Teeth can be saved for future stem cell harvesting

By Fred Michmershuizen, Online Editor

The Save-A-Tooth system can be used to transport teeth destined for cryopreservation and stem cell treatment of disease.

Recent research has shown that normally shedding baby teeth and extracted wisdom teeth can be a source of stem cells that are the equivalent of umbilical cord blood stem cells.

The use of umbilical cord blood as a source of stem cells has been routine for several years. However, this method has many problems.

The window of time for the retrieval of the cord blood is very short, the hospital staff needs to be well trained in the technique and it is expensive.

Every child loses 20 baby teeth over a period of six to eight years, and 1.4 million wisdom teeth are extracted each year. Each of these is a rich source of stem cells.

In the past, these teeth were thrown in the trash, but now they can be saved and shipped to a cryopreservation facility and the stem cells stored until needed for the many possible future clinical applications.

“This potential source of stem cells from teeth is a tremendous breakthrough,” said Dr. Paul Krasner, professor of endodontics at Temple University School of Dentistry.

“Four million baby teeth a year normally fall out, and for a small cost and virtually no effort, each can have The window of time for the retrieval of the cord blood is very short, the hospital staff needs to be well trained in the technique and it is expensive. Every child loses 20 baby teeth over a period of six to eight years, and 1.4 million wisdom teeth are extracted each year. Each of these is a rich source of stem cells. In the past, these teeth were thrown in the trash, but now they can be saved and shipped to a cryopreservation facility and the stem cells stored until needed for the many possible future clinical applications.

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“Four million baby teeth a year normally fall out, and for a small cost and virtually no effort, each can have applications.

The Save-A-Tooth system can be used to transport teeth destined for cryopreservation and stem cell treatment of disease.

Deliberating about a diode laser?

If you think you cannot afford a diode laser or it’s just too complicated to use, think again. Read what a dentist who is not a ‘high-tech’ junkie has to say about incorporating this technology into her practice. → See page 13A

Olympians screened for oral cancer

By Fred Michmershuizen, Online Editor

Many of the world’s top athletes were competing for medals during the 2010 Winter Olympic Games, held in Vancouver, British Columbia. When they weren’t skiing down slopes, skating around ovals or whooshing down tracks, several hundred of the athletes were undergoing screening for oral cancer.

That’s because the International Olympic Committee (IOC) mandated that 20 percent of athletes competing in the games receive a comprehensive examination that...
At the Winter Olympics in Vancouver, British Columbia, the VELSope System was used to screen athletes for oral cancer. The device was developed in British Columbia.

including screening for oral cancer. The device used to conduct the screenings was the VELSope system, which happened to have been developed right in British Columbia by LED Dental, in collaboration with the British Columbia Cancer Agency. During the games, a team of 72 dentists and their volunteer assistants were offering about 800 athletes everything from routine dental care to trauma surgery. All who were being treated received the oral cancer screenings.

“Year-round, the alpine athletes travel around the world to train, and they are at higher risk of lip and mouth cancers because of the altitude and sun exposure,” said Dr. Jon Suzuki, dean of dentistry at the University of British Columbia and co-head of dental services for the 2010 Olympic Games.

The athletes were also receiving education about the importance of wearing sunscreen to prevent oral cancers. Alpine sports athletes who train year-round at high elevations are especially prone to damaging ultraviolet rays, raising the risk of developing skin and lip cancers. The problem is compounded by the additional reflection of ultraviolet radiation off the snow and ice.

Dr. Jack Taunt, co-chief medical officer of the games. “The skin on the lips is thin and poorly protected. The damage is cumulative, and you have to consider they are exposed to these intense ultraviolet rays for up to 50 years, through their training and post-competitive coaching years in many cases.” Moreover, Taunt said, some athletes in Nordic events chew tobacco, which contains numerous carcinogens that can cause oral cancers.

The VELSope, a device that emits a special blue light inside the mouth to help detect suspect tissue that needs further investigation, was used to screen for cancerous and precancerous lesions in the athletes. According to LED Dental, the VELSope is the No. 1 oral cancer screening device in the world, having been used to conduct an estimated 5 million screenings in the past year.

“It’s a terrific adjunctive visual tool being integrated more and more into general dentistry practices,” said Dr. Chris Zed, associate dean of dentistry at the University of British Columbia and co-head of dental services for the 2010 Olympic Games.

The athletes were also receiving education about the importance of wearing sunscreen to prevent oral cancers. Alpine sports athletes who train year-round at high elevations are especially prone to damaging ultraviolet rays, raising the risk of developing skin and lip cancers. The problem is compounded by the additional reflection of ultraviolet radiation off the snow and ice.

Zed cited a German study that showed outdoor athletes seem unaware of the elevated cancer risks associated with their training.

Unless it is placed in a preservation solution, a knocked-out tooth dies within one hour.

their stem cells stored for future medical use.”

The Save-A-Tooth System from Phoenix-Lazerus — one method for storage of knocked out teeth — can be used to transport teeth that can be used as a source of stem cells. Provia Laboratories, the provider of the Store-A-Tooth system, said Dr. Verlander, chief scientific officer of Provia.

“The Save-A-Tooth system has a patented preservation and retrieval net that protects the teeth during transport, and none of the methods of transporting teeth have this safety factor.”

There are stem cells present on the roots of extracted wisdom teeth that are especially delicate and subject to crushing damage. The Save-A-Tooth method protects these delicate cells.

These stem cells are found at the root end of the wisdom teeth and could be damaged by hanging against container walls or crushing during removal from the container.

The Save-A-Tooth System has the American Dental Association Seal of Acceptance for transporting knocked out teeth and is used by dentists, schools, hospitals, ambulances and the U.S. Olympic teams. Because knocked out teeth will die within one hour of being knocked out, the Save-A-Tooth should be purchased ahead of time and kept in first aid kits just like bandages, burn cream and gauze.

If the Save-A-Tooth is used within 60 minutes of the accident, over 90 percent of knocked out teeth can be saved by reimplantation. The Save-A-Tooth system has been used to store, preserve and transport knocked out teeth for over 20 years.

Its preservation fluid, Hank’s Balanced Salt Solution, has been shown to be an effective preservation solution for knocked out teeth.

The value of a complete system for the storage of knocked out teeth is outlined in the dental trauma blog, Dental911.org.
An iconic icon
Recognizing today’s dentists who have devoted time outside their practice to help others

By David L. Hoexter, DMD, FACCD, FICD, Editor in Chief

Each generation has a different concept or image of an icon of contemporary culture. D. Walter Cohen is such an icon of dentistry. He is a pinnacle of energy and accomplishment with a glitter of idealism. Even today, in his 80s, he will play tennis early in the morning before he practices periodontics at his office. He understands the “gestalt” of life. For example, he talks about Dr. Harry Sicher, author of Bone on Bones: Fundamental of bone biology, as not only being a great orthodontist but someone who loves music and catching butterflies as well.

Cohen makes the time and effort to improve the lives of others and to encourage peace through education and understanding. Sharing his vision through unselfish seeds of giving, Cohen fertilizes the seeds with education and an interchange of knowledge.

With his nurturing, the seedlings grow into trees with strong roots and wide branches with spreading leaves. It is underneath the shade of these leaves that people learn and share knowledge.

He even manages to open eyes and ears that have been waxed shut through years of prejudice and ignorance.

In 1997, Cohen established the D. Walter Cohen Middle East Center for Dental Education in Israel at Jerusalem’s Hebrew University. Today, it continues to set the tone of learning for citizens all over the world.

It also allows for the exchange of dental students at Hebrew University with the students at the Al-Quds School of Dentistry in Jerusalem. This exchange illustrates true sharing between Israeli and Palestinians in Jerusalem by stressing knowledge, human compassion and understanding.

Cohen is a passionate man who has given the world a real opportunity to enhance peace efforts and change humanity through education and understanding.

Cohen is also helping to make strides in lowering the number of preterm, low birth weight babies. He is guiding the treatment and care of periodontal disease during pregnancy, especially among pregnant teenagers.

This may be a major step in order to lower the number of preterm, low birth weight babies. A favorite phrase of his is that “we have to keep trying so we can break through the glass ceiling.”

Cohen helped establish the University of Pennsylvania’s first department of periodontics and served as its first chair. Growing from professor to dean, Cohen advanced new concepts and raised educational standards.

During his career he has found the time to write and publish 22 books and hundreds of articles. Despite his busy schedule, he always finds the time to participate as dean emeritus of the University of Pennsylvania’s School of Dental Medicine.

Among his many honors, he has received the Legion of Merit from France, was named president of the Medical College of Pennsylvania, chair of the Pennsylvania Diabetes Academy, president of the National Museum of American Jewish History and chancellor emeritus of Drexel University College of Medicine.

These are just a few examples of the awards and leadership recognition that he has received.

When I asked Cohen what he considered his greatest achievement to date, he unhesitatingly replied “my family.” His daughters would probably agree.

Proudly, he related the wonderful family home in which he was raised, and that his father was the first periodontist in Philadelphia. As he related it, the encouragement and love that his family gave to him made it easy for him to give so much back.

If the question were posed to me as to who and what is an icon in dentistry, I would swiftly reply, “D. Walter Cohen.”

Limit staff access to drugs

Dental offices and the pharmaceuticals used there present the risk for drug abuse, but dentists can put policies in place that help reduce the chance of illegal use of controlled substances, according to an article in an issue of Anesthesia Progress (2009 edn., 56:12-115).

Joel M. Weaver, DDS, PhD, writes that dentists who place too much trust in their employees make themselves and their practices vulnerable to people who abuse controlled substances.

Dentists who regulate drug access and distribution are protecting more than their practice—they’re also protecting their patients, employees and reputation.

While it’s often easier to stick with the ways things have traditionally been done, making a few changes to drug access policies makes good business sense, Weaver says.

“Although change is difficult and usually meets with resistance, the thoughtful practitioner who can step back and observe his or her practice for potentially fatal weaknesses will be much less likely to succumb to a disaster,” Weaver writes. Accredited hospitals already have strict rules to help prevent drug theft, but private unaccredited offices without mandatory controls are highly vulnerable to drug theft and deception.

By taking sole responsibility for storing, filling and handling syringes with controlled substances, dentists reduce the chance for illegal drug use and mistaken dosages.

It’s important to rely only on those licensed to handle medications, Weaver says, such as physicians, dentists, nurses and pharmacists. Other employees who receive on-the-job training also may be more likely to make mistakes with drug dosages and concentrations.

“How should we have access to controlled substances in the dental office? The answer is simple: only licensed professionals and as few of them as is reasonable,” he says.

For more information on limiting prescription drug access, read the entire article, “Who Should Have Access to the Controlled Substances in Your Office?” at: www2.allenpress.com/pdf/anpr-15-4nl.pdf

(Source: Anesthesia Progress)
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April 16-17
Milwaukee, WI
April 16-17
Las Vegas, NV
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$22b for health information technology, but not quite so much for dentistry

By Thankam Thyvalikakath, BDS, MDS, MS and Titus Schleyer, DMD, PhD

When the Health Information Technology for Economic and Clinical Health Act (HITECH) was signed into law in 2009, $22 billion was set aside to improve patient outcomes through increased use of electronic health records (EHR) by clinicians during the next five years (2011–2015).

The proportion expected to go to dentistry; negligible. Prorating dentistry’s share of the health-care market (approximately 3 percent) would yield over $1 billion of the allocated amount, but we will be lucky if we receive a fraction of that.

You may ask why. After all, dentistry, with its more than 150,000 practitioners in the United States, is an important primary care discipline that cares for almost 200 million Americans in any given year.

The main reason we are pretty much left out is because the legislation was written with the interests of physicians and hospitals, not with those of other health-care providers, in mind. The consequence is a huge missed opportunity for dentistry.

The federal government requires providers to fulfill three criteria to become eligible for Health Information Technology (HIT) stimulus funds from the HITECH Act. They must use certified EHRs, demonstrate the capability to measure meaningful use of EHRs based on a pre-defined framework and have a patient population that includes at least 50 percent Medicare or Medicaid beneficiaries for oral health care procedures.

Unfortunately, these criteria make it very difficult for any dentist to qualify. At this time, not one dental EHR has been certified by the Certification Commission for Health Information Technology (CCHIT).

Meaningful use criteria have been developed mainly based on general, not dental, health needs. In addition, few dentists have patient pools that include a large share of Medicaid/Medicare beneficiaries.

Electronic health records, the use of which can be supported by the HITECH Act, are certified by CCHIT. CCHIT is an independent, 501(c)3 nonprofit organization that has been recognized by the U.S. Department of Health and Human Services (HHS) as the official certification body for EHRs since 2006.

CCHIT conducts the certification process by following industry standards for EHRs and checking how suitable EHRs are in achieving the meaningful use requirements specified by the HHS. As of today, no dental EHR has undergone this certification process.

Another stumbling block is the way meaningful use has been defined by the Office of National Coordinator for Health Information Technology (ONC).

The idea of meaningful use is to define a set of process measures that reflect good health care practices, for instance, periodically checking the blood pressure for hypertensive patients and monitoring glucose levels of diabetics.

While some meaningful use measures, such as generating problem lists for oral health conditions, maintaining lists of active medications and allergies, and recording primary language, insurance type, gender, vital signs and other patient-specific variables are certainly appropriate for dentistry, many measures only apply to physicians or hospital settings.

Unfortunately, the meaningful use measures, as currently defined, include very few criteria that are relevant to oral health. Dentists are unlikely to demonstrate the capability to enter orders through an EHR, perform medication reconciliation, submit information to immunization registries and electronically submit lab reports to public health agencies.
Thus, in general, meaningful use does not work for dentistry. Dentists and dental schools also need to have at least 30 percent of their patient population qualify for Medicaid reimbursement or Medicare services.

Very few dentists will qualify based on this criterion. Most likely, it will be those who provide dental care in federally qualified health centers or some dental schools. So, why would all this matter to us? As our studies have shown, more and more dental practitioners are adopting electronic patient records for a variety of reasons. Some see them as a more efficient way to manage patient information and their practice. Others use them to keep track of individual, group and population health outcomes. (What is the average survival time of a veneer for all your patients? A difficult question to answer without an electronic patient record.)

Down the road, more widespread adoption of EHRs in dentistry will enable us to track incidence and prevalence of various dental diseases; identify patients at risk for developing disease; systematically follow up on patients with certain conditions; and expand research through practice-based research networks. This is indeed a missed opportunity.

The HITECH Act clearly shows that oral-health outcomes were not on the radar screen when the legislation was drafted.

We encourage you to write to the American Dental Association and the Office of the National Coordinator for Health Information Technology (see box at right for complete address and fax information) and your local representatives to ask that dentistry be included in support from the HITECH Act.

Contact information

American Dental Association
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Chicago, IL 60611-2678
Tel: (312) 440-2500

Office of the National Coordinator for Health Information Technology
200 Independence Ave. SW, Suite 729-D
Washington, D.C. 20201
Fax: (202) 690-6079
E-mail: onc.request@hhs.gov

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www.di.dental.pitt.edu
Do you need 8-, 10- or 15-megapixels? How to choose a digital camera

By Lorne Lavine, DMD

As a technology consultant, I work with many dentists who have a variety of questions regarding the addition of technology to their dental practices.

Many of the questions are related to topics that I have previously written about in Dental Tribune: an overview of how to decide which technologies to purchase, how to choose dental software, digital radiography, etc.

The topic that seems to receive the most attention, and the most confusion, is digital photography and digital images in general. The sheer number of choices perplexes most dentists.

This two-part article will examine a number of issues that need to be answered when adding digital imaging to the dental practice.

We’ll explore:

• the pros and cons of both intraoral and extraoral cameras;
• examine the criteria that dentists should use in picking a digital camera for their office pathology;
• look at the software choices that exist for storing and manipulating these images (part two);
• delve into the myriad of options for digitizing existing non-digital images (in part two);
• choices for storing these images;
• printing images;
• and other options for sharing these images with other people (such as the patient, insurance companies and other dental colleagues).

Intraoral cameras

Intraoral cameras have been used for dental applications since the early 1990s. One of the first products was the AcuCam, made by New Image Industries. At one point, New Image held over 40 percent of the market share for these systems.

For many years, intraoral cameras were the cameras of choice. Although there was a bit of a learning curve, they were relatively easy to master and still have widespread acceptance today. Recent surveys have shown that intraoral cameras are found in about 50 percent of all dental offices, which seems to indicate that they may have reached their peak in this regard.

Anyone that has used an intraoral camera is aware of the advantages that these systems offer.

Most cameras are capable of magnifying images at 40–52x. This can be an invaluable tool in allowing the dentist to see pathology, such as open margins, fractures and caries, which wouldn’t easily be seen without this level of magnification.

The ability to have images on a computer monitor screen that is visible to the patient is of great benefit. Most experts agree that one of the keys to improving patient acceptance to our treatment plans is the concept of “co-diagnosis.”

In other words, allowing the patient to see the problems that we will see will allow them to participate in the diagnosis of their dental problems, and they will then be more inclined to accept our recommendations for treating problems that they may have been previously unaware that they had.

The cameras allow us to have a permanent record of a patient’s condition before we begin treatment. This can be quite beneficial for cosmetic cases where we can show patients before and after photos of their teeth.

In addition, for legal reasons, it will often be valuable to have a record of a patient’s condition before treatment began, just in case the patient is unhappy with the results and is considering legal action.

The cameras can be used to take photos of X-rays, which frees us from having to send in our original radiographs to the insurance companies. Moreover, adding photo documentation to an insurance claim will often speed up the approval of that claim.

How to evaluate intraoral cameras

When evaluating intraoral cameras, there are a number of factors to consider.

I would highly recommend that anyone considering the purchase of an intraoral camera attend a dental meeting where many of the different vendors will be on hand and it just doesn’t work!

Some of the more popular models that allow for this are manufactured by Digital Doc (Iris.), AcuCam Concept IV (DENTSPLA-GENEX) and the Clariis i310D from Sota Optics.

• Ease of focus. Does the camera require manual focus or is it autofocus? Most cameras have an adjustable focus, so you should evaluate how easy it is to change the focus.

The focus should be well labeled, and should have a range of motion that is less than 100 degrees so that you can easily change the focus setting with one hand.

• Built-in freeze-frame. Many of the older models do not have this feature, and most people prefer this element to be included with the system.

• Capture button location. Some units use a foot pedal to capture individual images, but other models have the capture button right on the handpieces.

For many dentists, this is simply a matter of personal preference, so you should try both types of systems to see which feels most comfortable for you.

• Single lens system. Many earlier systems contained two wands, one for true intraoral photos (90 degree lens) and one for extraoral photos (0 degree lens). Many of the newer systems now use one wand for both types of photos.

Because you may want to use the camera to take photos of X-rays on a view box, the key factor is the ability of the camera’s built-in light to be turned off when taking these types of photos.

• Unique features. Most camera manufacturers will add special features to their systems to differentiate themselves from their competitors.

Some of the features that you will see include flexible cords, extraoral light adjustments, printing from a portable unit, light and color adjustments and image...

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Dental Collab

DENTAL TRIBUNE | MARCH 2010
By Eugene Heller, DDS

For most dentists, ownership of their dental practice is the major focus of their energy expenditures, financial situation and professional lives. Years of blood, sweat and tears, coupled with the relationships formed with both staff and patients, have caused dentists to form a deep-seated emotional attachment to their practice. For many, the dollar value of that practice represents a significant portion of their financial assets.

For the new dentist, there is a definite value in acquiring the patient base that has taken the transitioning dentist years to develop and will provide an immediate and substantial cash flow.

Patients’ evaluation of the new dentist
Most senior dentists know and understand that the senior dentist’s own patients judge their clinical competence by non-clinical factors, such as personality, gentleness, office appearance, etc. It is generally not possible to assess clinical competence until a year or more of actual clinical procedures performed by the new dentist are reviewed.

Unless the transition is preceded by a period of employment prior to the actual ownership change, senior dentists must understand they will not be able to address the clinical competence issue.

Senior dentists must accept the fact that the only control they have over this subject is the fact that the new dentist has been tested and licensed.

Determining the transition plan
The first step in formulating a transition plan involves an appraisal of the practice. The information gathered and evaluated during the appraisal process will aid in determining available transition options. These options may include: (1) an outright sale, (2) role reversal sale, (3) partnership, (4) merger or (5) production acquisition transaction.

In addition, the appraisal will typically provide a comparison with other practices involved in transitions, thereby allowing an understanding as to how salable this particular opportunity might be.

Finally, the appraisal should also provide ideas regarding enhancing the value of the practice and its desirability as a transition candidate.

Locating a competent transition consultant
The next step is locating a competent transition consultant. A transition consultant is one who understands the entire transaction, the various types of transitions, contractual matters, the operational issues of running a dental practice and the need to have the relationships of the buyer, seller, staff and patients intact after the deal is done.

The best source for these individuals is word of mouth referrals and/or a recognized reputation. He or she may be a national or regional “transition guru,” the dentist’s personal accountant or another accountant who restricts his or her practice to health care providers and is familiar with the health care transition field; or an experienced local dental practice broker.

Some of the dental supply companies also have knowledgeable consultants who have been assisting in transitions for years.

The transition consultant will help the dentist identify various aspects of his or her transition. Questions that need answers include the dentist’s financial ability to retire and his or her personal transition goals.

For example, how long does the dentist wish to stay on as an associate and/or remain available to aid in the transition process? What is
When It's Time to Buy, Sell, or Merge Your Practice
You Need A Partner On Your Side

ALABAMA
Birmingham: 4 Ops, 2 Hygiene Labs, GR $675K $10108
Birmingham Suburb: 3 Ops, 3 Hygiene Rooms $10106
Florence: Beautiful Modern Office, room to expand, GR $650K
$10110
CONTACT: Dr. Jim Gale @ 404-513-1573

ARIZONA
Arizona: Doctor seeking to purchase general dental practice.
$12110
Show Low: 2 Ops, 2 Hygiene Rns, GR in 2007 $615,993
Phoenix: Dr Dentro seeking Practice Purchase Opportunity
$12108
Phoenix: 4 Ops - 3 Equipped, GR $151K, 5 Working Days
$12113
North Scottsdale: General Dentist Seeking Practice Purchase Opportunity
$12105
Urban Tucson: 6 Ops - 4 Equipped, 1 Hygiene, GR $800K
$12112
Tucson: 1,800 active patients, GR $800K, Asking $600K
$12116
CONTACT: Tom Kintzel @ 602-516-3219

CALIFORNIA
Alturas: 3 Ops, GR $611K, 3/2 day work week $12479
Atwater: 2 Ops, 1,080 sq ft, GR $177K $14107
El Sobrenante: 5 Ops - 5 Equipped, 1,500 sq ft, GR $350K
$14102
Fresno: 5 Ops, 1,500 sq ft, GR $114,550/300 $14250
Greater Sacramento Area: 3 Ops, 1,800 sq ft, GR $143K
$14504
Madera: 7 Ops, GR $112K, 467 $12493
Modesto: 12 Ops, GR $1,197,000, Same loc for 10 years $1,4289
Modesto: 5 Ops, GR $114K, w/ad, net income of $46K $11408
N California Wine Country: 4 Ops, 1,500 sq ft, GR $590K
$14292
Pine Grove: Nice 5 Ops fully equipped office/practice $111,500
$11459
Porterville: 6 Ops, 2,000 sq ft, GR $2,534 $12491
Red Bluff: 8 ops, 2008 GR $1M Hygiene 10 days a wk.
$12472
CONTACT: Dr. Dennis Hoover @ 805-513-1558
Dixon: 3 Ops, 1,080 sq ft, GR $122K $14265
Grass Valley: 3 Ops, 1,500 sq ft, GR $714K $14272
Redding: 5 Ops, 2,000 sq ft, GR $13425
Yuba City: 5 Ops, 4 d/h, 1,800 sq ft, GR $14273
CONTACT: Dr. Thomas Wagner @ 516-812-5255
Roncho Margarita: 4 Ops, 1,200 sq ft, Take over lease
$14301
CONTACT: Thinn Than @ 903-533-8508

CONNECTICUT
Fairfield Area: General practice doing $800K $10106
Southbury: 2 Ops, GR $215K $16111
Wallingford: 2 Ops, GR $600K $15113
CONTACT: Dr. Peter Goldberg @ 617-640-2980

FLORIDA
Miami: 5 Ops, Full Lab, GR $875K $18117
Jacksonville: GR $1.3M 3000 sq ft, 7 ops, 8 days hygiene
$18118
CONTACT: Dennis Wright @ 905-730-8883

GEORGIA
Atlantic Suburb: 3 Ops, 2 Hygiene Rns, GR $695K $19125
Atlantic Suburb: 2 Ops, 2 Hygiene Rns, GR $115K $19128
Atlantic Suburb: 3 Ops, 1,720 sq ft, GR $436K $13931
Atlantic Suburb: Pediatric Office, 1 Op, GR $425K $19131
Atlantic Suburb: Pediatric Office, 3 Op, GR $600K $19141
Dublin: GR $180K, Asking $825K $19107
Macon: 3 Ops, 1,675 sq ft, State of the art equipment
$19103
North Atlanta: 5 Ops, 5 Hygiene, GR $670K $19132
Northeast Atlanta: 4 Ops, GR $600K $19129
Northern Georgia: 6 Ops, 1 Hygiene, Ext for 43 years
$19110
South Georgia: 2 Ops, 3 Hygiene Rns, GR $721K $19115
CONTACT: Dr. Jim Gale @ 404-513-1573

ILLINOIS
Chicago: 1 Ops, GR $700K, Sale Price $461K $22126
1 FIr SW of Chicago: 3 Ops, 2007 GR $440K, 28 yrs old
$22125
Chicago: 3 Ops, GR $800K, 5 day work week $22119
Galena: GR $100K, leased in Historic Bed & Breakfast
$22119
Community: 23129
Western Suburbs: 5 Ops, 2,300 sq ft, GR Approx $1.5M
$22120
CONTACT: Al Howie @ 630-781-2717

MARYLAND
Southern: 3 Ops, 3,500 sq ft, GR $1.8M $24201
CONTACT: Sharon Messeri @ 410-788-4041

MASSACHUSETTS
Boston: 2 Ops, GR $212K, Sale $197K $30522
Boston Southshore: 3 Ops, GR $300K $30523
North Shore Area (Essex County): 3 Ops, GR $300K $30523
Western Massachusetts: 5 Ops, GR $1M, Sale $1.4K $30516
CONTACT: Dr. Peter Goldberg @ 617-680-2590

MICHIGAN
Suburban Detroit: 2 Ops, 1 Hygiene, GR $315K $31105
CONTACT: Dr. Jim David @ 313-550-0880

MINNESOTA
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MISSISSIPPI
Eastern Mississippi - 10 Ops, 4,685 sq ft, GR $1.9M
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NEVADA
Nevada: Free Standing Bldg, 1,500 Sq Ft, 4 Ops, GR $765K
$37106
CONTACT: Dr. Dennis Hoover @ 805-519-3458

NEW JERSEY
Marlboro: Associate positions available $3102
Mercer City: 3 Ops, Good Location, Turn-Key, GR $150K
$45112
CONTACT: Sharon Messeri @ 908-788-4071

NEW YORK
Brooklyn: 3 Ops (1 Fully equipped), GR $175K $41115
Woodstock: 2 Ops, Building also available for sale, GR $600K
$41112
CONTACT: Dr. Dan Cohen @ 645-660-3034
Syracuse: 4 Ops, 1,800 sq ft, GR over $700K $61107
CONTACT: Harry Hart @ 315-265-1315
New York City - Specialty Practice, 3 Ops, GR $500K $41115
CONTACT: Michael Zafiroff @ 631-851-9324

OHIO
Medina: Associate to buy 1/3, rest of practice in future.
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North Central GR $450K, 4 Ops, Well Established
$41100
CONTACT: Dr. Dan Moorehead @ 440-825-8037

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Northeastern Pennsylvania: 3 Ops, Victorian Mansion GR $1.2M
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scrolling through the foot pedal.

**Extraoral cameras**

While intraoral cameras have many benefits, there have always been some roadblocks for dentists who wished to use them in the office. As I stated earlier, there is a learning curve associated with their use; most have an upside-down image and so using them is similar to using a mirror in the mouth.

What most dentists wanted was a way to use cameras that they are already familiar with, which is the extraoral camera. The problem, for a long time, was the unavailability of digital cameras.

While there are many ways to get traditional photos into a digital format (more on that in part two of this article), it is still much more desirable and easy to have digital images from the start.

When the first digital cameras for consumer use were introduced, there were very expensive and, although they were suitable for the home, they did not meet the criteria for producing diagnostic dental photographs.

The first units that came out were 1.3 megapixel cameras. Since then, we have seen 2.1 megapixel units, 3.5 megapixel units and, lately, 12 and 15 megapixel cameras.

Because the issue of pixels is often misleading and confusing, here is a short primer on pixels.

**Pixels primer**

It helps to remember that pixel count doesn’t determine how good the image is — only how large a good print you can make! Image quality is determined more by lens quality, the imaging chip and its control circuitry, etc., not to mention the ability of the photographer to control those factors.

To put the “how big” issue in some kind of perspective: the rule of thumb I use is that with a continuous-tone print device such as a dye-sub or good quality ink-jet printer, you need to provide 300 pixels per inch in the print to provide “high quality” photographic results — ones that will stand up to close scrutiny and still look photographic.

If you can settle for “snapshot” photo quality, i.e., images that will be examined casually at normal reading distance or better, then you can get by with 200 pixels per inch in the print, and for “display” quality — meaning prints that will be viewed from several feet away — you would be OK with 100 pixels per inch or even less.

(Keep in mind that these quality levels are strictly my own personal preferences. Some people might be perfectly happy with 50-pixel-per-inch images.)

Anyway, if you’ve got a 2-megapixel camera (typically about 1,290 by 1,600 pixels in the image) the biggest print you can make and retain what I think of as “high quality” is 4 by 6 inches.

A 5-megapixel camera (let’s assume it’ll be 1,500 by 2,000 image pixels) will let you make a print of 5 by 7 inches at the same “high quality” level. That’s a difference of about an inch each way.

If your usual need is for “snapshot” quality, you can bump up these figures by 50 percent, but either way, I think it makes it pretty clear that the 12- and 15-megapixel cameras won’t make a big difference, unless you plan to print 8-by-10 inch photos.

The image on the computer monitor will look the same whether you are using an 8-, 10- or 15-megapixel camera.

Or to put it another way: if you have a choice of a 10-megapixel camera that’s perfect for your needs and preferences, or a 1.5-megapixel camera that would force you to compromise on the features and controls you want, don’t buy the 15-megapixel model just because it has more pixels.

When you are evaluating digital camera systems, I would recommend that you work with a company that specializes in systems designed for the dental market. Two known companies are PhotoMed and Lester A. Dine.

Both produce systems that include all the hardware and software that a dentist would need to get started in digital photography, although they take different approaches and have subsequently different costs of their systems.

The PhotoMed systems are typically cameras with all components included, such as a macro lens, flash diffuser or ring flashes, memory cards and battery charger.

These systems normally start around $1,200 and can go as high as $5,000 depending on the camera type and attachments that you purchase.

In part two of this article, we’ll cover making the move from analog to digital.
the dentist’s preferred timetable? Are there any preliminary steps required to enhance the value of the practice? Which method of transition has the greatest chance of successful completion?

Make a plan outline
The answers to these questions should result in a brief written outline of the plan. The topics should include:

1. goals,
2. a timetable,
3. appraised value,
4. anticipated post-tax and sale’s expense net sale proceeds,
5. planned transition options and
6. a list of consultants to be involved.

The plan should also contain an action plan for completion of any activities that will enhance the value of the practice or increase the chances the practice will be selected by prospective new dentists. Understanding that an inactive practice loses five percent of its value per week, an important part of the plan should also include a list of people to be called in the event of an un-anticipated career-ending disability or death.

A letter of instructions to family members should be included that lists those contacts and stresses the urgency to act expeditiously in transitioning the practice. A part of the plan needs to include sharing this letter and plan with significant family members.

Many dentists, especially if incorporated, will execute a power of attorney authorizing a specific individual to immediately begin transition proceedings if required due to a dentist’s death.

When and how to start
If an appraisal has not been completed or updated within the past two years, this is the first step. Developing an exit strategy plan, even if it is years away, should also begin as soon as the appraisal is completed.

A stockbroker will advise that one should set a target sale price the day one acquires a stock. Similarly, the exit strategy is part of the potential financial reward of practicing.

Good business sense dictates the plan should really have been started when the practice was first acquired.

Part of a transition plan started early in one’s career will allow for inclusion of a well-funded pension plan and less reliance upon practice sale proceeds for retirement needs.

The timetable for the actual implementation of the plan will be dependent upon the personal wishes, needs and financial resources of the dentist. Metro areas are seeing a common market time of one to two years from listing to sale. Rural area practices face three to five years if they can be transitioned at all.

The length of time required for location of a prospect and transitioning of the practice requires that the practice opportunity be listed at the earliest time that the dentist is willing to complete the transition. If the seller is fortunate enough to immediately locate a buyer after listing, the dentist needs to be ready to act.

At the time of listing, the dentist must also realize that he/she may continue to own the practice for a long time.

An alternative
For dentists considering retirement, many have a difficult time starting the process because of the emotional attachment to their practice.

These dentists, unless or until they find something else they would rather do than practice dentistry, will be unable to activate their transition plan. If the practice of dentistry is their only interest, their hobby and the center of their later life, there is no law stating that they must transition their practice.

For these dentists, their transition plan is to practice until they can no longer do so. Their plan may be as simple as one day closing the doors and retiring.

About the author
Dr. Eugene W. Heller is a 1976 graduate of the Marquette University School of Dentistry. He has been involved in transition consulting since 1985 and left private practice in 1990 to pursue practice management and practice transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental schools. Heller is the national director of transition services for Henry Schein Professional Practice Transitions. For additional information, please call (800) 730-8853 or send an e-mail to ppt@henryschein.com.
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By Fay Goldstep, DDS, FAACD, FADFE

While dental lasers have been commercially available for several decades, and their popularity among patients is unparalleled, the dental profession has taken to this treatment modality rather slowly.

Lasers have been thoroughly documented in the dental literature. They are an exciting technology, widely used in medicine, kind to tissues and excellent for healing. So why have they not been more widely embraced by the practicing dentist?

There is a general perception in the profession that somehow the dental laser is not useful, is too complicated and too expensive. These parameters have changed forever with the arrival of the diode laser onto the dental scene.

There is now a convergence of documented scientific evidence, ease of use and greater affordability that makes the diode laser a “must have” for every dental practice.

The science behind the laser
“Laser” is an acronym for light amplification by stimulated emission of radiation. Lasers are commonly named for the substance that is stimulated to produce the coherent light beam.

In the diode laser, this substance is a semiconductor (a class of materials that are the foundation of modern electronics, including computers, telephones and radios).

This innovative technology has produced a laser that is compact and far lower in cost than earlier versions. Much of the research has focused on the 810 nm diode laser.

This wavelength is ideally suited for soft-tissue procedures because it is highly absorbed by hemoglobin and melanin. This gives the diode laser the ability to precisely cut, coagulate, ablate or vaporize the target soft tissue.1

Treatment with the 810 nm diode laser (Fig. 1a, Picasso diode laser, AMD LASERS) has been shown to have a significant long-term bacterial effect in periodontal pockets.2,3

Lasers have a significant long-term bactericidal effect in periodontal pockets.3

Ease of use
Early-adopter dentists thrive on new technologies. They enjoy the challenges that come with being the first to use a product. Most dentists, however, are not early adopters.

Over the past two decades, lasers have intimidated mainstream dentists with their large footprint, lack of portability, their high maintenance profile, confusion about operating tips and complex procedural settings.

Common questions include: When do I use which tip? What setting works for which procedure? Why do I need a laser when I have been managing well without one?

Enter the diode laser. It is compact. It can easily be moved from one treatment room to another. It is self-contained and does not have to be hooked up to water or air lines. It has one simple fiber-optic cable that can be utilized as a reusable one treatment room to another. It is self-contained and does not have to be hooked up to water or air lines. It has one simple fiber-optic cable that can be utilized as a reusable
form some simple procedures. I have since taken online training, as well as lecture courses, which have enhanced both my comfort level and my competency. **Affordability**

Laser technology has traditionally come with a high price tag. Manufacturing costs are high and cutting-edge technology commands steep pricing. Diode lasers are less expensive to produce.

Breakthrough pricing for this technology has now arrived at under $5,000. At this level, the diode laser becomes eminently affordable for the average practicing dentist.

**Why do I need this technology?**

The 810 nm diode laser is specifically a soft-tissue laser. This wavelength is ideally suited for soft-tissue procedures because hemoglobin and melanin, both prevalent in dental soft tissues, are excellent absorbers. This provides the diode laser with broad clinical utility: it cuts precisely, coagulates, ablates or vaporizes the target tissue with less trauma, improved postoperative healing and faster recovery times.8–10

Given the incredible ease of use and its versatility in treating soft tissue, the diode laser becomes the “soft-tissue handpiece” in the dentist’s armamentarium.

The dentist can use the diode laser’s soft-tissue handpiece to remove, refine and adjust soft tissues in the same way that the traditional dental handpiece is used on enamel and dentin. This extends the scope of practice of the general dentist to include many soft-tissue procedures.

The following procedures are easy entry points for the new laser user:

- **Gingivectomy, haemostasis, gingival troughing for impressions**

  The diode laser makes restorative dentistry a breeze (Picasso, AMD Lasers). Any gingival tissue that covers a tooth during preparation can be easily removed because hemostasis is simultaneously achieved.

  The restoration is no longer compromised due to poor gingival conditions. There is no more battling with unruly soft tissue and blood (Figs. 1–5). Excess gingival tissue can be readily managed (Figs. 5a, b) for improved restorative access to Class V preparation (ezlase, Biolase Technology).

  Gingival troughing prior to taking impression (Picasso, AMD LASERS) ensures an accurate impression (particularly at the all-important margins) and an improved restorative outcome. Packing cord is no longer necessary (Figs. 6, 7).

  Diode lasers make restorative dentistry less stressful, more predictable and more enjoyable for the dental team and the patient.

- **Operculectomy, excision and/or recontouring of gingival hyperplasia, frenectomy**

  These procedures are not commonly offered or performed by the general dentist. They are examples of the expanded range of services readily added to the general practice.

  The dentist becomes more proactive in dealing with hyperplastic tissues that can increase risk of caries and periodontal disease (Figs. 8–10, courtesy of Ivoclar Vivadent). A frenectomy is now a simple and straightforward procedure (ezlase) (Fig. 10a).

- **Laser-assisted periodontal treatment**

  The use of the diode laser in conjunction with routine scaling and root planing is more effective than scaling and root planing alone. It enhances the speed and extent of the patient’s gingival healing and postoperative comfort.4,5

  This is accomplished through laser bacterial reduction (Picasso, AMD LASERS), debridement and biostimulation (Figs. 11, 12, courtesy of Dr. Phil Hudson).

A. actinomycetemcomitans, which has been implicated in chronic periodontitis, may also be implicated in systemic disease. It has been found in athertesclerotic plaque,4 and there has been recent data suggesting that it may be related to coronary heart disease.10 The diode laser is effective in decreasing A. actinomycetemcomitans5 and thereby indirectly improving the patients’ heart health.

**Laser education**

Most diode laser manufacturers provide some education to get the new user started quickly and effectively.

The most comprehensive online diode laser introductory course with certification — which includes the science, safety and clinical procedures — can be found at the International Center for Laser Education, www.dentallaseredu.com (telephone, (877) 522-6885).

This course provides everything necessary to get started with soft-tissue diode laser therapy. Advanced courses are available for more complex procedures.

**In conclusion**

The soft-tissue diode laser has become a “must have” mainstream technology for every general practice. The science, ease of use and affordability make it simple to incorporate. The laser is now the essential “soft-tissue handpiece” for the practice.

In fact, there is a case for having a diode laser in each restorative and hygiene treatment room. As a result, restorative dentistry becomes easier, more predictable and less stressful.

Laser therapy expands the clinical scope of a practice to include...
new soft-tissue procedures that keep patients in the office.

The patient's gingival health is improved in a minimally invasive, gentler manner. Every time the dentist picks up the diode laser the question is: Where have you been all my life? A complete list of references is available from the author.
AFFINIS 360 putty

Côlțene / Whaledent announces the introduction of AFFINIS System 560 putty. This new polyvinylsloxane impression material combines the viscosity and positioning pressure of putty with the convenience of automatic mixing device delivery.

AFFINIS 560 putty delivers a tactile, kneadable consistency directly after automated mixing. The material is hand pliable and can be molded and performed without sticking to gloves.

By using the automatic mixing device, AFFINIS System 560 Putty is consistently and homogeneously mixed, which prevents problems associated with improper dosing or mixing techniques. Likewise, the system saves time by eliminating the hand mixing and kneading necessary with traditional jar putty material.

In addition, the larger 380 ml capacity hard cartridges reduce material waste and provide up to 10 percent more material than foil bag systems.

With exceptional dimensional stability, the material resists warping and shrinking as well as the development of improper, unaligned mixtures. The putty material is hand pliable and can be molded directly after automated mixing. The material is hand pliable and can be molded and performed without sticking to gloves.

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Isodry makes its debut

Isolite Systems, maker of innovative dental isolation technology, introduced Isodry® at the Chicago Midwinter Meeting. The new product was assessed while conducting market research on the company’s original award-winning Isolite dryfield illuminator dental isolation system.

The original Isolite provides five levels of intra-oral illumination, comfortably retracts the patient’s tongue and cheek, protects the throat and keeps the mouth gently propped open with continuous suctioning of the dental patient’s mouth.

With the tongue out of the way and a bright, dry field in which to work, dental procedures are completed an estimated 20–50 percent faster, with less stress for the dental professional and improved comfort for the dental patient. The new product, Isodry, is exactly like the Isolite, but without the internal oral lighting.

“After conducting market research, we found that there is a segment of dental practitioners who, after years of practicing dentistry, prefer to work only with external lighting,” said the Isodry, which has all of the same retraction, protection, mouth-propping and ongoing aspiration of the original Isolite, but without the advanced intra-oral illumination of our premier product,” explained Jim Hirsch, president and product designer.

With no computer circuitry or advanced lighting technology, the Isodry has a lower manufacturing cost and the resulting price may make the company’s dramatic dental isolation benefits even more affordable to some dental practices.

“We have found many dental practitioners wanting to have our isolation technology installed in every operatory of their practice, but they don’t necessarily need the intra-oral illumination feature in every room.”

“In addition, we have clinics and teaching facilities with capital budget constraints, and the lower price point of Isodry will help them bring state-of-the art isolation to more operatories, allowing them to serve more patients,” added Sandra Hirsch, general manager.

“As with the original Isolite, the Isodry utilizes the patented, all-in-one Isolflex mouthpiece. The unique shape and softness of the mouthpiece is key to the system’s advanced dental isolation. The latex-free mouthpiece comfortably allows fluids and debris to be aspirated from deep within the oral cavity. A built-in tongue, cheek and throat shields protect the patient from injury and provide an added measure of assurance that the airway is better protected from possible dental debris. Single-use Isolite mouthpieces are available in five sizes to fit the spectrum of patients from small child to large adult.

Isolite Systems advanced isolation technology has earned a loyal following and broad recognition in the industry for its premier product, the Isolite dryfield illuminator.

About Isolite Systems

Isolite Systems was founded in 2001 by Thomas R. Hirsch, DDS, his brother, James Hirsch, industrial designer, and Sandra Hirsch, CPA, to bring to market the Isolite dryfield illuminator and other products.

The company is committed to transcending the limitations of existing dental technology with innovative, ergonomically efficient products that help dental professionals work more productively with less stress and fatigue. For more information about Isolite Systems, please call (800) 560-6086 or visit www.isolitesystems.com.

Picasso Lite

In January, AMD LASERS announced the introduction of the Picasso Lite soft-tissue dental laser.

Priced at $2,495, offering 2.5 watts of power and three customizable presets, Picasso Lite is the most affordable and easy-to-operate dental laser in the world, according to AMD LASERS.

It was designed specifically to replace the traumatic use of scalpels and electro-surge in the treatment of soft tissue.

“With Picasso Lite, we accelerate a paradigm shift in dentistry that began with the introduction of the Picasso soft-tissue laser in 2009,” said Alan Miller, president/CEO of AMD LASERS.

“We have ‘One Vision, One Goal’ — equipping every opera­tory with a laser. Record numbers of dentists are purchasing Picasso, and I’m sure Picasso Lite’s more attractive price and ease of use will quickly make it the most pop­ular laser in the world. “

“Picasso Lite was designed specifically for first-time laser dentists and hygienists, and at one-fifth the cost of other lasers, it’s truly affordable. We’ve shipped Picassos to more than 50 countries, and the number of dentists and distributors interested in Picasso is truly amazing. I think the real winners are the patients.”

Picasso Lite cuts and coagulates tissue with reduced trauma, bleeding and necrosis of tissue and is used for soft-tissue surgery, including troughing, gingivectomies, frenectomies, exposing implants/teeth/ortho brackets and treating aphthous ulcers and her­petic lesions.

Featuring an ultra-compact, lightweight and sleek design, Picasso Lite comes with an easy-to-learn DVD that explains set-up; online laser certification; accessories; a world power adapter and a two-year warranty.

Another first for the laser industry is Picasso Lite’s ability to use convenient disposable tips or a low-cost strippable fiber.

“We are proud to offer Picassos and now Picasso Lites free of charge to universities and dental schools, globally illustrating our commitment to education and charity,” said Miller.

www.isolitesystems.com
Changing dentistry 4mm at a time.

Over 10,000 new users have made SureFil® SDR™ flow one of the fastest-growing products.

Since launching SureFil® SDR™ flow in September 2009, over 10,000 dentists have tried the first and only bulk fill flowable posterior composite. What’s even more impressive is that over 90% of them said they would continue to use it. SureFil® SDR™ flow has self-leveling handling that provides excellent cavity adaptation, and it can be bulk filled in 4mm increments, dramatically streamlining your posterior restoration. Contact your DENTSPLY Caulk rep or visit www.surefilSDRflow.com to learn more.
If there is sufficient bone available, the placement of implants is a relatively simple and straightforward surgical procedure of modern dentistry. However, if there is massive loss of bone due to periapical or periodontal pathosis, implants can only be placed with bone augmentation.

In some cases, it is the extraction procedure itself that causes the loss of mostly the buccal wall of the alveolar socket. This also makes it very difficult to place the implant. Careful removal of the tooth from the alveolar socket, however, will leave the bony walls intact.

Even without augmentation materials, there will be good wound healing resulting in good bone height and width at the level of the alveolar ridge.

Luxators are ideal instruments for such a careful tooth removal. The action of the Luxator is based on the possibility of bone expansion. The Luxator is introduced in a rotating fashion, parallel to the long axis, down the periodontal ligament.

Ashtel Dental and 7 Day Dental donate toothbrushes for Haitian relief efforts

In wake of the earthquake that devastated Haiti, Ashtel Dental of Fontana, Calif. and 7 Day Dental of Anaheim, Calif., donated a combined 20,000 children’s toothbrushes to the Giving Children Hope Foundation of Buena Park, Calif., for their relief efforts in Haiti.

The donation was given to the foundation after executives from Ashtel Dental and 7 Day Dental heard of the foundation’s plans to send them to the children in Haiti that had lost their homes and their families in the earthquake.

“We want to help however we can,” said Yousuf Nabi, vice president of marketing for Ashtel Dental. “Our prayers are with everyone in Haiti and we hope our small donation helps those in need during this tough time.”

Giving Children Hope (GCH) has already sent 47,000 pounds of medical supplies and disaster relief, as well as $1 million worth of life-saving pharmaceuticals to treat the survivors in Haiti.

GCH has also sent two relief teams to Haiti to administer and distribute aid, as well as assess current needs on the ground.

The foundation will “continue to accept monetary donations and new relief product for those in Haiti,” said Harmony Trevino, the foundation’s communications coordinator. “This is an ongoing relief effort where Giving Children Hope will continually send food, water, hygiene products and medical supplies.”

To learn more about GCHope’s Haiti relief work or to donate, please visit www.aidtohaiti.org.

Prophy Magic Handpieces

Buying disposable prophy is something you need to do, so why not get something in return? Prophy Magic is pleased to announce “incredible deals” where you get the highest quality prophy angles in bulk and free handpieces.

Get unmatched deals on your disposable prophy and keep something tangible every time you order.

Introducing the ideal hygiene handpiece for your RDH that won’t break the bank. The Prophy Magic Hygiene Handpiece is ultra lightweight, perfectly balanced and accepts all prophy angles. The price is: Free! (Yes, you read that correctly: Free!)

For more information about Luxator visit www.directadetal.com.

Dr. Michael Liebler received his DDS from the University of Iowa. You may write him at: Kaisersstrasse 36 90 403 Nürnberg Germany

Implantology starts at the time of extraction

By Michael Liebler, DDS

If there is sufficient bone available, the placement of implants is a relatively simple and straightforward surgical procedure of modern dentistry. However, if there is massive loss of bone due to periapical or periodontal pathosis, implants can only be placed with bone augmentation.

In some cases, it is the extraction procedure itself that causes the loss of mostly the buccal wall of the alveolar socket. This also makes it very difficult to place the implant.

Even without augmentation materials, there will be good wound healing resulting in good bone height and width at the level of the alveolar ridge.

Luxators are ideal instruments for such a careful tooth removal. The action of the Luxator is based on the possibility of bone expansion.

The Luxator is introduced in a rotating fashion, parallel to the long axis, down the periodontal ligament.

Fig. 1 Using the Luxator instrument.
Dental imaging and software distributors Owandy USA and Ashtel Dental showcased the revolutionary new intra-oral induction sensor, Visteo at the 2010 Chicago Midwinter Meeting.

Visteo is the first digital X-ray sensor to use magnetic induction (patented exclusively by Owandy) combined with integrated positioning and versatile 560-degree angulator rotation. Its liberating design makes it a groundbreaking advancement in the world of dental imaging, allowing practitioners more mobility and ease in working with patients.

“The Owandy Visteo is an ‘Innovation Prize’ winner, an intra-oral sensor that features magnetic induction that makes it very easy to use because the cable isn’t fixed, and the sensor can be attached and detached with a snap,” said Anish Patel, CEO of Owandy USA. “The sensor also rotates and is more comfortable for patients.”

Visteo’s unique design revolutionizes the practitioner and patient experience with more comfortable sensors, which are smaller, thinner and designed with rounded edges for patient comfort. The sensor’s full rotation function makes it more convenient and faster to reposition in the patient’s mouth.

Beyond ease and comfort features, Visteo provides true resolution greater than 20 pl/mm, making it one of the highest real resolution sensors on the market. Technical specifications can be found at www.owandy.net/uk/Products/Sensors/Visteo/spec-tech.php.

Visteo features seven pre-defined sensor positions or an infinite number of positions using its free angulation option. It also features parallel positioning or the option to position it with the bisecting technique.

“Visteo has already received the ‘Professional Innovation Prize’ at the AD Dental Fair in Paris,” said Patel. Distributors will also be featuring Owandy’s I-MAX Touch pan + ceph + tomo digital panoramic imaging handsets at dental meetings across the country.

For more information or to purchase Visteo or other Owandy products, contact Ashtel Dental, www.ashtel dental.com.

Fight oral cancer!

Did you know that dentists are one of the most trusted professionals to give advice? Thus, no other medical professionals are in a better position to show patients that they are committed to detecting and treating oral cancer.

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerselfexam.com. This new Web site was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?

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Pearson
How can hygienists ‘straighten up’?
Offering patients information about orthodontic treatment will help the practice

By Keverly Sugden, RDH, BASDH

Hygienists are the health drivers for the dental practice. We are very fortunate to be able to create lasting relationships with our patients.

We see our patients many times per year. At each visit, we perform comprehensive oral cancer examinations, thorough periodontal examinations and caries screenings.

We listen to our patients’ questions, educate and motivate. We recommend and explain treatment and listen to our patients’ wants and desires. Many patients want straight, white teeth, but they do not discuss this with the dentist.

The hygienist can open up a dialogue with the patient about desired treatment by asking a few simple questions. When you ask the patient, “Would you like straighter teeth?” it can lead to much information about the patient and his or her dental desires.

Hygienists understand proper occlusion and can identify malocclusion and create space for erupting teeth and crowded and result in bite problems. Early treatment can preserve or create space for erupting teeth and correct harmful oral habits.

Hygienists need to understand orthodontic appliances and technologies so they can effectively explain treatment and the benefit of orthodontic treatment to their patients. Many orthodontists offer seminars to hygienists and this is a great way to learn about new techniques in orthodontics.

Many general dentists are offering Invisalign® to their patients, and this is another awesome opportunity for hygienists to learn about orthodontics. Dentists and orthodontists have to be certified to perform Invisalign treatment. More than 70 percent of U. S. orthodontists offer Invisalign.

Invisalign treatment involves clear, customized aligners that can straighten teeth with fewer visits than traditional orthodontics. The aligners are unnoticeable, comfortable, removable and effective.

One thing patients always ask about is time and price. Traditional orthodontics can take 15 and 50 months and Invisalign takes 9 to 15 months.

There are many types of systems available for traditional orthodontics. Orthodontic patients can now customize their look with multicolored bands,

New CD-ROM educates patients about oral hygiene

The National Museum of Dentistry has partnered with United Concordia to distribute the MouthPower oral health education CD-ROM

Everyone could use a reminder now and then about the importance of good oral hygiene.

To that end, the National Museum of Dentistry, located in Baltimore, has partnered with United Concordia Dental to produce a CD-ROM version of the museum’s popular MouthPower oral health education program.

The CD-ROM, which is modeled on the museum’s MouthPower online program, is designed to assist dentists and hygienists in educating their patients about the benefits of good oral health.

It will be distributed to 45,000 United Concordia participating dentists nationwide, as well as to those who request the program through the museum.

“The secret to a healthy smile is simple – taking good care of your teeth,” said National Museum of Dentistry Executive Director Jonathan Landers, in a press release announcing the CD-ROM. “The MouthPower program shows kids how to do that in a fun and educational way.”

The program features the “chatter-teeth” character, Mouthie, in an interactive laboratory, where children can learn how to brush and floss, make smart food choices and steer clear of the pitfalls of tobacco.

The CD-ROM includes easy-to-use, bilingual lessons and fun activity sheets that will help children learn good oral health habits.

“We are excited to partner with the National Museum of Dentistry to share this outstanding oral health education program with our participating dentists,” said Karen A. Whitesell, United Concordia Dental corporate vice president of professional relations.

“Our hope is that this exciting tool will help dentists teach their young patients lifelong habits that maintain healthy smiles.”

The National Museum of Dentistry’s MouthPower oral health education program teaches children about good oral health around the world through its online game (available in English and Spanish at www.mouth-power.org), across the country in a popular traveling exhibit and on site at the museum in Baltimore in a hands-on exhibit.

The program is also being adapted to be used with Head Start programs in Baltimore and as a mentoring program for Girl Scouts.

United Concordia Dental
Headquartered in Harrisburg, Pa., United Concordia Dental is one of the nation’s largest dental insurers, with nearly 8 million members worldwide and 2008 revenues of $1.4 billion.

The National Museum of Dentistry
The Dr. Samuel D. Harris National Museum of Dentistry, an affiliate of the Smithsonian Institution, is a lively national center where visitors discover the power of a healthy smile and the rich history of dentistry.

Designated by Congress as the official museum of the dental profession in the United States, the museum’s collection of 40,000 objects tells the story of dentistry through changing and traveling exhibits, school tours and family days.

Highlights include George Washington’s lower denture, Queen Victoria’s personal dental instruments and an extraordinary collection of toothbrushes ranging from the 1800s to the present. Call (410) 706-0600 or visit www.smile-experience.org for more information.

Page 3B
Dear Reader,

During a recent seminar, there was a pointed discussion about “I can” vs. “I will.” As I sat there listening to the lecturer, I began to think about these two statements in a way I hadn’t before.

I scribbled the two phrases on my note pad hoping to reflect on them after I returned home. About a month after that meeting I was still thinking about “I can” vs. “I will” when a situation arose to help me crystallize it for myself.

One day, a fellow hygienist asked if I could help her find someone to fill in at her office for two days during a planned absence. I of course said, “Yes, I can.” To both of us this actually meant, “Yes, I will.”

In actuality, I was successful locating a fill-in for one day, but not the other. When I realized I might not find someone to fill in the second day I began contemplating covering the day myself.

“I can work that day,” I thought, but I didn’t make the statement, “I will work that day,” until I had exhausted all other possibilities.

My point here is that saying “I can” didn’t mean I wanted to. Not until I had no other choice did my thought become “I will.” However, once my train of thought switched to I will, real action took place.

As a result of this, I have realized that our professional world is made up of those who choose either an “I can” or “I will” mentality.

When you treat patients, do you think about what you can do and then opt not to because you don’t want to? Do you live in an “I can” world until there are no other options and only then switch to “I will”?

Hygienists with an “I can” mentality are not treating patients optimally. Although living in an “I can” world is easy, it is an “I will” world where the rubber meets the road and patients are truly taken care of to the best of our abilities.

Here is another thought: Maybe there needs to be a third statement added to this lecturer’s discussion: 1) “I can.” 2) “I will.” 3) “I must.”

We owe to our patient’s to decide if the answer we choose is in the best interest of our patients’ oral hygiene.

Best Regards,

Angie Stone, RDH, BS

ADHA set to launch Survey/Research Center

The American Dental Hygienists’ Association, the largest national organization representing the professional interests of more than 150,000 dental hygienists across the country, recently announced that in concert with its Strategic Plan commitment to operational excellence through the use of data- and knowledge-based decision making, that a new ADHA Survey/Research Center will be launched.

The goal for the ADHA Survey/Research Center is to become the professional association resource for information on the dental hygiene profession and to support data/information needs for ADHA on the national, state and local level.

“Advancing the dental hygiene profession and building our association require solid data to facilitate the decision-making process,” said ADHA President Lynn Ramer, LDH.

“Increasingly, top performing professional associations consistently use data for decision making. The ADHA Survey/Research Center will formalize the data gathering process for our profession and allow us to make solid, data based decisions.”

McKenzie Smith, MPH, EdD, will be responsible for directing the ADHA Survey/Research Center and will oversee association research initiatives in his capacity with the center.

“This is an exciting development for the ADHA. The establishment of the ADHA Survey/Research Center is the first step toward building our dental hygiene research capabilities and working with a broad array of users including corporate partners, government agencies and national and state groups who need the latest data on the profession of dental hygiene,” said ADHA Executive Director Ann Battrell, RDH, MSDH.

For more information on the activities of the ADHA Survey/Research Center, contact McKenzie Smith at surveycenter@adha.net or visit www.adha.org.

Best Regards,

Angie Stone, RDH, BS
clear bands or the traditional metal brackets. Teens and children like the idea of having a choice and creating their own personal style. Brackets come in gold, ceramic and stainless steel.

There are various types of appliances that are also used with traditional orthodontics. Head gear is used on patients with an overbite. The headgear gently restricts forward growth of the maxillary teeth. The Herbst Appliance is used on younger, growing patients and reduces the overbite by encouraging the lower jaw forward and the maxillary molars backward.

The palatal expander puts gentle pressure on the maxillary molars and expands the palate. Positioners are clear, plastic appliances that complete traditional orthodontics and are an interim treatment between braces and a retainer. Retainers can be fixed or removable and hold the teeth in position when orthodontics has been completed. Separators are small rubber bands that are placed before brackets to space the teeth and ready them for brackets.

Hygiene after ortho treatment

Hygienists continue their role with the orthodontic patient by providing home care instruction and products for preventative care. Orthodontic patients are at a very high risk for demineralization, the dreaded white spots.

White-spot lesions are the earliest microscopic evidence of enamel caries. Once saliva pH reaches 5.5 or lower, acid begins to dissolve the enamel. Teens are one of the main age groups in braces and one of the main groups to use sports drinks and sodas. These beverages have a pH almost as low as battery acid: their pH is about 2.5 and battery acid is 1.0.

There are many types of remineralization products. MI Paste or MI Paste Plus, available through GC America, combines amorphous calcium phosphate (ACP) and casein phosphopeptide-amorphous calcium phosphate CPP-ACP, also known as Recaldent.

Tricalcium phosphate, TCP, is available in Clinpro 5000. Calcium sodium phospho-silicate is also available in many professional and over-the-counter products. Fluoride and remineralization products should be used in combination in orthodontic patients to prevent white spot lesions.

Xylitol is another necessity for orthodontic patients. Xylitol reduces the bacteria that cause caries. Xlear manufactures the Spry Dental Defense System® that contains an oral rinse, toothpaste, oral mist, mints and gum.

A final word

Orthodontic patients face challenges in home care and maintaining gingival health. Electric toothbrushes, such as Sonicare by Phillips and Oral-B by Braun, are excellent products that make for easier and more effective homecare for the orthodontic patient. Water-pik by Teledyne and the in-shower H2O irrigator are both very useful home care tools as well.

Adults, teens, children and parents need to understand periodontal disease and the destructive effect of periodontal bacteria. OralDNA manufactures a saliva test, MyPerioPath, that determines the patient’s periodontal bacteria. The dentist and hygienist can then recommend antibiotic therapy to reduce these bacteria.

Remember, orthodontic patients have invested heavily in their mouths and they want a pretty smile after treatment. We owe it to our patients to explain, educate and motivate about technologies, treatments and products that will make their orthodontic treatment a success.

Of course, it goes without saying that hygienists need to do a thorough periodontal examination on all patients. Technologies like the DentalR.A.T. 2.0., developed by hygienist Becky Logue, make periodontal charting easier by incorporating a foot pedal that can be used while doing computerized periodontal charting. (You can get more information at www.dentalrat.com.) Also, American Eagle Instruments (www.am-eagle.com) offers lightweight, ergonomic instrument handles with XP technology tips that stay sharp.

About the author

Keverly Sugden RDH, BASDH, is an author, speaker and practicing dental hygienist. She is also an adjunct faculty member at State College of Florida. Sugden is a member of the American Dental Hygiene Association, a vice president for her local component and works with local legislators on access to care for children.

She has written a training program for large group dental practices and has organized corporately sponsored continuing education courses for dental hygienists. Sugden can be contacted at keverly.sugden@yahoo.com.
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