GlaxoSmithKline taking zinc out of its denture products

By Fred Michmershuizen, Online Editor

GlaxoSmithKline (GSK), manufacturer of several versions of denture adhesive sold under the Super Poligrip brand name, recently announced it will introduce zinc-free versions of the products.

“While zinc is an essential part of the diet, recent publications suggest that an excessive intake of zinc-containing denture adhesives over several years may lead to the development of neurological symptoms and blood problems such as anemia,” a consumer advisory from the company reads.

“Neurological symptoms may include numbness, tingling or weakness in the arms and legs and difficulties with walking and balance.”

The company insists the products are safe when used as directed, but said that it is removing zinc as a precautionary measure for consumers who might use too much.

“Super Poligrip is safe to use as directed in the product label,” the statement reads. “The majority of consumers follow these directions. However, some consumers apply more adhesive than directed and use it more than once per day. Therefore, as a precautionary measure to minimize any potential risks to these consumers, GSK has voluntarily stopped the manufacture, distribution and advertising of these products.”

The new products will be clearly labeled on their packaging as zinc-free. GSK reported that it has discussed this situation with the FDA and that no further action is required.

Chile meeting a go despite earthquake

By Javier de Pison, Editor in Chief Dental Tribune Latin America

The director of Salon Dental Chile, the main dental expo in Chile, told Dental Tribune Latin America over the phone that the capital, Santiago, was only slightly affected by the recent powerful earthquake and that there was a tense calm in the nation, caught by surprise in the middle of the summer vacation.

Salon director Miguel Wechsler said that Chile’s “strict building Chile meeting a go despite earthquake
Record level of support for 20th annual OHA Gala

Oral Health America (OHA), a non-profit organization founded in 1955 and headquartered in Chicago, held its 20th annual gala and benefit on Feb. 24 at Chicago’s historic Union Station. Nearly 900 guests participated in silent and live auctions to benefit OHA while networking with fellow professionals before the Chicago Midwinter Dental Meeting.

The event raised more than $400,000 — the highest amount in the gala’s 20-year history — for OHA’s programs that bring healthy mouths to life.

Proceeds from the auctions support Smiles Across America® (SAA), an OHA program that assists oral disease prevention services in schools for children who are unable to obtain routine dental care due to lack of resources, low literacy or language barriers. The program was launched in Chicago in 1994 with the Chicago Department of Public Health, Chicago Public Schools and community partners, and now reaches 90 treatment partners in 27 states. Through 2009, SAA has provided $1.5 million in funding and supporting services to an estimated 250,000 children annually.

“Our gala shined a special spotlight on our work with children in school-based and school-linked settings across the country, and gave attendees the opportunity to support a national program that is at work with at-risk children and families in schools, clinics and neighborhoods in their own communities,” said Beth Truett, president and CEO of Oral Health America. “Our gala shined a special spotlight on our work with children in school-based and school-linked settings across the country, and gave attendees the opportunity to support a national program that is at work with at-risk children and families in schools, clinics and neighborhoods in their own communities.”

The gala was sponsored by DentalQuest, Patterson Dental, Ivoclar Vivadent, Midmark, I-800 DENT-TIST, Coltage-Palmoult, Henry Schein Dental, Chicago Dental Society, Belmont Publications, SciCan, National Dentex, Philips Sonicare, Unicode, Mr. and Mrs. Bernard J. Beazley, Burkhart Dental Supply, ConFirm Monitoring Systems, Argen Corporation, Tokuyama Dental, DENTSPLY International, GC America, DentalEZ Group and OralDNA.

Dentalcompare donated the production of a video, shown for the first time at the gala, that highlights the impact of OHA’s SAA programs. The video makes the case for oral health’s importance to overall health, and OHA’s support of community-based efforts to ensure that children get a healthy start through having a healthy mouth. The video can be accessed at www.dentalcompare.com/video_view.asp?videoid=528.

OHA’s mission is to change lives by connecting communities with resources to increase access to oral health care, education and advocacy for all Americans, especially those most vulnerable. For more information about Smiles Across America® or any of OHA’s programs, visit www.oralhealthamerica.org.

Most vulnerable. For more information about Smiles Across America® or any of OHA’s programs, visit www.oralhealthamerica.org.
Top tips to prevent tooth grinding

By Keri Kramer, Chicago Dental Society

How are Americans dealing with these difficult economic times? If you ask dentists, they’re taking the stress out on their teeth. In the fall of 2009, the Chicago Dental Society surveyed more than 250 of its members to see if stressing about the economy was wreaking havoc on patients’ oral health.

Nearly 75 percent of dentists surveyed said their patients reported increased stress in their lives. And 65 percent of dentists said they have seen an increase in jaw clenching and teeth grinding among their patients.

Jaw clenching and teeth grinding, or bruxism, can be a temporary nuisance during stressful times that causes headaches and sleep problems, but it can also cause lasting problems for your teeth and gums. It can lead to muscle inflammation, broken teeth or even damaged dental work, such as crowns and fillings.

Dentists are sharing the following tips with their patients to help them cope with the pressures of the world — before their teeth pay the price:

- Take a pain reliever. If grinding and clenching is causing you headaches and muscle soreness in your jaw, take an anti-inflammatory medication, such as Advil or Aleve, shortly before bedtime.
- Massage. Try massaging the muscles along your jaw line, from the joint near your ear all the way to your chin to relieve jaw soreness.
- Avoid caffeine. Coffee may help you get going in the morning, but caffeine combined with stress can lead to increased muscle tension. Increase your consumption of water. If cutting caffeine completely from your life won’t work for you, at least avoid it within several hours of bedtime.
- Be careful with your diet. When the jaw muscles get inflamed, it’s best to go easy on them for a while by avoiding foods that require vigorous chewing. Ice and gum chewing are a definite no-no. And don’t even think about that triple-decker cheeseburger that almost requires you to unhinge your jaw to eat it.
- Exercise. You didn’t want to hear this one did you? But exercise relieves stress and reduces anxiety, the two biggest culprits of grinding.
- Meditate. Try a yoga class to achieve some relaxation. Even taking a moment before bedtime to do some deep breathing can be a big help.
- Wear a mouth guard. If you have serious grinding and clenching issues, talk to your dentist about a mouth guard to wear at night.

The Chicago Dental Society recently held its 145th annual midwinter meeting, which brought more than 30,000 dental professionals to Chicago in February. The meeting is a forum for dentists to learn about new products, technologies and methods.
The Institute of Medicine Committee on Oral Health Access to Services was taken to task recently by the American Dental Association for its decision to exclude private practice dentists from two panels it is convening at the behest of the U.S. Department of Health and Human Services. The panels are tasked with studying oral health care delivery and access.

ADA President Dr. Ronald Tankersley testified before the Institute of Medicine (IOM) on March 4. He pointed out that private practice dentists represent nearly 92 percent of all professionally active dentists, and he said their input is crucial to addressing the oral health care access issue. “I am obligated, on behalf of our members, to protest the IOM’s continuing failure to include representatives of the private practice dental community on either of its two oral health panels,” Tankersley said. “We respect the experience and knowledge of the committee members, but I believe our input is critical to addressing the oral health care access issue.”

Tankersley went on to outline the ADA’s efforts to address ways to improve access for underserved populations. “The ADA believes that oral health depends on preventing oral disease,” he said. “The nation will never drill and fill its way out of this problem. Our efforts to improve access to care have taught us that there are many contributing factors and barriers to the problem. Some are economic and others environmental. Some are direct and others indirect. Some are related to the individual and others to the provider. The ADA has been on the vanguard of advocating access solutions.”

Tankersley cited the following ADA initiatives as examples:

• Designing and implementing a pilot program for its prevention-focused Community Dental Health Coordinator, a community health worker with dental skills now active in Philadelphia, rural Oklahoma and Indian tribal areas.

• Convening an Access to Dental Care Summit in 2009 for a broad range of 144 stakeholders to identify short- and long-term ways to improve oral health for underserved populations.

• Creating a Public Health Advisory Committee to provide a formal presence within the ADA to receive input on issues of public health significance.

• Convening the 2007 American Indian/Alaska Native summit to collaboratively address the unique needs of these populations.

• Implementing an initiative to address oral health needs of the vulnerable elderly, one outcome of which will be the introduction of federal legislation.

• Seeking to increase collaboration among private practice dentists and those working in federally qualified health centers and other dental safety net clinics, where about 69 percent of the dentists are members of the ADA.

• Lobbying for virtually every federal program that could effectively improve access for the dentally underserved.

“While the current dental delivery system serves most Americans well, we must work together to extend that system to the most vulnerable among us, who are at the greatest risk for developing oral disease,” Tankersley said.

He said the ADA believes that there are effective ways to help prevent oral disease:

• To rebuild the public health infrastructure and expand adequately funded safety-net programs, including Medicaid.

• To increase community-based prevention programs.

• To improve oral health literacy.

“Our current dental public health infrastructure is insufficient to address the needs of the underserved, and the gap between needs and the ability to address those needs is growing,” Tankersley said.

Best smiles at Oscars?

We’ve all heard of the best and worst dressed lists that fashionistas compile after the annual Academy Awards ceremony. Now, there’s a list of the celebrities who shed some of the best (and worst) smiles on the red carpet.

Dr. Catrise Austin, owner of VIP Smiles and author of “5 Steps to the Hollywood A-List Smile: How the Stars Get That Perfect Smile and How You Can Too,” surveyed the hottest smiles and author of “5 Steps to the Hollywood A-List Smile: How the Stars Get That Perfect Smile and How You Can Too,” surveyed the hottest smiles. The award for “A Smile Not Worth a Million Dollars” went to Morgan Freeman, whose teeth looked like they “desperately needed a boost of teeth whitening to brighten his dull yellow smile,” received the award for “A Smile Not Worth a Million Dollars.”

Teeth whitening is the No. 1 requested cosmetic procedure in cosmetic dentistry practices across the nation, said Austin, who also recommended either porcelain veneers or clear removable braces such as Invisalign or Clear Correct to make Freeman’s teeth straighter.

Another celebrity who could show improvement, Austin said, was Miley Cyrus. While the teen superstar has an “overall nice smile,” Austin said, she noted that her teeth appeared to be a bit asymmetric as one front tooth actually hangs a tiny bit lower than the other.

Austin recommends that a simple procedure such as tooth recontouring or perhaps redoing the upper front veneers will put the smile of the popular singer and actress back on the A-list.

Austin, who is based in New York City, calls herself a “celebrity dentist.” Her goal is to offer her patients “Hollywood-inspired” smiles.

By Fred Michmershuizen, Online Editor.
It’s likely you realized early on that as the owner of your practice, there are many hats you must wear. You are, after all, “the boss.” You are the one your team looks to for direction, guidance, mediation, fairness, etc. And for many dentists, it’s those “other duties as assigned” that create the biggest headaches in running a practice.

Employees are a needy bunch. You have to tell them what to do. They often require additional training. They can be mercurial. And one particularly frustrating characteristic of most employees — they want regular feedback from you, their boss. If only signing the paychecks was all that was required to effectively manage a team. Now you need a solid set of skills, a strong sense of integrity and professionalism and a willingness to encourage excellent performance through motivation, accountability and, yes, plenty of constructive feedback.

Most dentists pat themselves on the back if they give employees feedback once or twice a year. “Feedback” as many view it would be that perfunctory exchange that is commonly attached to the annual salary review.

If there are no problems, most likely the dentist tells the employees they are doing a fine job, slaps a couple extra percentage points on the paycheck and quickly strikes this routine matter off the to-do list. “There, that’s done. Now on to real work!”

Or perhaps you are one of those who reasons that if the employee gets a paycheck and isn’t shown to the door that is feedback enough in your book. “If I wasn’t happy they’d know it. Why would I need to give any more feedback than that?” If that’s your story, you’re probably filling vacancies in your office rather regularly. Maybe your idea of feedback is dropping a subtle hint here or there. The dirty instruments pile up in the sink and you stick a post-it-note above it with a frowning face.

Or let’s say, you’re looking at a record shortfall in income this year and you casually mention in a staff meeting that money is a little tight. This isn’t feedback because:

• It doesn’t help the collections coordinator understand that she needs to increase over-the-counter collections immediately.
• It doesn’t tell the scheduling coordinator that the scheduling to meet production goals is established for a reason.
• The staff members leave the meeting assuming everything is fine where they are concerned. After all, if money were a serious problem surely you’d do more than mention that things are a little tight.
• Meanwhile, you are sure the team is going to take some real steps to improve their performance. (Yet, this is, in fact, not true.)

Vague generalities don’t work and they don’t constitute feedback. So how does the dental practice actually incorporate effective feedback into its systems?

First, drop the notion that feedback is part of the performance/salary review. They are separate issues. Performance rewards must be based on performance measurements, but that is another article.

**Daily dose**

Constructive feedback should be given and received daily to help employees continuously fine tune and improve the manner in which they carry out their responsibilities. Feedback given and received constructively is a professional pixie dust for the employees.

It’s that unseen magical ingredient that helps them to improve and to grow. It’s also the dentist’s most vital tool in shaping and guiding average employees into effective, high-performing team members.

But expecting anything constructive or positive to come out of occasional doses of feedback is like having a patient who brushes his teeth occasionally yet expects to have excellent oral health. It simply doesn’t happen.

Verbal feedback can be given at any time, but it is most effective at the moment the employee is engaging in the behavior that you either want to praise or correct. If Sue at the front desk negotiated payment from the ever difficult Mrs. Jones with the deft and political acumen of a highly trained peace keeper/financial genius, tell her! Similarly, if her handling of a situation is not consistent with the prac-
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‘Feedback given and received daily is professional pixie dust for employees.’

Verbal, on-the-spot feedback should be the goal. The environment of the practice should be one that encourages positive feedback and openly provides constructive feedback when necessary.

Choosing to avoid opportunities to give employees feedback is like choosing to help them to fail.

What goes around comes around

Simultaneously, dentists should consider soliciting feedback from their teams. Scary thought, isn’t it? It can be handled as simply as asking every employee to anonymously write down one thing that they would change about the office — no personal attacks allowed.

The focus is constructive feedback on a system or a procedure that the employees believe would be an improvement. It could be daily/ monthly meetings, new patient packets, scheduling difficulties, increased training opportunities, clear office procedures, conflict resolution strategies, etc.

If you are particularly brave, ask your team to rate you personally on a task or procedure and, most importantly, as one of the most essential tools you can use to excel.

Too often supervisors and co-workers are so overly concerned about offending a staff member they shun opportunities to give feedback. So when a co-worker steps forward and actually offers feedback, he or she is taking a major risk and should be thanked for the willingness to help you become a better employee.

You asked for it

The best way to become comfortable in receiving and acting on feedback is to ask for it. We are completely incapable of seeing ourselves as others see us, which is why being open to feedback is essential in achieving our greatest potential and recognizing those professional habits and approaches that are interfering with that potential.

When receiving feedback, make a conscious decision to listen carefully to what the person is saying and control your desire to respond. In other words, resist the urge to interpret as unjust criticism. You have the right to ask for examples and listen to her constructive criticism.

She thanks Mary for calling her attention to the issue and decides to focus on addressing the matter constructively rather than reacting negatively to what she could choose to interpret as unjust criticism.

She develops a plan to raise the issue at the next staff meeting and solicit input from the clinical staff. Sue is prepared to share with the team situations in which she has felt the matter necessitated an interruption and would like guidance on how to handle similar matters in the future.

Don’t sit back and wait for feedback; actively solicit it and use it! Recognize that feedback is one of the most critical tools you have in achieving your practice’s full potential.

About the author

Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dental practices nationwide. She is also editor of The Dentist’s Network Newsletter at www.thedentistsnetwork.net; the e-Management Newsletter from www.mckenzie mgmt.com; and The New Dentist™ magazine, www.thenewdentist.net. She can be reached at (877) 777-6151 or sallymckenzie@mckenzie mgmt.com.
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, dollar value of that practice represents a significant portion of their financial assets. 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 with 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 recognized reputation. They may be a national or regional “transition guru,” the dentist’s personal accountant or another accountant who restricts his/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/her transition. Questions that need answers include the dentist’s financial ability to retire and his/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 Rms, GR $675K #10108
Birmingham Suburb - 3 Ops, 3 Hygiene Rooms #10106
Florence- Beautiful Modern Office, room to expand, GR$605K #10110
CONTACT: Dr. Jim Gate @ 304-513-1573

ARIZONA
Arizona- Dentist seeking to purchase general dental practice. #12110
Shaw Low - 2 Ops, 2 Hygiene Rms, GR in 2007 $65,995
Phoenix- General Dentist seeking Practice Purchase Opportunity #12108
Phoenix- 1 Ops - 3 Equipped, GR $515K+, 5 Working Days #12113
North Scottsdale - General Dentist Seeking Practice Purchase Opportunity #12109
Urban Tucson- 6 Ops - 4 Equipped, 1 Hygiene, GR $900K 12112
Tucson- 1-800 active patients, GR $850K, Asking $850K #12110
CONTACT: Tony Kimbel @ 602-516-3219

CALIFORNIA
Alturas- 3 Ops, GR $611K, 3 1/2 day week work #14279
Atwater- 2 Ops, 1,080 sq ft, GR #177K #14307
El Sobrante- 5 Ops - 3 Equipped, 1,300 sq ft, GR $515K #14302
Fresno- 5 Ops, 1,500 sq ft, GR $51,064,500 #14250
Greater Auburn Area- 4 Ops, 1,800 sq ft, GR $765K #14301
Madera- 7 Ops, GR $1,521,467 #14283
Modesto- 12 Ops, GR $1,931,000, Same loc for 10 years #14289
Modesto- 3 Ops, GR $884K w/adj. net income of $54,461 K #14108
N California Wine Country- 4 Ops, 1,500 sq ft, GR $595K #14290
Pine Grove- Nice 5 Ops fully equipped office/practice $111,500 #14039
Porterville- 6 Ops, 2,000 sq ft, GR $2,38M #14291
Red Bluff- 8 Ops, 2008 GR $1M Hygiene 10 days a wk. #14252
CONTACT: Dr. Dennis Hover @ 800-519-3558
Seacoast- 4 Ops, 1,100 sq ft, GR $122K #14265
Grass Valley- 3 Ops, 1,500 sq ft, GR $711K #14272
Redding- 3 Ops, 2,200 sq ft, GR $1M #14292
Yuba City- 3 ops, 4 days hyg, 1,300 sq ft #14273
CONTACT: Dr. Thomas Wagner @ 516-812-3253
Rancho Margarita- 4 Ops, 1,200 sq ft, Take over lease #14301
CONTACT: Thinh Tran @ 949-533-8508

CONNECTICUT
Fairfield Area- General practice doing $800K #16106
Southbury- 2 Ops, GR $25K #16111
Wallingford- 2 Ops, GR $60K #16114
CONTACT: Dr. Peter Goldberg @ 617-680-2980

FLORIDA
Miami- 5 Ops, Full Lab, GR $895K #18117
Jacksonville- GR $1.3M 3000 sq ft, 7 ops, 8 days hygienist #18118
CONTACT: Deanna Wright @ 800-730-8883

GEORGIA
Atlanta Suburb- 3 Ops, 2 Hygiene Rms, GR $685K #19125
Atlanta Suburb- 2 Ops, 2 Hygiene Rms, GR $631K #19128
Atlanta Suburb- 3 Ops, 1,270 sq ft, GR $434,000 #19131
Atlanta Suburb- Pediatric Office, 1 Ops, GR $425K #19134
Dublin- GR $1M, Asking $825K #19107
Macon- 3 Ops, 1,620 sq ft, State of the art equipment #19103
North Atlanta- 3 Ops, 5 Hygiene, GR $767K #19132
Northeast Atlanta- 4 Ops, GR $670K #19129
Northern Georgia- 3 Ops, 1 Hygiene, Ext. for 43 yrs #19110
South Georgia- 2 Ops, 3 Hygiene Rm, GR $721K #19135
CONTACT: Dr. Jim Ghee @ 404-513-1573

ILLINOIS
Chicago- 9 Ops, GR $709K, Sale: Price $611K #21216
1-Hr SW of Chicago- 5 Ops, 2007 GR $440K, 28 yrs old #21215
Chicago- 3 Ops, GR $800K, 3 day week work #21219
Galesville- GR $100K, Boarded in Historic Bed & Breakfast Community #21219
Western Suburbs- 5 Ops, 2,200 sq ft, GR Approx $1.5M #22120
CONTACT: Al Brown @ 630-781-2176

MARYLAND
Southern MD- 3 Ops, 3,500 sq ft, GR $1,85M #22910
CONTACT: Sharon Mazzetti @ 443-788-8971

MASSACHUSETTS
Boston- 2-3 Ops, GR $225K, Sale $197K #30122
Boston Southshore- 3 Ops, GR $340K #30123
North Shore Area (Essex County) 3 Ops, GR $400K, #30126
Western Massachusetts- 5 Ops, GR $435K, Sale $516K #30116
CONTACT: Dr. Peter Goldberg @ 617-680-2980
Middle Cape Cod- 6 Ops, GR $900K, Sale price $677K #30124
Boston- 2 Ops, 1 Hygiene, GR $302K #30125
Middlesex County- 7 Ops, GR $500K, #30120
New Bedford Area- 8 Ops, GR $620K #30119
CONTACT: Alex Lurie @ 617-240-2582

MICHIGAN
Suburban Detroit- 2 Ops, 1 Hygiene, GR $235K #11105
CONTACT: Dr. Jim David @ 313-960-0800

MINNESOTA
Grow Wings County- 4 Ops #32103
Fargo/Moorhead Area- 1 Ops, GR $318K, #32107
Central Minnesota- Mobile Practice, GR $730K #32108
Twin Cities- Move in, practice immediately GR $800K #32110
CONTACT: Mike Minor @ 612-961-2122

MISSISSIPPI
Eastern Central Mississippi- 10 Ops, 4,685 sq ft, GR $1.9M #13110
CONTACT: Deanna Wright @800-730-8883

NEVADA
Reno- Free-Standing Building, 1,500 Sq Ft, 4 Ops, GR 763K #37106
CONTACT: Dr. Dennis Hoover @ 800-519-3158

NEW JERSEY
Marlboro- Associate positions available #39102
Mercer City- 3 Ops, Good Location, Turn-Key, GR $191K #39112
CONTACT: Sharon Mazzetti @ 609-788-4071

NEW YORK
Brooklyn- 3 Ops (1. Fully equipped, GR $175K #44113
Woodstock- 2 Ops, Building also available for sale, GR $650K #44112
CONTACT: Dr. Don Cohen @ 945-460-3034
Syracuse- 4 Ops, 1,800 sq ft, GR over $700K #41107
CONTACT: Marty Hartz @ 315-265-1333
New York City - Specialty Practice, 3 Ops, GR $550K #44110
CONTACT: Richard Zelin @ 631-851-9024

OHIO
Medina- Associate to buy 1/3, rest of practice in future. #44150
North Central- GR $65K, 4 Ops, Well Established #44150
CONTACT: Dr. Mark Moorehead @ 440-825-8037

PENNSYLVANIA
Northeastern Pennsylvania- 3 Ops, Victorian Mansion GR $1.2M #371-80
CONTACT: Dr. Sam Shurt @ 412-855-0657
Lippincott County- 1 Ops, 1 Hygiene, GR $515K #47138
Chester County- High End Office, 4 ops, Digital, FISS - a few PPO's #47141
Philadelphia County (NE)- 4 Ops, GR $500K, Est 25 years #7142
CONTACT: Sharon Mazzetti @ 609-788-4071

RHODE ISLAND
Southern- 4 Ops, GR $790K, Sale $480K #48102
CONTACT: Dr. Peter Goldberg @ 617-680-2980

SOUTHERN CAROLINA
Charleston- 2-3 Ops, 3 Equipped #42142
Foilhills- 3 Ops #42122
Near Pinhuter- Dental emporium clinic, 3 Ops, GR in 2007 $517K #42134
New Hanover Copy- A practice on the coast, Growing Area #42145
Raleigh, Cary, Durham- Doctor looking to purchase #42127
CONTACT: Redhead Handsome Parker @ 1-919-889-1555

VIRGINIA
Greater Roanoke Valley- 2500 sq ft, GR $982K updated equipment #35111
CONTACT: Bob Anderson @ 804-640-2573

For a complete listing, visit www.henryschein.com/ppt or call 1-800-730-8883

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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 5 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 unanticipated 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 designated 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 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 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?

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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 5 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 unanticipated 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 designated 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 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 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,
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Welcome to a new topic area among the pages of Dental Tribune! The thanks for this new topic area go to a number of oral pathologists who seek to expand their role in the dental community by writing for Dental Tribune. These authors will provide us with selected case studies to help educate our readers about the various oral pathology situations they might encounter in daily practice.

We hope you enjoy this new topic area and welcome your feedback at feedback@dental-tribune.com.

In addition, if you would like to submit a pathology case for publication, please contact r.goodman@dental-tribune.com.

A 58-year-old male complains of multiple lobulated reddish to bluish swellings over the tongue and lower lip for the last two years.

No associated pain or paresthesia, no history of discharge and no history of trauma except for the discomfort caused by lobulated masses. The patient has an unremarkable medical history; no known allergies; and is not taking any medications.

Extra-oral examination
Lobulated masses of deep reddish to bluish lesions seen over lower lip.

Intra-oral examination
Lobulated masses of deep reddish to bluish lesions seen over lower lip and tongue region. The lesions are soft in consistency and have a smooth surface.

Questions
1) The clinical differential diagnosis may include:
   a) Hemangioma
   b) HIV-related lesion
   c) Lymphangangioma
   d) Drug allergy
   e) Multiple mucosal neuromas

2) Which of the following diagnostic tests may be useful (circle all that apply)?
   a) Pressure test
   b) Serology
   c) Biopsy

Turn to page 12A for the answers
Identify the swellings

1) The clinical differential diagnosis may include:
   a) Hemangioma
   b) HIV related lesion
   c) Lymphangioma
   d) Drug allergy
   e) Multiple mucosal neuromas

2) Which of following diagnostic tests may be useful (circle all that apply)?
   a) Pressure test
   b) Serology
   c) Biopsy

Answers
   1) a
   2) a

Going further...

The following tests were performed:
   • Pressure test = positive
   • ELISA test = negative
   • Histopathology as shown below

5) The histopathological differential diagnosis is which of the following?
   a) Pyogenic granuloma
   b) Capillary hemangioma
   c) Hemangiopericytoma
   d) Hemangioendothelioma

4) Are the following statements about hemangioma true or false?
   a) Pressure test positive
   b) ELISA positive
   c) Histopathology shows endothelial proliferation
   d) Histopathology shows chronic inflammatory cell infiltrate
   e) Histopathology shows stag horn pattern of vascular channels

5) All of the following statements are true about hemangioma except:
   a) A true neoplasm
   b) Hamartoma
   c) Common in darker-skinned individuals
   d) Three times more common in females

6) Are the following statements about Hemangioma true or false?
   a) Hemangiomas are present since birth
   b) Hemangiomas are more common in the head and neck regions and rare in the oral cavity
   c) Hemangiomas can be seen centrally
   d) Central hemangioma can have sunburst appearance

7) Hemangioma is a feature of each of the following syndromes except:
   a) Struge-Weber syndrome
   b) Rendu-Osler-Weber syndrome
   c) Kasabach–Merritt syndrome
   d) Gorlin-Goltz Syndrome

Discussion

Hemangioma is a hamartoma. It is never seen at birth but develops within the first year of life. It is more common in the head and neck regions and rare in the oral cavity. It is more common in females. Its occurrence is more frequent in white-skinned individuals. It can be seen centrally. Radiographically, central lesions can have a sunburst or honeycomb pattern.

Histopathologically, it shows areas of endothelial proliferation. Hemangioma is associated with many syndromes like Struge Weber, Rendu Osler Weber, Kasabach–Merritt.

Treatment modalities includes injection of sclerosing agents, intralesional injection of corticosteroids, flash lamp pulsed dye laser and embolization.

Answers
   3) b; 4) a) true, b) false  c) true, d) false, e) false; 5) c; 6) a) false, b) true, c) true, d) true; 7) d

About the authors

Dr. Ghom has more than 12 years of experience in the areas of teaching oral medicine and radiology and conducting scientific research. He has published textbooks on oral medicine, oral radiology and oral pathology as well as a mini atlas of oral medicine.

Ghom is also the editor in chief of the Journal of the Indian Academy of Oral Medicine and Radiology.

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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.surefilldrflow.com to learn more.
Clinical solutions to common problems when placing Class II direct composites

By Robert Lowe, DDS, FAGD, FICD, FADI, FACD

Direct composite restorations that involve posterior proximal surfaces are still a common finding in many dental patients. Unlike dental amalgam, which can be a very forgiving material technically and can be condensed against a matrix band to create a proximal contact, proper placement of composite restorative materials presents a unique set of challenges for the operative dentist.

The adhesion process itself is well understood by most clinicians as far as isolation and execution, however, there are some steps in the placement process that cause difficulty and ultimately lead to a less desirable end result.

In this article we will look at three specific areas: management of the soft tissue in the interproximal region; creation of proximal contour and contact; finishing and polishing of the restoration.

Management of the interproximal gingival tissue

The most common area for the adhesion process to fail is the proximal gingival margin. Compounding this problem is the inability to gain access to the area to effect a repair without removal of the entire restoration.

As stated by Dr. Ron Jackson, bonded restorations are unique in that minor defects (decay or micro leakage) at the marginal interface can often be “renewed,” or repaired by removal of the affected tooth structure and repaired with additional composite restorative material.

Because of the bond of the restorative material to enamel and dentin, the recurrence is usually self-limiting. This is not true with metallic restorations that are not bonded to tooth structure. However, if the defective area is at the proximal gingival margin or line angle, access is not possible.

Therefore, precise marginal adaptation of the direct composite restorative material and the seal of this margin in the absence of moisture or sublacer fluid contamination is of paramount importance.

However, whether due to the subgingival level of decay and/or gingival inflammation, it can be difficult to seal the gingival margin with a matrix in the presence of blood.

Proximal contact and contour

Another challenge for the dentist has always been to re-create contact to the adjacent tooth and, at the same time, restore proper interproximal anatomic form given the limitations of conventional matrix systems.

The thickness of the matrix band and the ability to compress the periodontal ligaments of the tooth being restored and the one adjacent to it can sometimes make the restoration of proximal tooth contact arduous at best.

Anatomically, the posterior proximal surface is convex occlusally and concave gingivally. The proximal contact is elliptical in the buccolingual direction and located approximately one millimeter apical to the height of the marginal ridge.

As the surface of the tooth progresses gingivally from the contact point toward the cemento-enamel junction, a concavity exists that houses the interproximal papilla.

Conventional matrix systems are made of thin, flat metallic strips that are placed circumferentially around the tooth to be restored and affixed with some sort of retaining device.

While contact with the adjacent tooth can be made with a circumferential matrix band, it is practically impossible to re-create the natural convex/concave anatomy of the posterior proximal surface because of the inherent limitations of these systems.

Attempts to “shape” or “burnish” matrix bands with elliptical instrumentation may help create nonanatomic contact, but only “distorts” or “indents” the hand and does not re-create complete natural interproximal contours.

Without the support of tooth contour, the interdental papilla may not completely fill the gingival embrasure, leading to potential food traps and areas for excess plaque accumulation. Direct Class II composite restorations can present even more of a challenge to place for the dentist because of the inability of resin materials to be compressed against a matrix to the same degree as amalgam, making it difficult to create a proximal contact.

Finishing and polishing composite restorations

Direct composite material does not carve like amalgam, although many clinicians wish that it did! Unfortunately, this means that most posterior composites are carved with a bur.

This is not part of the finishing and polishing of the restoration. It must be remembered that cuspal forms are convex and cannot be carved with a convex rotary instrument that imparts a concave surface to the restorative material.

Composite should be incrementally placed and sculpted to proper occlusal form prior to light curing. The finishing and polishing process is done to accomplish precise marginal adaptation and make minor occlusal adjustments.

Rubber abrasives further refine the surface of the composite, and surface sealants are used to gain additional marginal seal beyond the limitations of our instrumentation.

Case report

The patient shown in Figure 1 presented with radiographic decay on the mesial proximal surface of tooth No. 3. The operative area is isolated using an OptiDam (Kerr Hawe). The decay is minimal, so the operative plan is to keep the preparation very conservative.

After removal of the decay and completion of the proximal and occlusal cavity form, the operative area is isolated with a rubber dam in preparation for the restorative process. Figure 2 clearly shows that the proximal gingival tissue was abraded during cavity preparation and there is evidence of hemorrhage.

It is not advisable to try and “wash” the hemorrhage away with water and quickly apply the matrix band.

Even if this is successful, it is
likely that blood will infiltrate into the preparation in the gingival area and make etching and placement of the dentin bonding adhesive without contamination impossible.

An excellent way to manage the proximal tissue hemorrhage quickly and completely is to apply Expa-syl (Ker) to the area, tap it to place with a dry cotton pellet, and wait one to two minutes (Fig. 3).

Using an air-water mixture, rinse away the Expa-syl leaving a little bit of the material on top of the tissue, but below the gingival margin of the preparation (Fig. 4). The Expa-syl will deflect the tissue away from the preparation margin, maintain control of any hemorrhage and facilitate placement of the proximal matrix without the risk of contamination of the operative field.

Class II preparations that need a matrix band for restoration will require rebuilding of the marginal ridge, proximal contact and often a large portion of the interproximal surface.

The goal of composite placement is to do so in such a way that the amount of rotary instrumentation for contouring and finishing is limited. This is especially true for the interproximal surface.

Because of the constraints of clinical access to the proximal area, it is extremely difficult to sculpt and correctly contour this surface of the restoration. Proper reconstitution of this surface is largely due to the shape of the matrix band and the accuracy of its placement.

After removal of caries and old restorative material, the outline form of the cavity preparation is assessed. If any portion of the proximal contact remains, it does not necessarily need to be removed. Conserve as much healthy, unaffected tooth structure as possible.

If the matrix band cannot be easily positioned through the remaining contact, the contact can be lightened using a Fine Diamond Strip (DS25F, Komet USA). The Composi-Tight Matrix System was chosen to aid in the anatomic restoration of the mesial proximal tooth morphology of this maxillary first molar.

The appropriate matrix band chosen is one that will best correspond anatomically to the tooth being restored, and also to the width and height of the proximal surface.

The height of the sectional matrix should be no higher than the adjacent marginal ridge when properly placed. Because of the concave anatomic shape, the proximal contact will be located approximately one millimeter apical to the height of the marginal ridge.

The Composi-Tight Matrix Forceps are used to place the selected sectional matrix band in the correct orientation in the proximal area. The positive grip of this instrument will allow for more exact placement than a cotton plier, which could damage or crimp the matrix band.

The sectional matrix band (Garison Dental Solutions) is positioned...
and placed using the Composi-Tight Matrix Forceps to the mesial proximal area of tooth No. 14 (Fig. 5).

The orientation of the band and the positive fit make precise placement possible, even in posterior areas with tight access.

Next, the gingival portion of the band is stabilized and sealed against the cavosurface margin of the preparation using the appropriate size. The size of the WedgeWand® flexible wedge should be wide enough to hold the gingival portion of the matrix band sealed against the cavo-surface of the preparation, while the opposite side of the wedge sits firmly against the adjacent tooth surface.

To place the wedge, the Wedge Wand is bent to 90 degrees where the wedge meets the handle. The flexible wedge can now be placed with pressure conveniently, without the use of cotton forceps, that often can be very clumsy. Once the wedge is in the correct orientation, a twist of the wand releases the wedge.

The G-Ring® forceps are then used to place the Soft Face™ 3D Ring into position. The feet of the Soft Face 3D Ring are placed on either side of the flexible wedge and the ring is released from the forceps.

The force of the 3D Ring causes a slight separation of the teeth due to periodontal ligament compression. The unique pads of the Soft Face 3D ring hug the proximal morphology of the buccal and lingual surfaces of the adjacent teeth, while at the same time creating an unbelievably precise adaptation of the sectional matrix to the tooth cavosurface margins (Fig. 7).

Once the sectional matrix is properly wedged and the Soft Face 3D Ring is in place, the restorative process can be started.

A 15-second total-etch technique, 10 seconds on enamel margins and five seconds on dentin surfaces, is performed using a 37 percent phosphoric etch. The etchant is then rinsed off for a minimum of 15 to 20 seconds to ensure complete removal. The preparation is then air-dried and treated with AcQuaSeal desensitiser (AcQuaMed Technologies) to disinfect the cavity surface, create a moist surface for bonding and begin initial penetration of HEMA into the dentinal tubules.

A fifth generation bonding agent (Optibond Solo Plus, Kerr) is then placed on all cavity surfaces. The solvent is evaporated by spraying a gentle stream of air across the surface of the preparation. The adhesive is then light cured for 20 seconds.

The first layer of composite is placed using a flowable composite (Revolution 2, Kerr) to a thickness of about 0.5 mm. The flowable composite will “flow” into all the irregular areas of the preparation and create an oxygen-inhibited layer to bond sub-

Fig. 8: The composite restoration is completed prior to removal of the matrix band. Placement of the matrix precisely reconstructs the proximal tooth form.

Fig. 8a: The restoration immediately after matrix removal.

Fig. 9: The pointed Q-Finisher carbide finishing bur is used to make minor occlusal adjustments and refine the restorative margins.

Fig. 9a: The restoration immediately after matrix removal.

Fig. 10: The ulta-fine pointed composite finishing bur is used to further refine and finish the restoration’s adjusted areas.

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sequent layers of microhydrated material.

After light curing for 20 seconds, the next step is to layer in the microhydrated material.

First, using a unidose delivery, the fine blade of microhybrid composite (Premise, Kerr) is placed into the proximal box of the preparation. A smooth-ended condensing instrument is used to adapt the restorative material to the inside of the sectional matrix and preparation.

This first increment should be no more than 2 mm thick. After light curing the first increment, the next increment should extend to the apical portion of the interproximal contact and extend across the pulpal floor.

Facial and lingual increments are placed next (Fig. 9). A thick border without feathering is placed around the margins and smooth the surface of the composite.

Figure 8 shows the restoration after completion of the enamel layer prior to matrix band removal. The Composi-Tight Matrix Forceps were used to remove the sectional matrix after removal of the flexible wedge and Soft Face 5D Ring.

The Composi-Tight™ 5D Ring reduces flash to a minimum. Finishing and polishing were accomplished using Q-Finisher Carbide Finishing Burs (Komet USA). Typically, three grits and, correspondingly, three different burs are used to finish composite materials. With the Q-Finisher system, the blue-yellow striped bur with its flexible wedge and Soft Face 3D wedge is used to smooth and refine the margin areas during polishing.

The fine, white stripe ultra-fine finishing bur (H134Q-014) Q-Finisher was used to make minor occlusal adjustments on the restorative surface as needed and to smooth and refine the marginal areas of the restorative material where accessible (Fig. 9).

The fine, white stripe ultra-fine finishing bur (H134U-014) was used in the adjusted areas for precise fine finishing (Fig. 10). Komet Diamond Composite polishing points (green, polishing; and gray, high shine) were then used to polish and refine the restorative surface (Fig. 11).

Once polishing is complete, the final step is to place a surface sealant (Seal and Shine, Pulpdent) to seal and protect any microscopic imperfections at the restorative marginal interface that may be left as a result of our inability to access these areas on the micron level.

Remember, an explorer can “feel” a 50-micron marginal gap at best. Bacteria are 1 micron in diameter. The purpose of the Seal and Shine is to fill these areas. Figure 12 shows an occlusal view of the completed Class II composite restoration.

Conclusion

A technique has been described:

1) to control proximal tissue bleeding prior to matrix placement with Expaxyl (Kerr),
2) utilize a sectional matrix system (Composi-Tight 3D Ring, Wedge-Wand, Garrison Dental Solutions) and a nano-filled microhybrid composite (Premise, Kerr) to create an anatomically precise proximal surface, and
3) use the Q-Finisher, two-bur composite finishing system (Komet USA) to finish then polish with diamond composite abrasives (Komet USA), refining marginal integrity without destroying occlusal anatomy.

The interproximal surface has been re-created with natural anatomical contour and has a predictable, elliptical contact with the adjacent tooth.

With proper occlusal and proximal form, this “invisible” direct composite restoration will service the patient for many years to come.

The 98th Thomas P. Hinman Dental Meeting will take place March 25–27 in Atlanta. According to organizers, the 2010 meeting is where excellence will abound.

In fact, the Hinman meeting is known for its world-renowned reputation of excellence—bringing together the highest quality programming from the foremost authorities in the field of dentistry.

Some of the highlights at Hinman 2010 include the following:

• More than 60 leading experts in the field of dentistry will offer presentations.
• More than 25 percent of courses offer the opportunity for hands-on participation.
• New, all-day educational tracks will be offered for dental hygienists, assistants and business office personnel.
• Also new this year is Art in the Hall. Hinman and The Foundation for Hospital Art will combine forces to fill these areas. Figure 12 shows an occlusal view of the completed Class II composite restoration.

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• Also new this year is Art in the Hall. Hinman and The Foundation for Hospital Art will combine forces to create murals for medical facilities in need. Meeting attendees can stop by and paint for a few minutes or stay until a mural is finished.
• Two hours on Saturday will be dedicated exhibit hall time, with no education held during this period.
• The exhibit hall will offer courses for assistants and dentists, interactive artwork and the return of the popular Hinman Eatery.
• The meeting also offers plenty of networking opportunities and social events.

Educational opportunities

This year, Hinman has designed special, full-day courses for each team member. A “Prevention Convention” for hygienists will be held on Thurs-day, a “Business Office Bonanza” and an “Assisting Extravaganza” will be held on Friday.

These special courses are offered so that each team member can get a variety of information on different topics from six of the most respected lecturers in their specific areas of expertise.

In addition, there are separate speaker “tracks,” highlighting all the speakers who might be of interest to hygienists, business office staff and assistants.

Each lecture is 50 minutes with a mid-day break for lunch and to visit the exhibit hall. These unique courses are available at a special fee of $75 for the full day.

A variety of lunch options are available at the Hinman Eatery in the exhibit hall.

This year’s keynote session not only presents an esteemed roster of expert speakers, but also features one of Hinman’s more unique keynote speakers in recent history.

Frank W. Abagnale is one of the world’s most respected authorities on the subjects of forgery, embezzlement and securities documents. His name might sound familiar.

The movie Catch Me If You Can, starring Leonardo DiCaprio and Tom Hanks, was based on his life and book.
In addition, a dentist reception will be held on Saturday night and an auxiliary reception on Friday night.

With live music and buffets filled with the most appetizing foods, attendees will get to spend time catching up with friends and colleagues and dancing into the wee hours of the night.

Technical exhibits
Hinman’s 90,000-square-foot exhibit hall will feature the leading dental industry companies, sharing the latest products and services in the dental field.

The hall will not only feature nearly 400 leading industry companies, but will again include the Hinman Eatery, where attendees can take a break and grab something to eat and drink without having to leave the convention center and search for other options.

In addition, Hinman has heard many attendees say that they want more time in the exhibit hall that doesn’t conflict with the course schedule.

On Saturday, there will be two hours of dedicated time in the exhibit hall when attendees don’t have to worry about missing a course and can devote more time to visiting their favorite booths.

The exhibit hall floor will be open on Thursday from 10 a.m. to 6 p.m.; Friday from 9 a.m. to 6 p.m.; and Saturday from 9 a.m. to 4:30 p.m.

Meeting attendees can start their exhibit hall visits with complimentary morning and afternoon snacks each day. Snacks and drinks will be available in the rear seating areas while supplies last.

In the afternoon each day, cocktail bars will be open for attendees to purchase drinks.

The exhibit hall will also offer the following:

- **C.E. opportunities:** Meeting attendees can sign up and receive C.E. credit for attending courses offered by the American Dental Assistants’ Association. (These courses are limited attendance.)
- **Cyber café & C.E. printing station:** Attendees can search for exhibitor products, check e-mail, access the Internet and print out C.E. certificates.
- **Daily prize drawing:** Attendees can register to win a $500 American Express gift certificate by dropping the appropriate prize ticket in the Exhibit Hall tumble.
- **Free food:** Each day, complimentary morning and afternoon snacks will be available in the rear seating areas while supplies last.
- **Hinman Dining Dollars:** Attendees can redeem Hinman Dining Dollars for special values with food vendors in the Hinman Eatery and those located throughout the exhibit hall.
- **Hinman Eatery:** A central location offers food available for purchase and free wireless Internet access.
- **Hinman table clinics:** Attendees can earn one hour of C.E. credit by attending six table clinics.
- **Show specials:** Some exhibitors will offer show specials, offered only to 2010 Hinman attendees.

**Atlanta attractions**

For those who are looking for something to do after attending courses and visiting the exhibit hall, Atlanta is considered one of the most exciting cities in the country.

There are plenty of places to eat, shop and visit, including the following:

- Atlanta Botanical Gardens
- Atlanta History Center
- Braves Museum & Turner Field
- Fernbank Museum of Natural History
- High Museum of Art
- Jimmy Carter Library & Museum
- Margaret Mitchell House
- Martin Luther King Jr. National Historic Site & Sweet Auburn District
- Piedmont Park
- The Children’s Museum of Atlanta
- The Fox Theatre
- Underground Atlanta
- Woodruff Arts Center
- Zoo Atlanta

More information on the Hinman meeting is available online at [www.hinman.org](http://www.hinman.org).
Want to update your knowledge of implants?

Can’t make it to Heidelberg, Germany, for the eighth annual “Update Implantology” at the Steigmann Institute? Not to worry!

You can still catch the high-quality implant program, covering the most current topics in implantology. This meeting is geared toward new implantologists who want to update their knowledge of implants.

The program features a panel of renowned international speakers, who will share their recent findings and methods about surgery and prosthetics.

The FIZ Heidelberg e.V. and young implantologists developed this program to specifically provide an overall perspective on the new developments in implant dentistry.

Collaborating with different societies, a neutral view on established therapeutic methods and updated treatment aspects are offered.

Participants will learn tips and tricks to use immediately in their daily practice. The workshops and the pre-congress will provide a deeper insight on methods to improve everyday skills.

Take advantage of DT Study Club’s online version of this event in the course Update Implantology VIII. The program begins at 7:20 a.m. EST, Friday, March 26, and at 3 a.m. on Saturday March 27.

If you sign up for the live event, you will also have 50-day access to the recorded archive of each lecture (which means you can sleep in on Saturday and watch the courses you missed at another time).

The online course fee is $265, which is a 50 percent discount from the regular course fee.

All congress lectures will be simultaneously translated into English from German.

Friday, March 26
• 7:20–7:50 a.m. EST
  Dr. Frank Kistler, Landsberg
  Socket preservation as an alternative to immediate implant placement
• 7:50–8:20 a.m. EST
  Dr. Thomas Hanser, Olsberg
  Hard- and soft-tissue management with predictable results: guidelines to esthetical and functional implant success
• 8:20–8:50 a.m. EST
  Dr. Jordi Gargallo-Albiol, Barcelona
  Immediate loading: Where are the limits?
• 8:50–9:05 a.m. EST
  Discussion
• 12:35–1:05 p.m. EST
  Dr. Claas Ole Schmitt, Oppenheim
  Upgrade your implantology: computer-based surgery, implantation and CAD/CAM
• 1:05–1:20 p.m. EST
  Discussion
  Saturday, March 27
• 3–3:50 a.m. EST
  Dr. Marcus Parschau, Buchholz
  Integration of implantology in young practical experience
• 4–4:45 a.m. EST
  Dr. Philippe Russe, France
  One-piece implants: myths and facts
• 8:15–8:45 a.m. EST
  Dr. Jörg Schmoll, ZTM
  Wolfgang Bollack
  The team approach; surgical, dental technical implementation of complex implant treatment, 3-D planning, template technique, surgery, prosthetic-strategic proceeding, decision of fixed or removable dentures
• 8:45–9:15 a.m. EST
  Dr. Claudio Cacaci, Munich
  The role of provisional arrangement for long-term implant success
• 9:15–9:45 a.m. EST
  Dr. Ernst Fuchs-Schaller, Zug
  Preservation and reconstruction of the bioactive container
• 9:45–10:15 a.m. EST
  Dr. Túlio Valcanaia, Brazil
  Vertical bone growth, bone graft and distraction osteogenesis
• 10:15–10:45 a.m. EST
  Dr. Marius Steigmann, Neckargemünd
  Incision, cloth and seam — adapted for esthetical implantology
• 10:45 a.m. EST
  Discussion and end of convention

For additional information, please visit www.dtstudyclub.com.
Evolution of the toothfairy

Remember when you were little and you lost a baby tooth? The toothfairy was very real to you then, an airy apparition who visited you overnight and left something wonderful under your pillow. People believe they’ve outgrown the toothfairy, that she has become obsolete. Not so fast: the toothfairy has evolved into someone we can all believe in.

Today’s toothfairy has transitioned from simply rewarding children for their lost teeth to a very important role of helping children retain their permanent teeth, have beautiful smiles and enjoy healthier lives. This little mystical icon has become a dedicated champion in the fight against the No. 1 chronic childhood illness in our country: pediatric dental disease.

Now a revolutionary Superhero armed with a powerful message, she is not just any toothfairy; she is America’s toothfairy.

For many years caring dental professionals, including pediatric dentists, dental hygienists and other health-care groups, have worked tirelessly to bring dental treatment and preventive therapies to underserved children. Despite their efforts, however, pediatric dental disease continues to increase in America, causing pain and suffering for millions of children.

Dental disease affects us all

Children with untreated dental disease may find it difficult to eat, sleep and speak clearly, which affects their ability to concentrate in school, make friends and develop the social skills necessary to be successful adults.

It is a progressive disease, and children’s suffering worsens as they get older. They can experience chronic pain, and they can face gum disease, broken or lost teeth, abscesses, infections and even risk of death.

Until recently there was little emphasis on the connection between the mouth and a person’s overall health. Studies are now widely available that link tooth decay to heart disease, stroke, diabetes, pneumonia, poor pregnancy outcomes, secondary infections and dementia. But that is only part of the inherent risk. There is also a logical progression associated with this disease:

A child experiencing mouth pain may have difficulty eating a balanced diet with foods such as vegetables and grains, which are notoriously harder to chew. Additionally, a child suffering from pediatric dental disease is often not able to chew properly or long enough to promote good digestion, resulting in the loss of valuable nutrients.

Malnutrition because of dental complications ultimately leads to poor growth development, weakened bones and muscles, allergies, inability to concentrate, emotional problems and other systemic health ailments not immediately recognized as being linked to tooth decay.

According to the U.S. Department of Health and Human Services, more than 51 million school hours and 164 million hours of work are lost each year due to dental related absences.

The number of Americans without dental insurance is almost three times the number of those lacking medical coverage, and uninsured
"Online learning is not the next big thing, it is the now big thing."

Donna J Abernathy
Training and Development Editor

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The DT Study Club makes all of this possible from the comfort of your own computer and without travel expenses. In other words, welcome to the community!

The purpose of this study club to provide practitioners like yourself an opportunity to learn and network with like-minded colleagues in a friendly, non-threatening environment. We encourage you to take advantage of Dental Tribune’s global outreach to access a variety of fresh perspectives and cultures, enhancing your educational mix.

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children are two and a half times less likely than insured children to receive dental care. When these neglected mouths finally demand attention it is often through emergency room treatment, costing taxpayers millions of dollars each year for a disease that is largely preventable.

Information released by the Coalition on Oral Health Care estimates that for every $1 spent on oral health preventive measures, as much as $50 is saved in emergency and restorative treatment expenditures.

Overall higher health-care costs and insurance premiums, lower productivity levels of the workforce and even costs related to an elevated crime rate are a price we all pay when children with dental pain go untreated.

It’s easy to see the need for a certain kind of magic to fight pediatric dental disease. Fortunately, the toothfairy has evolved into America’s toothfairy and she is coming to the rescue.

America’s toothfairy: delivering hope
The National Children’s Oral Health Foundation is America’s toothfairy, a non-profit organization solely focused on eliminating America’s most common chronic childhood illness — pediatric dental disease — through comprehensive treatment and preventive and educational initiatives.

America’s toothfairy (www.americastoothfairy.org) serves as a national resource for health-care professionals and individuals alike, whether they are currently working to combat this devastating and preventable disease or looking to join the fight.

The organization raises public awareness of pediatric dental disease and the lifelong health complications associated with it, while supporting an affiliate network of non-profit oral health programs providing comprehensive care to underserved children across America.

In less than four years, America’s toothfairy has delivered more than $6 million in valuable product contributions and direct funding to affiliate partners, touching the lives of more than 1 million children nationwide! Because generous corporate underwriters cover all operational expenses, every additional dollar contributed to America’s toothfairy is allocated to programs giving children a healthier future.

The toothfairy has long been a symbol of the magic of childhood, a mystical figure only materializing as a child lay peacefully asleep, dreaming of the gifts to be found under his or her pillow the next morning.

Over 4 million children in America are suffering right now from oral pain so severe it keeps them up at night. For those children, and for anyone concerned with the healthy growth and development of our nation’s most valuable resource, National Children’s Oral Health Foundation has created America’s toothfairy.

She is a symbol of change: an educator, preventer, protector and, perhaps most importantly, a source of hope for children everywhere. Is America’s toothfairy real? She is as real as we make her.

For more information or to make a contribution, call (704) 350-1600 or visit www.americastoothfairy.org.
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The new line of Bien Air high-speed handpieces combines avant-garde technology with exceptional ergonomics. Utilized in aerospace, sailing and competitive sports, carbon fiber is the latest advancement in the dental industry.

Ten times the strength of steel, carbon fiber is extremely lightweight and offers improved resistance to wear, friction, torsion and impacts, making the material an easy choice for any dental practice. The new Blackline series also encompasses innovative LED lighting. LED has a service life that is 10 times longer than that of a traditional light bulb, dramatically improving the visibility of the operative field while leaving virtually no shadow area.

Coupled with the market’s only air-cushioned swivel, these handpieces provide unmatched maneuverability, free from drag caused by the tubing.

This series of handpieces comprises the Bora turbine, characterized by its extraordinary power, and the Prestige turbine, fitted with one of the smallest heads available on the market.

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Plak Smacker: Splash toothbrush

Plak Smacker has announced the latest addition to its line of toothbrushes: the Splash Brush. The Splash toothbrush is available in four bright colors: orange, blue, purple and green. This toothbrush has a comfortable, contoured handle for easy grip while brushing. The soft bristles add to the comfort of the Splash Brush and provide gentle massage to the teeth and gums. Patients are sure to rave about this brush. For more than 20 years, Plak Smacker has been focused on introducing new, innovative products to help patients feel good about a trip to the dental office. For more information or to place an order, please call (800) 558-6684 or visit www.plaksmacker.com.

Pentron’s new core material offers high depth of cure

Pentron Clinical, a leader in post and core technology, is proud to introduce new Build-It® Light Cure Core Material.

Build-It Light Cure Core Material is specifically designed for clinicians that favor the on-command cured light-cure only core materials.

The light-cure only formulation produces outstanding physical properties and is compatible with fourth through seventh generation bonding agents, ensuring compatibility with your preferred bonding agent.

The Build-It Light Cure addition to Pentron Clinical’s award-winning line of Build-It Core Materials cures to a depth of 10 mm with only 20 seconds of curing time per surface without the need for time consuming layering.

Pentron Clinical Technologies product manager Jeremy Grondzik said, “Ideal handling characteristics together with the ability to instantly light cure to a depth of 10 mm puts the clinician in complete control of the core build-up procedure from start to finish.”

Once cured, Build-It Light Cure performs just like the original Build-It FR™, meaning it sets to a rock-hard consistency that cuts like dentin. Non-sticky, sculptable handling that enables quick and easy adaption to tooth structure and the post are made possible by way of a proprietary new BisGMA-free resin.

To satisfy individual dispensing preferences, Build-It Light Cure Core Material is available in both a syringe and single dose delivery option.

Build-It Light Cure Core Material is one of the latest innovations from Pentron Clinical, an established leader in the dental consumables industry, offering a wide variety of affordable products to suit your restorative needs. As one of the pioneers of fiber post and nano-hybrid composite technologies, Pentron Clinical continues to demonstrate its commitment to the technological advancement of dentistry.

The company’s portfolio of innovative and award-winning dental products includes: Fusio™ Liquid Dentin, Bond-1® SF Solvent Free SE Adhesive, Mojo® Light Cure Veneer Cement and FibreKleer® Posts. For more information, call (800) 551-0285 or visit www.pentron.com.
The adjacent tooth is innocent

By Jan Johansson, DDS

When composite was first introduced for Class II fillings, the most common matrix technique used was the same as that for amalgam, a stainless-steel band wrapped around the whole tooth in conjunction with a retainer. There are many problems with this technique: attaining a good contact point, the retaining ring dislocating the position of the teeth, leakage of material and cervical overhang.

Major studies have concluded that during preparation for Class II fillings, in more than 60 percent of cases the adjacent teeth suffer damage unless adequately protected. The recent global focus on minimally-invasive dentistry has greatly increased interest in tissue preservation. There has also been a strong interest in being able to prepare and complete Class II fillings, in more than 60 percent of the cases. The adjacent teeth are not suffering unless adequately protected.

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Botox/dermal filler injections

Botox and dermal filler injections have been recently introduced to the dental field and are performed by a growing number of dentists worldwide. These procedures for dentistry, Botox injections can be used for dental treatments such as VibraJect® is not used to block the pain.

Dr. Louis Malcmacher, a leading opinion leader in the United States for Botox and dermal filler injections for dentistry, has used VibraJect and provided this endorsement: “Infraorbital and VibraJect is great for that and any regular dental injections.”

For more information on VibraJect, visit the ITL DENTAL Web site at www.itldental.com.

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World dental implant and bone graft market to top $4.5b by 2012

Recent survey projects that retirement and career changes could outpace the number of dental graduates

If current trends continue, getting an appointment with a dentist might become more challenging in coming years. A recent survey by the independent research firm The Long Group, and sponsored by the not-for-profit Delta Dental Plans Association, found that the dentist population could begin to contract as early as 2012. Researchers looked at current dentist retirement rates and at survey responses from dentists who expressed a desire to make a career change within the next five to 10 years and compared those numbers with the current dental school graduation rate.

Projecting these trends into the future, the study found that the 2009 dentist population of approximately 179,600 will increase through 2011 but retirement and career changes could outpace dentist school graduation beginning in 2012. By 2019, the dentist population could be smaller by nearly 7,000, assuming consistent dental school graduates of 4,500 annually.

“As more people acquire dental coverage through an employer, an individual policy or through some form of government-assisted program, it is crucial that dentists are available to actually see and treat them,” said Kim E. Volk, president and CEO of Delta Dental Plans Association.

Groups such as Delta Dental and others are having success attracting dentists to underserved areas and are providing prospective dentists with some hope that they won’t leave school with insurmountable debt. According to the American Dental Education Association, graduates of dental school enter the workforce with an average of $170,000 of debt. Increasingly, a dentist who is willing to practice in a federally designated...
Grow your dental practice
Three ways to start doubling your growth right now, even if you've hit a plateau

By Jay Geier

How would you like to double your practice growth? How would you like to double your net income? Of course you would! But what we want and what actually happens are two different things.

When you first started your dental practice, you felt the excitement. You experienced large percentages of growth for the first few years. Then your dental practice became stagnant.

You're not seeing growth in your dental practice now. Your “adjusted gross income” and “net income” decreased to the point where it depresses you to look at the numbers on your tax return.

You have hit a plateau, and it is commonplace for all businesses, including dental practices, to hit a plateau at some point in their life. Many will hit multiple plateaus.

I completely understand why hitting a plateau or even a decline in business would depress you. It’s because you’re seriously feeling the squeeze. You discovered that your expenses don’t plateau just because your income has flattened or declined.

• Your staff wants more money.
• You need more space.
• You need to purchase updated and emerging technologies and equipment.
• It takes more money to run your practice.

Not only do your expenses rise at the office, but they rise at home too. You’ve got kids, private schools, bigger houses, insurance, higher taxes.

So how can you as a dental practice owner get off the plateau, take your business to the next level and make more money?

Get the right training, skills and resources you need to build your business.

Look, you’re either on plan, off plan or you don’t even have a plan.

If you have been in practice for any significant amount of time and you are not investing heavily in your practice, I wouldn’t be surprised if you’re experiencing a plateau in your business right now.

You see, if you’re not learning better ways to build your practice then you are just doing the same thing over and over again. How is that going to solve your problem and take your practice to the next level? It isn’t.

Get the right employees: implement a ‘no mediocrity’ tolerance policy.

With so many people unemployed today, you can find top talent. There is no reason why you have to accept mediocrity performance.

Remember, you get what you deserve.

If you hire mediocre employees or if you keep mediocre employees, then you deserve to get mediocre or subpar results along with the gray hair you’ll get for dealing with these people.

In addition, it doesn’t take much effort to hire the right staff. In fact, I have a hiring system that allows you to hire new staff with less than 60 minutes of your time.

Get a ‘no excuses’ mindset.

If you want to shorten the lifespan of your plateau, then you need to stop being your own worst competitor. I mean this in the most caring, loving way. You make and accept too many excuses for why you can’t get new patients.

For example, you blame the recession. Yes, many small and large businesses are failing. However, we’ve doubled our business in this economy, I have clients who’ve been practicing dentistry for 35 years and they had their best year ever in 2009.

A few of these top performers are Michigan — one of the hardest hit states during the recession. If they can get new clients and double their practices in this economy, then you can too.

Yet, you have to adopt what I call the “two-economy system” mind-set that accepts no excuses.

I define the two-economy system as putting yourself in a bubble where the economy is good, and keeping everything out of the bubble that you don’t have control over.

Thus, unlike most dentists who let all of the negative energy ooze into their office and into their existence, I reject it like the plague.

I adopted the policy that you get what you deserve; there are no excuses. I haven’t made an excuse in 20 years.

If I get a bad result, I probably deserved a bad result. It’s that simple. So, I don’t make excuses. I just say, “I got what I deserved, and I need to figure out why and how I’m going to fix it so I get a better result next time.”

If you can figure out what actions and efforts it takes to deserve more, then “Bingo!” You can get it.

If you make excuses about your ability to generate new patients, such as your town or the economy or whatever other pathetic, whiny excuse you might have made in the past, you literally cannot do anything. It immobilizes you.

Want to start growing your dental practice?

Here are your next steps:

• Get the training you need.
• Adopt a “no mediocrity” tolerance policy.
• Don’t make or accept excuses.

When you complain, whine and moan, you take all the power out of your dental practice and completely destroy the mindset of your staff.

Remember, it starts with you. Are you ready to grow your dental practice?

About the author

Jay Geier says he adds 10 to 50 percent more new patients to his clients’ practices with little or no change to their marketing or advertising budget by simply leveraging their staff and getting them to focus on new patients as their No. 1 priority.

To see how your staff stacks up against your competition and more than 10,000 practices worldwide when it comes to turning prospects into scheduled appointments, take Geier’s new five-star challenge for free at www.schedulinginstitute.com.

“Types of programs are proving to be a win-win-win,” said Volk. They’re a win for the dentist who needs to pay down debt, a win for the local economy and a win for the residents in need of care.”

Delta Dental member companies currently support dentist school loan repayment programs in Arkansas, Iowa, South Dakota, Maine, New Hampshire and Vermont. Delta Dental also invests millions of dollars in dental education throughout the country.

The not-for-profit Delta Dental Plans Association (www.deltadental.com) based in Oak Brook, Ill., is a national network of independent dental service corporations specializing in providing dental benefits programs to 54 million Americans in more than 89,000 employee groups throughout the country.

Dr. Arvon McWilliams practices in rural Crawford County, Iowa, thanks in large part to the Fulfilling Iowa’s Need for Dentists (FIND) program, funded jointly by Delta Dental of Iowa and local business, government, health and civic organizations. With a population of just more than 7,000, the city of Denison might not have been the first choice of a dentist looking to establish a practice.

“If it was not for the FIND program, Dr. McWilliams would be practicing in another community,” said Don Luensmann, executive director of the Chamber and Development Council of Crawford County.

A similar sentiment is expressed by leaders in other rural parts of the country.

“Our health-care providers play a key role in our community’s economy,” said Jeffrey Johnson, branch president of BankWest in Gregory, S.D., a town with fewer than 2,000 people. “Delta Dental’s loan repayment program is helping ensure that our city’s one dental practice remains open.

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