Diagnose this: white lesions
The first in a series on the different types of mucosal and soft-tissue pathologies. ➤ page 64

How to reach practice goals?
Learn what has the most impact when it comes to achieving your practice’s goals. ➤ page 74

New products and more
Take a peek at some products that might be unfamiliar to you. ➤ pages 19A–22A

Retired orthodontist gives $4 million to East Carolina University School of Dentistry

By Fred Michmershuizen, Online Editor

Dr. Ledyard E. Ross, an 84-year-old retired orthodontist, has pledged $4 million to East Carolina University (ECU) School of Dentistry. The gift, one of the largest in the history of the university, will be used for student scholarships, faculty research and other academic enterprises.

Ross is a 1951 graduate of ECU (then called East Carolina College). He has been a supporter of several academic and athletic initiatives at the university since establishing his dental practice in Greenville. He is a member of the Leo Jenkins Society and Order of the Cupola.

Ross attended Greenville High School and Hardbarger Business College before being admitted to East Carolina College.

He graduated from Northwestern University Dental School with a DDS in 1953, and he received a master of science degree in orthodontics in 1959 from UNC-Chapel Hill. He served in the U.S. Marine Corps First Marine Division from 1945 to 1946.

His financial gift comes at a well...

Crown or same-day onlay?

Patients want to replace their old amalgam fillings, but they want to do it conservatively, consistently, efficiently, predictably and economically — and they want to do it in one visit. Review the advantages associated with indirect laboratory-processed composite resin posterior restorations and see the case study presented by Dr. Lorin Berland.

➤ See pages 10A–13A

5 ways dental practices can reduce waste and pollution

In honor of the 40th annual Earth Day, the Eco-Dentistry Association (EDA) — an international association promoting environmentally sound practices in dentistry — is encouraging dentists to do their part to help save the environment.

To help dentists be more environmentally conscious, the EDA has issued a checklist of standards for green dental offices. Specifically, the EDA is recommending that dental professionals make the following Earth Day resolutions to reduce waste and pollution.

Use an amalgam separator

Even if you don’t place amalgams, you still need an amalgam separator, according to the EDA. In a typical
Cloth sterilization wraps and pouches and reusable cloth patient bibs and barriers, popular in high-tech and spa practices, help dentists significantly reduce their environmental footprint. When a paper-plastic pouch is the best solution, separate the paper from the plastic and recycle each appropriately, the EDA says.

**Detoxify your infection control processes**

Using the right non-toxic, biodegradable cleaner and disinfectant is an important component of pollution-preventing infection control, according to the EDA.

Line cleaners and cold sterile solutions such as glutaraldehyde are a significant source of pollution from the dental industry and contribute to poor indoor air quality.

Modern dentistry has eliminated the need for cold sterilization, and there are several environmentally safe line cleaners on the market.

Making a switch to the non-toxic option will keep your office in compliance with hospital infection control standards while eliminating the “dental office smell” that patients hate, the EDA says.

**Take digital images**

Dental radiographs are an important part of preventive dentistry, but traditional dental X-rays will contribute as much as 4.8 million lead foils and 8.5 million barriers from U.S. dental offices every year. Every restorative practice will end up in landfills this year, according to the EDA.

The EDA offers “Best Practices for Waste-Reducing Sterilization and Infection Control” to help dental professionals become litter-free while maintaining the highest infection control standards.

Health Sciences campus, will have much more than 100,000 square feet. The North Carolina General Assembly has provided about $90 million for construction.

That appropriation covers both the dental school building in Greensville and 10 community-service learning centers in rural and underserved areas of North Carolina. The first three locations announced for those centers are Sylva, Ahoskie and Elizabeth City. Dental school faculty members will be based in the centers, along with advanced dental residents and senior students who will receive enhanced dental education in real practice settings.

The students and faculty will offer much-needed dental care to citizens in the areas surrounding the centers.

“The difference between being a good dental school and a great dental school hinges on private giving,” said Dr. James Hupp, dean of the school of dentistry.

“Dr. Ross’ very generous philanthropic gift will propel us toward greatness, allowing us to accomplish our grand vision of improving the health and quality of life of North Carolinians by leading the nation in community-based, service-learning dental education. We cannot thank you enough.”

The ECU dental school plans to admit its first students for the fall semester of 2011. About 50 students will enter the program every year.
Dental museum adds exhibit

By Fred Michmershuizen, Online Editor

The National Museum of Dentistry, located in Baltimore, has added a new exhibit that will help teach the public about the American College of Dentists, the oldest national honorary organization for dentists.

The gold-plated mace and torch that have been used in American College of Dentists membership ceremonies for nearly 70 years are among the highlights of the new exhibit. The display also features an American College of Dentists’ Fellowship pin, key and rossette. Also on view is the William J. Gies Award, which recognizes college fellows who have made outstanding contributions to the advancement of the profession.

“The National Museum of Dentistry preserves and celebrates the history of the dental profession,” said Jonathan Landers, executive director of the museum. “This is the perfect place to showcase these fragile and magnificent historic symbols of such a respected organization in dentistry.”

The American College of Dentists is the oldest national honorary organization for dentists. It was founded to elevate the standards of dentistry, encourage graduate study, and grant fellowship to those who have done meritorious work. Membership in the American College of Dentists is by invitation only.

There are more than 7,400 fellows, who are selected based on their contributions to organized dentistry, oral health care, dental research, dental education, the profession and society. Long regarded as the “conscience of dentistry,” its mission is to advance excellence, ethics, professionalism and leadership in dentistry.

“We are honored to have the mace and torch on view at the National Museum of Dentistry,” said Dr. Stephen Ralls, executive director of the American College of Dentists. “They represent an important historical link to key leaders of dentistry from the early 20th century onward.”

About the mace and torch

When the American College of Dentists was founded in 1920, a symbolic light—the torch—was designated to signify the role of the college as a source of enlightenment and guidance. The torch was crafted in 1939 by the Gorham Silver Co. of Providence, R.I., to serve as a symbol of office.

The fluted staff, more than two feet long, is made of gold-plated bronze and decorated with ribbons engraved with the names of the founders of the American College of Dentists. “They represent an important historical link to key leaders of dentistry from the early 20th century onward.”

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Two Egyptians holding the ends of an open scroll, is supported by depictions of 11 Egyptian scholars and a modern graduate.

To visit the museum

The National Museum of Dentistry is an affiliate of the Smithsonian Institution. Other exhibits include George Washington’s false teeth, vintage toothpaste commercials and hands-on displays that are meant to educate visitors of all ages about the power of a healthy smile.

The museum is located at 31 S. Greene St., not far from Baltimore’s Inner Harbor. Admission is $7 for adults, $5 for seniors and students with ID, $5 for children age 3-19, and free for ages 2 and younger. It is open Wednesday through Saturday from 10 a.m. to 4 p.m. and Sunday from 1 to 4 p.m. The museum is closed Mondays, Tuesdays and major holidays.

More information about the museum is available by phone, at (410) 706-0860 or online, at www.smile-experience.org.

(Source: National Museum of Dentistry)

The gold-plated mace of the American College of Dentists, at right, is now on display at the National Museum of Dentistry in Baltimore. (Photo/National Museum of Dentistry)
CareCredit®, a patient payment program, continued its support as founding donor of the American Dental Association Foundation Give Kids A Smile® expansion fund with its fourth consecutive $100,000 donation. The donation was made at the Give Kids A Smile National Advisory Board meeting, Feb. 24 in Chicago.

The American Dental Association’s Give Kids A Smile program has two objectives: first, to enable dental teams to provide free dental care, screening and education to underserved children; and second, to raise public awareness that the children of this country deserve a better health-care system that addresses their dental needs.

In 2009, with the help of CareCredit’s contribution, grants were awarded to the Hispanic Dental Association (HDA), the National Dental Association (NDA) and Oral Health America. The NDA is using its grant to fund local dental student-led oral health programs in Los Angeles, Dallas and Boston.

The NDA is enhancing the Deamonte Driver Dental Project and has assembled its Dentists in Action Monte Driver Dental Project and Los Angeles, Dallas and Boston.

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For more information on CareCredit, call (800) 500-5046, ext. 4519, or visit www.carecredit.com/dental. Information on Give Kids A Smile can be found at www.givekidsasmile.org.

Global lab revenues to exceed $14.5 billion by 2015

By Fred Michmershuizen, Online Editor

Increasing numbers of elderly people and more demand for high-quality dental esthetics are cited among the reasons for an increase in global demand for the services of dental laboratories.

According to a new report, the world market for dental laboratories is projected to exceed $14.5 billion by the year 2015.

The report, by Global Industry Analysts, a publisher of market research, states that dental laboratories are witnessing a significant increase in demand for dental prosthetics as well as other restoratives.

The report also cites the increasing purchasing power of the baby boomer generation as another factor driving the dental laboratory market.

The United States represents the largest market for dental laboratories worldwide, according to the report.

The scarcity of technicians and availability of modern restorative technologies and systems are driving dental laboratories to deliver quality dental restorations to dentists on time.

Outsourcing is a key element in the U.S. dental laboratory industry.

The report, “Dental Laboratories: A Global Strategic Business Report,” provides a comprehensive review of dental laboratories, market trends, recent industry activity and focus on market participants.

The study analyzes market data and analytics in terms of value sales for regions, including the United States, Canada, Japan, Europe, Asia-Pacific, Latin America and the rest of the world.

Key players profiled in the report include 1st Dental Laboratories, Attenborough Dental, Champlain Dental Laboratory, Dental Services Group, iDent Dental Lab, Lord’s Dental Studio, Knight Dental Design, National Dentex Corp., Southern Craft Dental Laboratory, Utah Valley Dental Lab and others.

The report is available for purchase from Global Industry Analysts.


(Source: Global Industry Analysts)
Changing dentistry 4mm at a time.

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

Since launching SureFil® SDR™ flow in September 2009, over 10,000 dentists have tried the first and only bulk fill flowable posterior composite. What’s even more impressive is that over 90% of them said they would continue to use it. SureFil® SDR™ flow has self-leveling handling that provides excellent cavity adaptation, and it can be bulk filled in 4mm increments, dramatically streamlining your posterior restoration. Contact your DENTSPLY Caulk rep or visit www.surefilSDRflow.com to learn more.
Diagnose this: white lesions

By Monica Malhotra, India

The purpose of this quiz, and the ones to follow, is to assist you in understanding the different types of mucosal and soft-tissue pathologies with different colors (red, white, mixed red/white) and other pigmented lesions seen in the oral cavity.

There has been a trend to ignore the overall examination of the oral-cavity and concentrate more upon the chief complaint a patient presents.

In this process we often don’t take advantage of the so-called “mirror of general health.” We can always take a little more time to overview the entire oral cavity, including the oral mucosa.

Please feel free to contact me with any feedback or questions you may have.

Part 1: case study
A 45-year-old, healthy man visited his dentist for tooth pain and was informed that his mouth contained “disease in disguise.”

Upon oral examination, buccal mucosa showed hyperkeratotic white, slightly elevated, diffuse patchy lesion extending toward the commissures of the mouth on the left side.

The lesion was non-scrapable in nature.

The patient had a habit of smoking five to six bidis (a crude form of cigarette used in India) a day for the past four years.

1) What provisional diagnosis would you make of this lesion?
   a. Leukoplakia
   b. Linea alba
   c. Lichen planus
   d. Leukoedema
   e. Candidiasis

See page 15A for the answer.
Looking for ‘love’ in all the wrong places

By Louis Malcmacher, DDS, MAGD

As a practicing dentist and a dental consultant, I know exactly where dentists are coming from when they describe their daily challenges to me. I hear routinely from dentists about all kinds of problems they are experiencing.

Every dentist that I talk to wants to know how to get more new patients, how to properly market their practice, how to be faster and more efficient clinically, how to reduce overhead, how to motivate more patients to bigger and bigger treatment plans and a whole host of other issues that are constantly on a dentist’s mind.

Dentists will spend all kinds of money on books, tapes, consultants, marketing programs, newsletters and all sorts of other things that they think will improve a particular part of their practice. Most dentists who are looking for these solutions are always, as I like to say, “looking for love in all the wrong places.”

Dentists often overlook the most obvious and impactful part of their practice: the dental team that they work with every single day.

The team
Having a great dental team will significantly improve all aspects of your dental practice immediately and for the long term. Having a great dental team solves so many of the issues and the challenges that dentists face every single day.

Do you want more patients? Your dental team should be out there asking everybody they know if they need a dentist as well as every single patient that comes through the door about referring their own families and friends as new patients to the practice.

Do you want to market your practice better and more efficiently? Having great dental team members will carry your message with them into every single treatment room and will accomplish that.

Do you want to motivate patients to more comprehensive dentistry and more elective dental procedures such as Aurum Ceramics Cristal Veneers? A great dental team will take the time to plant seeds in patients’ minds about what dentistry can accomplish, and these staff members are the most effective communication team you could possibly have.

It always amazes me that a dentist will spend thousands of dollars on a computerized education system that will describe dental procedures when a talented dental assistant can do the same thing with that human and personal touch. By the way, that doesn’t mean that digital education materials aren’t useful.

If your dental team members are poor communicators and you buy them an educational piece of equipment, then what you now have is a dental team with poor communication skills but with an expensive computer.

Why not spend that money to first go ahead to motivate and improve the morale and communication skills in your office so that everybody can talk to patients more easily and with more leadership?

Do you want to reduce your overhead? A great dental team will certainly help you accomplish this by streamlining so many of the inefficient processes that occur in daily dental practice and will help the dentist accomplish dental treatment much faster, easier and better.

Do you want to improve your cash flow and account receivables? A great dental team is the road to success in every dental office in every single aspect you could possibly imagine.

Valued partners in success
I see dentists wasting their time and money buying into all kinds of gadgets, toys, scams and supposed “systems for success” when they should be spending their time, energy and effort developing and motivating their valued staff members.

Every week when I am giving a lecture, for the most part, I can see immediately who the more successful dentists are just by looking at the audience in the first two minutes of the lecture. The most successful dentists I know and that I see at my lectures are the ones who have their dental team members sitting right next to them at the events they attend.

If you, as a dentist, go to a lecture and want to learn about something new or want to institute a new system in your office and you attend the lecture alone and then return to the office, your staff members will not have the same enthusiasm that you developed or the same initial level of interest. You must then force this new idea down their throats, to which they become resentful. Success in this scenario is going to be limited, but more likely will not happen. It frustrates me because I know the solution is really so simple.

Look at your dental team members as the valued partners in success that they really are.

Look at your dental team members as the valued partners in success that they really are. Staff appreciation is one of the most overlooked, inexpensive and easiest ways to begin to develop a great dental team.

It may surprise you to know that in many major studies in employee relations, money is not the most important factor to employees. No. 1 is staff appreciation and No. 2 is having a pleasant place to work in.

If your dental team members also realize they are fulfilling a mission of improving peoples’ lives through excellent oral health that also gives them a great sense of purpose.

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You could pay a dental assistant $100 per hour, but if she is miserable in the work environment, your office will never be successful. You could pay your front desk team member $100 per hour, but if you have never invested in having him develop the necessary skills to talk to patients, your office will not be successful.

If you pay your dental hygienist $100 per hour and she is just a housekeeper with no communication skills, your office will never reach its full potential.

Being in the ‘people’ business
Ultimately, dentistry is a people business. To be successful in this field, you have to love people and hire people who love people. If you hire people who love people, your office will become a different place.

Stress in dentistry is caused by the people who work in your office who are stressing themselves, you and your patients. Once your patients are stressed, they will stress you even more.

Hiring the right staff is the first step along the road to a happy office. The next steps include working with your team members and constantly training them and yourself in how to do better clinical dentistry, how to be better communicators, how to serve and how to achieve all of your goals together.

This has so frustrated me as I lecture to thousands of dentists a year that I have some resources on my Web site, www.commonsensedentistry.com, about building the best dental team ever.

You need to know how to hire, evaluate and give a bonus to great team members. You must lead and motivate team members with your vision of what you want your practice to be. It really is this simple: if you have a great dental team, you will have a great office!

The simple road to success
Stop wasting your time and money on all the schemes and supposed shortcuts out there that you think may improve your office from the outside in.

Hire, develop and motivate a great dental team by learning leadership skills and build your office from the inside out.

It doesn’t help you at all to get 100 new patients per month if your team members do not have the capability or the interest to properly build relationships with your patients.

You, as a dentist, typically spend 50, 40 or 50 hours per week in your dental practice — it is equally as easy to be happy there as it is to be miserable. Life is too short to spend your time in a miserable situation.

In addition, what does your office team look like? Do they have great smiles, are they well groomed, do they dress nicely and cleanly? This says a lot about your practice.

If you are looking to build an aesthetic practice, patients are more apt to accept treatment plans from team members (and dentists!) who have a great looking smile and great facial esthetics.

Now that nearly 10 percent of dentists are providing Botox and dermal fillers, it is not just about the teeth anymore in the dental office and the same is to be said about facial esthetics.

I often joke that Botox is the secret to staff retention — once you provide this to your team, they will never leave because this is a repeat procedure.

Yet the street here runs both ways — it helps build your practice when everyone looks their best — they feel better about themselves from a self-esteem perspective, they transmit a more positive image and treatment acceptance will go up.

If your dental office is a place that loves to work with people, that attitude alone will solve so many of the issues that have frustrated you throughout your career.

When we consult with dental offices and turn their team members around, and make them great and sincere communicators, the office becomes a stress-free, high-producing, low-overhead, fun place to work for everyone.

It is amazing what a little appreciation and respect will do in motivating and building a great dental team.

It is the quickest and straightest road to dental practice success.

Dr. Louis Malcmacher is a practicing general dentist in Bay Village, Ohio, and an internationally known lecturer and author known for his comprehensive and entertaining style.

An evaluator for Clinicians Reports, Malcmacher has served as a spokesman for the AGD and is president of the American Academy of Facial Esthetics.

You may contact him at (440) 892-1810 or e-mail dryowza@mail.com.

You can also see his lecture schedule at www.commonsensedentistry.com where you will find information about his Botox and dermal filler live patient hands-on training, practice-building audio CDs and free monthly e-newsletter.
When It’s Time to Buy, Sell, or Merge Your Practice
You Need A Partner On Your Side

ALABAMA
Birmingham—2 Ops, 2 Hygiene Rooms, GR $675K *10108
Shaw Low—2 Ops, 2 Hygiene Rooms, GR in 2007 $645,995
Phoenicia—General Dentist seeking Practice Purchase Opportunity *10106
Phoenicia—3 Ops, 1 Hygiene Room, GR $900K *10113
N Northside—General Dentist seeking Practice Purchase Opportunity *10109

ARIZONA
Artistic—Doctor seeking to purchase General Dental Practice. *12110
Shaw Low—2 Ops, 2 Hygiene Rooms, GR. in 2007 $645,995
Phoenix—General Dentist seeking Practice Purchase Opportunity *12108
Phoenix—1 Ops, 3 Equipped, 1 Hygiene, GR $513K *, 1 Working, Day *11113

CALIFORNIA
Altair—2 Ops, GR $611K, 1.5 day week *14279
Airways—2 Ops, 1,300 sq. ft., GR $177K $14287
El Dorado—3 Ops, 1,300 sq. ft., GR $535K *14292
Modesto—2 Ops, 1,300 sq. ft., GR $105,000 $14289
Greater Auburn Area—4 Ops, 1,300 sq. ft., GR $763K *14204
Modesto—12 Ops, GR $1,097,000, Same name for 10 years *14289
Modesto—6 Ops, GR $889K w/adj. sec. income of $469K *14310
N California Wine Country—4 Ops, 1,500 sq. ft., GR $958K *14291
Pine Grove—Nice 3 Ops fully equipped office/practice, GR $111,000 $14109
Porterville—6 Ops, 2,000 sq. ft., GR $2,289,000 $14291
Red Bluff—8 Ops, 2009 GR $1,000,000, Hygiene 10 days a week *14252
CONTACT: Dr. Dennis Hoover @ 805-519-3458

RECOMMENDATIONS

CONNECTICUT
Fairfield Area—General practice doing $800K + $16106
Southbury—2 Ops, GR $254K $16111
Wallingford—2 Ops, GR $600K $16115
CONTACT: Dr. Peter Goldberg @ 203-680-7290

FLORIDA
Miami—5 Ops, Full Lab, GR $835K $18117
Jacksonville—GR $2.1 Million, 3,000 sq. ft., 7 Ops, 8 days hygiene *11118
CONTACT: Donna Wright @ 800-730-8883

GEORGIA
Atlanta Suburb—2 Ops, 2 Hygiene Rooms, GR $863K $19125
Atlanta Suburb—2 Ops, 2 Hygiene Rooms, GR $633K $19128
Atlanta Suburb—2 Ops, 2 Hygiene Rooms, GR $848,365 $19131
Atlanta Suburb—Pediatric Office, 1 Op, GR $426K $19134
Dublin—GR $1 Million, Asking $285K $19107
Macon—3 Ops, 1,625 sq. ft., State of the art equipment $19103
North Atlanta—1 Op, 3 Hygiene Rooms, GR $678K $19132
Northeast Atlanta—GR $670K $19130
Northern Georgia—4 Ops, 1 Hygiene Room, GR for 43 years *19110
South Georgia—2 Ops, 3 Hygiene Rooms, GR $783K $19133
CONTACT: Dr. Jim Carter @ 404-513-1573

ILLINOIS
Chicago—4 Ops, GR $709K, Sale Price $461K $22126
1 HR SW of Chicago—3 Ops, 2007 GR $440K, 28 years old *22123
Chicago—6 Ops, GR $600K, 3 day work week *22119
Galesburg—GR $180K, located in Historic Bed & Breakfast Community *22129
Western suburbs—3 Ops, 2,200 sq. ft., GR Approx $155M $22123
CONTACT: Al Brown @ 618-781-2776

MARYLAND
Southern—11 Ops, 3,500 sq. ft., GR $1,810,628 $29108
CONTACT: Sharon Maschetti @ 410-788-0711

MASSACHUSETTS
Boston—3 Ops, GR $253K, Sale $197K #0312
Boston Southshore—3 Ops, GR $300K #0312
North Shore Area (Essex County)—3 Ops, GR $300K #0312
Western Massachusetts—2 Ops, GR $1 Million, Sale $314K #0311
CONTACT: Dr. Peter Goldberg @ 978-690-2950
Middle Cape Cod—6 Ops, GR $890K, Sale price $876K #0312
Boston—2 Ops, 1 Hygiene, GR $500K #03125
Middlesex County—7 Ops, GR $500K #03120
New Bedford Area—6 Ops, GR $728K #03119
CONTACT: Alex Lewis @ 508-250-2162

MICHIGAN
Suburban Detroit—2 Ops, 1 Hygiene, GR $213K #3110
CONTACT: Dr. James David @ 810-359-0080
Central Michigan—Mobile Practice, GR $475K + #31208
Twin Cities—More in & Practice immediately GR $800K #32110
CONTACT: Mike Minor @ 612-961-2132

MINNESOTA
CROW WING COUNTY—4 Ops, GR $2124
Fargo/ Moorhead Area—1 Op, GR $185K, $2327
Central Minnesota—Mobile Practice, GR $375K + #32108
Twin Cities—More in & Practice immediately GR $800K #32110
CONTACT: Mike Minor @ 612-961-2132

MISSISSIPPI
Eastern Central Mississippi—10 Ops, 4,695 sq. ft., GR $1.9 Million #51110
CONTACT: Donna Wright @ 800-730-8883

NEVADA
Reno—Free Standing Bldg., 1,500 sq. ft., 4 Ops, GR $765K #51110
CONTACT: Dr. Susan Hoover @ 800-730-8883

NEW JERSEY
Marlboro—Associate position available #51102
Mercer City—3 Ops, Good Location, Turn Key, GR $191K #51111
CONTACT: Sharon Maschetti @ 410-788-0711

NEW YORK
Brooklyn—3 Ops (Fully equipped), GR $575K #41113
Woodstock—2 Ops, Building also available for sale, GR $600K #41112
CONTACT: Dr. Dov Cohen @ 845-440-3004
Syracuse—4 Ops, 1,800 sq. ft., GR over $700K #41117
CONTACT: Barry Hazzard @ 335-253-9343
New York City—Specialty Practice, 3 Ops, GR $500K #41119
CONTACT: Richard Zalkin @ 631-661-6924

NORTH CAROLINA
Charlotte—2 Ops, 1 Equipped #42112
Forchills—5 Ops #42112
Near Pinehurst—Dental office, clinic, 3 Ops, GR in 2007 $525K #42114
New Hanover City—A practice on the coast, Growing Area #42134
Raleigh, Cary, Durham—Dentist looking to purchase #42127
CONTACT: Barbara Habner Parker @ 919-848-1555

OHIO
Medina—Associate to buy 1/3, rest of practice in future. #44150
North Central—GR $600K, 4 Ops, Well Established #44159
North Central—GR $700K, 3 Ops, Well Established #44157
CONTACT: Dr. Dave Montgomery @ 440-823-8077

PENNSYLVANIA
Northeast of: Pittsburgh—3 Ops, Victorian Mansion GR $52,5 Million #47140
CONTACT: Dan Shain @ 215-853-5037
Lackawanna County—3 Ops, 1 Hygiene, GR $515K #47138
Chester County—High End Office, 4 Ops, Digital, FFS + a few PPO’s #47141
Philadelphia County—6 Ops, GR $500K+ Est. 25 years #47142
CONTACT: Sharon Maschetti @ 484-788-0671

RHODE ISLAND
Southern Rhode Island—4 Ops, GR $1 Million #486K #48102
CONTACT: Dr. Peter Goldberg @ 401-680-2910

SOUTH CAROLINA
HIll—Dentist seeking to purchase a practice producing $500K a year #49109
CONTACT: Scott Carringer @ 704-811-4750
Columbia—7 Ops, 2,200 sq. ft., GR $675K #49102
CONTACT: John Cole @ 404-515-1573

TENNESSEE
Elizabethton—GR $333K #51107
Memphis—Large productive practice GR $82 Million #51112
Suburban Memphis—Anaging Practice in Area GR $8 Million #51113
CONTACT: George Lane @ 865-414-1527

TEXAS
Houston Area—GR $1.1 Million 50/50 net income over $500K #52103
CONTACT: Donna Wright @ 800-730-8883

VIRGINIA
Greene County Valley—2,500 sq. ft., GR $940K updated equipment #5511
CONTACT: Bob Anderson @ 804-640-2673

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

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Crown or same-day onlay?

By Lorin Berland, FAACD

“The trend in dentistry today is clearly toward more esthetic and less invasive. Indirect resin and ceramic inlays and onlays are not only compatible with this trend, but fulfill very nicely the restorative void between fillings and crowns,” wrote Ronald D. Jackson, DDS, FAGD, FAACD (Cosmetic Tribune, Dec. 2008).

Regarding durability, esthetic inlays and onlays are not new anymore. They have a track record and it is good. With today’s materials, longevity is mainly a matter of diagnosis, correct treatment planning and proper execution of technique.

The problem with replacing old amalgams with tooth-colored composites is they are difficult, inconsistent and unpredictable. Yet, the warranty on these 30-, 40-, 50-year-old silver fillings is running out. We have to remember that amalgam technology is more than 150 years old. At that time, people lost their teeth a lot earlier and died a lot earlier, too. Now, however, we have a large segment of the population that is more older than 50 and growing — and they want to keep their teeth feeling good and looking good.

Let’s think like our patients. Our patients want to replace these old amalgams, but they want to do it conservatively, consistently, efficiently, predictably and economically — and they want to do it in one visit.

So, what are the advantages of indirect laboratory-processed composite resin posterior restorations?

Restorations fabricated in this manner look better, undergo less shrinkage, help restore the strength of the tooth, have minimal porosity and excellent marginal integrity, and they have smoother surfaces that are kinder to the gums and result in less plaque accumulation. They are very durable and can be done in one visit.

Patients appreciate avoiding the inconvenient, uncomfortable and expensive second appointment. No second appointment means no temporaries, no emergency visits, and best of all, healthy tooth structure is preserved.

By contrast, replacing amalgam restorations with direct posterior composites, especially ones involving an interproximal surface, are difficult for the patient as well as the dentist.

For many reasons, these direct composite replacements frequently prove to be inadequate, especially over time.

The inherent problems of isolation, the large bulk of composite required and the layered curing of the composite, as well as the effects of shrinkage, all affect contacts, occlusion, margins and postoperative tooth sensitivity.

Gold will always be an excellent restoration for posterior teeth, but due to appearance, mass and an increasing price, it is becoming more unacceptable in today’s image-conscious society.

The prep

This patient came in with a dental emergency. The filling had fallen out of his broken, lower right molar the day before he was going overseas for three weeks on business. He wanted a “quick and permanent solution” (Fig. 1).

The tooth was anesthetized. Next, a FenderWedge (Directa Dental) was used to further isolate the involved tooth, protect the adjacent interproximal surface and pre-wedge the teeth for optimal contacts (Fig. 2).

The Isolite (Isolite Systems) was placed to obtain a dry and illuminated field. We used caries detector to ensure complete decay removal (Fig. 3). The tooth was then micro-etched, etched and desensitized with HemaSeal and Cide (Advantage Dental Products, Inc.). Two layers of self-etching bonding agent (OptiBond All-In-One Unidose, Kerr Dental) were applied to provide reduced postoperative sensitivity and high dentin bond strength. This was then air-thinned and light-cured.

Flowable composite (Premise Flowable, Kerr Dental) was added to the internal walls and...
floor, creating an even floor and filling in undercuts that were originally prepared for caries removal and amalgam retention (Fig. 4).

After the tooth was insulated, the prep was refined with a flat-end cylinder, fine-grit, short shank diamond. Two Identic hydrocolloid impressions (Dux Dental) were taken to make the onlay in the lab (Fig. 5).

**Lab work**

After disinfecting the impressions, the assistant immediately poured them with MACH-SLO (Parkell) and based them with a rigid, fast-setting bite registration material such as Blu-Mousse (Parkell) (Fig. 6).

Within two minutes, we had a silicone working model on which to build the onlay (Fig. 7). The undercuts were then blocked out with a waxer, paying special attention to avoid the margins (Fig. 8).

Starting with the Premise Indirect (Kerr Dental) dentinal shades and ending with incisal shades, the onlay was incrementally fabricated...
Fig. 6: Basting the poured impression.

Fig. 7: Silicone model.

Fig. 8: Model with undercuts waxed.

Fig. 9: Finishing the onlay.

Fig. 10: Onlay finished and polished.

Fig. 11: Expasyl prior to seat.

Fig. 12: Expasyl and FenderMate prior to seat.

Fig. 13: Adapting FenderMate.

Fig. 14: Seating onlay.

Fig. 15: Final onlay.

(Photos/Provided by Dr. Lorin Berland)
in layers.

The onlay was then placed in the Premise curing oven (Kerr Dental). In approximately 10 minutes, the onlay was ready to be finished with various finishing burs (Fig. 9).

The onlay was polished for a high shine and then checked on the model to verify accurate interproximal contacts and margins (Fig. 10).

**Seating the onlay**

When seating the onlays, the Isolite (Isolite Systems) was reapplied for isolation, ease of placement and patient comfort during cementation of the onlay.

Prior to cementation, Expasyl (Kerr Dental) was gently packed into the sulcus, creating a dry space between the tooth and tissue without any risk of rupturing the epithelial attachment (Fig. 11).

The aluminum chloride dries the tissue, reducing the risk of sulcular seepage and contamination.

The FenderMate (Directa Dental) was then inserted beneath the interproximal floor to slightly separate and isolate the adjacent teeth and to help facilitate seating the onlay (Fig. 12).

The Expasyl (Kerr Dental) was rinsed off thoroughly and FenderMate (Directa Dental) was adapted to the adjacent interproximal surface with a condenser (Fig. 13).

The enamel and composite core were then etched for 15–30 seconds.

A single component fifth generation adhesive (OptiBond Solo Plus Unidose, Kerr Dental) was applied in two coats and air-thinned until there was no more movement.

Flowable composite (Premise Flowable, Kerr Dental) was dispensed into the prepped tooth prior to inserting the onlay into the tooth.

The FenderMate (Directa) was removed and the onlay was further seated using a condenser with gentle pressure.

Complete seating was facilitated using the contra-angle packer/condenser (Fig. 14).

An explorer is helpful in removing excess flowable before curing.

The restoration was cured from all angles, starting at the interproximal gingival floors where leakage is most likely to occur.

Occlusal flash and excess flowable composite was "buffed" with a short flame carbide while the interproximal margins were adjusted with bullet or needle carbides.

A Bard Parker #12 scalpel was used to remove interproximal cement.

Once the proper occlusion was established, a diamond-impregnated point and/or cup was used to polish the restoration (Fig. 15).

**Conclusion**

There are certainly clear advantages for both the patient and the dentist when doing indirect composite resin restorations.

These restorations have helped me save my patients’ teeth, time and money.

Over the last 20 years, I have tweaked, updated and modified these restorations in terms of techniques, materials and equipment.

These restorations not only save time and conserve healthy tooth structure, they are a valuable service to provide to your patients.

Wherever you practice, however you practice, these restorations are durable, esthetic, economical and very much appreciated!
The Future of Dentistry
What's In, What's Out: Materials and Methods to Keep You on the Cutting Edge

Complacency
This Lane
Achievers
Merge Right

MOTIVATION
SOLUTIONS
SUCCESS

EXIT 1A
This EXIT
10 Miles
25 Miles

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Part 1: case study
A 45-year-old, healthy man visited his dentist for tooth pain and was informed that his mouth contained a “disease in disguise.”

Upon oral examination, buccal-mucosa showed hyperkeratotic white, slightly elevated, diffuse patchy lesion extending toward the commissures of the mouth on the left side.

The lesion was non-scappable in nature.

The patient had a habit of smoking five to six bidis (a crude form of cigarette used in India) a day for the past four years.

1) What provisional diagnosis would you make of this lesion?
   a. Leukoplakia
   b. Linea alba
   c. Lichen planus
   d. Leukoedema
   e. Candidiasis

Answer: A provisional diagnosis of homogenous type of oral leukoplakia was made.

Now let’s explore step-by-step given the patient’s information and assemble all the clues together to arrive at a diagnosis.

Clue No. 1
Age/sex/general health = 45-year-old healthy man

2) Each of the lesions below is found in a patient that falls into this age/sex category. Match the lesion to the appropriate sex/general health category.

Lesion
   a. Candidiasis
   b. Lichen Planus
   c. Leukoedema

Sex/general health
1. Male predilection
2. Female predilection
3. Commonly seen in a debilitating and malnourished group of society

Clue No. 2
Pattern = Hyperkeratotic white, slightly elevated, diffuse patchy lesion extending toward the commissures of the mouth.
Pattern
a. Thin elevated white line at the occlusal plane
b. White patch or plaque (homogenous type)/mixed red and white lesion (non-homogenous type)
c. White “milk curd” (pseudomembranous type)/white patch or plaque (hypertrophic type)/red (atrophic type)
d. Milky white alterations of the buccal mucosa, bilateral
e. Raised thin white lines in arcuate pattern (reticular type)/white elevated plaque (plaque type)/red (erythematous) areas with thin striae at the periphery (atrophic and erosive type).

Lesions
1. Leukoplakia
2. Linea alba
3. Candidiasis
4. Lichen planus
5. Leukoedema

We can narrow down the various specific clinical types of the lesions and exclude linea alba from the differential diagnosis (D/D):

a. Leukoplakia (homogenous type)
b. Lichen planus (plaque type)
c. Leukoedema
d. Candidiasis (hypertrophic/pseudomembranous type)

Clue No. 5
Is the lesion scrapable (S) or non-scrapable (NS)?

4) Letters a–d are NS; letter e is S.

3) 1 = b; 2 = a; 3 = c; 4 = e; 5 = d

6) a = True; b = True; c = True; d = NSK (studies not proven); e = False; f = True

Part II: Digging deeper
Let’s explore your knowledge of oral leukoplakia.

6) Mark true (T) or false (F) next to the following statements.

a) A predominantly white lesion of the oral mucosa that cannot be characterized as any other definable lesion.
b) It is a pure clinical term and has nothing to do with some specific histology.
c) The etiology proposed includes tobacco, alcohol, candidiasis, electrogalvanic reactions and (possibly) herpes simplex and papillomavirus have been implicated.
d) True leukoplakia is most often related to alcohol usage.
e) Oral hairy leukoplakia is a type of leukoplakia with hair-like projections on the buccal mucosa.
f) It has two main clinical types. Homogeneous type: lesions are white, uniformly flat and thin and exhibit shallow cracks of the surface keratin. Non-homogeneous type: lesions are mixed, i.e., red and white with nodular or verrucous type of growth.

Histology assessment
7) Mark true (T) or false (F) next to the following statements.

a) It may show atrophy or hyperplasia (acinanthosis) and may or may not demonstrate epithelial dysplasia.
b) The majority of leukoplasias will not show dysplasia and correspond to the hyperplasia category.
c) The dysplastic changes typically begin in the superficial zones of the epithelium.
d) The higher the extent of epithelial involvement, the higher the grade of dysplasia.

Treatment and prognosis
8) Mark true (T) or false (F) next to the following questions.

a) For the persistent lesion, definitive diagnosis is established by tissue biopsy.
b) Definitive treatment involves surgical excision or cryosurgery and laser ablation. Total excision is aggressively recommended when microscopic dysplasia is identified, particularly if the dysplasia is classified as severe or moderate.
c) Non-homogeneous lesions carry a lesser risk of malignant transformation than homogenous lesions.
d) It has a variable behavioral pattern but with an assessable tendency to malignant transformation.

About the author
Dr. Monica Malhotra is an assistant professor at the Sudha Rustagi Dental College in India and also maintains a private practice. In 2008 she was presented with a national award for the best scientific study presentation by the Indian Association of Oral and Maxillofacial Pathology. Malhotra completed her master’s in oral pathology at the Manipal Institute, India, in 2009. You may contact her at drmonicamalhotra@yahoo.com.
AACD logo gets a makeover

After more than a year in the making, the American Academy of Cosmetic Dentistry (AACD) is pleased to release its new logo and identity package to dental professionals and patients worldwide.

The new AACD brand is the culmination of a comprehensive organizational assessment in order to solidify the academy as the pre-eminent resource in cosmetic dental education and information.

“It is an exciting time at the AACD. The academy is continually growing and adjusting to advance excellence in our profession through responsible esthetics,” said Michael R. Sesemann, DDS, AACD president.

“The new AACD brand represents a combination of the scientific foundation of the organization with an eye toward the future of cosmetic dentistry.”

Responsible esthetics

In 2009, AACD established a new mantra of Responsible Esthetics, which forms the foundation for the new AACD.

“AACD will demonstrate that we unequivocally stand for the practice of responsible esthetics. The academy will be the primary dental resource for patients as they strive to maintain their health, function and appearance for their lifetime.

“The academy will clearly state and acknowledge that esthetic dentistry must complement the overall general and oral health of the patient, and do no harm.

“Our members will strongly encourage that treatment decisions are based on the foundation of evidence-based protocols combined with sound clinical judgment. The academy will strongly encourage that cosmetic dentistry integrates interdisciplinary medical and dental treatment to enhance outcomes and minimize the loss of healthy human tissue.

“Our members will champion and provide minimally invasive treatment protocols, when and where appropriate, that are consistent with the long-term health and needs of the patient. AACD will encourage the utilization of innovation in technology and materials to deliver dentistry that is predictable and long lasting.”

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 nearly 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.

(Source/AACD)

ADA unveils new Web site design

Enhanced for easier access to comprehensive, online oral health information

After a year and a half of extensive research, planning and design, the American Dental Association announced the unveiling of its new, enhanced Web site, ADA.org, encompassing the latest elements of Web development technology.

“The new ADA.org represents the collective input from our members and provides enhanced navigation tools for easier access to the wealth of oral health information we have online,” said Dr. Ronald L. Tankersley, ADA president.

“This information includes tools needed for practice management and continuing education as well as news about the latest developments in oral health care.”

Source for professional information and enhanced Find-a-Dentist feature

ADA.org is the dentist’s source for professional oral health information. For example, under the following tabs: “Professional Resources,” members will find an updated Member Center with a dental practice hub that includes tips and tools to thrive in challenging economic times.

An enhanced Find-a-Dentist feature, with updated profile information and photos, will also enable colleagues and patients greater opportunities to connect with each other.

“Education and Careers” includes information about licensure and education and online C.E. opportunities.

“Science and Research” features evidence-based dentistry resources and dental standards.

“Advocacy” addresses the ADA’s advocacy efforts on behalf of the dental profession on Capitol Hill and in state capitols across the country.

Many ADA members refer patients to ADA.org for oral health information. Housed under “Public Resources,” the redeveloped site will continue to offer news and extensive information on hundreds of dental topics, ranging from basic dental care to baby’s first tooth to gum disease to tooth whitening.

These topics also include an extensive video collection of various oral health subjects. The public also will find the site easier to navigate, making it more effective and easier for consumers to obtain needed oral health information.

“Refinements to ADA.org will continue as we build on our efforts to make our general and proprietary oral health information easily attainable for ADA members,” said Tankersley. “This will assist members in offering the highest level of patient care and maintaining thriving practices.”

About the ADA

The not-for-profit ADA is the nation’s largest dental association, representing more than 157,000 dentist members. The premier source of oral health information, the ADA has advocated for the public’s health and promoted the art and science of dentistry since 1859.

The ADA’s state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive.

The ADA Seal of Acceptance has long been a valuable and respected guide to consumer dental care products.

The monthly Journal of the American Dental Association (JADA) is the ADA’s flagship publication and one of the best-read scientific journal in dentistry.

For more information about the ADA, visit the association’s Web site at www.ada.org.

(Source/ADA)
Heraeus will host a number of educational sessions during the upcoming 26th annual AACD Scientific Session, which takes place from April 27 to May 1, in Grapevine, Texas.

The AACD meeting convenes world-class clinical leaders, dental professionals and journalists to discuss and showcase the latest and most progressive advancements in cosmetic dentistry.

“Once again, Heraeus has designed an impressive breadth of programs and hands-on workshops that will allow attendees to explore new clinical techniques, test-drive innovative materials and interact directly with leading clinicians and educators.

“The AACD applauds its ongoing dedication to education,” said Dr. Michael Sesemann, 2009-2010 AACD president.

“All of our programs and hands-on workshops feature cutting-edge content, techniques and materials,” said Sonny Serreno, director of program and product development for Heraeus.

“We hope that these programs both inspire and enable dental professionals to provide an even higher level of patient care.”

Heraeus supported program presenters and topics include:

Tuesday, April 27
• Drs. John Cranham and Albert Kominoff
  Interdisciplinary Solutions to Functional-Esthetic Problems

• Dr. John Cranham and Shannon Pace, DA, II
  Diagnosis and Case Presentation: The New Patient Experience

• Pinhas Adar, MDT, Dr. Steve Chu, Adam Mielczak and Bradford Patrick, Bsc
  Perfection in Dental Restorations … Is It Achievable?
  Understanding Light Dynamics and Translucency with Fully Synthetic Ceramics

• Dr. Jimmy Eubanks
  Composite or Porcelain for Superior Esthetics

Wednesday, April 28
• Dr. Robert Marcus
  Smile Design with Composite: An Aid to AACD Accreditation (hands-on workshop)

• Dr. Brian LeSage
  Minimally Invasive Dentistry: Mimic Nature with Composites (hands-on workshop)

Thursday, April 29
• Dr. Joyce Bassett
  Thursday, April 29

• Dr. Robert Marcus
  Maximize Your Esthetic Results through New Concepts in Preparation Design (hands-on workshop)

• Dr. John Weston
  Anterior Composite Bonding: Creating Esthetic Success (hands-on workshop)

Friday, April 30
• Dr. Michael Koczarski
  Anterior Direct Composite Restorations — Exquisite Beauty from a Practical Approach (hands-on workshop)

• Dr. Susan Hollar
  Optimal Provisional Techniques for Thin, Conservative Veneers (hands-on workshop)

• Dr. Corky Willhite
  Transitional Bonding: Major Esthetics and Oral Health Strategies (hands-on workshop)

• David Little, DDS
  Esthetic Implant Retained Overdentures (hands-on workshop)

For more information on the AACD Scientific Session or any of these programs visit www.aacd.org. For more information on Heraeus, visit www.heraeus-kulzer.com or call (800) 431-1785. (Source: Heraeus)

DTSC symposia on world tour

Earn C.E. credits online

The Dental Tribune Study Club is an educational-based online community that inspires new possibilities while creating greater expectations in online learning.

Dental Tribune has scoured the world to find dental meetings with a proven platform for education, communication and development. The following are premier attractions for the international dental community at large and will each feature a Dental Tribune Study Club C.E. Symposium in 2010.

• April 16-18: IDEM — International Dental Exhibition in Singapore
• April 26 and 27: Dental Salon, Moscow, Russia
• June 9-12: Sino-Dental, Beijing, China
• Sept. 2-3: FDI World Congress, Salvador da Bahia, Brazil
• Sept. 23-25: CEDE Poznan, Poland
• Oct. 28–31: DenTech, Shanghai, China
• Nov. 28-Dec. 1: Greater New York Dental Meeting, New York City

During each meeting, a leading panel of specialists will offer ADA C.E.-accredited lectures covering various dental specialties. Participation is free for show attendees, but pre-registration is recommended for preferred seating.

‘Getting started in ...’ Webinars

Each “Getting started in ...” program includes up to five successive Webinars that provide a thorough introduction to the techniques, products and practice management impact in that field of dentistry. Each Webinar will include a one-hour presentation followed by a live Q&A session between the online audience and the speaker.

Participants receive up to five C.E. credits and attendance is free for the first 100 registrants.

The 2010 schedule is as follows:

• May 22: Getting Started in CAD/CAM
• May 29: Getting Started in Implants
• July 24: Getting Started in Digital Imaging
• Aug. 14: Getting Started in Endodontics
• Aug. 27: Getting Started in Lasers
• Oct. 9: Getting Started in Cosmetic Dentistry
• Nov. 6: Getting Started in Magnified Dentistry

Discussion forums

DTSC offers discussion forums focused on helping today’s practitioners stay up to date.

With the ability to share resource material from colleagues, networking possibilities are created that go beyond borders to create a truly “Global Dental Village.”

Further, the site offers a growing database of case studies and articles featuring topics that are important to today’s dental practitioners.

We encourage you to share your cases for review with like-minded practitioners with the chance to win free tuition for C.E.-accredited Webinars.

Registering as a Study Club member is free and easy. We encourage you to visit www.DTStudyClub.com and join the community.

For additional details, please contact Julia Wehkamp at j.wehkamp@dtstudyclub.com or (416) 907-9856. [iii]
Directa CoForm
Matrix system provides transparent corner matrices, convenience and versatility

"Sealed surfaces and surfaces fin-
ished solely by a matrix were approxi-
mately 10 times less rough than after
other finishing procedures.

"The sealer failed to cover the
whole composite surface. The unfin-
ished and sealed surfaces lost their
shine three to seven days after place-
ment in the mouth."

Directa’s CoForm matrix system
is a unique set of pre-formed trans-
parent matrices made of celluloid
plastic that are specifically designed
to deal with composite restora-
tions around difficult incisal edges
to deal with composite restora-
tions around difficult incisal edges
and first molars.

The matrices conform easily to
the patient’s dentition to provide
a natural-looking restoration. They
are applied over the cavity after
etching and bonding with a slight
pressure to force composite material
into cavities and etched tubes.

There is little waste involved
when using CoForm compared to
using disposable matrices.

Light curing is carried out
through the transparent surface
of the CoForm matrix.

CoForm’s convenient ready-cut
mesial and distal corners do not
adhere to composite so that they are
easy to remove without causing
any drag after the restoration has
been light-cured.

The product is available in
four sizes to accommodate almost
any clinical application: canine, anterior
and first molars.

Packaging is a handy clinical dis-
penser with a simple size selection
system to find a suitable form, thus
providing ease of use for the clini-
cian.

Directa is a privately owned
Swedish dental manufacturer that
was founded in 1916. It is one of
the fastest growing manufacturers
of dental products.

Other Directa products include
FenderMate, FenderWedge, Lux-
ator Extraction Instruments, Prac-
tiPal Tray System and ProphyPaste
CCS.

A prime benefit of utilizing
CoForm is that the device aids pres-
sure to force composite material
into cavities and etched tubes.

Embrace retained antibacterial
activity against both bacteria over
time.

While all the materials tested
were capable of contact inhibition
of S. acidophilus and S. mutans
growth, the authors concluded
that Embrace had the longer last-
ing antibacterial activity when
in solution, especially against S.
mutans.

Embrace Pit and Fissure Sealant

A recent study published in the
Journal of Dentistry conclud-
ed that Pulpdent Corporation’s
Embrace™ Pit and Fissure Sealant
had the longest lasting antibacte-
rial activity of those studied.

The study, “Antibacterial sur-
face properties of fluoride-con-
taining resin-based sealants,”
was conducted at The University
of North Carolina at Chapel Hill
School of Dentistry.

The aim of the study was to
determine the antibacterial prop-
cies of three resin-based pit
and fissure sealant products.

The sealants were tested in
both an agar diffusion assay
and a planktonic growth inhibition
assay using Streptococcus mutans
and Lactobacillus acidophilus.

Embrace Pit and Fissure Sealant

The VibraJect Retrofit Kit

The VibraJect® retrofit kit that comes with two
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J. Morita USA partners with TDO

J. Morita USA, world leader in 3-D imaging, has announced a strategic partnership with TDO, a quality-centered endodontics organization, for complete 3-D imaging and software integration.

TDO’s practice management software is one of the most comprehensive and widely used endodontic software in the world. TDO users can now seamlessly incorporate any Morita 3-D unit into their practice with full compatibility.

Morita’s i-Dixel software, standard with all Morita 3-D units, has been programmed for a direct connection to the TDO environment. Patient files are comprehensively integrated, allowing for easy access between programs in one window to maximize productivity. Selected slice images can be transferred to TDO with a single click of the export icon. This highly efficient, interlinked system eliminates the need for duplicate files, simplifies data entry and reduces training time — all of which decrease administrative costs.

“Morita is committed to enhancing our customers’ 3-D capabilities,” said Kei Mori, vice president of technical engineering. “Our industry-leading hardware, combined with this sophisticated software program, offers a powerful, digital solution to manage 3-D data and improve return on investment.”

Morita’s 3-D imaging units have been demonstrated in clinical studies to offer the highest clarity available in the industry, coupled with the lowest dosage.

TDO users can choose from a wide range of 3-D models from three product lines including Veraviewepocs 3-D, Veraviewepocs 3-D, and 3-D Acuitomo. All units come standard with i-Dixel software and offer complete, automatic TDO integration.

Morita has a long history of innovative solutions for the endodontic market with products such as Root ZX, one of the world’s best-selling apex locator since the early 1990s.

“Partnering with a high-level, quality-focused organization like TDO fits very well into our core competencies,” commented Steven White, senior vice president of sales and marketing. “Our commitment to TDO further demonstrates Morita’s ability to understand and respond to the evolving needs of endodontists worldwide.”

“TDO users will now be in a position to bring class-leading, 3-D images into their system with the click of a button.”

For more information, contact J. Morita USA at (877) JMORITA (566-7482). Visit www.jmoritausa.com to learn more about Morita 3-D units and to view video of key opinion leaders’ comments and sample clinical images.

About J. Morita USA

J. Morita USA services North American dental professionals on behalf of one of the world’s largest manufacturers and distributors of dental equipment and supplies, Japan-based J. Morita Corp. The North American office was established in 1964 and is headquartered in Irvine, Calif. J. Morita USA is one of the leading companies in the dental market offering innovative and high quality 3-D/pan/ceph imaging units, delivery systems, small equipment and consumable dental supplies.
R.E. Morrison Equipment, the manufacturer of BaseVac Dental Dry Suction Systems, announces its compact C-VAC dry suction system for small dental offices.

Traditional dry-vac systems require large air flows to cool the pumps, meaning a two operatory office is often too small for a dry vac pump.

The BaseVac C-VAC 4.10 has been engineered to provide strong suction (up to 25 Hg) without the need for oil or water.

Compact, powerful and quiet, this two operatory dry vac will provide two dentists or a single dentist and hygienist with dependable suction.

The unique design integrates the rotary vane pump into the air water separator creating a remarkably small footprint.

BaseVac designers took care to position all piping connections at the back of the system for easy tight-to-wall installation.

The C-VAC 4.10 is powerful enough to be installed on systems with all sizes of pipe.

Based on feedback from practicing dentists, the high-efficiency air/water separator was designed to drain captured liquids every time the pump is turned off, eliminating the need for messy and difficult cleaning.

BaseVac Dental Systems offers a full range of dental suction equipment.

For more information, visit www.basevacdental.com or contact R.E. Morrison directly at info@remequip.com and (800) 668-8756.
Kank-A launches soothing beads

Mouth pain can occur at anytime throughout the day, and treating the problem while away from home isn’t always convenient. The best products provide a tailored solution to localized pain, but can be difficult to use on the go.

Kank-A® Soothing Beads™ provide two benefits: effective, comfortable relief for all-over-mouth pain and a form that is easy to carry and discreet to use.

Kank-A Soothing Beads are comfortable, smooth balls that melt in the mouth to deliver maximum strength medication (15 mg benzocaine per five-bead dose). Kank-A Soothing Beads can be rolled around the mouth for all over relief or held in one spot for concentrated treatment.

Each five-bead dose is individually packaged on a perforated card (like many over-the-counter caplets), making it easy to leave some at home, work or in any other location that’s handy throughout the day.

The beads are designed to deliver effective relief without excessive numbing and are ideal for use on gum irritations, mouth burns, canker sores, orthodontic appliances and dentures.

With a suggested retail price of $5.49–$7.99 for each 15-dose pack, Kank-A Soothing Beads will be available in May at food and drug stores nationwide.

Kank-A offers a full line of products designed to provide solutions tailored to specific oral pain needs. Each product offers maximum strength benzocaine to ease pain, other beneficial ingredients and unique application systems that deliver relief to sore spots.

Kank-A SoftBrush® is a super-effective treatment for toothaches and gum pain. It offers a dual-relief formula combining the maximum level of benzocaine (20 percent) with an active oral astringent, zinc chloride, for fast, deep pain relief. Its unique, pen-shaped applicator and soft brush tip make it easy to apply gently and comfortably anywhere in the mouth, especially between teeth and around braces. Kank-A Softbrush retails for $5.49–$7.99.

Professional Strength Kank-A Mouth Pain Liquid has received the ADA Seal of Acceptance for its effectiveness in the relief of canker sores and has long been the ideal treatment for pain caused by canker sores and other mouth sores.

Kank-A Liquid provides maximum strength medication for a liquid or gel (20 percent benzocaine), while forming a long-lasting film that protects sores from further irritation.

The protective coating holds the anesthetic in contact with the sore and acts as a barrier against further irritation. Designed for precise, convenient dispensing, Kank-A Mouth Pain Liquid has a built-in applicator, allowing consumers to easily place the medication where it’s needed. Kank-A Liquid retails for $5.49–$7.99.

For additional information about Kank-A products, visit www.Blistex.com.

Kank-A launches soothing beads
Every Generation Needs a New REVOLUTION

“The greatest revolution of our generation is the discovery that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives” - William James

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