of an implant at the time of augmentation avoiding the delay to permit consolidation of a graft. Chisels can be used in conjunction with screw type bone expanders to facilitate bone manipulation. The ridge splitting chisels come in widths of 3mm and 6mm. Each width is available in two blade thicknesses; 0.5mm and 2mm. For more information visit www.itldental.com.

Ridge Splitting Chisels FREE FACTS, circle 56 on card

Zen-X

Zen-X High Speed USB X-Ray Sensor has a 14-bit CMOS sensor capable of over 16,000 shades of grey. This sensor comes in both size 1 and size 2 to ensure a comfortable fit for any exam. Zen-X can achieve a fast two seconds transfer time between exposure and on-screen display. Compatible with existing imaging software's via TWAIN interface, Zen-X also comes with complimentary imaging software RayMage. For more information call 800-416-3078 or visit www.myrayamerica.com.

Zen-X FREE FACTS, circle 57 on card

Bone Augmentation by Deficit Six and Topography

The two- to five-bony wall defects

by Carl E. Misch, DDS, MDS, PhD(HC) & Craig Misch, DDS, MDS

The concept of prosthetic-guided treatment plans has evolved over the years as a method for achieving and maintaining predictable results when replacing the natural dentition. To satisfy the ideal goals of implant dentistry, the hard and soft tissues need to present ideal volumes and quality. The alveolar process is affected so often after tooth loss that augmentation is usually indicated to achieve optimum results, especially in the aesthetic zones. Augmentation is also required relative to functional conditions of the implant treatment plan, because a reduction of stress at the crestal bone region and a greater resistance to screw loosening and fatigue fracture occurs with a greater number and/or larger-diameter implants.[1]

The number of key factors present to grow bone and the geometry of a bony defect are important considerations in the selection of a modality for ridge augmentation.[2] The residual ridge deficit size and topography is a major key condition in the surgical approach for augmentation. The topography of the graft site affects soft tissue closure, space maintenance, graft immobilization, vascularization and the need for additional growth factors. It is also a factor for the selection of the graft material. The fewer the number of remaining bony walls in the host bone site, the greater the need for osteopromotive techniques. In 1993, Misch and Dietsh classified bone defects by the number of surrounding bony walls.[3] Each of these topographies have different factors to consider when bone augmentation is performed. This article will present concepts related to the two- to five-wall bony defect.

Five-wall Bony Defect

When the surrounding bone of an extraction socket is greater than 1.5 thick on the facial, lingual, mesial, distal and apical regions, a five bony wall defect is present. This is an ideal environment for bone growth, as most all the keys necessary to grow bone are already present, especially when the conditions exist immediately after the extraction of a tooth. The space will be maintained by the surrounding walls of bone and the graft is immobilized by the bony walls. Growth factors are released and a regional acceleratory phenomenon (RAP) begins from the periodontal complex and walls of bone as a result of the tooth extraction. As a result, bone grows in the site, even without initial soft tissue closure over a graft material. However, the rate of bone and soft healing is affected by the absence and/or graft materials selected.[4]

Three- to Four-wall Bony Defect

In the periodontal literature, it is well documented that a defect next to a tooth root with three walls of bone can be restored more predictably than a defect with two walls of bone. Likewise, a defect with three to four walls of bone in an edentulous site can be augmented with fewer osteopromotive techniques than a defect with two walls of bone. Most often, a three- to four-wall defect in implant dentistry corresponds with a 0 to 3mm lack of facial bone. The bone is present on the lingual, mesial, distal and apical regions (four-wall defect), or the apical region is too narrow or compromised (three-wall defect).

Guided Bone Regeneration (GBR)

The three- to four-wall bony defect requires more keys for bone augmentation than a five-wall defect, including: soft tissue closure, space maintenance, more osteopromotive graft material and graft immobilization. For example, the graft material in a three- or four-wall defect more often requires an autograft as a

continued on page 56

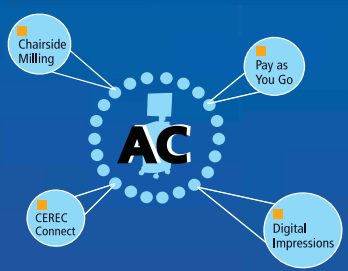
Please visit us at the GNY Dental Meeting at Sirona Booth #4625 or Patterson Booth #4601

INTRODUCING CEREC® AC

POWERED BY BLUECAM

DENTISTRY TODAY TOP 50 TECHNOLOGY PRODUCTS 2010

CAD/CAM FOR EVERYONE



CEREC AC offers solutions to everyone:

Impeccable results: Blue LED technology yields the most precise digital impressions available
Enhanced speed: Half-arch digital impression in 40 seconds; full-arch in under 2 minutes
Versatility: A system configuration for every entry point, including an economical "Pay as You Go" option
Future-thinking platforms: Access to CEREC® Connect, the world's largest digital dental network, plus integration with future dental technology advancements

Contact your CEREC Specialist for more information: 800.873.7683
Visit us online for more information: www.cereconline.com
FREE FACTS, circle 25 on card

Treatment Centers | Instruments | Imaging | CAD/CAM

Sirona
The Dental Company

continued from page 54

component, although not always the only material. Guided Bone Regeneration (GBR) using a barrier membrane and longer healing time are also usually necessary.[4] (Figs. 1-4)

As a general rule, particulate grafts with or without a guided tissue membrane are easier to learn and to perform then block bone graft procedures. They incur less incision line opening, have less postoperative discomfort from donor sites, have less altered nerve feeling from the donor site, may be more easily adapted to complex bone geometries in the host site and may be used more easily at the same time as implant insertion.

Two Bony Wall Defects

The most common two bony wall defects are residual sites, which require more than 3mm horizontal augmentation to the facial and the lingual/palatal bony wall is usually still present, but may be also deficient. A bony wall defect is treated very different than a three- to five-bony wall defect. Since defect size is usually larger and fewer walls of bone are present for vacularization and stabilization of the graft, more autograft is required in the bone graft and primary closure is mandatory. Rather than using a little autograft material mixed in the graft mixture, it is of benefit that an entire layer of bone from the ramus or symphysis be placed directly on the receptor site. As a consequence, more often a donor site from the mandible is required.[5] Incision line opening is more of a complication than a three- or four-wall defect, as the residual ridge form has less soft tissue and the soft tissue flaps must be advanced over the graft site.

Allografts and guided bone regeneration techniques have been used predictably in slight-to-moderate bone regeneration (primarily for inadequate width). However, these methods have limitations and have been found to produce less favorable results in the treatment of larger bone deficiencies. As a result, bone augmentation with GBR are usually limited to width augmentations of less than 3mm. The larger the defect, the less predictable the GBR result. Hard and soft tissue contours are more difficult to predict beyond this dimension. Extended healing times are necessary beyond 3mm of augmentation. The bone quality is often less than ideal in these defects. As a consequence, when more than 3mm of augmentation is required, more advanced osteopromotive procedures are indicated, including block bone grafts to fulfill the prosthetic-guided treatment plan. In other words, autologous cortical/trabecular bone grafts may be considered the gold standard in the repair of moderate to severe alveolar atrophy and bone defects.[5,6] (Figs. 5-8)

Block-type grafts are usually harvested from the residual ridge, mandibular symphysis, body, or ramus area. However, extraoral sites may be required in larger graft sites. The width

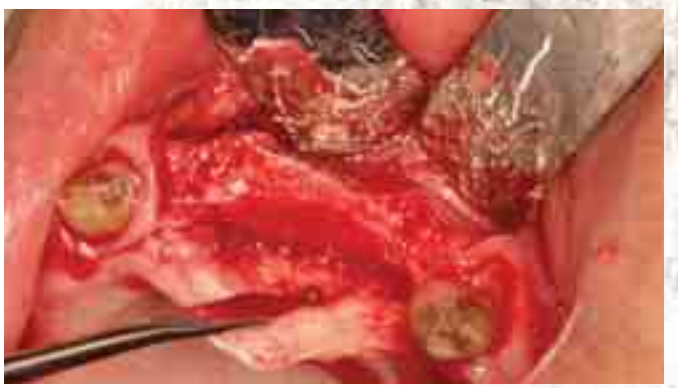


Figure 1: The irregualar topography of the host site may use guided bone regeneration (GBR) to increase the width of bone for a three- to four-wall bony defect.

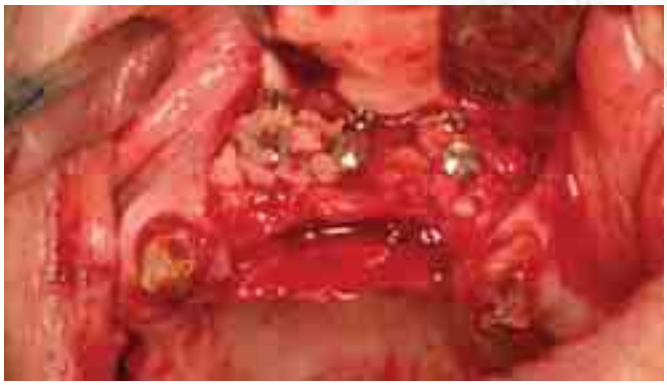


Figure 2: Autograft and tent screws are inserted at the host site.

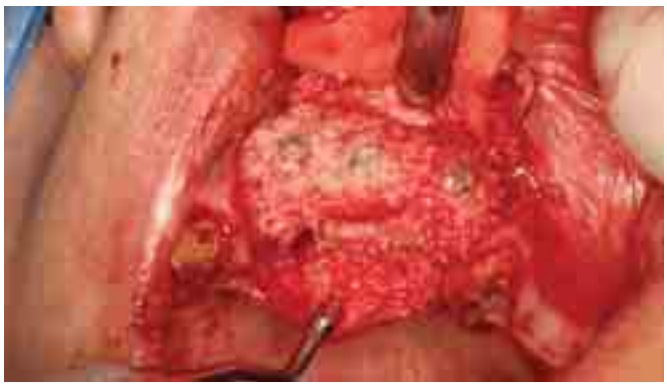


Figure 3: An allograft of freeze dried bone (MinerOs) is placed over the autograft.

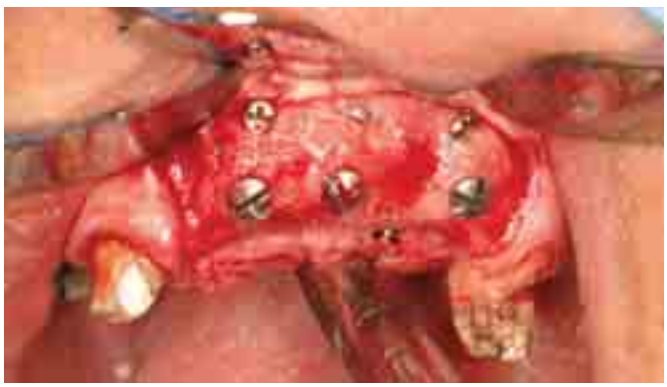


Figure 4: Re-entry after five months observes an increase in bone width.

Figure 5: The mandibular symphysis may be harvested when the defects are large (two-wall bony defect).

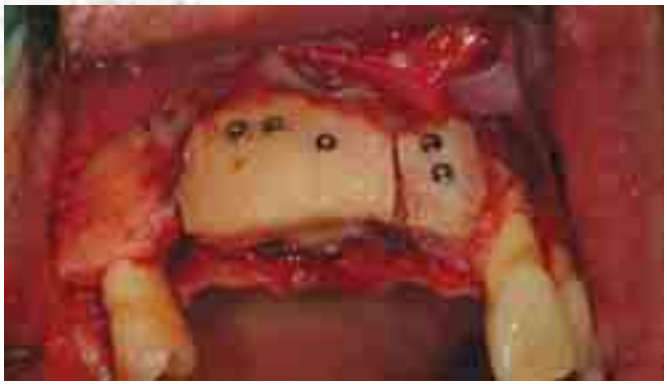


Figure 6: The block bone grafts are fixated to the host site.

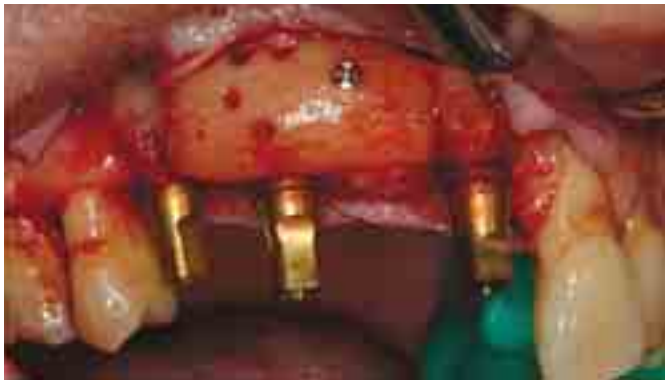


Figure 7: A re-entry at five months allows implant insertion (BioHorizons).

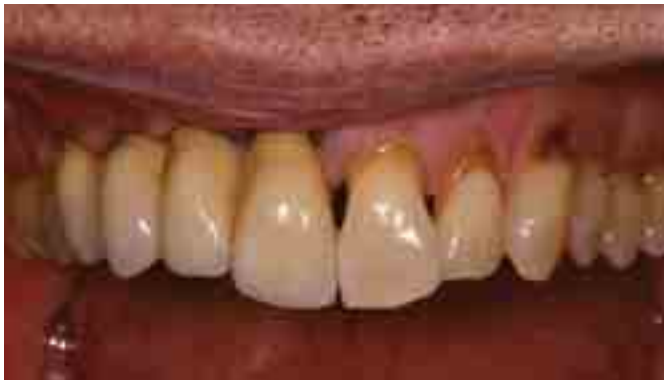


Figure 8: A fixed partial denture is cemented over the integrated implants.

and height requirements for augmentation will influence the donor site selected. As a general rule, when more than 4mm of width is desired, the mandibular symphysis is the most common donor site. A mandibular ramus is selected as a donor site when the bone graft width is less than 4mm. The ideal goal of a donor block harvest is to obtain sufficient bone, so the entire bone defect/augmentation dimensions are composed of the block autograft.

Summary

Prosthetic driven treatment plans in implant dentistry often require bone augmentation procedures to improve aesthetics and/or biomechanical stress factors. The reduced bone volume is one of the more important factors to consider, when determining the osteopromotive techniques to predictably obtain ideal bone volumes. An extraction site may be surrounded by bone (a five-wall defect) and most any treatment method may be successful. When only a minimum to moderate amount of bone width augmentation is required (four- to three-wall defect) GBR procedures are effective. A two-wall defect (less bone in the site and more augmentation required), requires more advanced procedures, as block bone grafts. Regardless of the procedures, the goal is to obtain ideal bone volumes, which support the aesthetics and function of the final restoration. n

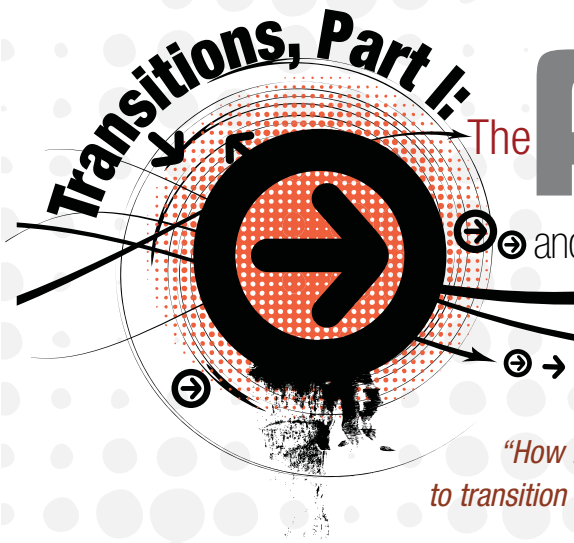
References

1. *Misch, CE. Treatment planning: Force factors related to patient conditions. In Contemporary Implant Dentistry, CE Misch editor, 3rd edition, 2008 Elsevier, Mosby, St. Louis, MO pp 105-129.*
2. *Misch CE. Misch-Dietsh F, Keys to bone grafting and bone grafting materials. . In Contemporary Implant Dentistry, CE Misch editor, 3rd edition, 2008 Elsevier, Mosby, St. Louis, MO pp 839-869.*
3. *Misch CE, Dietsh F: Bone grafting materials in implant dentistry. Implant Dent 2:158-167, 1993.*
4. *Misch CE, Suzuki JB. Tooth extraction, socket grafting and barrier membrane bone regeneration. In Contemporary Implant Dentistry, CE Misch editor, 3rd edition, 2008 Elsevier, Mosby, St. Louis, MO pp 870-904.*
5. *Misch CE. Mandibular donor block bone grafts: Symphysis and ramus. In Contemporary Implant Dentistry, CE Misch editor, 3rd edition, 2008 Elsevier, Mosby, St. Louis, MO pp 975-1012.*
6. *Misch CM, Misch CE. Resnick R et al. Reconstruction of maxillary alveolar defects with mandibular symphysis grafts for dental implants. A preliminary procedural report, Int J. Oral Maxillafac Implants 7:360-366, 1992.*

Author Bios

Carl E. Misch, DDS, MDS PhD (hc) is the Professor and Director Of Oral Implantology, Temple Dental School, Philadelphia, Pennsylvania; and Director, Misch International Implant Institute, Beverly Hills, Michigan.

Craig Misch, DDS, MDS, is a specialist in prosthodontics and oral & maxillofacial surgery, in Sarasota, Florida.



The Associate Buy-In and The Straight Sale

by Douglas Carlsen, DDS

"How much money do I need to retire?" and "How do I find a buy-in associate to transition my practice?" are among the most frequent questions I encounter.

The buy-in associate is not the only way to transition. This spring I conducted interviews with a variety of retired dentists for a CD series. Many of them had great insights for transition methods. I'll detail different approaches over the next two months.

The Associate Buy-In

A favorable outcome of the associate buy-in is the ability of the transitioning doctor to "hand pick" a successor.

Darrell Cain, of Cain, Watters and Associates, PLLC, has been a provider of associate buy-in transition advising for many years. He sets up the situation:

> *A young associate-to-partner joins an elder dentist's practice, helps grow the business, and becomes a partner, purchasing a portion of the practice. The elder dentist invests the profits, which grow over subsequent years. The elder dentist may wish to bring in another associate to purchase the other portion of the practice as the elder dentist slows his practice, ultimately retiring. Thus the elder dentist has the opportunity to sell part of his practice twice, realizing significant growth over the years from the first sale.*[1]

Mr. Cain provides a detailed video series of the process at www.cainwatters.com and has worked with many successful associate buy-in transitions.

Dr. Marc Cooper, consultant for dental partnerships along with large health care systems and other corporations, offered a more measured assessment in his March 2010 newsletter. His research has found there to be zero statistical evidence regarding the success or failure rate of associate buy-ins. In his anecdotal evidence, failures grossly outnumber successes. He illustrates one method he has seen succeed often; he called it "sponsorship."[2] From his newsletter:

> *What I mean by sponsorship is the senior dentist directly contacts residents or dental students himself or herself, who have a strong interest in practicing in their area. This is done two years ahead of when the associate is placed in an office…the senior dentist takes a student or two under his or her wing and generates a relationship as a mentor.*
>
> *…They stay in communication with the student to assist them in navigating the issues and concerns that invariably arise in the student's life and training. They emotionally support and nurture these individuals. They become a true sponsor of these students.*[3]

I recommend reading Cooper's book, *Partnerships: Why They Succeed and Why They Fail.*

Further comment was recently provided to me via interview with Dr. Peter Mirabito, founding partner of ADS Precise Consultants of Denver. Mirabito has been a practice broker since 1986 and facilitates buy-in partnerships. Mirabito has extensive experience with both straight practice sales and associate buy-ins. I'd like to share part of this interview with you.

How might a dentist evaluate whether an associate buy-in makes sense?

Mirabito: The dentist should first look at his or her situation. Does the dentist wish to cut back on office hours? Is he way too busy? If both of these are true, it makes sense to consider a partner. If only one, it might make sense. If neither, then I would discourage the arrangement.

Further, for a buy-in to work, the elder dentist needs to consider whether he is willing to give up working time and some income to the new partner. If either is a "no," then the arrangement probably will not work.

What steps are involved in the actual associate buy-in process?

Mirabito: First and foremost, a professional practice appraisal must be done. The associate needs to know, upfront, what the eventual price for the practice will be. Second, a buy-in purchase agreement, detailing the "when" and "how" of the purchase needs to be constructed. Third, an employment

continued on page 60

continued from page 58

agreement, identifying whether the associate doctor will be an independent contractor or employee, is constructed. Fourth, a partnership agreement, enumerating how the partnership will be legally maintained, as an LLC, PC, etc., is drawn up. And fifth, an operating agreement is needed. It details how the partners will be compensated and how practice management decisions will be made: Will the doctors be paid by a set percentage of production? Will leftover profits be divided according to percent equity in the partnership or the production percentage of each doctor? How much of those profits will be spent on capital improvements?

A frequently overlooked matter is possible dissolution of the arrangement. All possibilities, including practice vision differences, income disparities, disability and even death, must be discussed with solutions put in place at the beginning of the relationship.

The entire package needs to be assembled before a dentist searches for an associate or partner.

What potential problems may arise?

Mirabito: The elder dentist often does not have excess patients and may need to grow the practice substantially to accommodate another dentist. Often, the elder dentist assumes the younger colleague will be able to grow the practice while learning the ropes. This seldom works out.

Also, the entire process is much more stressful and requires much more detail than a simple practice sale and may take several tries to find the right partner.

Mitabito can be reached for further information at peter@adsprecise.com or 800-307-2537.

The Straight Sale

Let's now examine the straight practice sale, which is the most popular transition option.

I also recently interviewed Mr. Ken Rubin, CPA and owner of Ken Rubin & Company, Dental CPAs and Ken Rubin Practice Sales in San Diego. Rubin's company works strictly with practice sales.

Please relate advantages of the straight sale versus the timed buy-in.

Rubin: Most importantly, a selling dentist will come out farther ahead economically using a straight sale instead of a timed buy-in. With a timed buy-in, the elder dentist gives away significant profits every year during the transition period that otherwise would have stayed in his or her pocket. Since selling half to a partner prematurely (rather than simply hiring an associate) rarely makes up for the loss of income suffered during the transition, it's like giving away half of the practice for free.

The other main advantage is simplicity. The outright practice sale is infinitely less complicated than a staged buy-in and the issues that inherently arise with any partnership. The stress of growing a practice is absent.

Furthermore, staged buy-ins actually have a high failure rate for many reasons: lack of production to support two dentists, incompatible personalities, practice styles, speeds and skill sets, inability to make joint decisions, and unfair allocation of income and expenses, among other complications.

There are many steps involved in selling a practice. Please provide thoughts on key areas.

Rubin: First, preplan and make sure to keep your office in prime condition financially, cosmetically and personnel-wise leading up to the sale process.

Second, selection of a broker is key. Interview several brokers and call references. The right broker will make the process much easier and put more money in your pocket.

Next, assemble a top quality team including a CPA, attorney and practice consultant. Your broker can assist with this step.

Make sure that the practice information package put together by the broker is accurate, and your financial records are in order for the buyer CPA's due diligence.

How long does it typically take to find a buyer?

Rubin: In the San Diego area in 2009, we often found buyers within a month. In 2010, it is slower, with a couple months [being] the normal time frame. There is a high demand for Southern California dental practices, so they sell quicker than in the rest of the country.

Ken Rubin can be contacted at ken@kenrubincpa.com or 619-299-6161.

Obviously, there is disagreement among the experts regarding the associate buy-in process success rate. Be sure to carefully evaluate all options and vet any adviser or broker carefully before proceeding with either option.

Next month, in part II, we will examine other transition options available.

**Note: I have no financial or business connection to any transaction specialist, broker or consultant.* ■

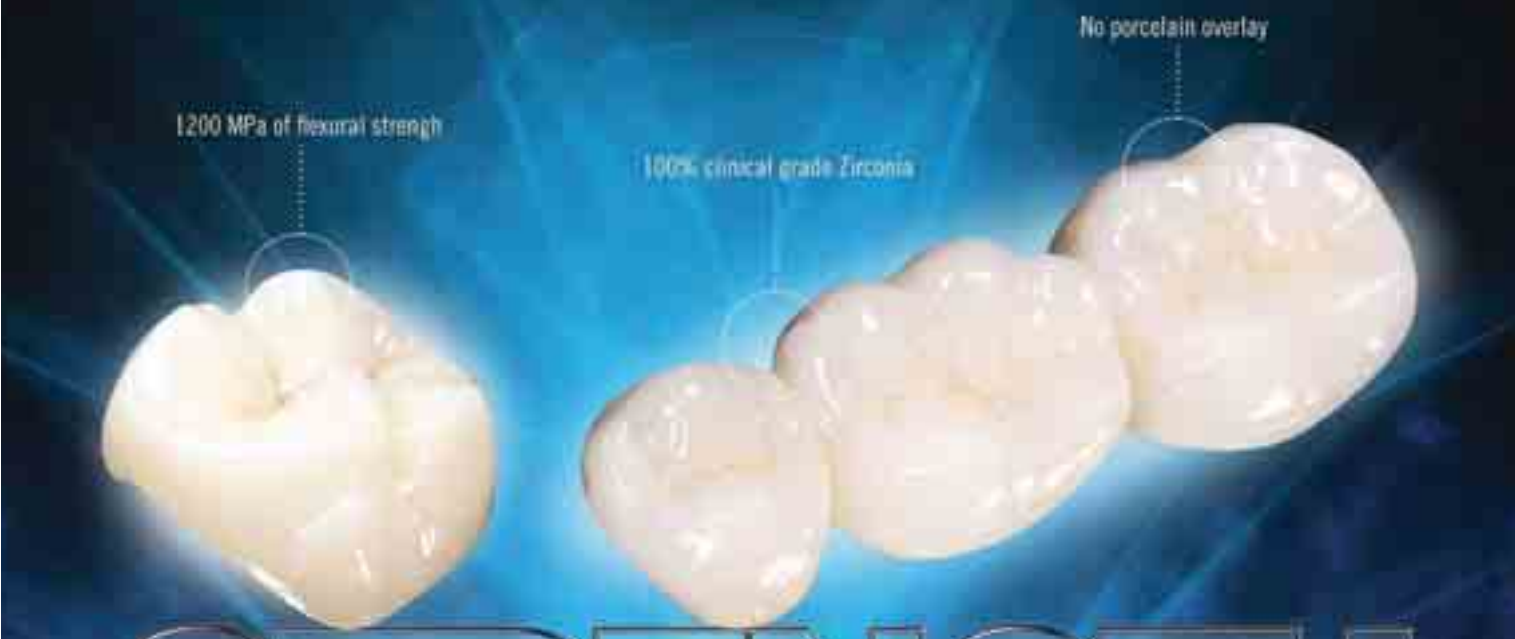
Refences

1. *Comments paraphrased from part 3 of video series at www.cainwatters.com/resources.aspx?section=video&subSection=cain3., viewed July 1, 2010.*
2. *Dr. Cooper's Web site is at www.masterycompany.com.*
3. *Downloaded on June 13, 2010 from http://archive.constantcontact.com/fs067/1011201218140/archive/1103124932897.html*

Author's Bio

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

NBC CERTIFIED | FDA APPROVED MATERIALS | NADL MEMBER



STRENGTH

The strength you need. No golden expense.

$89 per unit* | **Z-Crown Solid Zirconia**

> Esthetic alternative to PFM & full cast crowns
> Ideal for bruxers & grinders
> Posterior crowns & bridges up to 3 units
> Completely chip-resistant
> Minimal shoulder preparation saves tooth structure
> Glass or resin ionomer compatible (Fuji GC, Rely X, 3M)
> CAD/CAM technology ensures consistent fit

CALL **877.337.7800** TODAY
FOR YOUR DDS LAB STARTER KIT

crowns • bridges • dentures • partials • implants • attachments

DDS Lab

www.DDSLabSolutions.com

FREE FACTS, circle 2 on card

30 Years of Dentistry: Lessons Learned

Lesson #9: Don't Become a Slave to Your Equipment

by Joe Steven Jr., DDS

Oh, we dentists love our toys! I'm one of those also, but I try not to get carried away. Too many doctors think that they have to have the latest laser, digital X-rays, a CEREC machine, the iTero system, computerized anesthetic delivery systems… the list goes on and on and on. I have to tell you, some of the most successful practices that I have come across don't have hardly any of the things listed. They don't have intraoral cameras; they don't have lasers; they don't have electric handpieces; they don't have automated endo... Yet, they sit back and just smile because they are big producers with low overhead and great profits!

Please don't misunderstand me because I do believe in many of the great high-tech innovations that we have seen in our profession, and I really enjoy them. But, more doctors need to understand that high-tech equipment is not the most important thing for success. On the other hand, I have written and spoken about many benefits behind new technology to make our practices more efficient and profitable.

Unfortunately though, I see too many doctors who are saddled with so much debt because the sales rep says, "You can have this piece of equipment, and it's only going to cost you this much a month, but its going to make you so much more efficient. Then, you can have this laser and that is only going to cost you this much, but oh, the increased production is just going to come in..." Many doctors become slaves to equipment bank notes. Yes, it is nice to have some of these things, but trust me on this, that's not the answer for generating a highly profitable dental practice.

Too many of our leaders steer us in that direction because firstly, they look very impressive to their audiences when discussing this new technology. And secondly, many times doctors (myself included) who spend a lot of money on high-tech equipment, are so psychologically and emotionally committed to it, they don't see any of the negative aspects of the purchase. I recall when I got my electric handpieces about 10 years ago, I was so excited about them I just had to share this with everyone. I spent around $10,000 to get three rooms equipped with all the attachments, etc. and I started using them and I thought they were great! I know many doctors will disagree with me on this, but I'm not convinced that they are as great as many claim them to be. Sometimes I think our emotional excitement is part of justifying the cost. I have heard this from other doctors who attend my meetings who share the same thoughts about this.

So, equipment is not the answer to a highly productive and profitable practice. Yes, it will help, but you have to balance things out. You can't just sit back and say, "I need, this, this and that because when my patients see me use all this high-tech stuff, it's going to generate a lot of referrals and they will accept more of my treatment proposals." Yes, there is some truth to that, but not as much as some doctors would like to believe. I wish I could give you a formula as far as how much to spend on all of the high technology that is available for dentistry, but there is no such thing because every practice and every dentist is different.

Of course, our sales reps are more than willing to share with us specific "return on investment" information concerning pieces of technology. And they do sound very convincing. CEREC comes to mind! What a great concept: make the crown and seat it the same day without having to deal with temporaries or a second appointment. I've been tempted several times to take the plunge, then I met a doctor who said he tried one but didn't like it and sent it back. One concern that sales reps don't understand is that all dentists are different when it comes to the discipline of incorporating new technology into their offices. Some doctors dive into it and perfect the incorporation of their new purchase. Many others don't and the equipment may still be in the box.

I know, I know – many of you out there think I'm way behind the curve on this one, but we still don't have digital X-rays in our office. I have three estimates sitting on my desk right now so I will be pulling the trigger on this one soon. Once again, there are many highly successful dentists who still don't have this technology, yet they do extremely well. I never have believed the "return on investment" calculations from sales reps in regards to reducing staff salaries because of the time savings involved with digital X-rays. I haven't met a doctor yet who said their salaries have gone down once they went digital. Anyway, it's only a matter of a few years before it will be mandated that we all have digital X-ray systems in our office.

Regarding X-rays, I have always recommended what I consider the number-one best "return on investment" purchase to be a panoramic X-ray unit. I feel that should be at the top of the list before anything else. And yet, I see offices purchase many other high-tech items and they still take full series X-rays. Every new patient in our office receives bite wing X-rays and a pano film. Extremely diagnostic, educational, with less time and cost involved.

I'm still a big fan of intraoral cameras and believe they are extremely beneficial in presenting and selling dentistry. I like my three chairside air abrasion units and my Ellman electrosurge units. Automated endo has been a life saver and extremely profitable. Once again, you have to balance out what "toys" you want to bring in to your office. These are not easy decisions.

On another note, one thing that I have observed over my career in regards to technology is that few sales reps discuss the upkeep on equipment. There are days where I seem to be constantly repairing things around the office or calling the computer or service rep because something is not working properly. I long for the days when my main concern was not getting the dental chair to move. I recently had a conversation with a high profile dentist who complained about the same thing while telling me about his $300,000 investment ordeal of redoing his large office with a computer/X-ray system!

Several dentists have encouraged me to buy a perio laser unit because they said it was great for treating their perio patients and that their hygiene department is extremely profitable because of it. I think the price tag was somewhere around $50,000 or so, and I thought to myself, why do we need this? With four hygiene rooms, do I need four units? Of course, you can move it from room to room, but we all know that's no fun and many times you won't use it because of that. We have a very profitable and effective soft tissue management program with traditional instrumentation, so I think I would rather spend the money on something else or simply keep it!

So, look at your equipment needs and try not to make an emotional decision because the sales rep or lecturing doctor got you excited. One of the biggest mistakes that a struggling office makes is to buy a piece of equipment thinking it is going to save their practice. It will not! I prefer and recommend that a doctor first develop a highly successful practice so that it allows you to afford the new high-tech "toys" that will make you more efficient and even more profitable! n

Author's Bio

Dr. Joe Steven graduated from Creighton Dental School in 1978 and has been in solo practice in Wichita, Kansas, up until June 2007, at which time his daughter, Dr. Jasmin Rupp, joined him. He is president of KISCO, a dental products marketing company, providing "new ideas for dentistry," and is the editor of the KISCO Perspective Newsletter. Steven along with Dr. Mark Troilo present "The $1,000,000 Staff" and the "Team Dynamics" seminars. Steven also presents three other seminars: "Efficient-dentistry," "Efficient-prosthetics" and "Efficient-endo." Steven provides the KISCO Select Consulting Program to dentists in the form of a monthly audio CD recording. (Contact info: jsteven@kiscodental.com, 800-325-8649, www.kiscodental.com)

This story, originally published in the KISCO Perspective Newsletter, *is reprinted with permission.*

Mamma Mia!

Media, Marketing and the Power of **Mom's Purse**

by Vicki McManus, COO of Productive Dentist Academy

Fact: More than 83 million moms nationwide exert a whopping $2.1 trillion in spending power and control most family spending and shopping.

When it comes to family's health care, it's no secret that mom is the primary decision maker or CPO, Chief Purchasing Officer. She chooses the practitioners, schedules the appointments and approves (or vetoes) the procedures. So how do you get "choosy" moms into your practice? What factors weigh into a mom's decision when selecting a dentist? How can your practice increase its appeal to moms? What are you doing that may inadvertently be causing moms to stray?

It makes good financial sense to explore these questions. Women, in general, spend 85 cents of every dollar…over $2.1 trillion nationwide. It's no wonder that the winning prize in many sports competitions is referred to as "the purse."

Productive Dentist Academy is at the forefront of gender marketing and research. From reaching mom, to engendering her loyalty, to making it easy for her to refer friends and family – we've explored, dissected and developed each stage of the cycle. Along the way, we've learned some surprising things about what works and what doesn't when it comes to engaging moms. Here's some research that may help you in your practice:

Profiling Moms: What You Need to Know

The first and most important thing to understand is that moms are all different and cannot be treated as a homogenous group. A mom with toddlers has needs that are quite different than a mom with teens. Additionally, moms are unique within each subgroup – for example, a mom with an at-home infant may also be a self-employed businesswoman or she may be an older, first-time mom.

Two important points to keep in mind: 1). Women, moms especially, think and assess the longer-term ramifications of everything, and 2). Women tend to use both left and right brain in decision-making. As her dental health provider, it is important to understand the priorities a mom faces at each stage, and to evolve your conversations so that you can show and provide support according to her family's season of need. In conversations, it's important to cite facts and figures, yet also be aware of the empathetic right side of the brain she uses in decision making. As a general guideline, here are typical lines of division among moms and things on the forefront of their minds.

Different Stages

Pregnant or New Moms. Focus on prenatal health of the mom, special needs of pregnancy, and infant care, i.e., bottle-mouth syndrome.

Moms of Toddlers – busy hands and on the go. Make the office reception area family friendly and include a special area for children. Make sure staff is friendly and engages siblings during appointments.

Moms of Elementary Children to Teens – a time for further education and counsel. Provide nutritional counseling and stress importance of healthy dental habits. Introduce benefits of fluoride, Carifree, and xylitol for caries reduction. Discuss readiness level for orthodontic treatment.

Moms of Teens – preparing kids for high school and college. Help with third molars and explain saving extracted teeth in a Stem Cell bank (www.stemsave.com) for possible use later in life.

Empty-Nester Moms – progressive separation of children to college and beyond. Moms at this stage are experiencing new found freedom. This is an opportunity for self-reflection and self-nurturing. Consider complimentary whitening with complete re-exam (every three to five years) and cosmetic dentistry.

Differences in age of brood and careers aside, the single factor uniting all these moms is a desire to ensure the best for their families while managing the household budget. The bottom line is that each woman is different and the only relationship that truly endures is a one-to-one relationship. That means you must first listen to what she values in her dental service provider and then let her know she's been heard by following through on what is important to her.

She's Waiting! How to Reach & Engage Moms

Marketing to moms is so important, but with everyone from retail centers to automakers targeting moms, how does your practice reach them? After all, you're not just competing with practices in your community; you are competing with all companies, products and services that are vying for mom's time and attention.

It all starts with earning her trust. Selecting a health care provider is vitally important to a mom because the decision affects the well being of her whole family. The number-one thing that keeps mom coming back to your practice instead of heading to your competitor is a personal, one-to-one relationship with you and your staff. Authentic connection, respect and professional service all weigh heavily on her mind. Without those, not only is she quick to walk out the door, she's also quick to tell her friends and family about her experience.

A mom also relies on her intuitive instincts when it comes to relationships between you and your staff. They are quick to sniff out insincerity of any kind and favor practices that have a good working environment and promote harmonious relationships with employees.

Make it convenient for her to come to your practice. Create convenience for busy moms by allowing the entire family to schedule appointments at the same time. Announce "family day" twice a year (select a Thursday or a school holiday like in-service teacher days when kids are home from school). Make it a fun event for the entire team by declaring a theme or wearing your favorite sports team jerseys. Turn the entire office into an educational center with dental coloring books, refreshments, etc. An office with five operatories can clear about 50 child prophy appointments and minor restorations in one day, keeping the schedule open for valuable, late afternoon appointments for adult patients.

Help her help her family. Educate moms about nutritional facts and substitutes for healthier lunches and fewer cavities. Give away samples of chewing gum and mints containing xylitol – Trident for example – so kids can freshen breath and reduce opportunities for cavities. Also provide information on CariFree products to regulate children's pH levels.

Win her heart by doing good deeds in your community. When all other things are equal (and for many moms the initials behind dentists' names renders them equals) your practice's "good citizenship program" can be the deciding factor that builds a

Key Takeaways

- Women use intuition more than men. The practice has to "feel" right.
- The attitude of your staff affects decisions as much as the quality of your dentistry.
- Practices must not treat moms as a homogenous group – a mom with toddlers has needs that are quite different than a mom with teens.
- Practices must give busy moms a continued reason to be loyal.
- The relationship must be "recreated" every visit.
- Listen to moms and let them know that they are heard.
- Make financing simple and easy. Remember, moms are juggling a household budget.

continued on page 66

continued from page 65

bridge to your practice. Moms look for community in every walk of life and are drawn toward people and organizations that have similar values. They pay attention to products and service providers who are doing good deeds and support causes. It's the "practice halo" effect. Consider a 10K fundraising run/walk in your area. Or consider supporting a local charity by giving a portion of your proceeds to that charity. The opportunities to do good are endless and everyone (you, your staff and patients) benefit from what researchers coin the "helpers high," a reduction in stress and depression, a decrease in physical pain, and a rush of endorphins that makes people feel joy and happiness.

Ease her burden about managing the family budget. Offer convenient financial arrangements to make it easy for her to say "yes" to optimal treatment for her family.

Surprise and delight her with thoughtful and random acts of kindness. This is one of the strongest ways you can build and promote word-of-mouth marketing.

- Give moms a back-to-school supply gift card as part of your referral program
- Host a "night of pampering" for loyal patients http://pamperdoc.com/
- Provide a "treasure chest" of spa products for moms to choose from

Connect with her through new media. Moms rely heavily on their social network for referrals and recommendations, especially as it relates to matters about heart, family and home. Nine out of 10 moms regularly or occasionally seek the advice of others before buying a service or product. Additionally, 97.2 percent of moms give advice to others about the products or services they've used.*

In the past, moms relied almost exclusively on the old party line, but today's mom is wired. She embraces new technology and relies on it to get information on products and services and to enhance her circle of relationships. Perhaps even more important, is the speed at which that information now flows from mom to friends and family. If she is not happy with a product or service, it quickly becomes known; and the reverse is true as well. Use social media, such as Facebook and Twitter to get connected to moms. A survey by BIGresearch in conjunction with the Retail Advertising and Marketing Association (RAMA)* shows that women with children at home are more likely to use social media than the average adult. They use it to connect with other moms, research companies and products, share photos, etc.

The good news is that you can use technology, such as social media programs, to build relationships and engender loyalty among moms. It's also a great place to offer same-day service advertisements using online tools such as Smile Reminders.

Social Media Stats*

Facebook:
Women with children at home: **60.3%**
Average adult: **50.2%**

MySpace:
Women with children at home: **42.4%**
Average adult: **34.4%**

Twitter:
Women with children at home: **16.5%**
Average adult: **15.5%**

Give her what she wants. When asked to rank (on a scale from 0 to 5), what types of promotions most influence their purchase, Moms gave the following responses:*

- in-office product samples (3.8)
- product samples delivered to home (3.6)
- loyalty cards (3.5)
- special displays in practices (3.4)

To cater to these wants:

- Provide a back to school dental health kit for brushing at school
- Offer samples of related products (like skincare products)
- Engage in free "whitening for life" programs

There is nothing more powerful and loyal than a grateful mom. Earn her trust and take care of her family and she will serve as a powerful and loyal goodwill ambassador for your practice.

Gaining MOMentum in Your Practice

Want to learn more about the best ways to gain *MOMentum* in your practice? Attend Productive Dentist Academy's free Webinar: *Marketing to Moms.* Visit www.productivedentist.com or contact Jackie at jackie@productivedentist.com for more information. ■

Author's Bio

Vicki McManus is Managing Partner of Productive Dentist Academy (PDA), and a busy mom of teenagers.

A recognized authority on the psychology of marketing, Vicki has helped countless practices, already at the height of success, achieve an even greater level of productivity and success. She is the author of FUNdamentals for Dental Teams and contributes articles to leading publications nationwide.

Send Vicki an e-mail at vicki@productivedentist.com. Or visit the PDA Web site at www.productivedentist.com.

**BIGresearch's Simultaneous Media Usage Survey (SIMM 14) was compiled for the Retail Advertising & Marketing Association, a division of the National Retail Federation and published in Marketing Profs. The survey polled 4,206 moms and 22,624 adults 18+ and was conducted April 29-June 18, 2009. "Moms" are defined as woman with children at home who are under 18 years of age. Published in Marketing Profs, September 2009.*

PUMP UP YOUR PRODUCTION
IN 2010 BY $300/HOUR—GUARANTEED!

Productive Dentist Academy

Rated Excellent by 99% of Attendees

"Up 100% in 12 months." - **Dr. Kelly Carroll**

"Like propane to my practice." - **Dr. Charles Smurthwaite**

"Unbelievable surge in our production." - **Dr. Ryan Swain**

Course Location:
Dallas, Texas

- Jan. 20 - 22, 2011
- April 14 -16, 2011
- July 21 - 23, 2011
- Sept. 29 - Oct. 1, 2011

SAVE $400 WHEN YOU REGISTER 30 DAYS BEFORE PROGRAM DATE.

PROMO CODE: PDAJan2011

Are you frustrated by working *harder* without any real gains in productivity?

Has your *practice plateaued,* yet your team says, *"We're doing all we can"?*

Do you get a sense that *something is missing,* but not sure what?

Have you been working too hard for too long? Are you ready to cut back time *without sacrificing income?*

ADA C·E·R·P

PACE

Approved PACE Program Provider FAGD/MAGD Credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. 10/1/2009 9/30/2013. Provider ID#217561. 21 Credit hours.

OUR PROMISE AND 100% UNCONDITIONAL GUARANTEE:
Increase your production by $300/hour—or your money back.

Call 800.757.6077. Or visit www.productivedentist.com.

FREE FACTS, circle 44 on card

Looking Through the Lens of the Patient

by Teri Yanovitch

A truly customer-focused organization strives to see things through the eyes of its customer. This approach asks, "How does the customer see us?" A practice that looks at their operation from the patient perspective is a key element that separates an outstanding business from others. Using customer service to grow your business is an easy economical way to attract and retain patients. Creating a culture of service excellence and establishing a positive brand in the marketplace is an approach that will reap the rewards for years to come.

A tool to look through the lens of the patient and to continuously be examining ways to enhance the current level of service is called a service map. Whether you are in the business of dentistry, call centers, medical services, or retail operations, all customers go through a series of actions to do business with you. By sequentially mapping out all the points of contact, then analyzing, and brainstorming to move from mediocre service to excellent service at each point, you can create outstanding patient experiences that can be delivered consistently to *your* patients.

A service map is a tool to define the process that focuses on how to interact with the customer in a more friendly way and reinforce looking through the lens of the customer versus looking through the lens of the organization. It is not a one-time event, but should be used on an ongoing basis by every area of the practice in order to continually keep improving.

The first step in service mapping is to identify a process you would like to make better in order to improve the patient experience. One way to choose this process is to pick the one you hear the most complaints about. Maybe it is your billing process. Patients might complain it is too confusing, too much paperwork, or too long to wait for the billing receptionist. Map out the process starting with the first point of contact for the patient. It is easiest to use a flipchart and block out each step using the term *"the patient..."* For example, if we were doing a service map for "paying the bill," the first block might be *"the patient is directed to the payment window."* The next step might be *"the patient waits in line,"* and then the third step *"the patient is given a copy of the bill to review."* The entire process could consist of only a few blocks or it might consist of nine or more. My recommendation is, if it consists of 10 or more steps see if you can break it into two processes to analyze. Otherwise it might become too overwhelming. The key is to keep this simple.

Once the employee work group has identified all the points of contact and even potential points of contact, the next step is to look at each component of the service map and ask the question "What would mediocre service look like at this step?" By getting the group to identify mediocre service, they might start realizing that it is how they are currently delivering service. And while mediocre service is not necessarily bad service, it certainly will not give you the opportunity to build value with your patients for going beyond their expectations.

After describing mediocre service at each touch point, the next step is to describe excellent service at each step. Let all ideas be voiced and heard. Tell the work group to think outside the box. Ask them to think of organizations outside the dental profession and how they have seen this process accomplished. I have found it is better to have the big, wild, crazy ideas flowing in order to get the group thinking beyond the current way of doing things. While in the end not every idea might be able to be implemented, it's better to set the stakes high and get as close as possible to an ideal patient experience. Otherwise, what you will see as the result is little more than the current status quo.

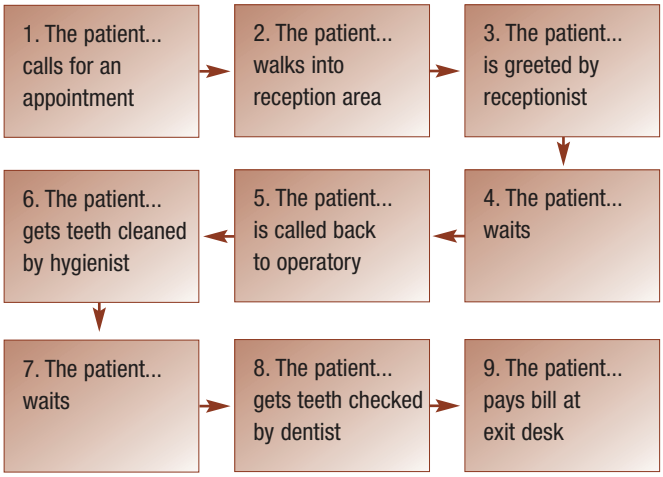
The final step in service mapping is to review and remap the experience showing only the excellent descriptions for each step. This becomes the way the process is done from here on out. This is what creates the consistency and a seamless experience for your patients. This is the way new hires are taught to do this process. If you have several practices, it can be shared with all the other locations. Below is another example of a service map

focused on the process of a patient coming in for a regular cleaning appointment.

Service Map

Process analyzed: Patient visit for cleaning

Step 1: Describe each step of the process looking through the "lens of the patient."



Step 2: For each block identified in Step 1, describe what would be considered mediocre service and what would be considered excellent service. Below is a sample of blocks.

We use service maps to improve our customer service because there are many choices for dental work in today's world. Most people will ask their friends and family for their recommendations. The practices that are responsive, caring, and helpful, as well as competent, will be the recipients of the referrals. I know of individuals who went to the most qualified dentists in terms of degrees, certifications, and education, but because they made the experience so unpleasant to do business with them, they were never referred to again. In the past, it was said one unhappy customer would tell nine or 10 people. Today with the Internet, blogging, Tweeting and Facebook, that number can be in the hundreds.

The patient experience must be carefully planned and managed to ensure the best possible experience every time. Put yourself in your patients' shoes and take a walk-through of your physical environment, your processes and procedures, your service delivery and see if it is just mediocre or does it create a positive feeling? Some things to consider: Does your office, Web site, and marketing materials send the message you want them to send? Do they look fresh and updated? Is your phone system welcoming and inviting? How does the paperwork make the patient feel? At ease or lost, confused, and frustrated?

Analyze how you address your patients: Does everyone in your office make them feel unique and individual? The key to outstanding service is personalizing and treating each patient as an individual, not just as "next" in line. Do you know when their birthday is? Do you know if they have children, grandchildren or pets? Patients will forget everything except how you made them feel. Patient emotions are input to delivering personalized service. Looking through the lens of the patient means that if you understand and acknowledge the patient's emotions, then you'll be able to meet the patient's needs more fully. Making the emotional connection will result in your patient feeling appreciated and that's what will drive referrals and repeat business.

Patients come into your office with a variety of emotions. Some will come in anxious, some will be rushed, others will be excited, and some will be worried. The secret is to identify with the patient's emotions, and then meet the patient's needs – in that order. Sounds simple, doesn't it? It can be a very simple technique, yet many overlook the power it projects in building the relationship of caring. For example, if the patient comes in looking harried and rushed, typically the staff will look to immediately try and get them into the operatory to start their treatment. That is meeting the "need." But by first acknowledging the emotions, such as "Mr. Jones, I can see you are in a hurry," then meet-

Step 2

Block No.	Mediocre Service	Excellent Service
1	Patient is immediately asked to hold when the call is picked up.	Thank you for calling Dr. _____ office. This is _____. How may I help you?
4	Clinical smells, looks outdated, has old magazines and dusty plastic plants	Pleasant smells, comfortable chairs, up-to-date interesting magazines, educational brochures.
5	Perfunctory: "Mr. Jones, your turn. Follow me."	Inflection, sincere interest: "Good morning, Mr. Jones. Great to see you again. I remember you had just gotten a puppy on your last visit. How is he?"
7	Hygienist leaves. Patient stares around room waiting for dentist to come in.	Dentist is ready and waiting with genuine greeting.

continued on page 70

continued from page 69

ing the need, "let me get you taken care of right away," the patient can hear and feel the connection beyond the business transaction. It provides the personal touch. All too often, we come across as mechanical and uncaring, not because we haven't helped the patient, but because we have failed to emotionally connect and acknowledge their feelings.

While many businesses will say they are customer-centric and will post this in their lobbies, on their Web site, and in their advertising – most are not. If you hear any of the below phrases, it is a good indication your staff is not looking through the lens of the patient.

I can't.
I don't know.
The only thing we can do…
You have to…
That's our policy.
You don't understand.
You don't see my point.
I never said…
That's not my job.
What's your problem?
Do you understand?
You're wrong or mistaken.

If you are looking for a way to grow your business to attract and retain patients, I would recommend you conduct a formal or informal survey of both patients and employees and ask them what processes they would like to see improved. It is those processes that you can start to service map. n

Author's Bio

Teri Yanovitch is a dynamic speaker, consultant and trainer. She was formerly a keynote speaker and seminar leader for the Disney Institute and an executive with Philip Crosby Associates, the noted quality management firm. In 1999, Teri became one of the first consultants to merge best practices in customer service and quality management into a comprehensive system for designing and implementing world-class service on every level. She is the co-author of *Unleashing Excellence – The Complete Guide to Ultimate Customer Service.* Teri can be reached at ty@retainloyalcustomers.com or 407-788-7765 for on-site workshops and presentations.

The Scoop on GROUPON

by Chelsea Patten, Staff Writer, *Dentaltown Magazine*

With phrases like "efficient, measurable marketing" and "risk-free advertising" being thrown around by Groupon (www.groupon.com) and its followers, Townies are buzzing about how this new company is influencing the dental profession.

Groupon started from a Web site called The Point, an effort to affect social change with a collective goal-oriented approach. From fundraising to cause-support, The Point directs interested parties toward group action. Founder and CEO of The Point, Andrew Mason, took the same idea of collective buying power and translated into a locally targeted advertising medium – Groupon.

Here's how it works: Millions of people who have signed up free-of-charge at Groupon.com receive online coupons in their e-mail inboxes each day. Recipients have the option to purchase the coupon offering products or services at a heavily discounted rate. Potential buyers have 24 hours[1] to decide whether they want the Groupon, however a certain number of buyers must commit before the deal is valid. If less than this set number of coupons sells, those who purchased are refunded their money. If the threshold is hit, customers receive the printable coupon in their e-mail inbox after the 24-hour period. Coupons are valid for a minimum of six months and with many Groupons, this time is extended.

So how does this apply to dentists? Groupon acts with the same goal as any other avenue of marketing – to get your name out there and to get patients in your practice. With Groupon's subscriber number at nearly 13 million, and availability in more than 90 cities, the avenue provides dentists with an already-established audience. Dentists need not provide any upfront advertising dollars to use Groupon. For each coupon sale, Groupon takes a percentage. After your ad runs for 24 hours, you receive a check in the mail. Groupon only benefits if the product or service sells. Since it's a one-time offer, once the discount gets patients in the door, it's the practice's responsibility to keep them coming back.

Townies have mixed feelings about Groupon. Here's what they're saying about this new marketing vehicle:

Sandy Pardue
Posted: 7/9/2010
Post: 68 & 64 of 104

This is not for every practice. It's great for startups and for practices in areas that are really struggling. If a practice has empty chairs with a lot of open time or they are trying to build a patient base, perfect!

My clients have been utilizing Groupon for over a year now. It's been difficult for some to accommodate everyone, but this will vary from practice to practice and area to area. I recommend bringing in a temporary hygienist for a week or two if you have the space and can see more people. One client had such a huge response; he had to get another dentist to come in temporarily to handle the flow. It gave them a huge jump start with this practice he just purchased. n

1. 24 hours is the duration of time for the majority coupons. Few run shorter or longer.

continued on page 72

continued from page 71

Brian
Posted: 7/9/2010
Post: 70 of 104

After reading the reviews posted by Groupon users, it appears that many of them will be one-timers who feel "pressured" into taking care of dental problems at full cost after their basically free initial dental visit. Not the kind of patient that I want in my practice. n

drlentau
Posted: 7/9/2010 & 7/14/2010
Posts: 74 & 82 of 104

Some people said that Groupon is for startups or for offices that are struggling. I do not fit in to either of those classifications. I have had the most successful year of my career to date.

From the patients who came in from Groupon, we have generated an additional $20,000 in production. n

- Sold 513 Groupons for his Philadelphia practice

Mbonanno
Posted: 5/14/2010
Post: 10 of 104

[These] are the type of patients that are going to give you the false sense of being busy, erratic and successful but when your blood, sweat and tears go into serving them and becoming a clinic, as opposed to a service-providing, quality-focused dental practice, you will be back at square one again. These are the patients that will go to your office because they are receiving a huge, out-of-this-world discount and will go to another office the next day. I would focus on my internal patients and sustainable growth. n

Jonathan Abenaim DMD FICOI DICOI
Posted: 7/11/2010 n Post: 77 of 104

…if you are in a good market like New York that sells say, 1,000 Groupons...that is a quick $25K that you just got as cash flow. Now if you get one

percent of those to do work then it's worth it. If you have a new practice or a practice that has some chair time, Groupon works great. ...Groupon is great for large markets; might not be the best in small markets. n

I have started to notice a "one and done" pattern with hygiene and Zoom patients, not surprisingly... I'm OK with it though, I just wanted as much exposure as possible… n **- Sold 1,950 Groupons for his NYC practice**

davidjanash
Posted: 7/27/2010
Post: 98 of 104

You don't usually make money on the first deal, with the obvious goal of repeat business. The good thing is you don't have any upfront costs, so if it doesn't do well you're not out thousands of dollars. n

Ziro Marketing
Posted: 5/12/2010
Post: 5 of 104

Some Townies are concerned that Groupon only provides one-time patients. Others think it's the best thing since sliced bread. Search: "Groupon" to rant or rave about it with your colleagues on the message boards of Dentaltown.com and visit www.grouponworks.com for more information about how it works or to get your practice on board.

Bringing Back the House Call

by Chelsea Patten
Staff Writer, *Dentaltown Magazine*

Amir Ghorbani and Lily Sarafan are married.

He is a dentist. She is the COO of an international senior care company.

Lily Sarafan

Now, with a mix of forward and backward thinking, their professions are married too.

In 2009 Ghorbani and Sarafan founded Home Care Dentist (HCD), a mobile dental practice serving the San Francisco Bay Area.

Prior to HCD, Ghorbani, a USC graduate, owned his own dental practice. While he enjoyed working at his practice, he craved a more humanitarian approach to dentistry. The couple explored their options, considered Doctors Without Borders, but couldn't see themselves living abroad long term. They found their niche somewhere between their two professions.

"We never thought our two professions would collide," Sarafan, the Stanford graduate says. Working with elderly people, she knows many who receive in-home care for meals and bathing, among other services. The couple decided dentistry should be one of these available in-home services. "It's one thing to think of doctors in the 1950s with their black bags and stethoscopes going into people's homes. It's another thing to think about the very real and practical nature of the dentistry we're doing," says Sarafan. Ghorbani serves a wide range of clients by offering his in-home services. While the less mobile senior population serves as their primary clientele, the several additional markets that use their services initially surprised them. These include people with agoraphobia (fear of public or unfamiliar places), dental phobia, disabilities, and even busy professionals just seeking convenience.

Home Care Dentist operates with a philosophy of practicing minimally invasive dentistry. Sarafan mentioned a 102-year-old patient who, prior to seeing Ghorbani, was told she needed $35,000 worth of work. Sensitivity to the needs of their older patients, as well as gauging their ability to handle dental work are HCD's top priorities.

The couple lives in Los Gatos, California, but branches throughout the Bay Area. Although a portable practice, a typical day still plays out similar to a regular practice. Ghorbani takes calls from referral sources and prospective patients. He answers insurance questions. He converses with patients, does initial exams and treatments. A similar process, except he must get everything into his car.

Similar to the backpacking department at a sporting goods store, all of Ghorbani's tools deflate, collapse or fold. Believe it or not, up until recently he operated his practice out of a Mini Cooper. Sarafan laughingly recalls one time he pulled up to a senior care facility and they thought it was a mistake. Ghorbani has since purchased a Dodge Magnum for comfort's sake.

Ghorbani's portable tools pack up into a series of silver boxes. Sarafan compares the unloading process to the movie *Transformers.* The setup includes collapsible patient and doctor chairs, a small compressor, a suction and light that are actually embedded in the boxes into which they pack up. He uses a portable X-ray, comparable in size and shape to a glue gun. He can develop the X-rays manually with solution or can view them digitally on his laptop, both on-site. This sophisticated and functional setup certainly trumps the once popular little black bag used for house calls.

Ideally, Ghorbani needs a 10x10 foot area to set up his equipment comfortably. But he must exhibit flexibility since that 10x10 area might be a kitchen, a bedroom, or a living room – his environment constantly changes. Sanitation in his practice space remains under complete control since he brings all the equipment with him.

Ghorbani can perform anything in-house that he would be able to perform in his practice, with the exception of procedures requiring sedation.

The couple's service impacts many in their community. "We've definitely had people get teary eyed on the phone,"

continued on page 76

Dental equipment and supplies pack up into a series of silver boxes, which fit into Home Care Dentist's Mini Cooper.

Name: **Amir Ghorbani, DDS**

Graduate From: **University of Southern California School of Dentistry**

Name: **Lily Sarafan**

Graduate From: **Stanford University (Bachelors, Masters in Management Science and Engineering)**

Practice Name: **Home Care Dentist**

Practice Started: **2008**

Staff: **Ghorbani-Full-time, Sarafan-Part-time, two assistants who rotate and one full-time patient coordinator**

Web Site: **www.homecaredentist.com**

continued from page 75

Sarafan says. "They'll say 'you don't know how long we've been looking for a service like this. I thought, I don't know what I'm going to do about my mom. I am so glad there is something like this out there!'" Ghorbani and Sarafan are just as affected by those they are able to help.

Sarafan mentions patients or families of patients who have given up on the chance of dental care. "They're just living in pain. They can barely eat. Sometimes it's a matter of something simple like dentures not fitting and they just aren't enjoying food anymore. It's amazing how a couple of these visits can turn everything around." She says they often hear from people who have gone without dental care for nearly a decade because of their inability to leave home. Ghorbani finds it particularly rewarding to listen to patients' life stories, which patients offer comfortably due to their familiar environment.

Amir Ghorbani sets up equipment from mobile boxes to perform much-needed dental services to a patient in-house.

Sarafan credits much of HCD's success to their comprehensive demographically-targeted marketing. She says about half of their new patients find them via the Internet – by press release, Yelp reviews, their blog, social media outlets, or their Web site. She names their Web site as a "mainstay" and an "integral part" of their practice. "It's a different world than it was 10 years ago," Sarafan says. "You need to have a Web site. You need to have an online presence." Fifty-to 60-year-olds are the fastest growing demographic on Facebook and since it is often the children of older parents who contact them, HCD markets with a Facebook page as well. The other half of new patients come from referral sources – particularly geriatric or senior centers.

As a visionary in both business and dentistry, Sarafan would like to see the perception of dentistry change in the next 10 years. "In this economy, dentistry is often put off. I'd like to see the perception of dentistry more in line with overall health rather than distinct." Poor dental hygiene is directly linked to heart disease, lung problems, and diabetes among other ailments. She would also like to see better consumer education for oral hygiene practice.

Sarafan notes Jeff Bezos, founder of Amazon.com, as a model for how she would like to see the profession of dentistry progress, as well as cites him as an inspiration for Home Care Dentist. Bezos said, "There are two ways to extend a business… Take inventory of what you're good at and extend out from your skills. Or determine what your customers need and work backward, even if it requires learning new skills." Ghorbani and Sarafan brought this business mentality to fruition. By figuring out their clients' needs – at-home dentistry with a minimally invasive approach – they landed their niche. Sarafan hopes dentistry progresses in a way that is patient-and community-oriented.

When the couple is not working, they enjoy traveling the world, as well as the food that accompanies the journey. Ghorbani enjoys working on classic cars, as well as going to shows and auctions. Sarafan compares her husband's love for classic cars to his ability to take the antique concept of a house call and turn it into a modern, accessible service. "My husband was able to be forward thinking by being backward thinking," she says crediting him with the idea of home care dentistry. How progressive! n

The Importance of Proper Denture Care and Maintenance

by Dr. Gregory Folse

Today more than ever, I am seeing patients in need of prosthetic teeth choose conventional dentures over implant retained prosthetics. Even with the increased demand of dentures, many patients are still in the dark about proper denture maintenance, fit and the use of adhesives. More importantly, they count on us, their dental team, to provide product and technique information which can greatly improve their denture experience and quality of life.

Surprisingly, a recent survey shows that a denture wearer's number-one complaint isn't lack of function or aesthetic concerns from wearing dentures, it's the discomfort they feel when food particles get trapped between the dentures and gums.[1] Trapped food particles can also lead to extreme and unnecessary discomfort and pain that can impact a denture wearer's overall satisfaction, confidence and quality of life.[1]

Many patients believe that they have well-fitting dentures and don't need a denture adhesive. However, even well-fitted dentures can allow food particles between dentures and the tissue causing discomfort.[2,3] Denture adhesives such as the newly-formulated Super Poligrip can help to protect food particles from getting trapped in dentures. This product in particular is clinically proven to seal out up to three times more food particles than not using adhesive at all.[2,3]

However, a denture adhesive is still no substitute for properly aligned dentures. To ensure that your patient's dentures are looking and feeling great, it is essential that their dentures fit properly. Dentures that fit properly will help to improve facial expressions and verbal pronunciations and will allow for more comfort and ease when eating.[4] As dental professionals, if we don't teach all facets of the denture wearing experience to our patients, they can't achieve the maximum comfort and function dentures provide.

In addition to sealing product, the study also examined the cleanliness of patients' dentures, what items or products patients used to clean their dentures, as well as the method used. The results concluded that only 11 percent of denture wearers have clean dentures.[5]

More than half of the patients, 52 percent, disclosed they were brushing their dentures with toothpaste or regular soap.[5] While wearers are under the impression that using these cleaning methods are the correct way to brush their dentures, they are actually scratching the surface – literally. Recent data has proven that brushing your dentures with ordinary toothpastes can cause roughness and scratches on the denture surface and can result in the dentures being more susceptible to bacterial growth.[6]

In order to properly remove bacteria-containing debris and plaque from the dentures, patients should be advised to brush them with a soft-bristled denture brush dipped in a nonabrasive denture cleaning solution, such as Polident, which can kill 99.9 percent of odor-causing bacteria and can remove tough stains as well.[7]

Proper cleaning, maintenance and well-fitted dentures are all key factors in a patient's overall denture satisfaction which can lead to confidence and improve the way they feel about their dentures.

A good way to boost patients' self-esteem and help them feel great is to encourage them to maintain their oral health and maintain a healthy diet. Remind them that while it seems that many nutritious fruits and vegetables can be tough to eat, using a denture adhesive along with well-fitting dentures can help them eat those more difficult foods that they may have been avoiding. Recommending an adhesive is critical to maximizing the retention and stability of dentures. Increased retention and stability from an adhesive go a long way in increasing confidence, thereby improving a denture patient's quality of life.

Clean, comfortable, sealed, retentive and stable dentures are what patients want, need and deserve. It is our job to help them achieve those goals by providing denture care instructions. We all want to provide each patient with the opportunity to maximize their denture experience because a happy patient with a smile they feel is worth showing off is a good thing. n

References

1. GSK Super Poligrip Sales Aid. Canadian denture care quality of life research; 2005.
2. GSK Super Poligrip Sales Aid.GSK Data on File. Study L3920659.
3. GSK Super Poligrip Sales Aid.GSK Data on File. Study L3920658.
4. American Dental Association. Oral Health Topics. http://www.ada.org/2996.aspx.
5. GSK Polident Sales Aid. GSK Data on File (Dikbas et al, Int J Prosthodont 2006; 19: 294-8).
6. GSK Polident Sales Aid. Kleber CJ 2006 Research Report Study L2630368.
7. GSK Polident Sales Aid. GSK Data on File (approved claim).

Author's Bio

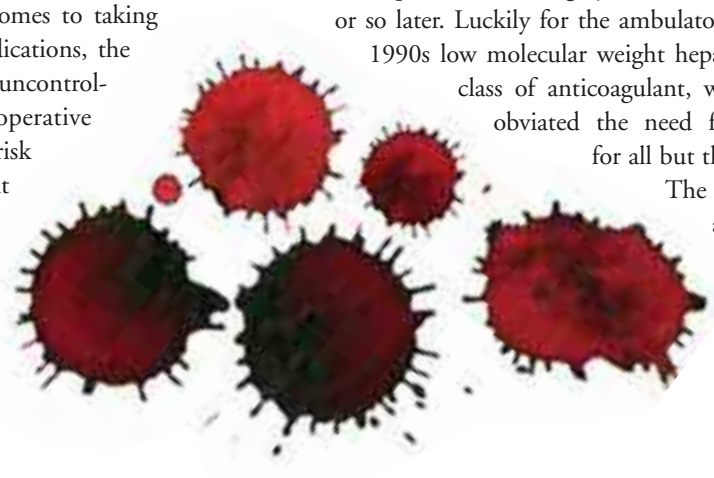
A 1989 LSU Dental School graduate, **Dr. Greg Folse** maintains a mobile geriatric dental practice in Lafayette, Louisiana. Dr. Folse is a recognized national and international speaker on geriatric dentistry, dentistry for Aged, Blind and Disabled special need patients, oral health advocacy, and functional and efficient denture care.

**Dr. Gregory Folse is a paid GlaxoSmithKline consultant*

by Jay B. Reznick, DMD, MD

One of the frequent issues in my practice is the protocol for patients who are taking anticoagulant medications. Things have changed in this regard since the time I was in dental school. Back then, we were required to get a physician's consultation and clearance before we treated any patient with any type of medical disorder. Many times we were amazed about how nonsensical doctor's recommendations were, but would be liable in a court of law if we had not taken their advice and the case went awry, so we went along. After entering oral and maxillofacial surgery residency, and later as a medical student, I came to appreciate that most physicians know next to nothing about dentistry. Many of them could not even tell you how many teeth an adult should have. Therefore, they based their recommendations on what they knew from medical surgery. If a patient has postoperative bleeding in the abdomen, chest, shoulder, nose or brain, they can be in serious trouble. Patients are placed on anticoagulant medications, such as Coumadin, Plavix, or aspirin in order to prevent formation of a blood clot in the coronary arteries, brain, abdomen or extremities following a stroke, mesenteric thrombosis, bypass grafting, deep venous thrombosis, or to prevent a thrombotic event when there are significant risk factors. So, patients who are on these medications are on them for good reason.

In medicine, clinical decisions are made by carefully evaluating the benefits, risks and complications of the various treatment options. When it comes to taking patients off anticoagulant medications, the risk of having significant and uncontrollable intraoperative or postoperative bleeding is compared with the risk and consequences of the patient having another thrombotic event. When we are talking about surgical procedures such as bowel resection, joint replacement, coronary artery bypass or septoplasty, such bleeding can be widespread or from a large blood vessel, and can be hard to adequately control in an anticoagulated patient. This can lead to disaster, and thus is weighed against the risk of a stroke, myocardial infarction or pulmonary embolus. For these types of procedures, it is commonplace to take patients off of their anticoagulant a few days before surgery so that their hemostatic mechanism is intact at the time of operation, and then to restart the medication once the critical period for bleeding has passed, which is usually two to three days. This makes the patient's surgery safer from the perspective of perioperative bleeding, but abruptly stopping their anticoagulant medication for surgery actually puts them into a hypercoaguable state, which increases their risk of thrombotic complications above their baseline risk.



For patients who have an increased risk of thrombosis because of their history, or the presence of a mechanical heart valve, that window of normal or hypernormal coagulation can be narrowed by following a protocol of intravenous heparin, which is stopped and restarted within hours of the surgical procedure. This requires the patient be hospitalized for at least two days before and two days after surgery, no matter how minor the procedure might be. Many of the patients who required this (during my residency) were cardiac patients who needed some infected, unrestorable teeth removed before heart surgery, or to prevent endocarditis from developing in the susceptible heart. After oral surgery, the patients were again anticoagulated, and if they were to have subsequent cardiac surgery, it would usually be done a week or so later. Luckily for the ambulatory patient, in the mid-1990s low molecular weight heparins (LMWH), a new class of anticoagulant, were introduced. These obviated the need for hospital admission for all but the highest risk patients. The patient would be given a supply of syringes and would self-administer the drug subcutaneously in the period before and after surgery. This generally

had to be coordinated with the patient's cardiologist to arrive at the best dosing regimen.

This was about the time that I started in private practice, and although using LMWHs was certainly much easier than hospitalization and intravenous heparinization, it was still a hassle, both for patients and dentists. This however, was the protocol that the cardiologists and hematologists had developed for all surgeons to follow. These regimens were developed by physicians who applied the same rules for abdominal surgery, neurosurgery, orthopedic surgery and oral surgical procedures. It always seemed to me that this was overkill. I remembered from residency and practice that most cases of bleeding from an extraction site, no matter how severe, could be controlled by packing with gauze, and maintained with a hemostatic agent, such as Gelfoam, Surgicel or topical thrombin. Unlike the abdominal cavity, chest or knee, where surgical bleeding can be widespread and cannot be easily controlled by packing, most oral surgical sites are very accessible to the surgeon and are very easily packed to control bleeding. Usually dentists or oral surgeons do not encounter many major blood vessels. As a dental student, I remember reading an article in one of my journals about research conducted at a dental school in Israel, in which they treated patients on Coumadin no differently than patients who were not anticoagulated. They found that for minor oral surgical procedures, including extraction of two to three teeth, biopsies, small mucosal excisions and quadrant alveoloplasty, that intraoperative bleeding was not appreciably different, and postoperative bleeding episodes occurred at only a slightly higher rate. When postoperative bleeding was encountered, it was usually managed very easily with local packing and hemostatic agents. They recommended that the protocol for managing the anticoagulated patient be modified to reflect their findings. I did not hear much about this afterward. I even suggested to my fellow residents and faculty that we consider the findings of this research, but was told to continue our standard protocol. Being a lowly resident, I went along with my superiors.

Once I got into private practice, I was in a better position to push the envelope and decided to keep some of my patients on their anticoagulants for surgery. I started experimenting first with single extraction cases, carefully minimizing my incisions and packing the socket with Gelfoam. I found that intraoperative bleeding was basically normal, and that the postoperative bleeding incidence did not increase. I soon expanded my range to include quadrant extractions, alveoloplasty, and various limited soft tissue procedures. I continued packing the sockets with Gelfoam, and used my cautery or laser for the soft tissue surgeries. Again, I found no increase in bleeding, either during or after surgery. Every other oral surgeon in my area was taking their patients off of Coumadin for simple single tooth extractions. This variation in protocol was one of the things that helped build my practice in its earlier days.

In January 2000 the *Journal of the American Dental Association (JADA)* published the article "Myths of Dental Surgery Patients Receiving Anticoagulant Therapy."[1] This article reviewed a number of scholarly papers dating back to

1. Articles can be downloaded free of charge from the JADA Web site at www.jada.ada.org

continued on page 80

continued from page 79

1954 and came to the conclusion that embolic complications, including death, following abrupt short-term discontinuation of anticoagulants for dental surgery, were three times more likely than were bleeding complications when anticoagulants were continued perioperatively, as long as INR (International Normalized Ratio) was less than 4.0. Another article, in the November 2003 issue of *JADA* presented "Lack of a Scientific Basis for Routine Discontinuation of Oral Anticoagulation Therapy Before Dental Treatment."[1] This article reviewed the previous literature – an analysis of the various anticoagulant drugs, laboratory tests, and assessment of risks related to this clinical problem – and came to a similar conclusion.

These papers brought a new line of thinking into the mainstream, and gave me the license to include this in my teachings of oral surgery to the masses. Every patient must be viewed as an individual, based on their risk factors.

For the majority of anticoagulated patients who are to undergo a minor oral surgical procedure, so long as their INR is less than 3.5, we can typically follow the guidelines I have discussed. Remember, the physician's recommendation is based on their knowledge of medical surgery not oral surgery, and they will always tell you the patient must be taken off Coumadin, Plavix or aspirin for surgery. Try to be as atraumatic as possible in performing surgery. Use minimally invasive techniques as much as possible, and pack the site with topical hemostatic material. You will find that your patients will be impressed by your up-to-date knowledge on the subject, grateful that you are not putting them at increased risk for a thrombotic complication, and looking out for their best interests. It is always good to be better than your competition. And, this is a simple way to do it. ■

Author's Bio

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

Crooked

Film Gets Straight to the Importance of Oral Health

by Chelsea Patten,
Staff Writer, *Dentaltown Magazine*

Dr. Steve Tinsworth, Executive Producer

Outdated PSA-style advertisements just don't cut it anymore for educating kids about the importance of oral hygiene. Stars North Films, with filmmaker Todd Thompson took the responsibility into their own hands by creating *Crooked,* a current day-in-the-life sketch of Samantha – a relatable kid-centered effort to demonstrate good oral hygiene practice.

Samantha, on the verge of her teenage years, brushes her teeth three times a day. Her concern for her oral hygiene keeps her teeth healthy and white, and keeps both her and her dentist smiling. Although Samantha's pearly whites are nearly flawless, she has one stubborn, crooked baby tooth that refuses to fall out. She tries everything – since once it falls out, she will have a perfect smile, and as fate would have it, the heart of the new boy at school as well.

The 17-minute film short is relevant and applicable for elementary and middle schools kids. The plot combines dental care with the comedic dramas of middle-school including popularity, image, and innocent romance, as well as the perils of home – an embarrassing mother and a sloppy, cavity-ridden brother.

Throughout the witty and fast-paced film, Samantha indirectly educates kids on the importance and responsibility of oral hygiene maintenance. She compares her smile to the smiles in several popular teen magazines. She knows and verbalizes that she cannot have a winning smile without making brushing and flossing a twice-daily habit. The short really packs a punch in the brushing and flossing department.

Executive producer and the first clinician to jump on board, Steve Tinsworth, DMD, says, "One of my biggest obstacles is getting patients to truly understand the life-long effects that good oral hygiene has on their bodies. You can remind them every time they come in for a check-up, but getting them to form the habit – that's the real challenge."

The film's stars Kendall Ganey, (*The Little Princess* and *Ace Venture Pet Detective*) and Bo Mitchell (*October Road* and *Eastbound and Down*) create role-model characters for kids to form their brushing habits after.

Crooked is available in the 2011 American Dental Association Catalog, as well as online at www.dentalmovie.org. It retails for $14.95. The DVD includes "play" and "play continuously" options to accommodate your waiting room area. It also has many various menu features including behind-the-scenes footage and a music video set. For more information visit www.dentalmovie.org. ■

"Crooked" Digi Pak DVD

Case Report:

CBCT-assisted Treatment of the Failing Long-Span Bridge with Staged and Immediate Load Implant Restoration

by Scott D. Ganz, DMD

Treating failed long-span bridges presents unique challenges for the clinician and the patient. When anchor abutment teeth fail, and it is recommended that the bridge be removed, often it can no longer be supported by natural teeth. The treatment option to replace the missing dentition would consist of a removable-type prosthesis, or an implant-retained restoration. Most patients do not want to be without teeth for an extended amount of time and desire the option which most closely replaces their missing teeth – a fixed prosthesis. In fact, many patients are now aware of treatment options which would allow for removal of the failing bridge and anchor teeth, followed by the immediate placement of dental implants to maintain an immediate transitional restoration. However, in order to present this treatment option to the patient, proper diagnosis and treatment planning is essential for a complete understanding of the available bone, soft tissue, opposing occlusion, vertical dimension and surrounding vital structures. Current two-dimensional panoramic and periapical radiographs can no longer be considered the most accurate diagnostic imaging modalities available.

To properly assess the patient's anatomy, I recommend a three-dimensional assessment utilizing Cone Beam CT scan (CBCT) technology, which empowers the clinician with new tools to make educated decisions regarding the plan of treatment.

Case Presentation

A 61-year-old male patient presented with pain and mobility in an existing posterior right mandibular long-span fixed bridge. A routine diagnostic work-up was completed, including periapical radiographs and study casts. The patient had a history of bruxism, which may have been contributory to the root fractures and mobility of the bridge. Radiographic loss of bone was evident around the mandibular second molar tooth, the terminal abutment for the fixed bridge, which exhibited a significant angular defect on the mesial (Fig. 1). The first bicuspid had previously been treated with root canal therapy, and appeared to be fractured from the stress of the restoration or recurrent decay along the margins. In order to determine the potential treatment alternatives, a CBCT scan was ordered to allow complete inspection of the three-dimensional bony topography, and the relationship of adjacent vital structures. Two-dimensional imaging modalities could not provide an adequate interpretation of the patient anatomy, raising the risk of treatment and potential injury to vital structures.

CBCT technology allows for an accumulation of data to accurately determine educated treatment decisions. There are four important three-dimensional views: (1) axial, (2) cross-sectional, (3) panoramic, and (4) 3D recon-

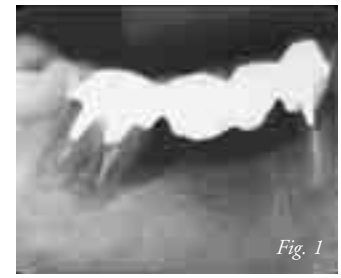


Fig. 1

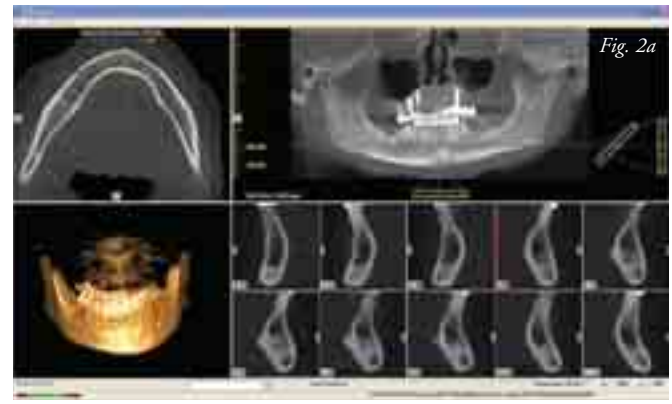


Fig. 2a

Fig. 2b

structions (Fig. 2a). Each of these views are individually important and when assimilated in total, due to the interactive nature of the CBCT viewing software, provides the ultimate overview of the patient's anatomic presentation. The data can be visualized utilizing interactive treatment planning software applications which have innovative tools to aid in the diagnosis and treatment planning. I have long advocated the concept "It's not the scan, it's the plan," meaning the clinician must evaluate the data provided by the CBCT machine. Once the scan is taken, it can be viewed on the computer workstation using the native software, or the DICOM data can be exported into an interactive treatment planning software where all available images can be processed and manipulated interactively to create an excellent diagnostic environment (Fig. 2b).

Three-Dimensional Planning

The panoramic image reconstructed from the CBCT dataset differs substantially from a conventional panoramic radiograph. This nondistorted image can be viewed interactively using the incorporated viewing software to assess the broader aspects of the arches (Fig. 3). The cross-sectional image is excellent for defin-

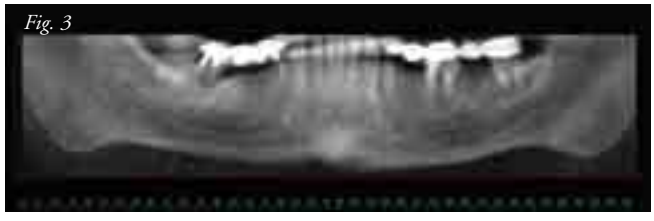


Fig. 3

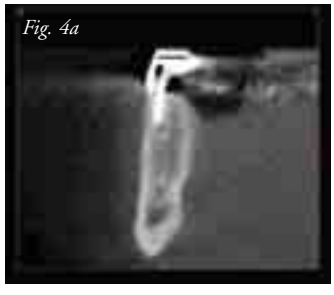


Fig. 4a

ing a slice of the mandible where the height and width of the bone can be accurately evaluated. Within an individual slice, the spatial location of the tooth and root can be appreciated (Fig. 4a). The facial, lingual cortical and intermedullary bone can be visualized based upon their radiopacity or grayscale density values. Nuances within the anatomical presentation can be assessed with greater accuracy than with any other imaging modality. Simulated implants can be placed in a position to effectively support the desired restoration, even with close proximity to the mental foramen (Fig. 4b). The cross-sectional slice of the posterior molar reveals the significant bone defect sur-

continued on page 84

continued from page 83

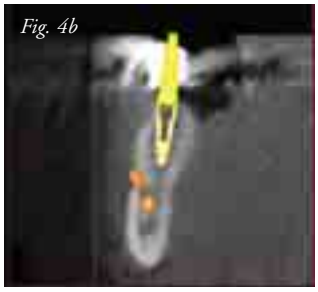


Fig. 4b

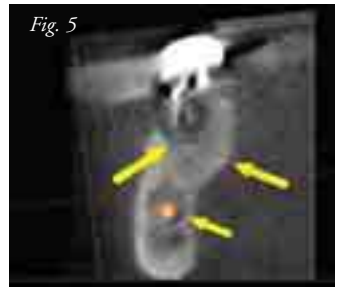


Fig. 5

rounding the apical roots (Fig. 5). There was cortical bone below the root apex, and the significant lingual concavity was noted. The inferior alveolar nerve can be carefully traced through the mandible to determine proximity to the tooth roots and potential implant receptor sites (orange). Although there was good quality bone above the location of the nerve, there was insufficient bone to adequately fixate an implant. It was therefore elected to extract the molar tooth and fill the defect with grafting material in anticipation of placing an implant after the new bone had matured.

Creating a fully interactive three-dimensional reconstruction from the CBCT scan data allows the clinician further insight into the patient's existing anatomical presentation. Utilizing advanced software masking or segmentation enables the various anatomical entities to be separated for improved diagnostic capabilities. The pre-existing bridge has been colorized (magenta) as have the adjacent molar and cuspid teeth (white) (Fig. 6). Simulated implants were positioned within the bone to support a new fixed restoration based upon the abutment projections which extended above the occlusal table (Fig. 7). Using advances in interactive software, "selective transparency" can be applied to change the opacity of various structures to aid in the diagnosis and planning phase. Accurate placement of realistic implants is enhanced by masking the adjacent tooth roots. The path of the inferior alveolar nerve can also be fully appreciated. Note the planned parallelism of the four simulated implants (Fig. 8). If the pre-existing restoration could not be physically removed in advance of CT/CBCT imaging and the old occlusion was found to be unfavorable, through further masking or segmentation, it is now possible to build a virtual occlusion using interactive treatment planning software. "Virtual teeth" (seen in yellow) can correct discrepancies, and allow for an ideal simulated morphology fabrication. The large defect around the molar was significant, and it was determined that it could not be used as a receptor site initially. It was elected to graft this site, and return in five months to place a single implant in the molar site. Once the plan has been verified in all four available 3D views, a virtual template can be fabricated based upon the implant positions (Fig. 9). Therefore, the final surgical template is only as good as the virtual plan.

There are three basic CT-derived template types which can be fabricated for dental implant placement: (1) bone borne, (2) tooth-borne, and (3) soft-tissue borne. Based upon the fact that there were adjacent teeth in the region, it was elected to utilize a tooth-borne template stabilized by the existing occlusion. The CBCT scan data was sent via e-mail for fabrication of a stereolithographic model (Fig. 10).[1] This model is a replica of the patient's anatomy at the time that the images were acquired. The pre-existing bridge was removed via the software prior to fabrication of the surgical guide. The template adapts well to the surrounding dentition and does not require further fixation to prevent movement. The stainless steel tubes 0.2mm are wider than the manufacturers' sequential osteotomy drills.

My novel modality utilizes a CT-derived stereolithographic model-based approach to link the implant placement and the eventual restoration. Implant replicas, or analogs were placed in pre-designated implant receptors on the stereolithographic partially edentate mandible (Fig. 11). In order to accommodate the immediate restoration, manufacturers' specific abutments were placed on the implant replicas. Note the interimplant distances for proper embrasure design. A diagnostic wax-up was accomplished and a clear matrix fabricated to facilitate the fabrication of a provisional prosthesis. Stock, 3inOne (BioHorizons) tita-

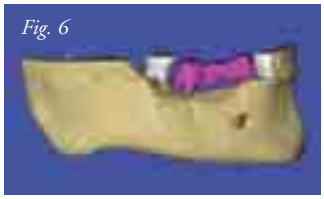


Fig. 6


Fig. 7

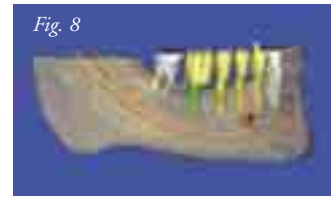


Fig. 8

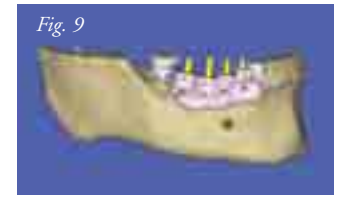


Fig. 9


Fig. 10


Fig. 11


Fig. 12


Fig. 13

1. Materialise Dental, Lueven, Belgium

nium abutments were positioned on the implant replicas to support the temporary restoration (Fig. 12a). The processed four-unit transitional acrylic bridge was supported by the implant abutments (Fig. 12b). As the molar site would not receive an implant immediately, a distal cantilever pontic was required. The actual implants, as simulated in the virtual plan, were chosen in advance, as well as how to best position the implants to take advantage of the reverse buttress thread design, coronal microchannels and internal hexagonal connection design features. The tapered internal implants with the Laser-Lok microchannels allow for the implants to be placed in a "transitional" position where the lingual cortical plate is higher than the facial cortical plate of bone (Fig. 13).

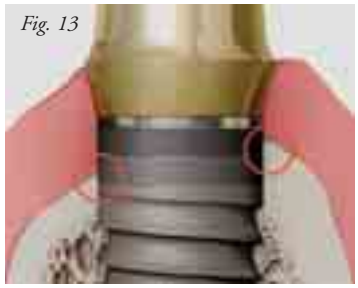


Fig. 13

Surgical Intervention

The occlusal view of the failing long-span bridge can be seen in Fig. 14a. Once the failed restoration was removed, the underlying fractured tooth roots were assessed. The volumetric change in the pontic areas was assessed by comparing the facial lingual dimensions of the molar and bicuspid with the pontic area with diminished keratinized tissue (Fig 14b). All of the planning decisions had been made prior to the surgical intervention except the design of the flap to expose the underlying alveolar ridge. To preserve the keratinized tissue, a full thickness muco-periosteal flap was required, followed by extraction of the two natural abutment teeth (Fig. 15). The tooth-borne template was then placed over the site and examined for fit (Fig. 16). As per the CBCT-derived plan and template, the first three implants were placed. The implants were well fixated allowing for immediate restoration by aligning the internal hexagonal connection to the facial with the attached


Fig. 14a


Fig. 14b


Fig. 15


Fig. 16

continued on page 86

continued from page 85


Fig. 17


Fig. 18

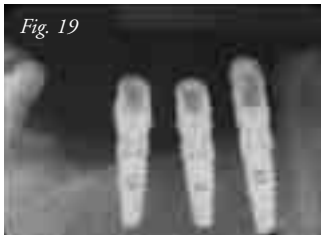


Fig. 19


Fig. 20


Fig. 21

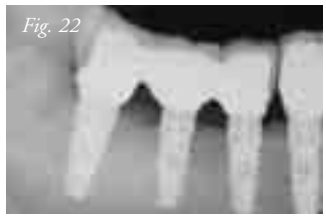


Fig. 22

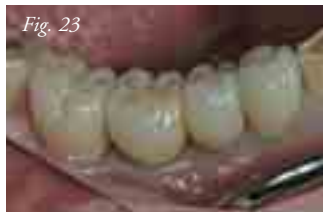


Fig. 23

3inOne abutments (Fig. 17). The posterior molar extraction socket was filled with a cortico-cancellous mineralized bone graft material (MinerOss, BioHorizons).

The prefabricated four-unit provisional restoration was seated and relined to fit the three anterior implant fixtures. The distal-extension cantilever replaced the missing molar with care taken not to place pressure on the underlying graft. The soft tissue was sutured to allow for near primary closure as they were wrapped around the abutment projection while helping to establish embrasures (Fig. 18). The postoperative periapical radiograph confirms the placement of the anterior three implants and the bone graft in the molar defect (Fig. 19). The transitional restoration was cemented, retained and left in place for more than two months. Once the posterior molar bone graft had matured, the fourth implant was placed according to the original CBCT plan. When the fourth implant had integrated after eight weeks in function, an abutment was connected, and the existing transitional restoration was relined. Impressions were made and a soft tissue working cast fabricated for the laboratory process. The favorable parallelism afforded by the CBCT-derived planning required only minor preparation of the implant abutments to allow for adequate clearance for the metal alloy and porcelain veneer (Fig. 20).

Due to the patient's bruxism, it was elected to splint the posterior three units within the framework of the ceramo-metal restoration, while the anterior, longer implant was fabricated as a single unit. The bisque-bake try-in revealed improved soft tissue contours and emergence profile (Fig. 21).

The completed ceramo-metal units seen in the periapical radiographs show nice parallelism and interimplant distances (Fig. 22). The emergence profile of each implant illustrates a smooth transition important to long-term maintenance. The final glaze and porcelain characteristics of the posterior four units blend in nicely with the surrounding dentition and soft tissue (Fig. 23). Note the excellent adaptation of the embrasures.

The purpose of this case presentation is to illustrate the enhanced diagnostic and treatment planning capabilities of CBCT data combined with interactive treatment planning software. The combination of careful diagnosis with proper planning aides the clinician in understanding existing bone topography, bone density, adjacent tooth roots, lingual concavities, occlusion, and the path of the inferior alveolar nerve. Once the information has been gathered, an accurate plan can be established. This plan will then be transferred to a surgical guide, allowing for precise implant placement. In a phased approach, three initially placed implants were immediately loaded with a transitional cantilever restoration, while avoiding the lingual concavity and within a zone of safety above the inferior alveolar nerve. The posterior molar tooth with resulting socket defect was found to be unfavorable for implant fixation, and therefore site development was accomplished with bone grafting. This was anticipated and documented preoperatively after interpretation of the CBCT data. Once matured, the molar area became an excellent implant receptor site. The patient was given a transitional restoration the day of surgery, although there was a staged approach and delayed implant placement in the molar area. This case represented one treatment alternative to replacing a failed long-span mandibular and bridge which was made possible through CBCT scan technology, interactive treatment planning software and CT-derived surgical templates to guide the placement of the implants based upon the restorative needs of the patient. ■

Author's Bio

Dr. Scott D. Ganz presents extensively on national and international podiums on the Prosthetic and Surgical phases of Implant Dentistry and is considered one of the world's leading experts in the field of Computer Utilization for Diagnostic, Graphical and Treatment Planning Applications in Dentistry. Dr. Ganz has published more than 60 articles, many textbook chapters, and currently serves as associate editor for the peer-reviewed journal, *Implant Dentistry,* and president of the Computer Aided Implantology (CAI) Academy. For more information, visit www.drganz.com.

LOCATOR®

Bar Attachment System

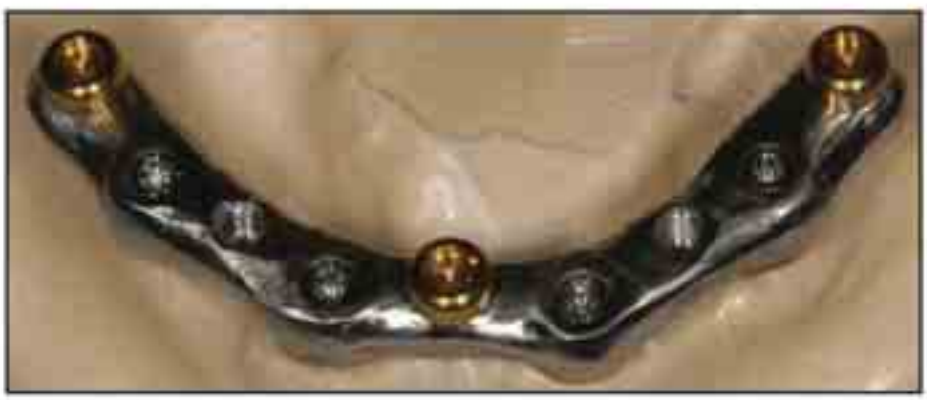
The LOCATOR Bar Attachment system contains the same self-aligning feature, superb retention, long-lasting durability and low attachment profile that is currently enjoyed with the top-selling Locator Implant Attachment. These benefits are available for your use when the splinting of implants is required with a bar for added stability.

Uniformity with the LOCATOR Attachment system allows existing denture components already on hand to be used in combination with the LOCATOR Bar Attachment.

A delrin Castable Threaded Insert creates a 2.0mm threaded site for a LOCATOR Bar Attachment and can be cast in any alloy of choice.

The resulting threaded socket will allow a Locator Abutment to be torque tightened into place for retaining an overdenture.

The low-profile LOCATOR Bar Attachment height of only 2.5mm provides the best attachment choice for implant retained bars.



To learn more about the LOCATOR visit our Web Site at www.zestanchors.com

ZEST ANCHORS

2061 Wineridge Place
Escondido, CA 92029

Place orders online or call toll-free

1-800-262-2310

FREE FACTS, circle 3 on card

Patience is a Virtue

The new way to process old scrap metal

by George Doskoris, DDS

It seems difficult to go three days without seeing a brochure or a small jar from a scrap metal company piled up on my desk. It also seems that at least once a week my receptionist tells me that a guy with a scale comes around and offers to buy our scrap metal from us. She even tells me some of the creative sales pitches she has seen – including buying the staff a pizza, Starbucks gift cards, Panera Bread bagels – you name it, we've seen it. I used to sell my scrap metal to a guy like this, as do many dentists. The scrap buyer was a pleasant and funny fellow and the staff was thrilled when he came around for them to get some "office cash."

While I was always curious to find out how much my scrap was really worth, it wasn't a big deal because the office would receive several hundred dollars and the staff up front could sell some old jewelry, etc. As I watched the gold prices soar for the last few years and the frequency with which the office was being solicited for our scrap, I thought the scrap must be of considerable value – which would explain why so many people wanted it so badly.

I called one of my colleagues who had been practicing for many years and sought his advice on what to do with my scrap metal. He referred me to a company called Scientific Metals and told me "try them, I think you'll be very happy." I responded by saying "I don't think I have ever heard of them nor have I seen any literature in the mail from them." He asked if I wanted their brochures in the mail or an accurate return for the scrap. I went to their Web site and read about their affiliations with dental associations. I decided to give them a try. I called their office and spoke to a woman who scheduled the pickup for me and told me that FedEx would bring me a shipping label when they picked up the box. All I had to do was place my scrap in a small lab box, put my name inside, and have it waiting at the front desk for FedEx. FedEx came that very day and as promised, brought the shipping label and slapped in on the box. I took down the tracking number so I could track the package if necessary and off the package went. The staff at the office was a little reluctant because they did not want to wait a week for the money, and told me they were quite happy with the amount they had been receiving from the guy who came by the office. I made them a deal that if the money we got from Scientific Metals was less than what we were used to getting, I would chip in the difference. The staff told me they were expecting anywhere from $400-600.

To make a long story short, a week later I received an e-mail saying the scrap had been processed and we were getting a check for $1,247. Needless to say, the staff no longer cared about waiting a week to get the money. My two cents worth: wait a little longer for the money and send it in. The extra wait is well worth it.

Scientific Metals can be contacted at 888-949-0008 or visit their site at www.scientificmetals.com. n

Author's Bio

George Doskoris, DDS, of Beverly Hills Smiles works with some of the nation's leading dental practitioners and has substantial experience in both cosmetic and advanced restorative dentistry. Please visit www.bhsmilecenter.com for more information.


Two innovative webcasts
are coming your way
Reinventing "Word-of-mouth" with Social Media,
Using Facebook and other social media to improve your bottom line
When: 8 p.m. (EST) on Thursday, November 18, 2010
Speaker: Jason T. Lipscomb, DDS and Jeffrey C. Barrera, DDS
Sponsored by: Demandforce Inc.
A Deep Dive into Large Group Practice USA
Speakers: Dr. Brad Guyton, Amy Logan and Dr. Rob Berg
Sponsored by: AspenDental practice made perfect
What you need:
• Computer with Internet connection
(minimum fo 56k – preferably broadband)
• Computer speakers
Register Today!
www.dentaltownwebcasts.com
dentaltown webcast

Newly Improved LSK121 Chairside Shade Guide

The LSK121 Chairside Shade Guide has been upgraded and improved. What's different? After selling hundreds of the original Chairside Shade Selection Guide, we asked our clients what they liked or thought needed improvement. In response to those answers, we have streamlined the product, reduced its size to four inches long and one inch wide, for a better fit in the mouth. We increased its thickness and made cleaning with disinfectant cloths even easier. We also simplified the categories for the two separate but complete anterior/rehabilitation and posterior guides.

Because tooth color varies according to its location in the mouth, we have, in the new edition, simplified the selection process for the clinician and assistant by categorizing the color according to its location: central, lateral and cuspid, or molar and premolar.

Anterior Specifications

Anterior teeth need special consideration because of their aesthetic appeal. Central teeth color is often heavier and more intense whereas the translucency, mamelon and enamel color in the laterals and cuspids will present a different appearance than the centrals.

First, choose your color from one of our 27 overall anterior tooth color choices, based on Vita dentin shades but blended with incisal and enamel translucency all the way to the gingival area, to create a more natural appearance. Central, lateral or cuspid category, this step takes the place of matching your patient's teeth with a regular shade tab because now no other shade tab is required.

Second, choose the predetermined incisal one-third in the one-color code. You choose modifications according to location in the mouth: translucency, transparency, mamelon, crack line, surface texture and after prep color, as needed.

Cosmetic Rehabilitation Design Section

A one-color shade tab is not natural and will therefore give a monochromatic appearance, if prescribed. To avoid this problem, we created this important addition to our anterior shade guide.

Choose a color from one of nine bleaching to A2 colors, pre-blended with enamel translucency. Second, choose patient smile design based on one of the nine choices available. Also, choose any extra characteristics such as: translucency, surface texture, after prep color and tissue color if the case is an implant or has gingival height problems

Posterior Specifications

The 24 basic colors are based on A0-D6 Vita dentin shades and are blended with enamel overlay as well as enamel translucency and occlusion stain, for a look just like natural teeth.

First, choose your natural-appearing overall color, according to molar or premolar specification, already blended with enamel overlay, dentin color and occlusion stain.

For highly aesthetic restoration duplication, LSK121 recommends GC Initial Porcelain Ceramic System.

In many cases, no other prescription choices are necessary. However if a few extra modifications are required: you can go to the Enamel Modification section for maxillary and mandibular molars and premolars and follow the three views of the dentition characterizations per page: Perspective, Occlusal and Buccal – for easy screening and selection.

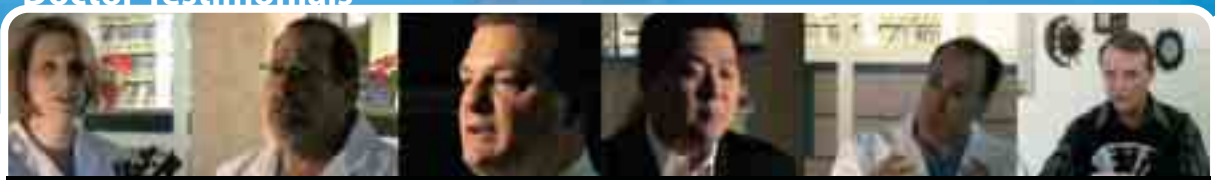
One posterior tooth prescription choice – with everything included – leads to a simple one-step matching process. LSK121 makes the perfect color match easy with indicated shade guides. Why not receive a crown that mimics a custom shade restoration every time? You can with the newly updated Chairside Shade Guides. Make your patients happy and improve your professional life as well. n

Contact Info

Call 888-405-1238 or www.lsk121resources.com to find out more.

Improved Chairside Shade Guide!™

Doctor Testimonials



What is it? An updated and improved version of the extremely popular LSK121 Chair Side Shade Selection Guide™, first introduced in 2009. For a simple selection process, the inventor has created two guides, one for Anterior/Rehabilitation and one Posterior, all sold together in one package. The 63 total Vita dentin color choices have been pre-blended with enamel translucency and enamel overlay in order to mimic natural looking teeth - all with only one code choice necessary! Along with 12 natural-looking cosmetic colors, 9 smile design choices have been added. Product size has been shortened to a 4 X 1 inch size and made thicker for a better fit in the mouth - also making it easier to clean and sterilize. Every consideration has been given to creating better doctor/patient communication regarding esthetic design!

I·II·I
LSK121
Oral Prosthetics

For highly esthetic restoration duplication, LSK recommends GC initial™ Porcelain Ceramic System.
GC
GC America Inc.

How to use? Two newly created instructional DVD's are included with each package - one for anterior and one for posterior teeth. All system usage is covered in these DVD's. **FREE FACTS, circle 39 on card**

Call today 888.405.1238 www.lsk121resources.com

Right Implant, Right Place

by Chelsea Patten, Staff Writer, *Dentaltown Magazine*

Welcome to the newest installment of Office Visit, where we visit a Townie's office and profile his or her equipment, design or unique practice philosophy. If you would like to participate or nominate a colleague, please e-mail ben@dentaltown.com.

This month, Dentaltown Magazine *had the opportunity to speak with Drs. Michael Hoffman and Stephen Barnes, of Falls Oral Surgery and Dental Implant Center, in Ohio. This two-surgeon team talks about their evolving interest in implants, along with how technology has affected the way they practice, and the influence Dentaltown has had on their practice philosophy.*

Photography by Visualizations Photography

Office Highlights

Bonding Agents
- Dyract Flowable Composite
- Integrity Acrylic

Burs
- Sabra Dental

Implants
- Nobel Biocare
- ImplantDirect

Impression materials
- CP Mix by Schein

Patient Financing and Management Software
- CareCredit/Springstone Patient Financing
- PracticeWorks Win OMSCS Practice Management Software for Oral Surgeons
- Tel-A-Patient on-hold messaging
- PBHS Web site Design

Operating Equipment
- Sabra OMS45 Handpiece
- A-dec Dental Lights
- DCI International Lubrication System
- W&H Osseoset 100 Implant Handpiece
- Satelec Ultrasonic Handpiece used for Apicoectomies
- Orascoptic Loupes
- Boyd Surgical Chairs

Miscellaneous Items
- Midmark M11 Ultraclaves
- Tech West Air Compressor
- Drager Compact Anesthesia Machine
- Post MXR for nitrous oxide delivery

Technology
- Kodak 9000 3D Pan/Cone Beam CT
- Kodak RVG 6100 Sensors
- Welch Allyn Atlas Monitors
- Olympus E-10 Camera

Why do you think dental implants are important to the dental profession as a whole?

Barnes: Technology as far as implants go has really taken off and it's now allowing us to do things that 10 or 15 years ago were virtually impossible. We can do anything from restoring single teeth and restoring multiple teeth to providing excellent retention of patients' dentures. Implants allow patients to regain function that had been lost. Since we remove a lot of teeth, it's nice to have a reliable option to replace them in a way that is almost as good, if not just as good as the teeth were prior to becoming decayed or infected. Implants improve aesthetics and most of all they can restore self-confidence in patients.

Hoffman: It really gives patients a second chance at a normal set of teeth. We didn't have that ability until recently.

continued on page 94

Name: **Michael Hoffman, DDS**
Graduate from: **The Ohio State University College of Dentistry, 1987**
Specialty in Oral & Maxillofacial Surgery: MetroHealth Medical Center, 1992
Name: **W. Stephen Barnes, DMD**
Graduate from: **Case Western Reserve University School of Dental Medicine, 2004**
Specialty in Oral & Maxillofacial Surgery: MetroHealth Medical Center, 2008
Name: **Lewis Winston, DDS, retired**
Graduate from: **Case Western Reserve University School of Dentistry, 1973**
Specialty in Oral & Maxillofacial Surgery: MetroHealth Medical Center, 1982
Practice Name: **Falls Oral Surgery and Dental Implant Center**
Practice Location: **Cuyahoga Falls, Ohio**
Practice opened: **1962 by Leon Wyant, DDS**
Staff: **13 full-time, plus two surgeons**

continued from page 93

Mike and Steve's Top Five

	Kodak 9000 3D Pano/Cone Beam Scanner	Plasma Rich in Growth Factors (BTI)	Triad Light Cure Acrylic	Propofol and Laryngeal Mask Airways	OsteoCel Bone Grafting Material
When did you start using it?	Winter 2008	Fall 2008	2010	1999	2010
Why can you not live/work without it?	It provides extremely accurate 3D renditions of patients' hard tissues and takes the guess work out of diagnosis and treatment planning.	We like to call this "fertilizer for the tissues." We're able to observe natural healing faster when we use this with our bone and soft tissue grafts.	Triad materials set up rapidly, are easy to work with, and are stable. Also easy conversion from denture to temporary fixed restoration.	Makes general anesthesia much safer to administer in-office. LMAs protect the airway from saliva and blood.	Time will tell. Initial results look promising.
When do you use the item?	To determine existing bone prior to grafting for implants. Also for evaluation of impacted cuspids and nerve positions around impacted third molars.	We use this with all of our soft tissue grafts, with our sinus lift grafts and lateral bone augmentation grafts.	To convert our dentures to fixed restorations in some of our implant cases where we place the implants and restore the same day.	For almost every general anesthesia case we perform in the office.	For lateral augmentation bone grafts prior to implant surgery.
How do you market this item to your patients?	It markets itself. Patients understand pictures and pictures are worth a thousand words.	We provide pamphlets and explain why and how it is beneficial.	Option is comparable to cost of sinus lifts and implants but without grafting or healing time.	We explain our experience with advanced outpatient anesthesia techniques and explain monitoring and airway management.	We explain that by using this material, we can avoid a second surgical site for donor bone.
If you could change anything about the item, what would it be?	Would like to be able to scan soft tissue profiles as well.	Faster process time for the PRGF.	No issues with this one. It works how it's supposed to.	This item is pretty much perfect. It is easy to place and adds safety to our general anesthetic cases.	Handling. The graft must be used within 48 hours since it needs to stay frozen.

Why did you choose dentistry/oral surgery as a profession?

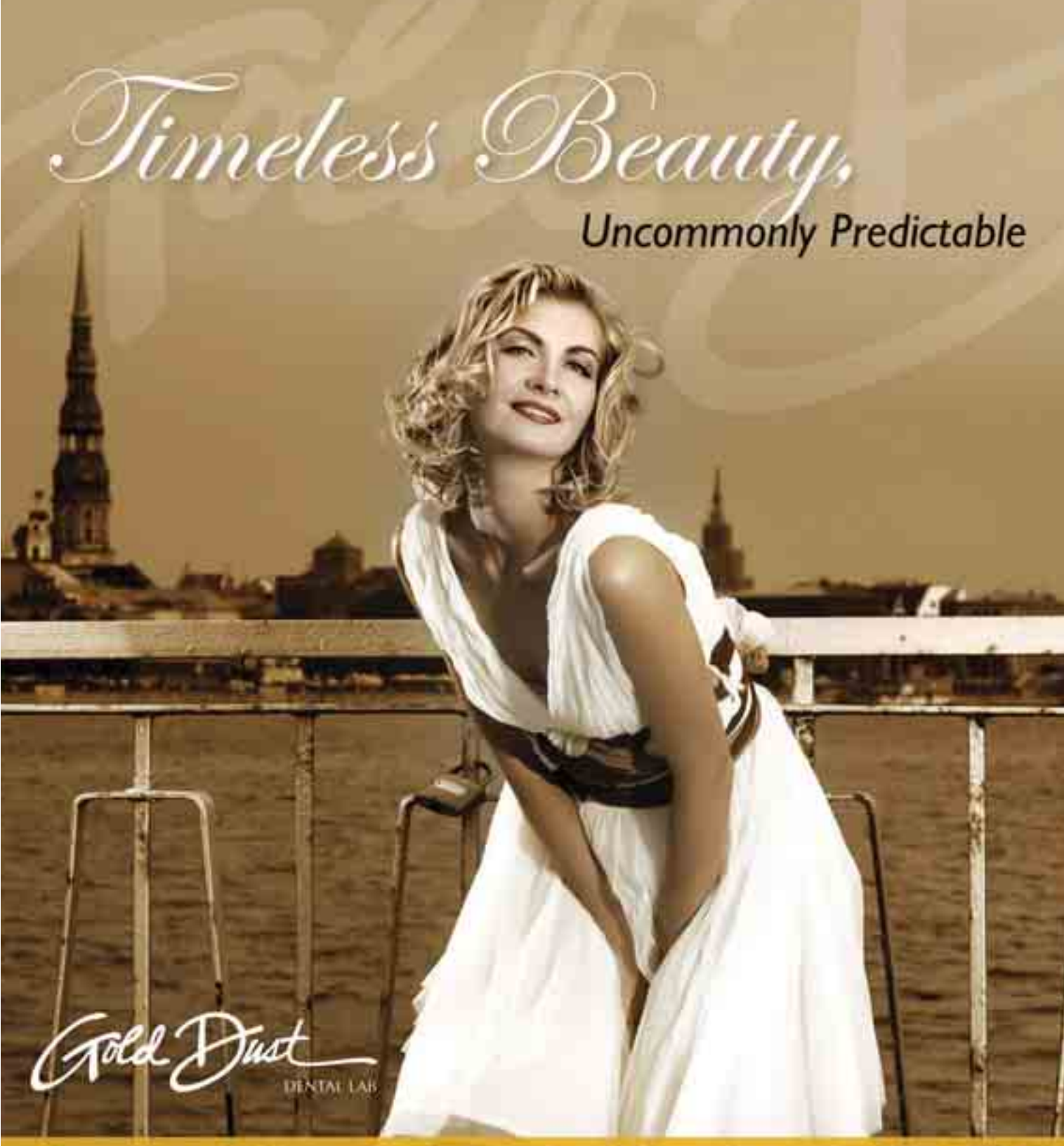
Hoffman: When I was a child I went through the usual stages of wanting to be a police officer and a fireman and for some reason in the third grade, I decided I wanted to be a dentist. It was an opportunity where I could own my own business and still have a positive impact on people's lives. Once I was in dental school I found that I really enjoyed the variety that oral surgery presented and now, I can't imagine doing anything else.

Barnes: I come from a family of physicians actually. When I had to do a career day in high school I went and spent a few days with an oral surgeon in his office. I liked the ability to have your own practice, do your own anesthesia, perform surgery, but still at the same time have at least some semblance of a home life. It's great. I wouldn't choose to do anything else.

What is your current practice philosophy?

Hoffman: We want to provide the finest oral surgical care to every patient in a gentle, comforting environment. We're going to go the extra step to make each experience special and make our patients want to return to the practice.

continued on page 96



You entrust your dental laboratory to manifest your vision and make it a reality. It requires confidence in the fabrication process, and an understanding about what is important to you and most importantly the talent to deliver. Every case you seat is a reflection of your personal integrity and skills. At Gold Dust, we get it. Which is why our commitment is to delivering uncommon predictability in fit, occlusion, aesthetics, and function for every patient. When your patient is happy, we know you are too.

For more incredibly happy patients,

Call 800.513.6131 today or visit us online www.golddustdental.com

FREE FACTS, circle 46 on card

continued from page 94

What does your practice do that sets you apart from other oral surgeons in your area?

Barnes: We pride ourselves in our surgical work and our expertise. We are both board certified surgeons, and I think that demonstrates an elevated level of knowledge in a variety of surgical topics and shows a commitment to continued learning that we both share. Also I like to think that our communication with our referring dentists is top notch. We really try to make things easy for the restoring dentist. We are up to date with technology and really utilize our Web site to educate patients about procedures and postoperative care.

Hoffman: In regards to the office, the idea in designing it was that it not look like a clinic. When you walk in, it looks like your living room and that was the whole idea to make people comfortable as opposed to make it a threatening environment. Another thing that makes us different is our low employee turnover. We treat them as our most valuable assets and that makes it nice for patients to see a familiar face when they return.

Falls Oral Surgery and Dental Implant Center Reception Room

How might a patient benefit from implants? And how are they different or better than a bridge or crown alternative?

Hoffman: With implants you don't have aggressive removal of adjacent tooth structure to get a restoration. The research out there clearly shows the longevity of implants versus traditional bridgework. Implants in the long run are much more conservative and they offer a better longevity than traditional crown and bridge.

How did the team meet?

Hoffman: When Dr. Winston was looking to practice part time, I interviewed a lot of candidates to join the practice, but really didn't find anyone who shared our people-centered personality. If you know Dr. Winston and me, we're pretty low-key. We don't throw instruments, stomp our feet or yell. We were looking for someone with the same comforting attitude. Steve came down when he was chief resident at Metro to observe implant techniques. I loved his personality. We started talking about joining together. I was thrilled when I asked him to join the practice and he accepted.

Who are some of your dental mentors?

Barnes: Dr. Jon Bradrick, my residency chairman, and Dr. Barry Stein, who introduced me to the field of oral surgery. Also, Michael Pikos, Anthony Sclar, and Robert Marx –they are all oral surgeons and I'm fascinated by their contribution to the profession.

Hoffman: Dr. A. Thomas Indresano, my program director who really got me started. And Dr. Winston was really big in getting me started and piquing my interest as well. Also, Anthony Sclar's textbook is a must for anyone doing aesthetic implant work.

What is your favorite procedure to perform?

Barnes: My favorite procedure to perform is an open sinus lift.

Hoffman: That's also my favorite.

Barnes: It's fun, it's predictable, and it's an impressive surgery to observe.

Describe your most rewarding experience.

Barnes: Currently I have the privilege to work on a gentleman who was the victim of a pretty bad fall. He is a young college student who unfortunately sustained a lot of dentoalveolar injuries. The case has so many facets. I think he is going to be my most rewarding case from a personal standpoint, first because of his story and second because of all of the surgical complexities that are involved with his care.

I have also been involved with a charitable organization called Convoy of Hope. It was so gratifying to provide much needed dental care right here in Northeast Ohio.

Hoffman: I've gone to Honduras twice with medical mission teams doing oral surgery. We'll travel up into the mountain villages where people see a dentist maybe every three or four years. It's a very humbling experience. It's also a test of surgical skills since there's no electricity, handpieces or suction. You get pretty good with working with hand instruments. It's challenging and rewarding.

Staff: the most valuable asset of Falls Oral Surgery and Implant Center

"As we go forward, I'd like dentists to stop looking at the dentist down the street as a competitor and more as a colleague."

Since you began your career, what are the three biggest changes you've seen in the profession?

Hoffman: First, the explosion of implant dentistry. When I started practicing 18 years ago, patients came to the office not knowing what implants were. Now they come to the office, and not only do they know what implants are, they know that they want an implant and they usually have a friend or a neighbor that already has one.

Second, the computerization of dental offices. When I started I never even dreamed of having a computer in each treatment room. I can't imagine not having them now.

And third, the new grafting materials – BMP products, PRGF, Osteocel. All these products are making bone grafting easier and more predictable with less discomfort for the patient. That's going to be the next big area that takes off in oral surgery.

Looking ahead, what would you like to see dentistry do in terms of the way it operates as a profession in the next five to 10 years?

Barnes: I think as technology continues to improve, you're going to see more computer-guided surgical procedures. I also foresee better, more predictable and cheaper grafting alternatives. You're looking at shorter healing times as they continue to modify implant surfaces. As predictable as implants are now, they're only going to get more predictable.

Hoffman: I think what I'd like to see is what you are doing at Dentaltown. Dentists as a group need to come together more and become a unified force. One of the things I love about Dentaltown is the idea that dentists are all there learning together and learning from each other. It's a very nice, nonthreatening place for discussion. As we go forward, I'd like dentists to stop looking at the dentist down the street as a competitor and more as a colleague. There are patients for everybody. I'd like to see dentists come together and become a more cohesive unit.

What would you say is your biggest source of new patients and how do you market to get new patients?

Barnes: Our biggest source of new patients comes from our strong referring dentists. We are extremely grateful for the dentists we have as a referring group to our practice. We have a lot of very loyal and very good practitioners who have entrusted their patients with us and that's how we get most of our new patients.

Hoffman: Probably 90 percent of our patients are referral-based. So we nurture that relationship with our referrals. All business aside, we're actually good friends with a lot of our referring dentists.

What do you like to do in your free time?

Barnes: I enjoy working out and golfing. I like to garden and enjoy traveling. I spend a lot of time with my wife who's a general dentist.

Hoffman: I spend a lot of time racing soapbox derby cars with my kids. I have three children. I also enjoy running. My wife has got me running marathons. I have finished six marathons; she's run 13.

Anything else you would like to add?

Hoffman: I think it's important for dentists to take practice management courses and really understand how to run a business. It doesn't matter how good at dentistry you are, if you can't run an office and be somewhat profitable. n

Entrepreneurial Evolution:

Blending Education and Technology

by Alan M. Miller

With nearly 27 years of experience in the health care industry, I've used just about every means and technological modality possible to perform professional training. I've learned a lot and have made a lot of mistakes, but throughout my career I have made it a priority to find innovative ways to provide practitioners with the most up-to-date training possible. Now, with Apple's introduction of the iPad, training on new products has taken a "leap frog jump" to the next level.

Throughout the years, I have experienced first-hand the application of how industry training has evolved. I learned a few lessons along the way, which helped me in the development of the world's first dental laser app for the iPad.

Lesson One, Age 20

For one of my first training opportunities I walked into the conference room energetic and enthusiastic. The audience smiled and laughed. Everyone seemed to really be enjoying themselves throughout the presentation. As I walked to the car afterward, I realized my zipper was down. I quickly figured out what or shall I saw "who" was so funny. **The lesson: Overall appearance is important.**

Lesson Two, Age 23

Trying to gain experience and pay for college, I took every job the hospital would offer me. I was given the chance to train doctors on how to implant pacemakers in surgery. I was training in surgery centers all over Indiana. Luckily I learned early on that eight hours of using a slide projector, handouts and hands-on training proved long, laborious and boring for both me and the audience. I learned to teach by speech and to be concise. **The lesson: Keep it short, to the point and accurate.**

Lesson Three, Age 26

I became focused on training in mobile and modular cardiac catheritization, as well as MRI and CT labs. The difficult subject matter required me to create a tactical game plan – to have a schedule, to build endurance, and to learn by repetition. I would begin with the basics, move through the guts of it and begin again. Talk. Show. Learn. Repeat. **The lesson: Have a strategy and teach by repetition.**

Lesson Four, Age 28

Accucam hired me, welcoming me to the world of dentistry. Training in dentistry proved to be very different than my previous experience of teaching in hospitals. I developed my own teaching style – demonstrate it and let the staff run with it. During that period, I discovered that practitioners needed some type of support material, so I wrote brief "how-to" and FAQ manuals. I learned that generally, dentists favor visual learning while staff favor auditory learning. **The lesson: Adapt training methods to people's needs.**

The Culmination of Lessons, Age 45

With each jump in technology our visual aid tools have become easier to work with. Slides and the projector were effective but clumsy, VCR tapes were functional but not easy to work with; however, as the digital age has paved the way for computers and DVDs, our training aids have become more compact and eas-

The iPad™ with a custom designed AMD LASERS App is currently offered in conjunction with the Picasso brand dental laser package.

ier to facilitate. When I developed the Picasso, I knew a whole new world of dentists would enjoy the benefits of laser dentistry. Designing, manufacturing and selling the number-one laser in the world is fulfilling, but an equally great need is a focus on training. First I developed an online training and certification program which was adequate, but not great. Issues with bandwidths and "glitchiness" made online training challenging. We then tried the same curriculum on DVD. This time we had issues with compatibility among different brands of DVD players and CPUs. There had to be a better avenue to get this training to the physicians…

Taking lessons from my youth – knowing overall appearance is important; understanding that people only pay attention if information is short, accurate and to the point; using strategy and repetition for learning; and knowing that different people learn in different ways – helped me develop the first ever dental laser app for the iPad, a whole new vehicle of technology for training.

What's H"App"ening Now?

The Apple iPad presents the ability to educate and communicate instantly without scouring manuals, looking for DVDs, or dealing with frustrating online issues. It is compact, efficient and state-of-the-art technology, and creating an AMD Lasers app became an obvious solution to intelligently access company educational and marketing materials.

The company enjoyed a huge success earlier this year with iPads at the California Dental Association Presents (CDA). While other companies were firing lasers into apples, we were educating with our iPads by showing clinical cases. The overall response resulted in a packed booth, and nearly 200 professionals placed orders for new Picassos. Much of our success can be attributed to educating about the lasers rather than "selling" them.

"How do you create an app anyway?" you ask. Most importantly, I can tell you that you must be completely dedicated to the process.

Developing an app is not as easy as one would think. Although Apple allows anyone to do it and there are some off-the-shelf programs that will help, writing something that hasn't been written before has its challenges.

First I started with a list of priorities and a list of what I wanted the app to include. As a business owner, philanthropist and a normal all-American guy, I wanted to pave the way for other dental manufacturers in going green. Reducing the paper (manuals, etc.) and the plastic (DVDs) we send to our clients has its advantages.

I wanted an easy-to-use app that could be downloaded from iTunes, preloaded onto an iPad and shipped with our laser. It would include all of our manuals, articles, quick start guides and patient educational brochures – basically anything we would have printed. I wanted set-up videos, "how-to" videos and of course our six-hour soft-tissue laser certification course with an interactive test. Let's throw in electronic coupons for free laser accessories, a direct link to our e-commerce site for ordering supplies and a RSS feed to send our clients instant updates and messages. I researched third-party companies that can help with app development and found a wide range from $5,000 for help from India to more than $100,000 for help from California. I elected to go with a local Indianapolis company and I am glad we did. Many back-and-forth conversations and multiple site visits were necessary to accomplish writing and delivering a breakthrough app.

After months of design and redesign, Apple approved[1] the 1.0 version and we were already at work on 1.1 and 1.2.

Because appearance is important (Lesson #1) we chose a familiar and aesthetic look – iBooks. Our app looks much like a book shelf with icons of PDFs and videos. Manuals and laser articles have easy-to-view icons and descriptions – just touch and they are instantly readable.

Because I know people are more interested and engaged when the information is accurate and to the point (Lesson #2), you can zoom, rotate and print files and the "How-To" section is comprised of short videos. When you press the icon for "How to Initiate a Fiber," it instantly plays a clinical video in either portrait or landscape format. Same is true for the entire group of "How-To" icons. All are easily viewed and understood.

I am especially proud of the six-hour certification course and test. The course is divided into 12 chapters and made the test interactive so you can save your progress if you do not finish in

continued on page 100

continued from page 99

one sitting. It allows for an entire office to enter their name and take the test. This way video chapters can be reviewed if there are questions, because I know that repetition is key (Lesson #3) and that various team members may need to further review how-to manuals or watch demonstration videos to cater to their learning styles (Lesson #4). When they hit the "submit" button they get an instant grade and are shown which answers are wrong so they can go back and review and retake. When they pass, their name and grade are sent to our server and a certificate is generated. All with a touch of a button.

When the course is passed, it instantly pings our server with the demographics and laser serial number, and will generate a printable PDF certificate. It's a very seamless process but delivering CE credits for passing a test on device a thousand miles away was very challenging to set up. I think I am most proud of the test.

The state-of-the-art security built into the app limits the number of downloads per office. This is a programming feature that compares serial numbers to ensure multiple offices are not using the same serial number. The volume of detail to work through is incredible, but the size of the content proved to be the most challenging. The resizing and compression of the existing DVD-based videos proved to be most challenging. It had to look great but be compressed enough to be downloadable.

The app works like most any other app. When we add, delete or modify content it auto-alerts users to download the update when connected to iTunes. Recent research reports that 30 percent of people who are familiar with the iPad are interested in purchasing one.[2] An important caveat: don't forget to include (in the cost) the time you must individually devote overall from concept through fruition.

Ralph Waldo Emerson said, "Build a better mousetrap and the world will beat a path to your door." By incorporating a few lessons I learned through the triumphs and mistakes of my youth, listening closely to what potential users wanted, having a commitment to up-to-date technology, and keeping a vision in mind, I reached my goal. AMD Lasers has the first laser dentistry app available, and just as I had envisioned it, it is now loaded onto iPads and is being shipped with our products. n

Author's Bio

Alan Miller is president and CEO of AMD LASERS, LLC. He resides in Indianapolis, Indiana where AMD LASERS, which was founded in 2008, is currently headquartered. He has more than 25 years of experience in high-tech medical and dental technologies, and is revered by dentists around the world for making laser technology affordable for all.

1. *Apple requires all apps go through an approval process and they charge on average 30 percent of whatever your list price is. This approval process is necessary in order to get updates and Apple support.*
2. *techfever Network. (2010, June 7). Let's talk about numbers survey. Retrieved October 1, 2010, from http://www.techfever.net/2010/ipad-statistics*

Z-Crown – Strong and Aesthetic

by Bill Warner, CDT, Crown and Bridge Manager

Problem

As the cost of gold continues to rise, doctors are looking for comparable alternatives to the long standing industry standard PFM crown. PFM crowns are strong, durable and generally biocompatible with all patients. With the price of gold forecasted to hit $2,000 per ounce, it is becoming cost prohibitive to use semi-precious, noble or full cast crowns. Doctors need a product that they can feel comfortable using that will both satisfy their patients and their budget.

Solution

Z-Crown, available from DDS Lab, takes strength and aesthetics to a new level. Clinical-grade zirconia, already known for its biocompatibility and strength, has been widely used as an alternative to conventional alloys. Available in both solid and porcelain layered options, Z-Crown gives you perfect anterior and posterior options at a lower cost than the existing top brand name zirconia crowns. Dentists and patients alike will see the long-term benefits of this product. It is biocompatible, virtually unbreakable and naturally aesthetic. Z-Crown solid zirconia is also a perfect option for patients who may have bruxing or grinding issues.

Results

Z-Crown requires no bonding, as traditional cementation methods are suggested. Additionally, a knife or feather edge may be used as opposed to a shoulder preparation. This saves chairtime for both the doctor and the patient. Patients will experience a comfortable fit, natural aesthetics and no gingival graying if gum line recession should begin.

Summary

Restore your patient's smile with Z-Crown, the perfect restoration for any case. For more information on DDS Lab's products and services, please call 877-337-7800 or visit www.ddslabsolutions.com. n

Author's Bio

Bill Warner has more than 26 years of dental laboratory experience as a technician, supervisor and laboratory owner. He is an expert in all phases of fixed prosthetics, including product selection and planning for the most complex cases.

Expanding Your Practice with Clear Aligner Therapy

by Willis Pumphrey, DDS

Much of the public understands that doctors can straighten teeth with clear aligner therapy, aka, "invisible braces." Demand for it is growing as an alternative to, as well as a "finishing tool" for traditional orthodontia. Clear aligner therapy, the orthodontic treatment where a series of clear removable aligners gradually moves the teeth to improve aesthetics and bite function, is a hot growth area for doctors looking to add services and grow their practices.

About two-thirds of patients who wear conventional braces could use clear aligner therapy, and about a third of patients in every doctor's database are good candidates for it. Since patients have an ongoing relationship with their dentist, it makes sense to add services where it can help patients and expand the practice. While some dentists might be reluctant to try something unfamiliar, a few tips can help minimize the challenge and maximize the benefit of growing your dental practice with clear aligner therapy.

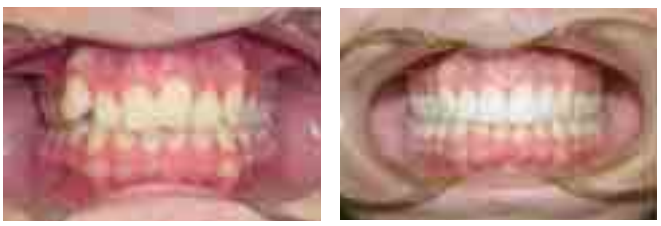
Fundamentals

Before dentists can persuade patients to try clear aligner therapy, they first have to understand it. That means learning fundamentals, practicing the technique and building the confidence to offer it to patients.

Here's how clear aligner therapy works: after the dental practice takes photos and impressions of the patient's mouth, these are sent to the lab. At the lab, a 3D computer image is created, along with models from which a series of custom clear plastic aligners are made for the patient to wear. As the patient wears each consecutive aligner, it puts pressure on their teeth, which gradually move closer to their ideal alignment.

While it doesn't take a lot of force to move a tooth, it does take consistent force. That's why patient education is critical, since patient noncompliance is the number-one cause of treatment difficulties when the aligners don't work properly. To get patient compliance, doctors need to explain basic orthodontic physiology, or how teeth move through bone, which is easily done with an illustrated flipchart or other visual aid.

Here's what patients need to know: As aligners put continued pressure on dental crowns, pressure is transferred to the periodontal ligament. This causes osteoclastic activity, a breakdown process of the bone that takes 48-72 hours to get going. Osteoblastic activity, the required bone rebuilding process, also takes the same time to get going and about 90 days to finish. Stabilizing the results usually takes another 10-12 months with a final retainer.



Before clear aligner therapy (left) and after (right).

Here's what's critical: If a patient leaves an aligner out of his mouth for more than four hours, the osteoclastic and osteoblastic activity needed so the tooth can move through bone totally stops and takes 48-72 hours to get going again. So each time a patient fails to wear his aligners for four or more hours, he is setting himself back 48-72 hours in his treatment. Patients, in fact, need to wear their aligners at least 22 hours each day to get desired results.

Make Good Choices

Since patient noncompliance can throw off the treatment schedule and require clear aligner refinements or midcourse corrections at added cost, it's a good idea to avoid having aligners made too far in advance. For instance, instead of having a whole course of aligners shipped at the beginning, it's often better to have the aligners made and shipped in several phases. Phase-based delivery makes it easier to do midtreatment corrections without wasting a bunch of previous aligners that no longer fit; this minimizes cost and storage space as well.

To keep clear aligner therapy on track, it's also a good idea to have some form of compliance indicator built into the system, something that tells you if the patient is wearing the aligners and complying with treatment instructions. The key question any such system should answer is: Is the treatment on track? If the answer is yes, the patient is likely complying because the teeth are moving how they should be. If the answer is no, then the appropriate corrective actions can be taken before the treatment gets too far off track, saving time and money for both doctor and patient.

Sooner or later, patients will lose or break an aligner or retainer. This can throw off the treatment schedule by several weeks and add cost, when it requires taking a new impression and sending it to the lab to make a replacement. Instead, it can be better to consider a dental lab that provides clear aligner

patient models for every step of treatment with each shipment. This allows doctors to immediately fabricate replacement aligners and retainers at their practice, avoiding extra lab fees; some actually make a nice residual profit by offering a retainer replacement program. The aligner patient models can also be used to track treatment progress over time.

Expand Your Practice

As dentists we have to keep a sharp eye on the bottom line and charge enough to cover overhead and upfront costs including initial exam, X-ray, diagnosis and lab costs. Since dental work and clear aligner therapy isn't an exact science, we must leave enough profit margin to cover unexpected treatment challenges and potential rework.

When doctors ask how much they should charge patients for their services, a good rule of thumb is to charge a minimum of four times the lab fee. This is the profit margin that was recommended to me by the successful doctors I admired when I was starting out, and it still holds true today. That's what I've charged for my dental services, and that's what I charge for clear aligner therapy.

To hold those profit margins, however, it helps to minimize lab fees. Toward this end, it's best to work with a lab with no refinement, final retainer, or midcourse correction fees when possible. While some doctors choose to share these savings with patients to build sales volume, they're under no obligation to do so as long as the market will bear it.

Keeping lab fees reasonable also gives doctors the flexibility to offer patient discounts when it makes sense. For instance, it's often profitable for a practice to offer a $500 off coupon to patients if they get started with clear aligner therapy by a certain date. Or the practice can lower the price of aligners to a patient if they get other dental work done such as hygiene, fillings, restorations, or veneers.

While these tips are just the "tip of the iceberg" in getting started, I hope they'll help you minimize the challenge and maximize the benefit of growing your dental practice with clear aligner therapy. n

Author's Bio

Dr. Willis Pumphrey has practiced general dentistry for 30 years and has treated more than 2,000 clear aligner cases. He owns the Dental Cosmetic Center of Houston, of which aligners are roughly 30 percent of total practice production. He is Founder and Chairman of ClearCorrect, Inc., a Houston-based manufacturer of clear aligner therapy with the purpose to make clear aligner therapy more affordable for dental professionals and their patients (www.clearcorrect.com). He graduated from the University of Texas Dental Branch, Houston in 1980.

Dentist Sets Sights Deep

by Chelsea Patten
Staff Writer, *Dentaltown Magazine*

Dr. John Chung

John Chung has practiced dentistry for 11 years. In the office, he's dedicated to caring for patients and determined to provide quality dentistry. Out of the office, he shows his dedication and determination in other ways.

Chung and five other male swimmers – Mike Shaffer, Jim McConica, Kurt Baron, Tom Ball and Jim Neitz – together sought to tackle a world record, an ocean relay swim, covering 202 miles of territory.

The "Ventura Deep Six" – all members of the Buenaventura Swim Club Masters swim team – made quite a name for themselves as they worked toward their goal, before and during the actual swim. An effort of this magnitude takes extensive training and support including nautical accommodations, technical assistance, provisions, emergency and nonemergency personnel, not to mention the mental and emotional support accompanying such a trying journey. After the proverbial ducks were in a row, the team dove in, in pursuit of the world record.

With the goal to break the current world record of 78.2 miles for open water relay, the team began at 6:03 a.m. on September 16. Each of the six participants swam a one-hour interval before tagging off to the next person. The team swam 24 hours a day. In order to break the record, the team had to keep the same order of swimmers throughout the relay, and could wear only approved gear, which included a FINA-approved swim suit (no wetsuits), goggles, a swim cap, and ear/nose plugs – not a small feat in the unseasonably cold waters of the Pacific Ocean.

From left: Jim Neitz, John Chung, Mike Shaffer, Jim McConica, Kurt Baron and Tom Ball hold an American flag and celebrate their 202-mile record-breaking accomplishment.

The official swim started at the Ventura Harbor and proceeded northwest to Stearns Wharf in Santa Barbara. Chung made the 180-degree turn just past the Wharf and headed back toward the South; all eyes were on La Jolla Cove in San Diego, California – their final destination.

After nearly 42 hours of swimming, the team broke the world record. They paused briefly to celebrate but Neitz, swimmer at the time of the record-break, continued on, saying "I've got work to do." Seventeen additional hours landed them on the shores of La Jolla Cove at 11:45 a.m. on September 20, tired, but with a sense of accomplishment and a world-record to boot.

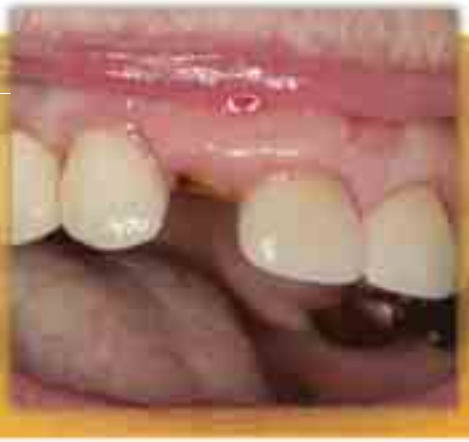
Thousands of hours of training go into preparing for such an achievement. Training involves not only endurance, but also learning to be a strong ocean swimmer since the elements are completely different than when swimming in a pool. Chung compares his swimming venture to his practice. He says, "I had to be disciplined but able to adapt my approach depending on the conditions, just like in my practice, each patient is different." John and the team have been nominated for Open Water Swimming performances of the Year. This is an international category from performance throughout 2010. Voting is done online through December 31 with winners announced January 1. The Web site to vote is http://www.openwatersource.com.

John Chung graduated in 1998 from Marquette University – School of Dentistry. He practices dentistry in Ventura, California and he swims in his free time, and now…he holds a world record! Congratulations to Dr. Chung and his five other "Ventura Deep Six" teammates. Chung is proof that dedication and determination pay off both in and out of the office. n

Our advertisers make it possible for us to bring *Dentaltown* to you each month free of charge. Support these advertisers by using the reader service numbers listed below and the reply card. Also, almost all of the advertisers provide telephone numbers in their advertisements for your convenience and fast response. Our advertisers want to hear from you.

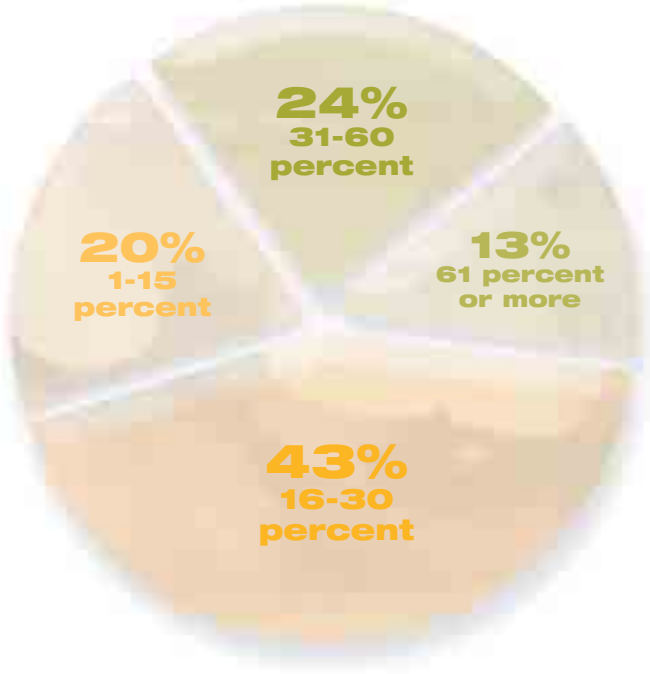
Dentists' Opinions about Prosthodontics

Find out what types of prosthodontic procedures other dentists are doing in this poll conducted from September 9, 2010 to October 12, 2010. Don't forget to participate in the current online poll at Dentaltown.com.



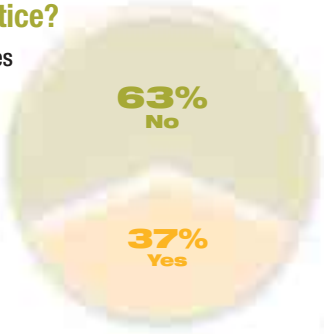
What percentage of teeth that you crown have already had RCT?

352 total votes



Are you placing implants in your practice?

352 total votes



What is your preferred method of delivering impression material?

30% Automatic mixing machine

70% Gun delivery

349 total votes

Do you apply a desensitizer to your crown preps on vital teeth?

26% Yes, at prep appointment

15% Yes, at seat appointment

59% No

352 total votes

In the last 12 months have you restored a single patient with more than 15 crowns (i.e. full mouth rehab)?

33% Yes

67% No

353 total votes

What percentage of your partial dentures include an attachment?

30% None

52% 1-20 percent

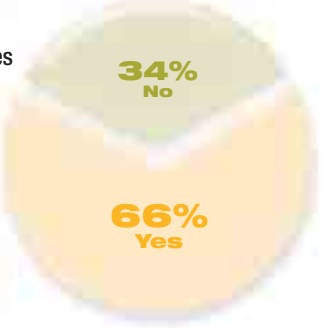
10% 21-50 percent

8% 51 percent or more

347 total votes

Does your practice have a Web site?

354 total votes



The Link Between Bad Breath and Periodontitis

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

Have you diagnosed periodontal disease while standing in line at the grocery store, in church or perhaps sitting next to someone on a plane? That's the smell of volatile sulphur compounds (VSCs). The three VSCs associated with oral malodor are hydrogen sulfide, methyl mercaptan and dimethyl sulfide and each has a particular odor. Hydrogen sulfide smells like rotten eggs, methyl mercaptan smells of feces and dimethyl sulfide is a combination of cabbage, sulfur and gasoline. Add a minty cover-up candy or rinse and you have the smell of minty perio breath.

VSCs are released with the breakdown of food, protein, cells, blood and saliva. In periodontal disease, dead and dying epithelial cells release VSCs. The turn-over rate of junctional and sulcular epithelial cells in health is two to four days; increasing eight fold in disease, which could mean replacement of epithelium every six hours. This leads to a level of VSCs that becomes clinically, as well as socially, significant. Thus your ability to diagnose periodontitis with your nose! Another source of VSCs is the breakdown of methionine, which is found in the gingival crevicular fluid in higher levels during periodontal disease.

Besides acting as the cause of bad breath, VSCs have a significant role in the initiation of periodontal disease and in the healing of both connective tissue and bone. Work published in the 1970s by Dr. Joseph Tonzetich, at the University of British Colombia, provided the first evidence of VSCs making junctional epithelial cells more permeable. Permeability of mucosa was measured in the presence of 95 percent air and 5 percent carbon dioxide as a control. Volatile sulfur compounds were added to the control atmosphere in varying concentrations, resulting in significant increases in permeability of the mucosa. Therefore, the volatile sulfur compounds of bad breath are not only a result of disease, but seem to contribute to the initiation and progression of disease by allowing bacterial antigens and toxins to easily penetrate the crevicular epithelial barrier.

More recent research confirms these early findings, demonstrating how VSCs can trigger epithelial cell death or apoptosis, thus increasing permeability of the junctional epithelium. With increased permeability, bacterial antigens and toxins are able to penetrate the junctional epithelium and move to the underlying connective tissue. This triggers a cascade of immune responses that leads first to gingivitis and eventually to the destruction of supporting periodontal structures.

To maintain bone levels and to repair damage associated with periodontitis, osteoblasts are needed. In the presence of VSCs, the DNA of osteoblasts is damaged, leading to fewer osteoblasts and increased proliferation of osteoclasts. With the balance now swaying to osteoclasts, bone loss occurs. Fibroblasts exposed to VSCs show compromised maturation due to lack of protein synthesis. This action will prevent connective tissue from healing adequately and repairing the damage associated with periodontitis.

Not everyone with bad breath has periodontitis. Even young children suffer with bad breath caused by VSCs. The greatest source of VSCs for those without periodontal disease is a coating on the dorsum of the tongue. Since research suggests bad breath is actually a precursor to periodontal infection, as well as a result, addressing bad breath in all patients, even very young ones, may be an important step in preventing future bone and connective tissue loss due to periodontitis. n

Trisha Speaks

Here's where you can catch Trisha live! To schedule Trisha to speak at your next national, state or local dental hygiene meeting, e-mail trisha@hygienetown.com.

January 13-15, 2011
Rocky Mountain Dental Conference n Denver, Colorado

January 22, 2011
Make Yourself Indispensable n Phoenix, Arizona

January 29, 2011
Drs. McCawley & DeTure n Fort Lauderdale, Florida

February 26, 2011
Make Yourself Indispensable n Spokane, Washington

In This Section

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

Perio Reports Vol. 22 No. 11

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

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

Calcium-Modified Acid Candies for Cancer Patients

Patients receiving head and neck radiation therapy experience reduced saliva flow, leading to dry mouth and complications with swallowing. These patients often suck acid candies to stimulate salivary flow, while eroding tooth enamel at the same time.

Researchers at the University of Copenhagen in Denmark compared acid candies to candies modified with calcium to determine the impact of each on the enamel erosive potential. Nineteen cancer patients (average age 51) who underwent radiation and a group of healthy control subjects (average age 25) participated in the one-day study. Saliva was collected for five minutes at baseline and after sucking randomly assigned control or calcium-modified candy for 10 minutes. Subjects repeated the test one hour later with the other candy.

The basic acid candy contained water, isomaltose, tartaric acid, strawberry and rhubarb flavors and light red coloring. The calcium-modified candy also contained calcium lactate. Both candies were five grams. Salivary flow rates were determined and saliva samples were collected after candy consumption.

No differences were observed between the two candies for salivary flow rates in either healthy or cancer patients compared to baseline levels. The saliva of the cancer patients was thicker and stickier than the controls and thus held more of the calcium than saliva of the controls. The erosive potential of the saliva was determined by levels of hydroxyapatite crystals in saliva samples. Levels were significantly lower for the calcium-modified candies compared to the acid candy.

Clinical Implications: Adding calcium to acid candy might be helpful for reducing postradiation enamel erosion while still stimulating salivary flow.

Jensdottir, T., Buchwald, C., Nauntofte, B., Hansen, H., Bardow, A.: Erosive Potential of Calcium-Modified Acidic Candies in Irradiated Dry Mouth Patients. Oral Health Prev Dent 8: 173-178, 2010. n

Is Caries a Sugar Disease?

Diet and nutrition are important factors for many diseases, including dental caries. According to the research, dietary sugars, especially sucrose, play an important role in the etiology of caries. Recent findings suggest that other factors might be important.

A researcher from the University of Melbourne in Australia and one from the University of Peradenlya in Sri Lanka evaluated several caries risk factors among 15-year-olds in Sri Lanka. Based on statistical calculations, they needed a sample size of 1,225 students. This was easily achieved in the schools with assistance from the teachers. Students and their parents completed questionnaires and each student was examined clinically.

Caries prevalence was 47 percent of the total group with the average caries rate of just over one. Three dietary patterns were identified: sweet, healthy and affluent (desserts). These patterns were drawn from 13 foods or food groups. Those with a sweet dietary pattern were more likely to have caries. Greater household income was associated with the healthy and affluent dietary patterns. Surprisingly, the healthy dietary pattern did not predict fewer dental caries.

In a study of low-income American adults, four dietary patterns were identified, with none of them emerging as a determinant for caries. Another study of low-income African American children failed to show a link between dietary patterns and caries in deciduous teeth. More factors need to be considered besides sugar and a sugary diet. Recent findings suggest that salivary pH and the presence of specific oral bacteria might be key factors determining the risk for caries.

Clinical Implications: It seems more is at play with caries than simply a sugary diet.

Perera, I., Ekanayake, L.: Relationship Between Dietary Patterns and Dental Caries in Sri Lankan Adolescents. Oral Health Prev Dent 8: 165-172, 2010. n

Bad Breath Linked to Periodontitis

Bad breath affects approximately 50 percent of the population with 90 percent of cases due to oral factors and 10 percent from disease or infection in other parts of the body. These two sources can be distinguished between mouth breath and nose breath, as the volatile sulfur compounds are expelled through the lungs with extraoral malodor.

Researchers at the Darshan Dental College and Hospital in Udaipur, India evaluated 113 patients with malodor and 109 age- and sex-matched controls to identify a relationship between oral malodor, tongue coating and periodontal disease.

An odor judge evaluated the mouth breath of each of the patients. The judge and patient were separated by a screen in which a tube was inserted from the patient's mouth to the judge's nose. Breath was scored as 0 - no malodor, 1 - slight malodor, 2 - clearly noticeable malodor or 3 - strong intensity malodor. Tongue coating was measured by dividing the dorsum of tongue into nine sections, three across and three from front to back. Periodontal disease was measured clinically with probing depths, attachment levels and bleeding.

Tongue-coating scores were significantly higher in those with oral malodor compared to controls. Average bleeding scores were 15 percent of sites in those with malodor, compared to five percent in those without malodor. Probing depths and attachment loss were also slightly greater in those with malodor compared to controls. Statistical analysis demonstrated a positive association between periodontal parameters and oral malodor.

Clinical Implications: These results are no surprise to clinicians, and these findings add to research supporting what you experience clinically.

Kumar, S., Phoophalia, A., Tibdewal, H., Tadakamadla, J., Duraiswamy, P., Kulkarni, S.: Oral Malodour: Its Association with Tongue Coating and Periodontal Disease. Dental Health 49: 5 and 6, 6-9, 2010. n

Perio and Oral Piercing

Body modification including tattooing and piercing have been performed by various cultures for centuries. Today, oral piercing is becoming more popular, across both social classes and age groups. The tongue and lips are the most common sites for oral piercings. Immediate complications might include swelling, pain, speech difficulties, chewing and swallowing problems, upper airway obstruction, problems with blood vessels or nerve innervations and infection. Dental problems linked to oral piercing include tooth wear, fracture, and recession.

Researchers at the Federal University of Minas Gerais in Brazil evaluated a group of 60 individuals with tongue piercings and a control group of 120 individuals with no tongue piercings. Subjects ranged in age from 13 to 28 years and all came from a low socioeconomic area in Brazil. They were all examined clinically and completed written questionnaires.

The piercings were predominantly metal with 13 percent being metal and silicone and 15 percent being metal and plastic. Forty-three percent of subjects with piercings had them for two years or less, 43 percent had them for two to four years and eight percent had them for more than four years. Half the group reported a habit of biting the piercing and 75 percent reported a habit of rattling the piercing. Immediate complications upon insertion of the piercing were reported by 37 percent, with tooth fractures occurring in 20 percent of cases. Greater mandibular lingual recession was found in those with tongue piercings. Those with a tongue piercing were 18 times more likely to have gingival recession.

Clinical Implications: Clinicians should advise patients about the risks associated with oral piercing.

Pires, I., Cota, L., Oliveira, A., Costa, J., Costa, F.: Association Between Periodontal Condition and Use of Tongue Piercing: A Case-Control Study. J Clin Perio 37: 712-718, 2010. n

continued on page 110

continued from page 109

Recommendations for Cleaning Between the Teeth

Neither the toothbrush nor toothpaste reaches interproximal surfaces where caries and periodontal disease begin. The primary tools for cleaning between the teeth are floss, toothpicks and interdental brushes, with variations in each category. Delivering fluoride to proximal surfaces is best done with fluoridated toothpicks and dental floss, not toothpaste.

Researchers at the University of Gothenburg in Sweden carried out a three-part study, asking clinicians and patients to complete a questionnaire and measuring the clinical effectiveness of interdental plaque removal by the patients.

Questionnaires were mailed to 500 dental hygienists and 500 dentists, with 800 returned. A total of 1,000 test subjects were selected from the town registry of Västra Götaland in southwestern Sweden to receive the questionnaire. This group was equally divided among men and women and among age groups. The clinical evaluation of proximal plaque removal was carried out with a group of randomly selected patients, 20 using dental floss, 20 using toothpicks and 20 using interdental brushes.

Dental hygienists reported more frequent recommendations of interproximal tools with more specific instructions than dentists. Dental floss was recommended for younger patients and interproximal brushes for older patients. Patients reported brushing twice daily with 57 percent of 15- to 20-year-olds cleaning between their teeth daily, 76 percent of 21- to 60-year-olds and 81 percent for those over 60 years of age.

The interdental brush was more effective in removing proximal plaque (83 percent) compared to toothpicks (74 percent) and dental floss (73 percent).

Clinical Implications: Patients should receive individualized recommendations for cleaning between their teeth.

Särner, B., Birkhed, D., Andersson, P., Lingström, P.: Recommendations by Dental Staff and Use of Toothpicks, Dental Floss and Interdental Brushes for Approximal Cleaning in an Adult Swedish Population.Oral Health Prev Dent 8: 185-194, 2010. n

Barriers to Providing Smoking Cessation Counseling

It is now estimated that 21 percent of Americans older than age 18 smoke. Approaches assisting with tobacco cessation include interactive CD ROM courses, motivational interviewing, and use of multiple nicotine replacement options. The U.S. Public Health Service Clinical Practice Guidelines suggest using the "Five A" counseling approach: Ask, Advise, Assess, Assist and Arrange. No single approach insures success, however smokers do report that advice from a health-care professional is an important motivator in their attempts to quit smoking. Despite efforts and research, tobacco cessation counseling (TCC) is not routinely offered to patients by dentists or hygienists. Ideally, it should begin in dental and dental hygiene schools and carryover into practice.

Researchers at the University of Pittsburgh School of Dental Medicine surveyed and trained both students and faculty in the "Five A" counseling approach, plus training from the School of Pharmacy in the addiction process, nicotine replacement therapies and available prescription medications.

Baseline surveys of 32 students and eight faculty members identified three barriers to TCC: time, effectiveness and confidence. Six months following training, a second survey was returned by 26 students and only four faculty members. Students reported that TCC didn't take as much time as they anticipated and they felt more knowledgeable and prepared to provide TCC. However, self-confidence was still lacking.

The lack of buy-in to this project by the faculty, with only half of the eight faculty completing final surveys, might explain an underlying problem. Faculty have heavy workloads and adding more to an already oversaturated curriculum is met with reluctance.

Clinical Implications: Tobacco Cessation Counseling should be part of dental and dental hygiene visits for smokers.

O'Donnell, J., Hamilton, M., Markovic, N., Close, J.: Overcoming Barriers to Tobacco Cessation Counseling in Dental Students. Oral Health Prev Dent 8: 117-124, 2010. n

You care enough to brush with toothpaste...

WHAT IS XYLITOL?
Go to whyxylitol.org

Shouldn't you be using a nasal spray with xylitol?

The only nasal spray with 100% Xylitol, Xlear® (pronounced "clear") has been clinically shown to reduce airborne contaminates in the sinuses and upper respiratory tract, while soothing and moisturizing. Like brushing, a daily spray should be a part of your family's health routine.

VISIT US ONLINE: www.xlear.com

XLEAR INC
THE XYLITOL EXPERTS®

FREE FACTS, circle 9 on card

Available at:

The Vitamin Shoppe · WHOLE FOODS · Vitamin Cottage · SuperSupplements · and other fine stores.

Probiotics.
They aren't just for digestion anymore.

Introducing EvoraPro™ probiotic mints from Oragenics – the first professional-strength probiotics for oral health.

Used just once a day for 10 days after a professional cleaning, EvoraPro supports dental and gingival health and extends the "fresh from the dentist" clean. Each mint contains an extra-strength blend of ProBiora3® probiotics. These beneficial bacteria bind to teeth and go deep under the gingival margin, crowding out harmful bacteria.

A 2009 *Journal of Applied Microbiology* study determined that use of ProBiora3 promotes periodontal and dental health by helping to maintain a healthy balance of bacteria in the mouth[1]. Since a professional cleaning removes both good and bad bacteria, the days immediately after a cleaning are an ideal time to replenish the good bacteria that are essential for oral health.

After using the 10-day supply of EvoraPro, patients should use regular-strength EvoraPlus® for ongoing maintenance. Used daily over a period of weeks, EvoraPlus substantially reduces levels of certain oral bacteria associated with bad breath. Beneficial bacteria in EvoraPlus also produce a continuous low dose of hydrogen peroxide as a natural metabolic by-product. In a four-week laboratory study, this process provided continuous whitening on stained dental surfaces.

Oragenics probiotic products were developed from basic research begun more than 30 years ago at the Harvard-affiliated Forsyth Institute in Boston. This body of research has shown that a few key naturally occurring oral bacteria can act as antagonists to harmful oral bacteria. EvoraPro and EvoraPlus are 100% natural, and will not harm tooth enamel, dental work, bridges, or dentures.

Let us help you maintain your patients' oral health while making them more active in their own care. For more information, call us at 877-803-2624 ext. 248 or visit www.ForEvoraPro.com.

1. *Journal of Applied Microbiology*, 2009; 107: 682-690.

EvoraPro PROBIOTIC MINTS AT A GLANCE

- Professional-strength probiotics for oral care
- Contains ProBiora3 blend of beneficial bacteria
- Promotes healthy bacterial balance in mouth
- Extends effects of professional cleaning
- Does not harm tooth enamel, dental work, or dentures
- 100% natural

ORAGENICS

Innovative Biopharmaceuticals from Oral Science

877-803-2624 ext. 248 | www.ForEvoraPro.com

See us at the Greater New York Dental Meeting, Booth 2923.

FREE FACTS, circle 4 on card

Recommending Xylitol to Patients

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

Xylitol is no longer a new topic. Journal articles cover the science and speakers endorse the preventive benefits of xylitol. Hygienetown even has a free online CE course titled: *Xylitol, The Good Sugar.* Xylitol is an essential ingredient in CAMBRA protocols to prevent caries. The research has been accumulating for 40 years, yet translating the science into quick and easy recommendations patients will follow is more elusive.

It's easy to give patients information and reasons why xylitol should be part of their daily oral health program, but getting follow-through is not always as easy. It requires a repeatable and predictable plan of action, resulting in patient compliance with product purchases outside the dental office. A few practices stock products for their patients and sell them directly, but the majority prefer their patients to purchase recommended products outside the dental office. Recommendation to patients should include these three simple steps:

1. Use 100 percent xylitol sweetened products,
2. Strive for five xylitol exposures each day; and
3. Shop for xylitol products in a health food store.

A History Lesson

It all began in Finland during World War II. The ports were blocked so no sugar made it to Finland. The government asked scientists what other sugars might be available in Finland and were told that the bark from birch trees contained xylitol. The government built the factory to extract xylitol from the cellulose in the tree bark and provide a natural sugar to their cit-

izens. After the war, it was decided that importing sugar was cheaper than extracting xylitol, so the country went back to cane sugar. Years later, dentists noticed that children whose teeth erupted during the time xylitol was used had fewer caries than childern before or after. A few more comparisons with other Scandinavian countries confirmed that indeed something good happened when xylitol replaced sugar. With this information, researchers began investigating how xylitol impacted oral bacteria and the caries process.

Early Studies

In two short pilot studies, researchers asked subjects to refrain from all oral hygiene and gave them xylitol several times a day as a sweetener in coffee, caramels and sweet rolls. In just four days, plaque levels were reduced by 50 percent. When the study was repeated over five days, the results were the same – 50 percent reduction in plaque. As a dental hygienist, this finding is amazing. Oral hygiene instructions don't always deliver a 50 percent reduction in plaque levels. Imagine getting this result with several exposures to xylitol each day. Sweet success.

Next were the complete sugar replacement studies, to replicate the wartime xylitol diet and compare it to a traditional sucrose diet, as well as a fructose diet. Providing and monitoring food intake for subjects over a two-year period was an enormous and expensive undertaking. Results of the Turku Sugar Studies showed an amazing 85 percent reduction in caries for those in the xylitol group. Researchers then wondered how chewing xylitol sweetened chewing gum several times a day would compare to results of the meal replacement studies. Dropping the total daily intake of xylitol from 67 grams to 6.7 grams produced the same results, 85 percent reduction in caries after one year compared to sucrose chewing gum. Researchers were amazed and excited with this finding.

Long-term studies are essential to confirm the outcomes of shorter studies. These studies are difficult and expensive to perform. Researchers from Finland and the University of Michigan undertook a 40-month study in Belize City, Belize, including every fourth grader in the city. Several chewing gums were tested – 100 percent xylitol-sweetened gum, sorbitol-sweetened gum, sucrose-sweetened gum and a combination of xylitol and sorbitol in a chewing gum. The study results confirmed the caries preventive benefits of 100 percent xylitol-sweetened chewing gum were better than sucrose, sorbitol and xylitol plus sorbitol. Both sucrose and sorbitol provide a nutrient source for bacteria, allowing bacteria to produce the acid necessary to stick together in a biofilm on the teeth and to dissolve enamel leading to caries.

These early studies created a foundation for a wide variety of xylitol studies and repeatedly showed chewing gums and other candies and products sweetened with only xylitol provided the greatest caries prevention. Products with only a small amount of xylitol will not provide the benefits reported for 100 percent xylitol-sweetened gums and candies. This is a key point to remember when recommending xylitol products, be sure they are sweetened only with xylitol.

Mothers, Children and Xylitol Use

Preventing the very first carious lesion is our goal. To do that, a mother's oral flora needs to be low in strep mutans and high in lactobacil-

continued on page 116

continued from page 115

lus. Several studies confirm that 100 percent xylitol chewing gum used by mothers for a period of two years, prior to tooth eruption in their infants, leads to 70 percent less need for restorative care. When researchers went back several years after completion of the study, a long-term effect was measured. The children of mothers who chewed 100 percent xylitol-sweetened gum were five times less likely to have strep mutans colonized in their mouths and still had 70 percent less caries than children whose mothers received several applications of either a fluoride or chlorhexidine varnish over two years. Chewing gum sweetened only with xylitol provided on oral flora conducive to health for both the mothers and their children. Looking across the board at many xylitol chewing gum studies, caries rates are reduced from 40 percent to 85 percent. Many factors will influence study results, including compliance and frequency of xylitol consumption each day.

Hundreds of xylitol research studies over the past 40 years demonstrate the ability of 100 percent xylitol-sweetened products used several times each day reduce both caries and periodontal pathogens, stimulate salivation, enhance remineralization, and reduce bad breath.

Strive for Five Xylitol Exposures Each Day

The key to achieving the results reported in the research is to use products sweetened only with xylitol and to use these products several times throughout the day. Research has demonstrated that it's not the total amount consumed, but rather the frequency of exposure throughout the day. Xylitol molecules have a five-carbon structure rather than six carbons, helping them to easily pass through the outer membrane of bacteria, blocking entry for the sugar molecules. However, the bacteria cannot digest the xylitol and must use its own energy to pump the xylitol molecule out, where it repeats the process, using up valuable energy of the bacteria with no acid production. With no acid production, the bacteria can't maintain the biofilm structure, cannot remain attached to the teeth and cannot dissolve enamel. The bacteria are simply flushed off the teeth down the digestive tract. The same is true for Xlear xylitol nasal rinse. Bacteria, dust, dirt and other irritants are simply flushed from nasal passages, preventing ear infections in children and colds, sinus infections and even asthma.

Target Groups in Your Practice

There are several target groups in your practice that will benefit from adding 100 percent xylitol-sweetened products several times each day. Begin with pregnant patients. By changing their oral flora, they will pass on a healthy balance of bacteria to their new baby when teeth are erupting. Infants benefit from Xlear Nasal Rinse, squirted in their noses to prevent ear infections. Children can use xylitol gel to prevent caries. Xylitol use will raise the pH of the mouth, reducing the potential for caries.

Adults will benefit from a reduction of oral pathogens associated with both caries and periodontal disease. Those suffering with xerostomia will experience stimulated salivation and a reduction in plaque levels, providing preventive benefits. Patients investing in restorative and cosmetic dentistry will protect their investment with xylitol products that prevent recurrent caries around restoration margins. The elderly are the least able to perform adequate oral hygiene on a daily basis, so xylitol products will help them reduce bacterial biofilm levels, stimulate saliva flow, raise oral pH and reduce bad breath.

Shop for Xylitol Products in Health Food Stores

Chewing gums available at the grocery store checkout are not sweetened with 100 percent xylitol. These chewing gums do not contain enough xylitol to achieve the benefits reported in research. These popular chewing gums advertise xylitol on their packaging, but the list of ingredients that will often read sorbitol, mannitol, aspartame, acesculfame K, and sucralose, often listed before xylitol. In some products, xylitol is listed as less than 2 percent. These chewing gums do not reduce plaque formation, but instead provide a nutrient source for the bacteria and the acid production continues. The benefit of other "sugar-free" chewing gums is salivary stimulation, not bacterial reduction.

Chewing gums, candies and other oral health products sweetened with only xylitol are available in health food stores, not grocery or drug stores. Find a good health food store in your area, visit them and see if they carry 100 percent xylitol-sweetened products such as Spry or Xlear products. You can also visit www.xlear.com and type in your zip code to get a list of health food stores in your area that carry Spry and Xlear products. Have this store information ready for your patients when you recommend 100 percent xylitol-sweetened products. You might also include this information in your office newsletter or on your practice Web site. Share the exciting xylitol science with patients and tell them about www.xylitol.org, where they can read more about this sweet ingredient for oral health. This independent Web site provides information, videos, science and product recommendations for consumers as well as medical and dental professionals.

Conclusion

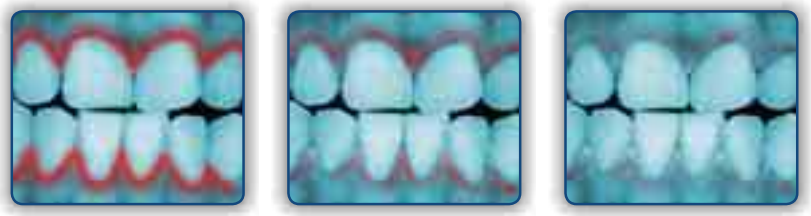
Xylitol is an exciting ingredient that will make dental disease prevention both easy and sweet. Try it yourself. Use your tongue to feel the plaque accumulating along the mandibular lingual surfaces of the posterior teeth and the facial surfaces of the maxillary posterior teeth. Chew Spry 100-percent xylitol-sweetened chewing gum after meals and snacks and on the first day, you'll feel a reduction in bacterial biofilm accumulation on these tooth surfaces As Townie Erika Feltham said in a xylitol message board: "Use Spry and let your mouth tell you why!" n

Don't just deflate.

Virtually eliminate gingivitis.*

With powerful mechanical and antibacterial actions, the **NEW Clinical PRO-HEALTH™ SYSTEM for Gingivitis** helps break the cycle of gingival inflammation and gingival bleeding for improved oral health in patients with mild to moderate, persistent gingivitis.

Specialized images show the average area and magnitude of improvement in gingivitis over time*



Before using the system:
Significant gingivitis

2 weeks of use:
Initial improvement of gingivitis

6 weeks of use:
Further improvement in gingival health

NEW SYSTEM!

Crest Oral-B

PRO-HEALTH™

CLINICAL

GINGIVITIS SYSTEM

To learn more, visit **dentalcare.com/clinical**

*Six-week clinical results with NEW Crest® PRO-HEALTH® Clinical Gum Protection Toothpaste, NEW Oral-B® Glide® PRO-HEALTH® Clinical Protection for Professionals Floss, and Oral-B® Professional Care SmartSeries 5000 Electric Toothbrush with SmartGuide™.

FREE FACTS, circle 20 on card

 PGC-3060 OPAD10984

Crest Oral-B

Continuing the Care That Starts in Your Chair

Scaling Decalcified Areas

The practice protocols for treating soft enamel and dentin vary from no instrumentation and the application of remineralizing products to aggressive instrumentation of the area prior to applying remineralizing products. This message board has received 24 replies and 706 views.

funrdh
Posted: 1/17/2010
Post: 1 of 25
Total Posts: 34

I worked at an office last week where I had an 82-year-old woman come in with a mouth full of plaque and food debris. I know at this age this is common because of poor oral hygiene. She had a lot of decalcified areas. I used a toothbrush then the Cavitron to deplaque. I told the dentist that I was trying to be gentle because of her compromised enamel. He told me that I needed to scale the soft enamel off her tooth to get down to good solid tooth because the soft tooth can hold bacteria. I have always tried to save as much of the tooth as possible and when I see the enamel start to chip away I stop. Is this right? What should I be doing? ■ Crystal

lindadouglas
Posted: 1/17/2010
Post: 2 of 25
Total Posts: 3,429

I think your cautious approach makes sense; you want to preserve as much enamel as you can. Once iatrogenic cavitation occurs in these areas, it precludes remineralization. ■

JDMM
Posted: 1/18/2010
Post: 6 of 25
Total Posts: 32

I had a similar experience. There was some root caries on the mandibular anterior teeth, so I was extremely careful. When the dentist did the exam, I explained the situation. He proceeded to pick up a curette and gouge the heck out of the root into the caries! I was mortified! I was afraid he was going to go right into the nerve by the aggressive digging. It wasn't calculus he was removing; it was decay. He wasn't going to put any fillings in right at that appointment either! I had never seen anyone do this. ■

hamanj
Posted: 1/23/2010
Post: 8 of 25
Total Posts: 10

I'm a DDS. I would probably advise my hygienist to scrape the decalcified areas with either an excavator or a curette, removing as much of the "white" stuff as possible, and asking the patient if things were still OK. Then we would place a bonding agent such as Brush and Bond by Parkell and cure. John Kanka's Surpass might be OK here. And, recently Kerr has advertised a bonding flowable which appears to be an extension of Optibond (these need etching). If you can place a sealant, you can work on a buccal decalcification. Other than that, a fluoride varnish would be a good service.

You have all seen "recalcified" areas on the buccals of lower posteriors which correspond to where the plaque/biofilm was when the person was 11 years old. Then the teeth erupted, the kid found out what a toothbrush was really all about and lo and behold, the soft spot was now recalcified enamel. ■

lindadouglas
Posted: 1/17/2010 ▪ Post: 2 of 25
Total Posts: 3,429

While the procedure you describe could be a quite reasonable plan of action, note that one of the previous posters was asked to curette a caries lesion which was not going to be restored at that time.

We are also aware of the type of arrested caries that you describe: many dental professionals now build on that phenomenon to initiate successful remineralization protocols for caries lesions which have not yet cavitated. These include use of fluoride varnish. However, fluoride alone might not be enough as it remineralizes the enamel surface, while casein phosphopeptides and amorphous calcium phosphate in Recaldent remineralizes subsurface lesions. I always exercise caution when working on teeth with incipient caries or white spot lesions, as one can cause cavitation by removing the thin enamel over the subsurface lesion, necessitating restoration, when there might have been a chance to remineralize it. ■

trishaohehir
Posted: 1/23/2010
Post: 10 of 25
Total Posts: 3,157

I have to agree with hamanj. My experience has been to remove all soft enamel, getting to a hard surface, then applying remineralizing products and being sure the patient knows how to keep the area plaque free. Doesn't make sense to leave soft enamel. Soft surfaces indicate the enamel is broken.

When I was in India seeing the kids in the orphanage, I used my O'Hehir curette to remove all the soft enamel until I reached hard tooth structure. All I had was fluoride varnish so I applied that and hoped for the best. A dentist was scheduled to visit the orphanage in October, but with the H1N1 flu, visas to India were made too difficult to get, so the trip was postponed. GC America Triage would have been a good product to use in those cases, had I known what to expect. I'm curious why you might want to leave the soft tooth surface. ■

Lindadouglas
Posted: 1/23/2010
Post: 11 of 25
Total Posts: 3,429

I had in mind the thin, kind of "flaky" enamel over a subsurface lesion. I also had concerns about curetting a soft caries lesion if there were no immediate plans to restore it. Triage would be a great product too. ■

hamanj
Posted: 1/24/2010 ▪ Post: 12 of 25
Total Posts: 10

What's a subsurface lesion? Sub to what surface? Enamel? Dentin? Plaque/biofilm? ■

trishaohehir
Posted: 1/25/2010
Post: 14 of 25
Total Posts: 3,157

I agree with you, Linda. If the enamel is still hard and slightly "flaky" as you describe it – that area might benefit from remineralization therapy. I'd go easy on the instrumentation and go for remineralization.

The soft, sticky surfaces (generally cervical areas) I do instrument down to a hard, sound surface, the patient can then maintain and remineralization products can reach. Patients can't keep a soft, sticky surface clean, so the decay process continues deeper into the tooth. I've learned this from previous employers who did just what the original poster's dentist did. ■

The Farmer and His Mule

ONE DAY AN OUT-OF-TOWNER DROVE HIS CAR INTO A DITCH IN A DESOLATED AREA. LUCKILY, A LOCAL FARMER CAME TO HELP WITH HIS BIG STRONG HORSE NAMED BUDDY. HE HITCHED BUDDY UP TO THE CAR AND YELLED, "PULL, NELLIE. PULL." BUDDY DIDN'T MOVE. THEN THE FARMER HOLLERED, "PULL, BUSTER. PULL." BUDDY DIDN'T RESPOND. ONCE MORE THE FARMER COMMANDED, "PULL, JENNIE. PULL." NOTHING. THEN THE FARMER NONCHALANTLY SAID, "PULL, BUDDY. PULL." AND THE HORSE EASILY DRAGGED THE CAR OUT OF THE DITCH. THE MOTORIST WAS MOST APPRECIATIVE AND BECAME VERY CURIOUS. HE ASKED THE FARMER WHY HE CALLED HIS HORSE BY THE WRONG NAME THREE TIMES. THE FARMER SAID, "OH, BUDDY IS BLIND, AND IF HE THOUGHT HE WAS THE ONLY ONE PULLING, HE WOULDN'T EVEN TRY!" ■

Education Entertainment Camaraderie

townie meeting

Vegas **May 4-7** **2011**

Register online at townniemeeting.com or call 866.336.8696.

PROGRAMS FOR EVERYONE AND SPEAKERS LIKE NO OTHER.


Dr. Tarun **AGARWAL**


Dr. Bruce **BAIRD**


Dr. Howard **FARRAN**


Dr. Louis **MALCMACHER**


Ms. Sandy **PARDUE**


Dr. Sameer **PURI**


Dr. Raymond **YUKNA**














KARREL REID HYMAN JULIANI KURTHY LEUNG MELKERS MIRZAYAN O'BRIEN, RDH PATEL REEVE REZNICK ROSENBLATT SHAMSTAD WEED

PROGRAMS IN CLINICAL, IMPLANT, TEAM, HYGIENE, CEREC, PERSONAL DEVELOPMENT, WORKSHOPS, PARTIES AND MUCH MORE!

SIX MONTH SMILES CERTIFICATION


MARKETING SUMMIT by New Patients Inc.

NTI: NOT TOTALLY INDICATED with Dr. Jim Boyd


ALL BETS ARE OFF Townie Poker Tournament


BRING ALL YOU HAVE at the Townie Golf Tournament

Earn up to **24** CE Credits

SAVE NOW!

	EARLY BIRD by [illegible]	REGULAR RATE
Dentist	$1,295	$1,495
RDH	$649	$849
Staff/Spouse	$549	$649
Social	$199	$199
Student	$499	$499
Poker	$250	$250
Golf	$200	$200
OPTIONAL WORKSHOPS		
Dental Marketing	FIRST ATTENDEE	$695
	SECOND ATTENDEE	$199
6-Month Smiles	DENTIST	$1,095
	STAFF	$300
NTI-TSS Course		$595

SPECIAL TOWNIE RATE **ONLY**

$189 per night

Call toll-free [illegible]
A reservation code
SCTOW1

For more information, including the latest speaker details, visit us online at

townniemeeting.com

Get Townie Meeting updates on Facebook & Twitter.

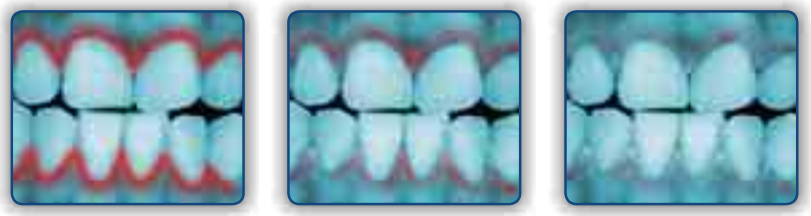
FREE FACTS, circle 40 on card

Don't just deflate.

Virtually eliminate gingivitis.*

With powerful mechanical and antibacterial actions, the **NEW Clinical PRO-HEALTH™ SYSTEM for Gingivitis** helps break the cycle of gingival inflammation and gingival bleeding for improved oral health in patients with mild to moderate, persistent gingivitis.

Specialized images show the average area and magnitude of improvement in gingivitis over time*



Before using the system:
Significant gingivitis

2 weeks of use:
Initial improvement of gingivitis

6 weeks of use:
Further improvement in gingival health

NEW SYSTEM!

Crest Oral-B

PRO-HEALTH™

CLINICAL

GINGIVITIS SYSTEM

To learn more, visit **dentalcare.com/clinical**

*Six-week clinical results with NEW Crest® PRO-HEALTH® Clinical Gum Protection Toothpaste, NEW Oral-B® Glide® PRO-HEALTH® Clinical Protection for Professionals Floss, and Oral-B® Professional Care SmartSeries 5000 Electric Toothbrush with SmartGuide™.

FREE FACTS, circle 20 on card

 PGC-3060 OPAD10984

Crest Oral-B

Continuing the Care That Starts in Your Chair