Report says 1 in 5 children lacks access to care

By Fred Michmershuizen, Online Editor

A recent report from the Pew Center on the States paints a sad picture about the oral health of many children in the United States. The report, “The Cost of Delay: State Dental Policies Fail One in Five Children,” says that millions of disadvantaged children do not have access to adequate dental care.

“Millions of disadvantaged children suffer from sub-par dental health and access to care,” the report states. “This is a national epidemic with sobering consequences that can affect kids throughout their childhoods and well into their adult lives.

“A ‘simple cavity’ can snowball into a lifetime of challenges,” the report states. “Children with severe dental problems are more likely to grow up to be adults with severe dental problems, impairing their ability to work productively and maintain gainful employment.”

Leaders of two of the nation’s leading dental associations weighed in with their opinions on the report.

“We welcome the Pew organization to our longstanding fight to improve the lives of American children by helping more of them enjoy the good oral health that too many of them now lack,” said Dr. Ron Tankersley, president of the American Dental Association (ADA).

“Pew’s presenting its informa...”

Murder fugitive found by dentist after 40 years

By Daniel Zimmermann, Dental Tribune International Group Editor

An oral surgeon from Bellevue, Wash., has been helping authorities to identify a fugitive who murdered his grandfather almost 60 years ago. Dr. Clem C. Pellett, who is currently listed as one of the top dentists in oral and maxillofacial surgery in the Puget Sound area near Seattle, tracked down 78-year-old Frank Dryman in Arizona with the help of private detectives.

Dryman was immediately arrested and is expected to return to Montana State Prison where he had...
tion in the form of a report card makes it easy for anyone to understand that too many kids in too many states are suffering. And we face huge challenges in changing that.

“We don’t agree with everything in the report,” Tankersley continued. “But certainly, it highlights some of the major policy areas that the ADA and state dental societies have advocated for years — things like increased Medicaid funding, school sealant programs and community water fluoridation.

“It also highlights the urgent need for reliable routine data collection so that policies are well informed and kids are not left suffering,” Halpern said.

“Dr. David F. Halpern, president of the Academy of General Dentistry (AGD), offered similar sentiments.

“With more than 51 million school hours lost each year because of dental-related illness, the way in which states ensure that children have access to oral health care services is clearly an issue that deserves the devotion and dedication necessary to reach a solution so no child suffers needlessly from dental pain,” Halpern said.

“The Pew Center report is not all grim. It states that a number of improvements can be made.

“By making targeted investments in effective policy approaches, states can help eliminate the pain, missed school hours and long-term health and economic consequences of untreated dental disease among kids,” the report says.

“Although a handful of states are leading the way in breaking down these barriers, every state must do more to put proven policies in place to ensure dental health and access to care for America’s children.”

“The report does omit some policy areas that we believe are equally important to improving children’s access to care,” Tankersley said. “For instance, some states have innovative programs — like student loan forgiveness and tax incentives — to help dentists establish practices in underserved areas or practice in community health centers.

“And when it comes to fixing Medicaid, money is a huge issue, but it isn’t the only issue. Patients and parents need oral-health education to help them take care of themselves and their families to prevent disease.

“Many of them need additional services, like transportation, in order to be able to get to dental appointments.

“If Medicaid did a better job of these things, treatment costs would decrease because we would be preventing more disease and treating less.”

“It is also the AGD position that improvements in Medicaid reimbursements to meet the costs of service to the public, and expansions in water fluoridation and sealant programs, are needed.

“The AGD is opposed to independent dental providers who have not graduated from dental schools performing irreversible procedures for the very reason that a provider who has not met the minimum educational requirements in dentistry might be a danger to the patient if he or she is providing the primary care.

“According to the AGD, accessibility without quality echoes the "something is better than nothing" approach to care, which does not ultimately serve the public need.

“Both the ADA and the AGD have worked with state and federal agencies, dental schools and other organizations to promote public funding, volunteerism and loan forgiveness for dental students working in underserved areas.

“The ADA and state dental societies have a long history as the nation’s leading advocates for oral health,” Tankersley continued. “ADA members donated some $2.16 billion in free care to disadvantaged children and adults, both as individuals and through such programs as Give Kids A Smile and Missions of Mercy, in 2007 alone.

“But we’re the first to admit that we can’t do this alone, and charity is not sufficient for an effective, equitable oral-health delivery system.

“We’re grateful for assistance from the Pew Center and others who are willing to lend a hand in what undoubtedly will remain a long, tough fight.”

‘The AGD is opposed to any promotion or support of an independent midlevel dental provider,’ said Dr. David F. Halpern, president of the AGD.
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NYU dental professor receives $1.2 million to study bones and teeth

By Fred Michmershuizen, Online Editor

Dr. Timothy Bromage, a New York University College of Dentistry professor whose research on the microanatomical structure of ancestral human teeth and bones is recognized with having established the modern fields of human evolution growth, development and life history, has received the 2010 Max Planck Research Award.

The award, chosen by a joint Max Planck Society and Alexander von Humboldt Foundation selection committee, includes a stipend of approximately $1.2 million (750,000 euros), which will enable Bromage and Dr. Friedemann Schrenk of the Senckenberg Research Institute to collaborate on the microanatomical study of bones and teeth, and to research the link between metabolic states, growth rates, life spans and biological features such as sex and body size.

A portion of the award will be dedicated to training junior scientists in the United States and Germany to assist on this research.

“Dr. Bromage has fundamentally altered the field of human evolution by prompting paradigm shifts in morphology, fieldwork and experimental biology, thereby establishing the modern field of growth, development, and life history in paleoanthropology,” said Dr. Charles N. Bertolami, dean of the NYU College of Dentistry, upon announcement of the award.

Bromage is a professor of basic science and craniofacial biology and of biomaterials and biomimetics at the NYU College of Dentistry. The award selection committee cited his research with showing a relationship between bone density and body size, metabolic rate, age and other biological features.

According to the NYU College of Dentistry, Bromage was the first to use biologically based principles of craniofacial development to reconstruct early hominin skulls. His computer-generated reconstruction of a 1.9-million-year-old skull originally discovered in Kenya in 1972 by renowned paleoanthropologist and archaelogist Richard Leakey showed that Homo rudolfensis, modern man’s earliest-known close ancestor, looked more apelike than previously believed.

Bromage’s reconstruction had a surprisingly smaller brain and more distinctly protruding jaw than the reconstruction that Leakey assembled by hand, suggesting that early humans had features approaching those commonly associated with more apelike members of the hominid family living as long as 4 million years ago.

In human evolution fieldwork, Bromage’s 1992 discovery of a 2.4-million-year-old jaw in Malawi unearthed the oldest known remains of the genus Homo. The discovery, made in collaboration with Schrenk, director of paleoanthropology at the Senckenberg Research Institute in Frankfurt, Germany, marked the first time that scientists discovered an early human fossil outside of established early human sites in eastern and southern Africa.

In experimental biology approaches to human evolution research, Bromage discovered a new biological clock, or long-term rhythm, which controls many metabolic functions.

Bromage discovered the new rhythm while observing incremental growth lines in tooth enamel, which appear much like the annual rings on a tree. He also observed a related pattern of incremental growth in skeletal bone tissue — the first time such an incremental rhythm has ever been observed in bone.

The findings suggest that the same biological rhythm that controls incremental tooth and bone growth also affects bone and body size and many metabolic processes, including heart and respiration rates.

“The rhythm affects an organism’s overall pace of life and its life span,” Bromage said. “So a rat that grows teeth and bone in one-eighth the time of a human also lives faster and dies younger.”

The Max Planck Research Award is presented jointly by The Max Planck Society, which promotes basic scientific research at top international levels, and by the Alexander von Humboldt Foundation, which promotes collaboration between scientists in Germany and other countries.

Dr. Timothy Bromage is an expert on the microanatomical structure of ancestral human teeth and bones. (Photo/ NYU College of Dentistry)
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The secret tool: patient questionnaire

By Dr. Bhavna Doshi, United Kingdom

A powerful way to find out exactly what your patients want so you can boost your income and patient base

Many patients regularly suffer from cosmetically debilitating features of their mouths. Most of these patients often suffer silently because they believe that there are no solutions to their problems or think they can’t afford it.

They think having their mouths completely, once and for all “fixed” is something that is for the rich and famous.

My experience with treating “Extreme Makeover UK” patients has confirmed my thoughts of how much people suffer in silence with negative beliefs.

Uncovering hidden pains

The tool to help diagnose the required and much needed dentistry for patients is the patient questionnaire. This may sound simple, yet its effects are immeasurable. It can be designed to be as intricate or simple as you want.

For example, it can contain a series of beautiful photographs of the applications of cosmetic dentistry. This can be your work or that of others — it simply visualises the possibilities for the patient. But more importantly, it must contain thought-provoking questions that allow your patients to focus on their cosmetic concerns.

The questionnaire should be strategically designed to root out the major concerns patients may have. It forms part of a discovery process between you and your patients in making your patients aware of their fears, wants, desires and needs.

It can form part of a beautiful patient-friendly package. This means there is no work for you to do except have an informative discussion with your patients about their response to the questions.

What should you ask?

Simple thought-provoking questions need to be mentioned in the questionnaire. It needs to be used as a regular tool in your practice. Every practice member must understand its significance and be able to talk to the patient about its importance in discovering his/her needs and the overall evaluation process.

Sample questions

• Do you have any concerns in your mouth?
• If you had a magic wand and could change something in your mouth, what would you change?
• What do you like about your mouth and smile?
• What don’t you like about your mouth and smile?
• What is the most important thing to you about your mouth and smile?
• Are there any aspects of dentistry you have been thinking about that you would like to discuss?

Maximising performance

Sit down (in a preferably non-clinical environment) with the patient for a consultation. Systematically go through each question on the card and ask why the patient gave that particular answer.

Use the pleasing photographs of the various smiles and cosmetic work you may have done in the past to ask what the patient is looking for in a nice smile.

If you could have extra-oral and intra-oral photographs taken beforehand of your patient, this would really optimise and visually reinforce your solutions to the patient.

For example, if you had a photograph of a markedly deteriorating restoration in an anterior tooth, it would be easier to justify the need for a new, cosmetically-improved...
Sample patient questions

• Do you have any concerns in your mouth?
• If you had a magic wand and could change something in your mouth, what would you change?
• What do you like about your mouth and smile?
• What don’t you like about your mouth and smile?
• What is the most important thing to you about your mouth and smile?
• Are there any aspects of dentistry you have been thinking about that you would like to discuss?

and protective restoration on that tooth. Especially if this was a concern the patient expressed in his/her answers to the questionnaire. You will find after this discovery process that you will be able to advise a lot more than you would have initially. This process allows you to better understand your patients so that you can take better care of them. It helps to build a rapport and a long-term relationship of trust and faith. Many times patients require an authoritative person who would simply listen to them. This act alone, if sincere, is enough to build trust for patient loyalty. It also is a major factor in influencing patients to accept treatment recommendations.

Income generation
This patient questionnaire would allow you to generate more revenue because it would act like an extra activity in marketing your practice or you. It is a well-known fact in the marketing arena that the more activities you perform, the greater the number of potential customers you are likely to attract. This methodology is a simple but extremely effective system to acquire new revenue sources.

It can be applied to both existing patients and new patients alike. The process itself is one of discovery, and other aspects of dentistry can come to light as a result of this investigative procedure. The more comprehensive the dentistry you provide your patients, the more dentistry you do, hence the more income you generate. Patients that have developed a good relationship with you as a result of being listened to will be happy customers of the services you provide. Happy customers are more likely to refer other income-generating patients like themselves.

Don’t underestimate this tool
The patient questionnaire is a dynamic marketing tool. It can promote your work and develop your practice by giving you the ability to grow and generate income. It is a diagnostic tool to help you and your patients on the road to discovering your patients’ needs and requirements.

The closer you are to meeting those needs and requirements, the greater is the likelihood that your patients will accept your treatment recommendations. This in turn will allow you to promote your dentistry and generate more income.

Uncover the successful and effortless nature of this tool by simply using it to unveil the hidden dentistry.

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. Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

Conducting your own inspection of patients’ oral cavities provides the perfect opportunity to mention that this is something they can easily do themselves as well. You can explain the procedure in brief and then let them know about the Web site, www.oralcancerselfexam.com, that can provide them with all the details they need. 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?

**About the author**
Bhavna Doshi is a senior dentist at The Perfect Smile Studios, www.theperfectsmileacademy.co.uk. She has a special interest and focus on practice productivity, marketing and growth strategies.

If you have enjoyed this article and would like a free leaflet on “Cost-effective Marketing for Dental Practices,” then e-mail Doshi at bhavna@unlimitednewpatients.com with your name and address.
Changes and opportunities for health-care practitioners’ finances

By Keith Drayer

There are many areas that can bring small and large changes to a practice’s income as well as the individual health-care practitioner. Outlined below are a few of the changes and opportunities.

The practice's finances

An area to take advantage of is the 2010 IRS Section 179 Tax Code that allows business owners to lower their taxable income by acquiring eligible property (such as dental equipment, technology and off-the-shelf software). What makes the 2010 Section 179 benefit important is that in the year 2011, this generous allowance will come down to $25,000. As more and more dentists embrace equipment and technology, such as all-tissue lasers, comprehensive scanning, designing and milling CAD/CAM systems and cone-beam dentistry, this benefit can be applied to lower the buyer's taxable income. These investments make a practice more efficient, productive and profitable.

One of the key areas we suggest dentists to focus on each year is their current fee schedule. Too many dentists leave thousands of dollars in the hands of insurance companies every month because of an unbalanced fee schedule. We recommend that dentists set/balance their fees into the proper percentiles for their particular zip code. This will not only help to maximize the coverage of insurance the employer has purchased for the employee, but it will also be the best way to increase profitability.

Finance and partnerships

A change in today’s lending environment affects partnerships. Before the financial crisis hit, many lenders needed one partner or 50 percent of ownership to have decent credit. “Decent” is defined differently among different lenders, but a FICO score of 675 could have helped a health-care practitioner on an application-only loan (which means providing your name, address, social security, license number) to obtain approximately $250,000. In today’s lending environment, all owners are scrutinized. Thus, if one partner or an owner with more than a 20 percent stake has weak credit (FICO below 675), then that could be a detriment for the practice obtaining financing. It’s prudent to be proactive in finding out your partner’s credit before you obtain financing. This is a surprise you want to avoid.

Personal finances

Most people have multiple credit cards. The odds of unused credit cards being canceled should not be discounted. Many of us keep extra, unused credit cards for a “rainy day” (often in a fireproof box, hidden in our home or off-site at a bank-rented vault). Additionally, many people have taken a retailer’s credit card, as they were making a purchase, for the instant 10 percent one-time rebate, which was the incentive for taking that credit card. What has changed in the new era is two-fold. Financial institutions incur a marginal cost for providing credit. Thus, many lenders are still reducing assets and/or being selective about whom they are renewing. Canceling unused cards has been happening over the last year and a half and is not ending. The credit-card consumers holding onto credit cards for a rainy day could mean “the flu” for lenders. Lenders are worried that the person who has not used a card in more than a year is taking out their card because of worst-case scenarios (recent unemployment, need to raise funds for a called in home equity line, etc.).

To protect your credit card lines, you may want to use your cards in intervals (every six to nine months).

About the author

Keith Drayer is vice president of Henry Schein Financial Services (HSFS). Henry Schein Financial Services provides equipment, technology, and practice start-up and acquisition financing services nationwide. HSFS can be reached at (800) 855-9495 or fxds@henryschein.com. Please consult your tax advisor regarding your individual circumstances.
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Western Massachusetts—3 Ops, GR $65K, #12023

CONTACT: Dr. Peter Goldberg @ 617-480-2929

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- Dr. Ted Murray Dubuque, Iowa

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Using resorbable barriers to make root recession coverage predictable

By Drs. David L. Hoexter, Nikisha Jodhan and Jon B. Suzuki

Gingival recession is defined as the location or displacement of the marginal gingiva apical to the cemento-enamel junction (CEJ). Recession is the exposure of root surface, resulting in a tooth that appears to be of longer length.

From a patient’s perspective, recession means an unesthetic appearance and is associated with aging.

The gingiva consists of free and attached gingival tissue, as seen macroscopically. The free marginal gingiva, located coronal to the attached gingiva (AG), surrounds the tooth and is not attached to the tooth surface. The AG is the keratinized portion of gingival tissue (KG) that is dense, stippled and firmly bound to the underlying periodontium, tooth and bone.

In ideal health, the most coronal portion of the AG is located at the CEJ, where the most apical portion is adjacent to the muco-gingival junction (MGJ). The MGJ represents the junction between the AG (keratinized) and alveolar mucosa (non-keratinized).

There are numerous etiological factors that may result in recession. Generally, the etiology can be categorized as either mechanical or as a function of periodontal disease progression.

Recession usually occurs due to tooth malposition, alveolar bone recession, high muscle attachments and frenal pull, and iatrogenic factors related to restorative and periodontal treatment procedures.

The detrimental effects of recession include compromised esthetics, an increase in root sensitivity to temperature and tactile stimuli, and an increase in root caries susceptibility due to cementum exposure. Thus, the main therapeutic goal of recession elimination is gingival root coverage in order to fulfill esthetic demands and prevent root sensitivity.

Miller classifies recession defects into four categories:

- Class I: marginal tissue recession does not extend to the MGJ;
- Class II: marginal tissue recession extends to the MGJ, with no loss of interdental bone;
- Class III: marginal tissue recession extends to or beyond the MGJ; loss of interdental bone is apical to the CEJ but coronal to the apical extent of the marginal tissue recession;
- Class IV: marginal tissue recession extends beyond the MGJ; interdental bone extends apical to the marginal tissue recession.

A possible treatment modality for recession includes restorative/mechanical coverage, such as cervical composite restorations. This kind of treatment may effectively manage root sensitivity and root caries. However, such treatment entails a long-term compromise from an esthetic perspective. Composite restorations stain over time, and any marginal leakage may lead to secondary caries, recurrence of sensitivity and/or local inflammatory changes.

Additionally, color matching can be difficult and such restorations may
involves the undesirable removal of vital tooth structure in order to create adequate retention form. Thus, clinicians must determine whether the restorative benefits outweigh the esthetic shortcomings and whether it is possible to employ a treatment modality with few, if any, functional and esthetic disadvantages.

Another treatment modality for recession is muco-gingival surgery. Muco-gingival surgery refers to periodontal surgical procedures designed to correct defects in the morphology, position and/or amount and type of gingiva surrounding the teeth. In the early development of muco-gingival surgery, clinicians believed that there was a specific minimum apical-coronal dimension of AG that was necessary to maintain periodontal health.

However, subsequent clinical and experimental studies have demonstrated that there is no minimum numerical value necessary. However, for esthetics, a uniform color and value of AG is desirable among adjacent teeth.

Some of the earliest techniques for correcting recession involved extension of the vestibule. The subsequent healing usually resulted in an increase of AG. However, within six months, as much as a 50 percent relapse of the soft-tissue position was reported. Thus, as a 50 percent relapse of the soft-tissue position was reported. Thus, as a 50 percent relapse of the soft-tissue position was reported. Therefore, within six months, as much result in an increase of AG. How -

sion of the vestibule. Correcting recession involved exten-

tional flap and the rotational flap. Later modifications of the technique included the double papilla flap and the rotational flap. Another type of gingival movement flap was described later as the coronally repositioned flap. This technique involves mobilizing a full-thickness flap and repositioning the tissue to the CEJ, thereby covering the exposed recession.

The use of free-gingival grafts was described in the 1960s by Sullivan and Atkins. The free autogenous graft can be made up of either epithelialized gingiva or connective tissue. Initially, the therapeutic goal was to increase the zone of KG. The clinical objective has now evolved to cover -

ging the recessed root with a zone of attached KG. This can be achieved in one or two stages. Initially, Sullivan and Atkins described a one-stage procedure in 1968. Its purpose was to increase the zone of KG without concentrating on coverage of a recessed root. In the 1980s, a two-stage modification was suggested for an increase in root coverage, which proved to be more successful with increased predictability. This involves first placing the free gingival graft or the free connec-

tive tissue graft apical to the area of recession and using the coronally repositioned technique after healing. Free autogenous grafts are predominantly harvested from the palate. Recently, materials other than gingival grafts have been used. Using a guided tissue regeneration (GTR) technique, an acellular dermal matrix has been reported to yield favorable outcomes in root coverage. This material may provide the patient with a less invasive alternative than a palatal donor site in order to achieve root coverage.

Procedures combining both free grafts and pedicle techniques have also been detailed. For instance, when a connective tissue graft is employed, the graft is placed sub-epithelially with a coronal advancement of the flap, such as e-PTFE. The function of the membrane is to maintain space during the healing period for tissue regeneration to occur. From a patient’s perspective, biodegradable membranes with GTR may be preferable in order to avoid a second-stage surgery for membrane removal.

The goal is to restore gingival health, color and esthetics by covering the exposed root predictably with healthy gingival tissue and, in doing so, decrease sensitivity. Using GTR and coronal repositioning techni-

ues, we achieve predictably covered recession.

Variations in muco-gingival procedures have been developed to include root surface bio-modifications by treating the root surfaces with a vari-

ety of materials. These measures enhance the regeneration process of a new connective tissue attachment. In order to increase root coverage, a new clinical attachment is necessary.

Root surface bio-modification involves treating the root surfaces with citric acid, tetracycline or EDTA in order to remove the smear layer and expose dentinal tubules and thus facilitate a new fibrous attachment. An enamel matrix derivative claimed to support the action of enamel matrix proteins by inducing acellular cementum, periodontal ligament and alveolar bone formation is also available in the range of root surface bio-modification materials.

The following case report considers predictable esthetic root coverage by comparing a GTR technique to a non-GTR technique in a split-mouth procedure involving the same patient.

Case report A young, adult male patient presented with recession bilaterally in his maxilla. The upper left maxilla had extensive recession on teeth #6 and #7 (Fig. 1). The upper left maxilla had similar recession on teeth #11 and #12. Additionally, tooth #11 had a cervical groove, which was stained and hard but not decalcified.

After local anesthesia using lidoca- ine, the desired flap design was completed. There was an adequate zone of KG present before treatment, which was preserved and reposi-

tioned coronally. Upon reflection of the tissue, the full extent of the under-

lying recession was evident (Fig. 2). The area and recession were uncovered following removal of debride-

ment and glycerin treatment. The resorbable membrane material was shaped and placed on the exposed roots. The membrane was first placed on tooth #6 and thus the
Clinical 13A

Tooth appeared darker as it absorbed blood. The membrane was placed on tooth #5 second and thus the tooth had not absorbed the blood at the time of the photograph, which accounts for the color difference at this time.

The coronally repositioned flap was sutured in place with the flap covering the now submerged membranes and previous recession (Figs. 3, 4). Periodontal dressing (Coe-Pak, GC) was utilized as a bandage and placed over the surgical area. It was removed a week later at the same time as the sutures. The patient then lavaged and returned to the usual oral hygiene routine, initially lightly and gradually more vigorously.

Once healed and oral health was maintained, the recession was covered and health regenerated. Upon periodontal probing, no pockets were present (Fig. 5). The final view presents a visual symmetry of health and color that is maintainable.

Recession was also present at the maxillary left side (teeth #11 and #12; Fig. 6). After local anesthesia of the areas involved, a full thickness muco-periosteal flap was completed. This exposed the extent of the recession defects (Fig. 7). Tooth #11 was treated, as was the other side of the mouth, by utilizing the GTR technique using an acellular connective tissue membrane to preserve the space for regeneration.

Tooth #12 was treated the same way, except that no membrane barrier, resorbable or non-resorbable, was used (Figs. 8, 9). Thus, there was no use of a GTR technique on tooth #12. Both teeth had the flap manipulated with the coronally repositioned graft, covering the recessed root and suturing to the CEJ level.

Both sides were covered with periodontal dressing. Antibiotics (tetracycline) and an analgesic (Tylenol-Codeine) were prescribed for the first week after the operation.

One week after the surgical phase, the dressing and sutures were removed and the mouth lavaged. Oral hygiene was restored to good, maintainable habits following the healing phase of over two months. Upon observation, tooth #11, for which the GTR membrane had been employed, had re-attached healthy gingiva that was not probable.

The recessed root and the stained cervical groove were covered. In contrast, tooth #12, for which no GTR

Before ...

Fig. 6: Pre-op labial view of anterior teeth.

Fig. 7: Cervical groove on tooth #11 is solid, hard and non-carious.

Fig. 8: GTR membrane placed over the root surface of tooth #11 only; no membrane was placed on the surface of the recession of tooth #12.

Fig. 9: Gingival tissue coronally repositioned to cover the GTR membrane on tooth #11 and tooth #12.

Fig. 10: Post-op view.

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AACD to hold 26th scientific session

By Fred Michmershuizen, Online Editor

The 26th Annual American Association of Cosmetic Dentistry Scientific Session will take place at the Gaylord Texan in Grapevine, Texas, from Tuesday, April 27, through Saturday, May 1. Educators from around the world will lead the charge in reinvigorating dental continuing education.

Highlights of the meeting include deeper learning during lectures and hands-on workshops, the debut of AACD Digital World, a bigger team program, the exploration of international laboratory models and more.

“It is an exciting time at the AACD. The academy is continually growing and adjusting to better advance excellence through responsible esthetics,” said AACD President Michael R. Sesemann, DDS, “The scientific session is where participants recharge in order to live the AACD’s core values and purpose every day at the office.”

More than 80 educators will offer presentations at the meeting, including Pat Allen, DDS; Newton Fahl Jr., DDS; John Kois, DMD, MSD; and Lorenzo Vanini, DDS, MD. These world-class educators will lead the charge in reinvigorating dental continuing education.

“I feel fortunate to be part of the AACD at this time when we can inspire and invigorate so many individuals,” Sesemann said.

Here are some highlights of the upcoming meeting.

General Sessions

Clay Shirky, a writer, consultant and teacher on new media and the Internet, will speak on Wednesday, April 28, about emerging technologies. Shirky is an expert on economics and culture, media and community, and the open source movement.

His consulting practice is focused on the ways network technologies provide new ways for groups to get things done, including collaboration tools, social networks, peer-to-peer sharing, collaborative filtering and Open Source development. His recent book, “Here Comes Everybody,” explores the effects of open networks, collaboration and user-created and disseminated content on organizations and industries.

Tim Sanders, a business and motivational speaker and tech trends guru, will offer a presentation on Thursday, April 29, on strong business relationships, both internal and external. “Get them right,” he says, “and you’ll grow your business during good and bad times alike.” Sanders is author of “Love Is the Killer App: How to Win Business and Influence Friends,” “The Likeability Factor” and “Saving the World at Work.”

Amber MacArthur, a Web consultant, strategist and journalist, will offer a presentation on Friday, April 30, about the social media generation. MacArthur will trace the profound impact of emerging technologies on the way we live, work and play — and she will make it all fun, informative and accessible.

Poster session

Without the dedication and passion of researchers within the dental community, the advancements of cosmetic dentistry would not be where it is today. The AACD Poster Session will be on display as an outlet for researchers and clinicians to share their scientific findings. The poster session will be held Wednesday, April 28, through Friday, April 30, from 9:30 a.m. to 5 p.m.

Orientation

An orientation will be held on Tuesday, April 27, from 5 to 9 p.m. for new AACD members and for those who are attending the annual scientific session for the first time. Participants can join AACD colleagues as academy leaders and staff provide an in-depth overview of the 26th Annual AACD Scientific Session, from the layout of the exhibits to the must-attend social and networking events.

AACD’s orientation will assist attendees in determining how they can reach their educational goals while getting the most out of their scientific session experience.

Silent auction

At the AACD Charitable Foundation (AACDCF) silent auction, meeting attendees will be able to place bids on an array of items, including autographed memorabilia from Hollywood and sports stars to dental equipment for use in one’s practice. Auction items are gathered through the generous donations of AACD’s dental partners and those concerned with stopping domestic violence.

Proceeds will help the AACDCF make a significant impact on the lives of survivors of domestic violence. By donating items to the AACDCF Silent Auction, contributors can help heal the affects of domestic violence. For more information on donating, contact the AACD Charitable Foundation at givebackasmile@aacd.com or (800) 545-9220

Celebration of Excellence Gala

A Celebration of Excellence Gala will be held on Saturday, May 1, from 6 p.m. to midnight. The night begins with a cocktail reception followed by the newly accredited members and accredited fellows recognition. Next, attendees will enjoy five-star dining, then the AACD awards ceremony, inauguration of the AACD president, followed by, live music and dancing. Tickets are $125 per person.

About the AACD

The AACD is the world’s largest non-profit membership organization dedicated to advancing excellence in comprehensive oral care that combines art and science to optimally improve dental health, esthetics and function.

Composed of more than 7,000 cosmetic dental professionals in 70 countries around the globe, the AACD fulfills its mission by offering superior educational opportunities, promoting and supporting a respected accreditation credential, serving as a user-friendly and inviting forum for the creative exchange of knowledge and ideas, and providing accurate and useful information to the public and the profession.

Meeting registration

Dental professionals can register for the 26th Annual AACD Scientific Session online at www.aacd.com or by calling (800) 545-9220 or (608) 222-8583.

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It's always nice to plan a little fun along with a trip, especially a meeting such as the AACD. Dallas is a city with plenty of theme parks, cultural venues and outdoor spaces.

Family fun
If you are traveling with your family, there are many options for entertainment. Consider the following: Amazing Jakes (indoor amusement park); Dallas Heritage Village (living history museum portraying life in Texas from 1840 to 1919); Dallas Mozzarella Company (cheese-making classes and factory tours); Dallas World Aquarium; Dallas Zoo, Fair Park (location of the annual State Fair of Texas); Galleria Dallas (featuring ice skating); Louis Tussaud’s Palace of Wax and Ripley’s Believe It or Not!; Medieval Times Dinner & Tournament; Mesquite Championship Rodeo; Six Flags Hurricane Harbor (water park); Six Flags Over Texas (theme park); Southfork Ranch (film location tours of the 1980s TV show “Dallas”); Speedzone (amusement park); and Westin City Center (featuring ice skating).

Outdoor spaces
With moderate weather year round, Dallas offers beautiful outdoor spaces for learning and play.

Such picturesque places include the Dallas Farmers Market; Katy Trail (hike and bike trail); Pioneer Plaza (bronze monuments commemorating the trails that brought settlers to Dallas); Texas Discovery Gardens; The Dallas Arboretum; and the Trinity River Audubon Center.

Museums
For more family learning opportunities, visitors travel to the numerous one-of-a-kind museums throughout the city. From historic to cultural, these venues invoke emotion and inspiration.

The following are located throughout the area: African American Museum; American Museum of Miniature Arts; Cavanaugh Flight Museum; Crow Collection of Asian Art; Dallas Firefighters Museum; Dallas Museum of Art; Dallas Museum of Nature and Science; Frontiers of Flight Museum; Dallas Holocaust Museum; Mary Kay Museum; Meadows Museum at Southern Methodist University; Museum of the American Railroad; Nasher Sculpture Center; Old Red Museum; the Sixth Floor Museum at Dealey Plaza; and the Women’s Museum: An Institute for the Future.

Cultural attractions
Dallas is an art-centric and cultural city. With the largest urban arts district in the nation and countless museums and art galleries, the city gives families plenty to explore.

In addition to the art-themed museums mentioned previously, Dallas also boasts the following cultural and musical venues: Dallas Center for the Performing Arts — including the Margot and Bill Winspear Opera House, Dee and Charles Wyly Theatre, Annette Strauss Artist Square, Sammons Park and later City Performance Hall; the Dallas Children’s Theatre; Latino Cultural Center; Morton H. Meyerson Symphony Center; Music Hall at Fair Park (venue for Dallas Summer Musicals); South Dallas Cultural Center; and The Majestic Theatre.

To learn more, visit the Dallas Convention & Visitors Bureau online, at www.visitdallas.com.

A complete list of references is available from the publisher.

(Photos/Dr. David L. Hoexter)

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CEREC goes to Vegas

Sirona celebrates 25 years of CAD/CAM success with three days of speakers, courses and entertainment

By Kristine Colker, Managing Editor, Dental Tribune Show Dailies

We’ve all heard the saying: “What happens in Vegas, stays in Vegas.” Except this time, you’re not going to want it to stay there. This time, three days in Vegas could change your practice forever.

From Wednesday, August 25, to Saturday, August 28, Sirona will hold its CEREC® 25th Anniversary Celebration at Caesars Palace in Las Vegas to commemorate the company’s 25 years of CAD/CAM leadership and success. The event will bring leading educators from across the globe together to give CEREC owners, staff members and dentists interested in knowing more about CAD/CAM an opportunity to learn as much as they can in a single location.

“A quarter century of CEREC is a big deal,” said Sirona CEREC’s Marketing Manager Julie Bizzell. “We’ve all heard the saying: ‘What happens in Vegas, stays in Vegas.’ Except this time, you’re not going to want it to stay there. This time, three days in Vegas could change your practice forever.

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Using risk identification and credit granting to build your practice

By Paul Zuelke

In 1980, when we took our first dentist as a client, almost all dental offices were routinely granting credit to their patients. If a patient/parent needed a few months to pay for his/her clinical treatment, a payment plan was usually allowed.

Thirty years later, things have clearly changed. Dentists today rarely grant credit because they don’t want to assume the risk. Patients are pushed to pay in full or to use third-party financing.

In fact, many of the practice management consultants who are active today are recommending their dental clients be “cash only” and only provide third-party financing (finance company, bank, credit card) for their patients.

The result is simply horrible rates of case acceptance, postponed/phased treatment, more single-tooth treatment than ever in the past, significant increases in failed appointments, a reduction in the number of new patient referrals and a net reduction in production per dentist hour worked in many practices.

This defensive behavior is unnecessary because credit granting, internal credit granting, is safer and more productive today than it has ever been in the past!

While choosing not to grant credit, to be a cash-only practice, solves some delinquency and cash flow problems, that policy often makes other problems worse. Failed appointments do not improve and often become worse because when money is tied to appointments, patients often find good reasons to postpone or cancel the appointments, and in more serious cases simply become a “no show.”

Although collection rates are good, actual cash flow does not improve because of the single biggest problem with being a cash-only practice, weak case acceptance.

If your patients are not having you perform the work for conditions you have diagnosed, or if they only accept work covered by insurance, your production will be down and cash flow will be down as well. Ultimately, being a cash-only practice contributes to the biggest problem of all: poor referrals and weak new patient flow.

Let me note that there is no legal, ethical or moral reason why any dentist needs to grant credit. The only reason to grant credit is the obvious and practical one: You will have more patients who will accept more of your treatment recommendations.

It is not a coincidence that during the last three years, while our economy has been less than stellar, practices that routinely allow their patients monthly payments for their treatment have experienced significantly less of an impact from the economy than have the cash-only practices.

Appropriate credit granting is often the answer to building a consistently growing, productive and profitable practice. Of course, “appropriate” is the operative word.

While you cannot afford to have your great patients postpone their treatment because of your financial policies, neither can you afford the financial loss and other problems associated with granting credit to the wrong patients.

Obtaining credit reports on patients was the answer to this dilemma in 1980, and it is still the answer today. The difference today is that learning a patient’s potential risk to the practice is much less expensive, less intrusive, less time consuming and much more accurate than it has ever been.

The Zuelke Automated Credit Coach (ZACC) is a Web-based tool available from DentalBanc that has been specifically designed for the dental profession. ZACC evaluates stability, maturity and credit integrity in exactly the same fashion as a bank loan officer, but ZACC does it in a few seconds.

Once ZACC has evaluated your patient/responsible party, ZACC assigns a credit grade and even makes a recommendation regarding the most liberal financial arrangement that you can safely offer the patient. Although ZACC reads and interprets every line and every column on a credit report, a ZACC inquiry does not affect a patient’s credit score nor does a ZACC inquiry show up as an inquiry to your patient’s other creditors.

You can grow your practice with safe and appropriate credit granting. Take a look at ZACC at www.getzacc.com.

About the author

Paul Zuelke is president and founder of Zuelke & Associates, a management consulting firm specializing in teaching credit management and receivable control techniques to health-care practices. Zuelke’s extensive professional background in lending and corporate finance, combined with 50 years of experience with more than 1,000 client practices located throughout the United States, Canada and Australia, position him as a leading authority in using effective credit management to build a quality health-care practice.
Integrate

verb [trans.] 1. combine (one thing) with another so that they become a whole

Integrating the Vibraject® dental needle accessory into one’s dental practice and including it as an integral part of an established injection protocol will result in measurable benefits for both the practitioner and patient.

Progressive dentists are proactive when it comes to the adaptation and integration of new dental technologies into their practices.

The Vibraject dental needle accessory easily attaches to virtually any aspiring or intraligamental syringe to block the pain of dental injections based on the principles of the Gate Control Theory. Its effectiveness has been documented by a university study, the results of which may be examined at: bit.ly/dental.com/cmtdoc/Queens_University_Study.pdf.

Fear of injection pain rates high upon the list of excuses for dental appointment cancellations and no shows. Removing the pain and stress of dental injections can become fundamental to building a practice and appointment regularity. Once the Vibraject has been integrated into your current office dental procedures, a significant number of your patients will have no excuse for avoiding necessary dental care and treatment.

In addition, by integrating Vibraject into your injection protocol, you will be increasing office value to your patients. Satisfied patients experiencing comfortable injections will not keep silent about their pleasant new dental experiences, resulting in multiple referrals and an increased bottom line.

Long-lasting benefits of Vibraject are that it’s economical, easy to use and does not require extended, valuable chair time. For more information, about Vibraject visit www.illidental.com.

The Atlas Denture Comfort System

Narrow implants require no surgical incision and no sutures

It’s been said that more dentures can be found in their rightful owner’s bedside drawer than in their mouth. In fact, eight out of every 10 denture wearers experience problems with the fit and function of their prosthesis.

It is known that loss of all teeth causes disability for most people who wear conventional dentures because they have difficulty performing two of the essential tasks of life, eating and speaking. Eventually, ill-fitting dentures compel patients to seek repeated professional help to adjust the fit.

The use of two to four implants to support mandibular overdentures has been shown to have high success rates. For many patients, though, financial constraints and health issues limit ideal bone augmentation and conventional implant placement.

The design of the Atlas® Denture Comfort™ System by Dentatus considers all aspects of edentulism and eliminates known deficiencies associated with conventional osseointegrated and metal housing technologies, thus providing affordable comfort to the estimated 50 million edentulous patients in the United States.

The very narrow implants of the Atlas Denture Comfort technique require no surgical incision and no sutures. Available in 1.8, 2.2 and 2.4 mm diameters, they can be placed in thin, atrophic ridges without the need for grafting procedures.

What’s more, patients can walk out of the office wearing their refitted dentures right away. This implant system is designed to overcome financial, physical and time limitations.

The denture is retrofit to create a “seamline” that encases the Tuf-Link silicone reline material, eliminating the need for adhesives. This allows the implants to be placed at diverging angles. The soft resilient Tuf-Link material grasps on and around the implant’s head providing a cushioned fit, all in less than an hour.

This proprietary design feature is considered to be significantly beneficial to both clinicians and patients as the Tuf-Link can be lifted out to scissor away excess material and returned into its self-aligning position and hermetic encapsulation in the base.

The easy removal of the liner, as opposed to having liners that are attached with various adhesives, prevents bacterial infection and odor accumulation that occur at the denture interface of bonded liners.

Dentatus makes getting started with Atlas Denture Comfort easy with a half-day hands-on workshop. You will learn step-by-step how to drill osteotomies in the model, install four Atlas implants, prepare the denture base for retrofitting and reline the denture with the Tuf-Link silicone material. Participants will keep the model for staff training and patient education.

References


Tuttnauer unveils the Elara11

Tuttnauer, a global leader in sterilization and infection control, has introduced the Elara11 pre- and post-vacuum autoclave, the newest addition to its line of autoclave products.

The Elara11, with its new 11 inch chamber, automatic double-locking device, digital readout and touch pad, brings a whole new dimension to fulfilling the pre- and post-vacuum sterilization requirements to reverse or replace sterile and unwrapped, solid, hollow or porous products and goods wrapped, unwrapped, solid, hollow products and goods. The Elara11 comes equipped with five staining cycles, a table-top Class B sterilizer. It also comes with five staining cycles, a touch pad, brings a whole new dimension to fulfilling the pre- and post-vacuum autoclave, the newest addition to its line of autoclave products.

The new design of the Elara11 provides the options of an easily accessible front water-fill or top water-fill with sight glass indicator. The Elara11 with its 7.5 gallon chamber, automatic double-locking device, digital readout and touch pad, brings a whole new dimension to fulfilling the pre- and post-vacuum autoclave, the newest addition to its line of autoclave products.

The Elara11 comes standard with five FDA-cleared cycles plus two test cycles — the Bowie Dick Test and Vacuum Test — to meet all of your sterilization needs.

The new design of the Elara11 provides the options of an easily accessible front water-fill or top water-fill with sight glass indicator. The Elara11 with its 7.5 gallon sterilization chamber is the largest table-top Class B sterilizer. It also comes equipped with five stainless steel trays and there are no requirements to reverse or replace the rack to switch between trays or cassettes. For more information, visit www.tuttnauerusa.com.

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The denture is retrofit to create a “seamline” that encases the Tuf-Link silicone reline material, eliminating the need for adhesives. This allows the implants to be placed at diverging angles. The soft resilient Tuf-Link material grasps on and around the implant’s head providing a cushioned fit, all in less than an hour.

This proprietary design feature is considered to be significantly beneficial to both clinicians and patients as the Tuf-Link can be lifted out to scissor away excess material and returned into its self-aligning position and hermetic encapsulation in the base.

The easy removal of the liner, as opposed to having liners that are attached with various adhesives, prevents bacterial infection and odor accumulation that occur at the denture interface of bonded liners.

Dentatus makes getting started with Atlas Denture Comfort easy with a half-day hands-on workshop. You will learn step-by-step how to drill osteotomies in the model, install four Atlas implants, prepare the denture base for retrofitting and reline the denture with the Tuf-Link silicone material. Participants will keep the model for staff training and patient education.

References

Air abrasion unit from Velopex fits many occasions

There are many uses of the Velopex Aquacut Quattro Fluid Air Abrasion Unit. Here are some of them:
- minimally invasive and cosmetic dentistry,
- patient-friendly stain removal and cavity preparation,
- fast, efficient cutting and cleaning,
- ideal for repair of composites.

The Aquacut Quattro will give you greater control and flexibility than any other piece of equipment you own. Some of its other benefits include:
- no vibration, turbine noise, heat generation or smell,
- greatly reduced need for local anesthesia,
- a handpiece that creates a fluid curtain around the powder medium,
- a triple-action foot control that speeds treatment by allowing cut, wash and dry operations through the same handpiece,
- no chipping or stress fracturing,
- minimal loss of sound tooth material.

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“I just got back from LVI and my world has changed. I can’t possibly look at dentistry the same way again!”
– Dr. Balaji Srivisan

“My LVI education has enabled me to not only survive, but to thrive.”
– Dr. James R. Harold

“There is nothing out there that even comes close to the LVI experience. The amount of enthusiasm I am bringing home with me is unbelievable. What an experience and a treat!”
– Dr. Robert S. Maupin

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Dentin hypersensitivity is a painful dental condition often left untreated. Prevalence of dentin hypersensitivity in the adult population can range from 8 to 50 percent, with the majority of the sufferers between 25 and 45 years of age.

Therefore, a clinician will see, on an average day, between one and three patients who show varying degrees of sensitivity. The condition is slightly more prevalent in women and periodontally involved patients.

With the population aging and keeping their teeth longer, there is an increased incidence for dentin hypersensitivity, recession and periodontal disease.

According to the majority of this older population is on medications that cause xerostomia. Differences in salivary flow or composition may increase the incidence for dentin hypersensitivity. Acids present in many foods and beverages, such as citrus fruits, vitamins, condiments, spices, wine, sauces and carbonated drinks should be suspected more than any other stimulus of dentin pain.

Chemical stimuli are possibly the most overlooked triggers of dentin hypersensitivity. Acids present in many foods and beverages, such as citrus fruits, vitamins, condiments, spices, wine, sauces and carbonated drinks should be suspected more than any other stimuli of dentin pain.

Acid foods and drinks have been shown to soften dentin and may remove deposits on the dentin surface. Ascorbic acid, from chewable vitamin C tablets, can even be a stimulus.

Up to 90 percent of individuals suffering from dentin hypersensitivity report that the effect of a thermal stimulus, particularly a cold stimulus such as breathing through the mouth on a cold day or consuming a cold drink, causes the painful sensation associated with sensitive teeth.

Osmotic flow within the dentin tubules is important; there may be variations in the way in which different stimuli affect fluid flow. Bacteria produce acid when fermentable carbohydrates are available; it is this acid by-product, as it relates to demineralization or root caries, which can also cause sensitivity.

An increase or decrease in sensitivity may be attributed to the mechanisms of metabolic breakdown and products the bacteria produce.

Related to periodontal disease, it is known that periodontal pathogens can penetrate dentinal tubules a considerable distance. Once in the tubule, the bacteria may create a continual source of sensitivity.

Patients with sensitive teeth often have larger, more numerous

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"And all it takes is a little education and a toothbrush to combat it."

During National Children's Dental Health Month, hundreds of dental hygienists in California and across the country participated in community outreach programs.

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Dear Reader,

I have been thinking slightly outside of the box with my clinical practice for about six years now. My thoughts began to take a different direction after I was exposed to an amazing hygiene meeting and the hygienists in attendance. I returned from that meeting rejuvenated and vowed I would switch things up a little bit. This was a difficult undertaking for me because I am a very traditional thinker.

The first thing I did is begin practicing without any ceiling lights in my operatory. While my patients loved it, the dentist was sold. Now they can’t imagine practicing with the lights on!

Since this time I have incorporated more small steps to incorporate a bit of “Spa Hygiene” into my practice. Patients are treated to a back massage while getting their teeth cleaned. A bolster pillow is placed under their knees to conform their lower back to the chair and the massage pad. An extra pillow placed under their neck provides support while their neck is arched. A fleece blanket is available for those who feel chilled while receiving treatment.

Patients have become so accustomed to these small additions we have incorporated them into the other hygiene operatory. Patients enjoy coming to their appointment. It is a time to rest and relax. Many times, they don’t want to leave.

Our office staff has created a special niche because I ventured out of the box. Then, eventually, others joined me.

Don’t be afraid to open your mind to something out of the ordinary and try something new. It may be the beginning of something amazing!

Rest Regards,

Angie Stone, RDH, BS

Have you been thinking ‘outside of the box’ and seeing wonderful results? If so, share your story with us and it might be featured in Hygiene Tribune! Please send stories to Group Editor Robin Goodman at r.goodman@dental-tribune.com.

‘Prevalence of dentin hypersensitivity in the adult population can range from 8 to 50 percent, with the majority of the sufferers between 25 and 45 years of age.’

Dental tubes.
Managing dental hypersensitivity

It is important to note that dental hypersensitivity is a manageable condition. Management includes:

1. (dental) diagnostic to determine that tooth pain is actually a result of dental hypersensitivity;
2. prevent, modify, remove or control etiologic factors such as plaque, improper toothbrushing, and a diet high in fermentable carbohydrates and/or acidic foods;
3. (patient) home care and product use and
4. (professional) application of desensitizing agents.

Diagnosing root sensitiv-
ity requires a careful history and methodical dental and radiograph-
ic examination.

The clinician must first rule out dental caries, pulp patholo-
y, vertical cracks, cracked cusps, abstractions, leaking restorations and/or teeth in hypertension.

Often, the dental hygienist is the first practitioner to recognize dental hypersensitivity. It is imperative to document dental hypersensitivity as a part of the treatment record.

Testing for hypersensitivity should be part of an initial examination and can be as simple as an air-blaster test.

Patients who experience hypersensitivity appreciate it when teeth are dried carefully with gauze or cotton rolls before using the air syringe. It would be important to have a pretreatment record for sensitive teeth before periodontal therapy.

Treatment agents

Two groups of agents can be used in the treatment of dental hypersensitivity: chemical or physical.

Chemical agents include:

• potassium salts (most commonly potassium nitrate);
• fluoride agents in concentrations greater than found in dentifrices (with or without iontophoresis);
• sodium citrate;
• corticosteroids, silver nitrate;
• strontium chloride;
• formaldehyde and
• calcium hydroxide.

Physical agents include:

• composite, microfilled and unfilled resins;
• sealants;
• dentin bonding agents;
• glass-ionomer cements;
• varnishes and soft tissue grafts.

Desensitizing agents may be classified by their mode of action. Agents act either by inactivating the nerve or by occluding the tubule. For example, potassium nitrate is an agent that inactivates the nerve.

Potassium nitrate is the most common desensitizer in dentifrices. At the concentration of 5 per cent potassium nitrate, Sensodyne® (GlaxoSmithKline, Jersey City, N.J.), has been shown in clinical trials to significantly reduce symptoms within two weeks when applied on a toothbrush twice daily.

It works by allowing the potas-

sium ions to penetrate the length of the dental tubules and block repolarization of sensory nerve end-
ings, reducing the pain response.

Frequent use is necessary to avoid recurrence of symptoms. For this reason, it is ideal via a dentifrice.

Potassium nitrate-containing toothpastes include Aqua-fresh Sensitive, Colgate Sensitive, Crest Sensitive Protection, Dental Care Sensitive Formula; other products for sensitive teeth are Protect Sen-
sitive Teeth Gel Toothpaste, Rembrandt Whitening Toothpaste for Sensitive Teeth and Orajel Sensitive Pain Relieving Toothpaste for adults.

All of these toothpastes contain fluoride to strengthen dental enamel and protect against cavity formation.

To ensure maximum compliance, patients should be advised to select desensitizing toothpaste similar to their current preference — be it whitening, baking soda, gel or tartar control, or a specific flavor (such as fresh mint).

Patients should be advised to read and adhere to the labeling found on the product packaging.

References

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