San Francisco practice makes house calls

In a society where expert medical care seems ever more elusive and impersonal, the last thing you might expect is a dental practice that makes house calls. However, Bay Area House Call Dentists (BAHCD), based in San Francisco, has built a thriving practice around visiting their patients where they live.

Rather than serve the well to do, BAHCD specializes in helping some of the Bay Area’s least-served populations: the elderly, the housebound and the infirm. BAHCD is a service of the Blende Dental Group, headed by Dr. David Blende, a practitioner with more than 20 years of experience providing comprehensive dental care and a leader in the field of dental surgery.

“We serve not only people with disabilities, which is what people think of when they think of special needs, but also people with severe phobias and complex medical conditions,” explained Dr. Cheryl Elacio, director of house call services and geriatric services for BAHCD. “Basically anyone who is not a good candidate for a traditional dental office for either physical, emotional or cognitive reasons.”

BAHCD patients may include a child with autism, a senior with Alzheimer’s disease, an obese or otherwise immo-

Let’s hear it for hygienists!

Crest Oral-B will recognize five deserving dental hygienists who go above and beyond the call of duty on a daily basis. Nominated by their peers, these professionals truly make an impact on patients and the oral health cause.

Another reason to stay in shape

The health complications of being overweight, such as increased risk of heart disease, type 2 diabetes and certain cancers, have long been reported. Health care professionals often urge patients to manage their weight and strive to get physical exercise each day to achieve and maintain overall health.

And now, researchers have uncovered another benefit of maintaining a fit lifestyle: healthy teeth and gums.

In a study published in the August
the equipment used, patients can be examined in their own favorite chair or even lying in bed. Not only can such treatment bring immediate relief, but it can also save the patient and his or her caretaker many subsequent, arduous trips out of the house.

“If a patient needs a lot of work requiring several specialists, he might have to visit one office after another — an endodontist’s office for a root canal, a periodontist’s office for gum surgery, a dentist to deal with decay,” says Blende. “But when we do a house call, we’re going to gather all the information we need to make a diagnosis and bring in members of our specialist team. So we’ve saved them, maybe, three or four appointments. If they need follow-up treatment, they’re all done in the home. So a patient might go from leaving home for six or seven trips in a year to leaving home just once if they need treatment that must be done in our office or in a hospital.”

That can save a lot of anxiety for a caregiver and can mean the difference between receiving or forgetting comprehensive dental care for some one who can’t or won’t, leave his/her home without difficulty. If the patient needs treatment that cannot be done in the home, the BAHCID team handles the arrangements for the follow-up work at the BAHCID office or in a local hospital, instead of my having to drive my mom to the local hospital. That includes helping to arrange her treatment, completing the work itself and having a specialist on hand to keep the patient calm, comfortable and safe.

Elacio and her BAHCID colleague, Dr. Samer Itani, perform many of the house calls. Once a patient is found to need hospital or in-office work, Blende frequently takes the helm in planning and providing this care. Blende is an expert in using general anesthesia during dental procedures, which is essential for insured children and phobic patients. Allowing a confused or frightened patient to sleep through dental surgery considerably reduces stress for all concerned.

When their patients do need hospital attention, Blende, who is chief of the Division of Dentistry at Kaiser Permanente San Francisco and chief of the Dental Division at California Pacific Medical Center, and Itani, vice chief of the Division of Dentistry at Kaiser Permanente San Francisco, are well positioned to make that happen quickly and smoothly.

Increasingly over the past two years, the BAHCID team has assembled a staff of experienced and compassionate assistants, visits senior communities, where they may see up to 20 patients in an afternoon. The problem of undiagnosed dental issues is particularly acute in such communities, according to Itani. And those issues, he says, are much more dangerous to a patient’s overall health than many people realize.

We recently went to a community where we saw 19 seniors,” Itani says. “Several had been there for over a year, yet their caregivers weren’t even aware they had partial dentures. So, clearly, those dentures weren’t getting cleaned properly. That’s when infection starts to set in, not to mention the obvious issue of discomfort. We might find broken teeth or gum disease, lesions that can be a sign of oral cancer, and gum disease, which is quite dangerous because it breeds bacteria which gets into the blood stream, contributing to pneumonia, heart attacks and stroke.”

“All these things have to be treated, but they often aren’t,” Itani says. “It’s a crucial issue for the elderly, not just for their daily comfort but for their overall health.”

In fact, Bay Area House Call Den-
tist teams frequently receive referrals from other dentists who are in despair over getting their elderly or infirm patients in for office visits, who turn to the BAHCID’s in-house treatment capabilities as the best answer.

“House calls are not easy, but we firmly believe that helping the everybody can have, and everybody deserves, the best possible care,” Itani says.

A success story

Minerva Dutra of Petaluma, Calif., is more than convinced of the value of in-home dental care. Dutra’s 76-year-old mother, Dolores Dawson, has Alzheimer’s disease, uses a wheelchair and lives in a residential care home. Dawson recently received at-home care from BAHCID followed by surgery performed by Blende.

“My mother has specific needs, and other dentists weren’t able to accommodate her,” Dutra says. “I was very happy to have a dentist come to us instead of my having to drive my mom all around. The doctor who came to our home, Elacio, and her assistant were sweet, caring and extremely skillful. When it was time for the sur- gery, Blende was fantastic, always letting me know what was going on and taking extra steps to be sure my mom was comfortable. I had all the confidence in the world in him. Now my mom feels much better. It’s a great relief.”

(Source: PRWEB)

A study indicates that weight control and physical fitness may help reduce the risk of severe gum disease.

(Photograph/Paul Moore, Dreamstime.com)

issue of the Journal of Periodontol- ogy, researchers found that sub- jects who maintained a healthy weight and had high levels of physical fitness had a lower incidence of severe periodontitis. Using body mass index (BMI) and percent body fat as a measure of weight control, and maximal oxygen consumption (VO2max) as a measure of physical fitness, researchers compared sub- jects’ weight and fitness variables with the results of a periodontal examination. That included helping to arrange her treatment, completing the work itself and having a specialist on hand to keep the patient calm, comfortable and safe.

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In fact, Bay Area House Call Den-
Dr. Thomas Grams, 51, an American dentist who had been working with humanitarian relief organizations for the past five years to provide free dental care in Afghanistan, was among a group of aid workers killed in an attack by the Taliban in August.

Dr. Grams had given up his dental practice in Durango, Colo., to work full time in the war-torn county.

A total of 10 medical relief volunteers — six Americans, two Afghans, a German and a Briton — were killed in the attack, which drew widespread media attention. The incident was covered on major network news broadcasts, and Grams’ picture was printed on the front page of The New York Times along with the other slain workers.

The group had spent two weeks treating villagers in a remote valley in northern Afghanistan before being ambushed by Taliban extremists on their way back to Kabul, according to published reports.

“Dr. Tom humbly served the men, women and children of Afghanistan, working tirelessly to provide dental care to those who would not otherwise be able to reach medical clinics,” Khris Nedam, founder of Kids 4 Afghan Kids, a humanitarian aid organization with whom Grams worked, told Dental Tribune.

“Dr. Tom loved his work and cheerfully brought hope to rural areas, showing them that someone cared enough about them to reach out and help. He used his professional skills to build bridges in some of the most difficult, rural areas,” Nedam said. “In return he was loved and respected by all and will be sadly missed by everyone.”

Tim Grams, Grams’ twin brother, told news organizations that his brother started traveling with relief organizations to Afghanistan, Nepal, Guatemala and India several years ago. After he sold his practice, Grams started going several months at a time, his brother said.

“He was shocked by the dental condition of the villagers,” Nedam said in an online posting. “In one of our first conversations during his first visit he wondered if the children ate a lot of sugar. I replied no, their teeth are in such bad condition because of lack of dental care and malnutrition.”

“Dr. Tom worked to teach the children how to brush their teeth and worked out a system to use his drills more efficiently given the limited amount of electricity,” Nedam wrote. “He spoke to groups about his work in Afghanistan raising funds and organizing dental supplies to take with him. He also collected and transported hundreds of toothbrushes for the village families and at the same time, a desire grew within him to help the village in ways other than dental care.”

In addition to Grams, the slain aid workers also included Dr. Tom Little, an optometrist from Delmar, N.Y.; Glen Lapp, a nurse from Lancaster, Pa.; and Cheryl Beckett, an expert in nutritional gardening and mother-child health from Knoxville, Tenn.

“We are heartbroken by the loss of these heroic, generous people,” said U.S. Secretary of State Hillary Rodham Clinton, who condemned the Taliban for the deaths.

“Dr. Tom’s life truly represents servanthood and caring, as his work touched so many lives,” Nedam told Dental Tribune.

By Fred Michmershuizen, Online Editor

Dentist from Colorado among 10 aid workers killed in Afghanistan

DENTAL TRIBUNE | SEPTEMBER 2010

News 3A
A recent study by Harvard University revealed that eating fruit daily is the best way to whiten teeth. Through a three-month clinical study, it was determined that strawberries, orange peels and lemon juice are the most effective teeth whiteners in the world.

Strawberries can be made into a puree and smeared on the teeth. Strawberries have a natural enzyme that removes tooth stains, according to teethwhitener.net. Orange peels can be used to remove tooth stains, just by rubbing the inside of a peel against tooth surfaces. A little lemon juice and salt work very well to remove stains. Just wash your mouth out with this or even rock salt to remove stains. Just wash surfaces.

Researchers say the best teeth whitener is fruit.
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Dental career or daily drudgery?

If walking through the door of your practice creates instant anxiety, it’s time to ask for outside help

By Sally McKenzie, CEO

Recently, I was sitting with a small group of dentists during the lunch break at a dental meeting and they were commiserating, divulging their war stories from the “front” if you will. Obviously, in my line of work it is not uncommon to have dentists willingly share their often painful experiences. This was no exception. The dentists were talking about some major problems they were having in their offices.

One of the dentists, I’d say he was probably 45 years old, a mid-career guy — let’s call him Doc No. 1 — was asking Doc No. 2 (I’d put him around 55 years old and should be nearing retirement) about how his office schedules patients.

Doc No. 1 explained that his days are a string of frustrations, stops and starts; frantically running until everything comes to a screeching halt. There was no rhyme or reason to how his scheduling coordinator is organizing the day. In addition, his practice’s production was nowhere near where he thought it should be, regardless of the current economy: one day it’s $5,000 the next it’s $1,000.

Doc No. 2 asked him if he’s talked to his scheduling coordinator and Doc No. 1 replied with an emphatic, “Definitely. I’ve probably told her 100 times that I want to be busy.” He notes that when he brings it up, things will improve a little for a while but then it’s back to the same erratic production.

Well, it’s true that misery loves company because Doc No. 2 proceeded to open up about the staff conflict and collections nightmares he’s been experiencing for the past three years. Thus, this has been going on far longer than the current economic downturn.

Suffice it to say that Doc No. 1 was certainly feeling much better about his scheduling woes after hearing Doc No. 2’s blow-by-blow account of the turf wars and serious financial worries he’s facing.

Worn down over time

It’s true: you can become cynical as the years pass. You deal with disappointments and frustrations. People you count on let you down. Principles you once believed in become hollow, and the professional dreams and goals you once had lose their luster.

I see this happen to too many dentists. I hear it in your voices when you call me, and I see it on your faces at dental meetings. Even after all the years I’ve worked with dentists, I still cannot understand why you are so willing to settle for a practice that you don’t want. That being said, I do understand how this happens.

The reality is that most dentists are committed to being truly excellent clinicians. You are dedicated to your patients and to providing what is best for them. But you don’t come out of dental school with management degrees or human resources experience. Most of you have never even considered writing a business plan for your practices.

You are not experts at guiding your scheduling coordinator in developing the best systems to create the most effective and profitable schedule for your practice. You see conflict on the team and want to run in the opposite direction. You want to pay your staff a fair salary, but overhead is a nightmare.

As committed as you are to providing the best for your patients, you cannot do so effectively if your own systems are struggling, your teams are dysfunctional little fiefdoms, or you are stressed out from the worry of paying bills and dealing with staff problems.

All the while I’m thinking to myself: Why are these dentists living in such misery? Suffering is truly optional. These dentist desperately need the help of an outside management consultant. It doesn’t have to be McKenzie Management, but they need someone to help them identify a plan of
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An important clinical advance in at-home oral care.
action. Otherwise, they are going to be on the misery march to retirement for many, many years.

Searching for answers
In nearly 50 years of working with dentists, I know how incredibly difficult it is for dentists to acknowledge that they don’t have all the answers. They don’t have the training or the expertise to deal with the multitude of issues and problems that come up just by nature of running a business.

Yet, I also know that once they reach a point when they have had enough — when the thought of walking through the doors of their practice generates so much anxiety and unhappiness — it is often at this point that they will finally seek out a company that can help them realize the dream they had given up hope of ever achieving.

These dentists finally come to terms with the fact that sometimes it takes someone else besides the dentist or his/her spouse to look at the practice and objectively assess what is working and what isn’t; identify why production is down one month and up the next; figure out who is working and what isn’t; identify why patient retention is or it’s below 95 percent; gross salaries are more than 20 percent of income; overhead is more than 55 percent of income; gross salaries are more than 20 percent of income; there are no performance measures in place to evaluate employees; job expectations are either nonexistent or unclear; staff conflict is a common distraction; production practice has leveled off or declined.

The list goes on, but the bottom line is you really don’t like going to work. I dare say, it’s time to hire a management consultant.

Check experience and references
There are many consultants out there, and, obviously, I firmly believe that McKenzie Management is the best. Yet, no matter whom you hire, you need to be completely honest with him/her. Just as your work with patients, you need a consultant who can help your team implement systems that will benefit the total practice.

You need a consultant who can help your team implement systems that will benefit the total practice. You want a consultant who can effectively explain the recommendations, the “why” behind them, and provide access to training and tools that will enable the team to effectively implement your vision. Talk to the CEOs of these firms and ask questions, seek references and talk to those references. Do the consultants you’re considering have a reputable company behind them? Do they have the expertise necessary to address the challenges specific to your practice? Will they customize their recommendations to address your needs?

Will they be there for you in the long run to help you overcome hurdles that will arise along the way? Do they offer training and educational materials that can help specific members of the team? Can they explain to you exactly how they have helped other practices? Will they seek not only your input, but that of your team as well?

Finally, will they tell you what you want to hear or will they tell you the truth? It is that last point that is the most difficult for anyone. Just like the patient who doesn’t want to hear that he needs three crowns, you’re likely not going to want to hear everything the consultant needs to tell you.

However, it is in listening that you learn and it is in learning that you can take the steps necessary to build the practice that you thoroughly enjoy walking into every day of your career.

About the author
Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dental practitioners nationwide. She is also editor of The Dentist’s Network Newsletter at www.thedentistsnetwork.net; the e-Management Newsletter from www.mckenziemgmt.com; and The New Dentist™ magazine, www.thenewdentist.net. She can be reached at (877) 777-6151 or sallymck@mckenziemgmt.com.
Snoring and sleep apnea
How they can adversely affect relationships and health

By Dr. Brock Rondeau, DDS, IBO, DABCP

It has been estimated that approximately 90 million people in North America suffer from sleep disorders including insomnia, snoring and sleep apnea.

Snoring is extremely common in our society, as it has been estimated that 60 percent of men snore and 40 percent of women over age 50 snore. Snoring occurs when there is a partial obstruction of the airway that causes the palatal tissues to vibrate.

Snoring is a serious social problem for the bed partner and adversely affects many relationships. I treat many patients where snoring is a significant negative factor in their lives.

Some studies report that the bed partner's sleep is seriously affected by as much as one hour per night, which can have a negative affect on their health as well due to their lack of adequate sleep (this is similar to the negative health issues associated with second hand smoke).

USA Today reported that 27 percent of couples over age 40 sleep in separate bedrooms. I think there is a direct correlation between this and the incidence of snoring. As the incidence of obesity continues to increase in our society, these numbers are going to continue to increase.

Sleep apnea is a medical disorder that can only be diagnosed by a sleep specialist in a sleep clinic. The patient must have an overnight sleep study called a polysomnogram that is evaluated by the sleep specialist.

Many sleep specialists prefer to prescribe the CPAP (continuous positive air pressure) device to treat obstructive sleep apnea and do not appreciate the effective role that oral appliances can provide for patients who have mild or moderate OSA (obstructive sleep apnea) or patients who cannot tolerate the CPAP device.

A significant breakthrough occurred for the dental profession in 2006. In the January issue of the medical journal Sleep, the American Academy of Sleep Medicine (medical sleep specialists) issued guidelines stating that for patients with mild to moderate obstructive sleep apnea, the oral appliance was the No. 1 treatment option.

The guidelines also stated that oral appliances were a viable option for treatment for patients who do not respond to weight loss or have tried the CPAP device and were unable to tolerate it.

The diagnosis for OSA is made using an apnea-hypopnea index (AHI). The diagnosis is made during an overnight sleep study in a hospital or private sleep clinic. This sleep study is known as a PSG (polysomnogram). The number of apneic and hypopnic events are recorded as follows:

Sleep apnea: tongue completely blocks airway
• apnea: a cessation of breath for 10 seconds or more
• hypopnea: the blood oxygen level decreases 4 percent or more cessation of breath for less than 10 seconds
• mild sleep apnea (osa): 5-15 events per hour
• moderate sleep apnea (osa): 16-50 events per hour
• severe sleep apnea (osa): more than 50 events per hour

There are three treatment options for obstructive sleep apnea:
• oral appliances
• CPAP device (continuous positive air pressure)
• surgical removal of structures causing the obstruction

The diagnosis of obstructive sleep apnea can only be made by a medical professional, and it is usually a sleep specialist. Therefore, dentists must send their patients to a hospital or private sleep clinic for a polysomnogram (16-channel overnight sleep study). Only when the written report is received from the sleep center can the dentist proceed with the fabrication of oral appliances.

The dentist should review the sleep study with the patient once the AHI page 10A
has been determined. Patients that are diagnosed with severe OSA should be encouraged by the dentist and sleep specialist to wear the CPAP device. This device consists of an air compressor that blows air up the patient’s nose and forces air into the lungs. It is extremely effective when it is worn faithfully every night, however, the problem is that approximately 60 to 70 percent of patients cannot tolerate the CPAP device after one year. If the patient has mild to moderate OSA or cannot tolerate the CPAP device, then dentists are encouraged to treat these patients with oral appliances.

There is also a high correlation between patients who have GERD (gastroesophageal reflux) and OSA. With regard to diabetes, excessive apneic events affect the production of insulin, which encourages the onset of type 2 diabetes. These apneic events also affect the permeability of the endothelial lining of the arteries. This increases the buildup of plaque in the arteries and the chance of cardiovascular complications such as a heart attack. The weakening of the walls of the arteries increases the susceptibility of rupturing of these vessels which occurs during strokes.

Nasal obstruction
Before treatment, clinicians must determine whether or not there are any nasal obstructions that would interfere with the patient’s ability to breathe through his/her nose. If the patient is a chronic mouth breather, the patient should be referred to an ENT specialist to check for a deviated septum, enlarged turbinates, polyps, or other nasal obstructions.

A determination must be made whether or not the nasal mucosa is swollen due to allergies, which might cause a nasal obstruction.

In our office, we have a diagnostic device called as a rhinoscope that is an initial screening device to determine if there is a nasal obstruction in either nostril. The rhinometer is an accurate, non-invasive device that evaluates the potential obstruction by sending sound waves up the nose and any obstructions are recorded on a computer.

Hypopharyngeal obstructions
Our office uses a pharyngometer to diagnose the size of the airway during the daytime as well as nighttime. It is used at the initial appointment to check the patient’s normal airway (daytime) and the collapsed airway (nighttime). To assess the size of the collapsed airway at night, the patient is instructed to exhale all the air from his/her lungs and a measurement of the airway is taken.

The normal size of a collapsed airway is 2.0 cm. Patients with OSA usually have a much smaller collapsed airway. Bite registrations in different positions are taken to see how much the airway may be increased.

By moving the mandible forward at different vertical heights, we determine if the oral appliance will open the airway in that position significantly. In most cases, when a bite registration reveals that the airway opens significantly when the oral appliance is fabricated in that position, the treatment is usually successful.

Oral appliances
Oral appliances are extremely effective in eliminating snoring and OSA, particularly in patients with mild to moderate OSA. They function by moving the lower jaw and, consequently the tongue, forward to open up the airway. They hold the lower jaw forward when the patient sleeps on his/her back, which keeps the airway open all night.

The literature is replete with articles regarding the effectiveness of different oral appliances. Patients find that oral appliances are extremely comfortable to wear.

Three different oral appliances that are used to prevent snoring and OSA include Respire, EMA and the Suad appliance. The appliances all work essentially the same way by gradually moving the lower jaw forward in small increments and increasing the vertical dimension, which ultimately increases the size of the pharyngeal airway.

It is imperative that dentists learn to treat patients with mild to moderate OSA and those who cannot tolerate the CPAP device. There are thousands of patients who have been diagnosed with OSA and cannot wear the CPAP. The health of these patients is continuing to deteriorate and their life expectancy shortened while the dental profession holds the key to their treatment.

I have treated many patients with severe OSA who could not wear the CPAP device and successfully reduced their apneic events below five times per hour, which is normal. This treatment certainly improves their health and prolongs their life by reducing their blood pressure and their susceptibility to heart attack, stroke and type 2 diabetes.

Conclusion
The prevalence of OSA is exceedingly high in first-world countries mainly due to the increase in the rate of obesity. An estimated 25 percent of males and 9 percent of females will develop obstructive sleep apnea in their lifetime.

It is important for the dental profession to educate their staff and themselves so they can learn to diagnose and treat the large number of appropriate patients with oral appliances.

The failure rate with CPAP is close to 70 percent, which means a large number of patients will seek alternative treatment. The medical and dental profession has not done an adequate job in educating the CPAP failure patients about the existence of oral appliances as an alternative.

Dentists can significantly improve the health of these patients and the profession must get involved now when the need is so critical.

A complete list of references is available from the publisher.

Fig. 1: This is what happens to those who suffer from sleep apnea: the tongue completely blocks the airway. (Photo/Provided by Dr. Rondeau)

Fig. 3: A pharyngometer. (Photo/Provided by Sleep Group Solutions)

Fig. 4 (Photo/Provided by Sleep Group Solutions)

Fig. 5: This is a dorsal type appliance composed of two pieces (www.respiremedical.com). (Photo/Provided by Dr. Rondeau)

Fig. 6: One of three appliances used to prevent snoring and OSA. The elastic mandibular advancement (EMA) appliance. (Photo/Provided by Dr. Rondeau)
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Members corner: Dr. Stuart Johnson

In this issue of WDC, we are pleased to have FDI Dental Practice Committee and Dental Amalgam Task Team (DATT) member, Dr Stuart Johnston discuss his involvement with FDI World Dental Federation and share his vision for oral health.

As a practicing dentist, what made you decide to devote your time to addressing issues affecting dental practice at an international level? I initially became involved with organized dentistry at the local level because I was dissatisfied with the system of dentistry in the UK. After some time, I became Chairman of the local body and went on to represent the UK at the national level. People gave me jobs to do and I didn’t say “no”. I enjoyed it … I enjoyed learning and actively making a better future for my colleagues in the UK.

“Accidentally” I had the opportunity to attend the FDI Congress in New Delhi, in 2004, as a representative of the British Dental Association. I wasn’t sure what to make if it at first, it seemed very complex. But after this experience, I reflected on the opportunities FDI involvement presented and quite liked it—the complexity of it, it was something new, I wanted to understand FDI, what we could do, how I could help raise the profile of my home association there. There is a symbiotic relationship, representing BDA at FDI and bringing benefits back to dentists in the UK.

You were recently invited to join FDI Dental Amalgam Task Team (DATT). What is the rationale behind the formation of DATT? It is fascinating work—the way these colleagues have communicated with one another around the world, all cooperating, and the quality of debate is superb.

The FDI Council mandated that a Dental Amalgam Task Team (DATT) be established to ensure that the international dental community and issues regarding dental amalgam were properly and accurately discussed. The discussions regarding mercury and would be based on the best available science.

For details see UNEP Intergovernmental Negotiating Committee www.unep.org/hazardoussubstances/Mercury/Negotiations/INC1/tabled324/language/en-US/Default.aspx

The DATT consists of a representative from each of the FDI standing committees, three Council representatives and where required be supplemented with subject matter experts.

Where does the DATT stand now and what role does it play in FDI overall mission? At the UNEP meeting in Stockholm, 7-11 June 2010, I was privileged to represent FDI Dental Amalgam Task Team. This meeting saw a continuation of the process begun in November and we had the opportunity to lobby delegates to our position to avoid an all-out amalgam ban. DATT is approaching development for member NDAs to take back to their countries to communicate with their governments directly. It will be governments who vote on this, so we require a team effort to achieve the desired result.

In regards to dental amalgam, it is not a health issue because the dental profession has a significant body of evidence that the use of amalgam as a restorative material is safe with respect to human health. However it is the broader considerations with regards to mercury that the intergovernmental negotiating committee is addressing.

Is FDI developing a position on environmental waste? We must be seen as doing everything we can, including:

- Make sure all waste is collected properly in dental surgery and properly disposed of and recycled wherever possible, to avoid contamination.
- Move away from bulk mercury, which can be misappropriated for small scale gold mining, towards capsule mercury, which avoids spillage.

What does the FDI World Dental Federation offer to the dentist?

For more than a decade, the FDI’s World Dental Development Fund (WDDF) has made a difference to the lives of disadvantaged people in many places around the globe through its support of oral health education and outreach programmes.

Established in 1998, the World Dental Development Fund aims to improve oral health primarily in disadvantaged populations through education, oral health promotion, disease prevention and primary health care. The variety of projects that are funded highlights different approaches to better oral health in contrasting settings. Current projects range from capacity building in Africa, to improving oral health in rural India, through to integrating oral health in primary healthcare in northern Pakistan, and oral cancer awareness and HIV/AIDS awareness training for dentists in Latin America.

The Word Dental Development and Health Promotion Committee, the body responsible for the management of the World Dental Development Fund within FDI, recently completed a project in Cambodia. Here, the prevalence of HIV/AIDS and hepatitis is one of the highest in South-East Asia. Due to the lack of established standards and training materials regarding infection control for dental personnel, the Cambodian Dental Association proposed a project to develop a national cross infection control programme in collaboration with governmental, non-governmental agencies and individuals, and supported by the FDI member association are encouraged.

The World Dental Development Fund accepts applications on a continuous basis. To improve oral health and oral health care services in developing countries, educational projects delivered in collaboration with governmental, non-governmental agencies and individuals, and supported by the FDI member association are encouraged.

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The numerous applications received from community organisations and initiatives highlights the enormous need for effective oral health programmes. FDI invites well-wishers to support this very important work by making donations to the WDDF, so that we are able to expand and sustain the funds successful activities. For more information: www.fdiworldental.org/en/node/109.

The world is changing and FDI helps us understand this change at international or national level. For example, amalgam is prime issue. FDI can respond this at the world level for the dental profession. Another example is GCI and how it fits together, there is serendipity—the strategy for dealing with carries a reduction in need for amalgam.

There is a huge opportunity to...
FDI Revisits Suntec Center, Singapore

Eight months after the successful 2009 FDI Annual World Dental Congress at the Suntec International Convention and Exhibition Centre, Singapore, FDI returned to Singapore to promote FDI and to extend FDI’s spirit of partnership among participating stakeholders.

“IDEM Singapore brings together many facets of FDI’s work towards improving oral and general health. Together with the Singapore Dental Association, FDI develops outstanding Continuing Education programmes—based on relevant and timely topics for the profession—which not only play an important role in the development of dentistry and dental professionals, but also in advocating the importance of oral healthcare to the population,” said Dr Vianna at the IDEM opening ceremony.

Organised by Koelnmesse and the Singapore Dental Association (SDA), in cooperation with FDI World Dental Federation, the 2010 edition of IDEM Singapore delivered cutting-edge insights into the very latest in dental technology, techniques and patient treatment.

The 2010 Scientific Conference at IDEM Singapore, which featured 18 international thought leaders in their respective fields, brought to the fore new protocols in patient treatment. Moreover, the most recent innovations that help dentists minimize the risks involved in advanced procedures, while delivering the results for patients, were showcased by 352 exhibitors from 51 countries.

Participants equally benefited from the Congress Education Forum, organized by the Singapore Dental Health Foundation, in conjunction with IDEM Singapore. The forum sought to update the public beyond the basic principles of good oral care, exploring topics such as the relative advantages and disadvantages of implants, what patients should ask their dentists about implants and the intriguing Teeth-in-an-hour. Participants went away with valuable insights into the challenges and limitations of dental implant procedures.

IDEM Singapore 2010 also saw the introduction of ‘Let’s Talk Business seminar’ in which participants deliberated on how they can leverage technology to transform the delivery of dental treatments.

Looking forward, the theme and speakers for IDEM 2012 Scientific conference have been chosen. IDEM 2012 will focus on ‘Advances and Controversies.’

It will have the following personalities as keynote speakers: Dennis Tarnow from the Columbia School of Medicine, New York; and Dr Michel Magne and Dr Pascal Magne from the University of Southern California, Los Angeles.

make a real difference through FDI. For some associations from more advanced countries, part of FDI’s work is the duty to help colleagues in developing areas. There is a global responsibility which is enhanced now by amalgam issue—this shows that we are one world, working together for better oral health.

What plans does the FDI Dental Practice Committee (DPC) have for 2010?

I have been a Member of DPI for just over a year. It is nice to meet with colleagues and see how we approach problems differently. It can be difficult to produce the consensus statements due to different legal systems and philosophies of care, so when we produce a statement it is even more satisfying. Benefits of being part of the DPC include meeting more of the people involved in FDI work, and feeling more that I am part of the team.

Looking at purpose of the committee, there will be fewer but more focus projects with the DPC collaborating with other committees to contribute to FDI strategic objectives. We are looking at the dental team, risk management in dental practice, indemnity, infection control and waste management.

Also we have been approached by colleagues at the Indian Dental Association, which is a positive development.

Where do you see your work taking you with FDI?

I am enjoying what I am doing now. It means a juggling act with FDI involvement, the BDA where I am chair of the Representative Body, running dental practice, and European work.

Dr Stuart Johnston qualified in 1972 from Cardiff Dental School and has worked in his own practice for the last 12 years. He is the DPC member on the FDI Dental Amalgam Task Team (DIATT).
Out and about in Columbus

By Robin Goodman, Group Editor

If you are planning to attend the 144th Ohio Dental Association Annual Session, to be held Sept. 23-26 at the Greater Columbus Convention Center in Columbus, Ohio, there is no shortage of things to do after meeting hours. Some of the events listed below have been going on since March or June and others will take place only during the week of the dental meeting.

- **Hot Times Community Music & Arts Festival**
  Where: Old Towne East, Main & Parsons
  When: Sept. 10–12: Friday, 5:30-11 p.m.; Saturday, noon-midnight; Sunday 10 a.m.-9 p.m.
  Web: www.hottimesfestival.com
  This annual festival is community based and run entirely by volunteers. It takes place in a big grassy area filled with mature trees. Take a gander at local and nationally recognized dancers, performance artists, poets and professional musicians. Admission is free.

- **Pearl Market**
  Where: Pearl Alley
  When: Friday, 10:30 a.m.-2 p.m.
  Web: www.downtowncolumbus.com/pearlmarket
  This market is located in downtown Columbus and is a cornucopia of fresh produce direct from the growers as well as baked treats, gifts, handmade treasures, jewelry and tasty offerings for lunch. Admission is free.

- **Ohio Quality Wine restaurant promotion**
  Where: Restaurants throughout Columbus
  When: Through Nov. 30
  Web: www.ohioqualitywine.com
  Don’t just eat local, drink local too! Some restaurants will offer a five-course dinner, a winemaker dinner or a prix fixe menu, all of which will feature Ohio Quality Wine. In Columbus the following restaurants are part of the promotion: Barceló, Deep Wood, La Chaletaine, G. Michael’s, Refectory and Tutto Vino. Price will vary depending on the restaurant.

- **Glassblowing Hot Shop**
  Where: Franklin Park Conservatory, 1777 E. Broad St.
  When: Through Jan. 2, 2011; Monday–Friday 11 a.m.–2 p.m., Saturday and Sunday 11 a.m.–5 p.m.
  Demonstrations every half hour.
  Cost: Adults $11, seniors and students $9, children $6 and children under 2 years are free.
  Web: www.fpconservatory.org
  Located in an outdoor glassblowing pavilion, master glass blowers (a.k.a. professional gaffers) have been giving demonstrations since March 15. Each step of the glass blowing process is explained as the gaffers create a piece of blown glass artwork. The works may be purchased at Botanica, which is the conservatory’s gift shop and greenhouse.

- **Eastern Ohio Quarter Horse Show**
  Where: Ohio Expo Center
  Dates: Sept. 9–15, Thursday–Monday, 8 a.m.
  Address: 717 E. 17th Ave., Columbus, 43211
  Where: Ohio Expo Center
  Web: www.eoqha.us
  This annual festival is community based and run entirely by volunteers. It takes place in a big grassy area filled with mature trees. Take a gander at local and nationally recognized dancers, performance artists, poets and professional musicians. Admission is free.

- **Jack Hanna’s Fall Adventure Overnight**
  Where: Columbus Zoo and Aquarium, 4850 W. Powell Rd.
  Cost: $75
  When: Sept. 10, 6 p.m. to 10 a.m.
  Web: www.columbuszoo.org
  Spend the night in a real museum with an LED installation known as Light Rainfall II. Every month there is a botanically themed cocktail among the regular full-bar selection and hors d’oeuvres. DJs start spinning at 5:30 p.m. and at dusk, watch the Palm House glow with an LED installation known as Light Rainfall II.

- **Cocktails at the Conservatory**
  Where: Thursdays through Dec. 30, 5:30-10 p.m.
  Location: Franklin Park Conservatory, 1777 E. Broad St.
  Cost: $10 minimum at the door, and you receive $10 in tokens for food and beverage
  Web: www.fpconservatory.org/cocktails.html

- **Annual Bonsai Show**
  Where: Columbus Jaenmerchor, 966 S. High St.
  When: Sept. 11 and 12, 10 a.m.–5 p.m.
  Web: www.columbusbonsai.org
  Germany and Japan come together in this year’s. The Bonsai Society will display bonsai — the Japanese art of miniature trees — in the German Village’s Jaenmerchor club. Admission is free.

- **Salsa Fever**
  Where: La Fogata Grill, 790 N. High St.
  When: Friday through Dec. 31, 8–11:45 p.m.
  Cost: $7–$10
  Web: www.lafogatagril.com
  Do you cha-cha, merengue or salsa? Well get ready to burn up the dance floor on Friday night with DJ Gigi. If you need to brush up on your moves, join the dance lesson with Caron Rubio from 8–10 p.m.

- **Savage Gardens**
  Where: Franklin Park Conservatory, 1777 E. Broad St.
  Cost: Adults $11, seniors and students $9, children $6, children under age 2 are free.
  Web: www.fpconservatory.org
  Carnivorous plants abound, both real and imagined, at this family friendly event with special activities for all ages. There is also a juried art show.

- **Cocktails at the Conservatory**
  Where: Thursdays through Dec. 30, 5:30-10 p.m.
  Location: Franklin Park Conservatory, 1777 E. Broad St.
  Cost: $10 minimum at the door, and you receive $10 in tokens for food and beverage
  Web: www.fpconservatory.org/cocktails.html

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  Cost: $75
  When: Sept. 10, 6 p.m. to 10 a.m.
  Web: www.columbuszoo.org
  Spend the night in a real museum exhibit, the Rattle Ice Bear Outpost Interpretive Building. Before you head to sleep you’ll get to dine with Jack Hanna and the polar bears and then listen to some of Hanna’s bear adventure tales.

(Source: www.columbusconvention.com; www.visitgahanna.com)
Speakers at-a-glance (short list)

Please see the ODA website, www.oda.org, for the complete speakers list.

**Thursday, Sept. 23**
- Daniel Becker, DDS Pharmacotherapeutics in Dental Practice: Managing Pain and Infection, 9 a.m.–noon
- Gordon J. Christensen, DDS, MSD, PhD The Christensen Bottom Line, 9 a.m.–5 p.m.
- Marc Geissberger DDS, MA, BS, CPT Capturing Flawless Impressions and Delivering Outstanding Temporary Restorations, 9 a.m.–noon
- James “Hooch” Houchard Preventive Dental Equipment Maintenance, 2 p.m.–5 p.m.
- Noel W. Jackson, DDS, FAGD Perfecting and Understanding Occlusion, 1:30 p.m.–3 p.m.
- Amy Kirsch Dynamic Customer Service and Internal Marketing Skills, 2 p.m.–5 p.m.
- Tierona Low Dog, MD Women’s Health: A Woman’s Guide to Wellness, 9 a.m.–noon

**Friday, Sept. 24**
- Judy Zack Bendit, RDH, BS Enamel Therapy: The Next Generation of Care, 2 p.m.–5 p.m.
- Debra Grant, RDH, CA Therapies for the Dental Hygienist, 9 a.m.–noon
- Fred S. Margolis, DDS Esthetic Dentistry for Children and Teens, 9 a.m.–noon
- Joseph J. Massad, DDS Spive Up Your Practice with Dentures and Implants, 9 a.m.–noon
- Michael Miyasaka, DDS Using the Diode Laser to Assist in Routine General Dentistry, 10:30 a.m.–noon
- Stephen Poss, DDS Predictable Esthetics with Direct Composites, 9 a.m.–noon
- Maureen C. Vendemia, RDH, MEd Radiography for the Dental Assistant, 9 a.m.–5 p.m.

**Saturday, Sept. 25**
- Carl Drago, DDS, MS New Technologies in Digital Dentistry: The Encode Impressioning System, 9:45 a.m.–11:15 a.m.
- Barry Goldenberg, DMD, MS The Ankylos Implant System: The Impact of the Conical Connection on Tissue Stability, 9 a.m.–noon
- Shannon L. Pace, CDA, CDD The Esthetic Dental Assistant: Techniques and Materials, 9 a.m.–noon
- Stephen Poss, DDS Predictable Esthetics with Direct Composites, 9 a.m.–noon
- Maureen C. Vendemia, RDH, MEd Radiography for the Dental Assistant, 9 a.m.–5 p.m.

**Sunday, Sept. 26**
- Christopher A. Moore, MA Infection Control and Regulatory Compliance, 9 a.m.–noon
- Daniel M. Newman, PhD, DDS Objectives of HIV/AIDS Certification Program, 10 a.m.–noon
- John S. Olmsted, DDS, MS R U Ready for the 2 NU R’s in Endodontics?, 9 a.m.–noon
- Larry J. Sangrak, DDS Nitrous Oxide Sedation, 8:30 a.m.–5 p.m.
Crest Oral-B is thrilled to recognize professionals who go above and beyond the call of duty daily. With the “Pros in the Profession” contest, Crest Oral-B will reward five deserving dental hygienists, as nominated by their peers, who truly make an impact on patients and for the oral health cause.

From September 2010 to April 2011, nominations can be submitted for dental hygienists by dentists, fellow hygienists, dental assistants, professional colleagues and collegiate colleagues explaining why they are a true “Pro.”

In order to be considered for the program, nominees must meet the following:

- Registered dental hygienist with two or more years of practice experience after graduation from dental hygiene school.
- Registered dental hygienist with community service involvement. General volunteer/non-oral health-specific examples welcome, but oral health-related volunteer experience preferred.
- Registered dental hygienist with examples of work that goes above and beyond the call of duty. Examples include: excellent patient relations/special care/retainment, involvement in research and/or clinical experience, published work, ability to generate additional business for their practice.
- Registered dental hygienist with additional C.E. credits over state requirements.

Five extraordinary dental hygienists will be selected throughout the year. Winners will receive an award, a VIP all-expense-paid trip to ADHA’s 88th Annual Session in Nashville, Tenn., a pampering spa experience and recognition at major conferences throughout the year. Plus a $1,500 monetary prize and an exclusive trip to P&G headquarters!

So, do you know a ‘Pro’?

Nominate a Pro online or at the Crest Oral-B booth at upcoming conventions.

For more information about Pros in the Profession, including program criteria and rules and regulations, please visit www.dentalcare.com/prosintheprofession.
Join California Implant Institute

The California Implant Institute was developed in 2001 by Dr. Louie Al-Faraje to provide quality continuing education on the subject of dental implants and related topics using a hands-on approach. As director, Al-Faraje has trained more than 1,000 clinicians in a hands-on, yearly forum of education in implant dentistry. Al-Faraje holds diploma status at the American Board of Oral Implantology, fellowship status at the American Academy of Implant Dentistry and fellowship status at the International Congress of Oral Implantologists.

The California Implant Institute offers a one-year comprehensive fellowship program in implant dentistry. This program is made of four sessions designed to provide dentists with practical information that is immediately useful to them, their staff and their patients.

The four sessions combined offer more than 140 hours of lectures, laboratory sessions and live surgical demonstrations.

The goal of the faculty team, which is composed of some of the most respected instructors from the United States and around the world, is to provide you with comprehensive knowledge that will enrich your practice and improve your clinical skills so you can confidently perform predictable, prosthetically driven implant dentistry.

Session one topics

During the first session of this one-year comprehensive hands-on implant training program, the following topics are covered: anatomy, bone physiology, patient evaluation for implant treatment, risk factors, vertical and horizontal spaces of cross-section, bone density, step-by-step implant surgical placement protocols, impression techniques, restorative steps for implant crown and bridge and more.

Session two topics

During session two, computer-guided implant placement and restoration using SimPlant® software, immediate-load techniques for single and full-arch cases, biology of osseointegration, arch cases, biology of osseointegration, and pharmacology will be discussed.

Advanced implant surgical techniques, such as alveolar ridge expansion with miniimplants, bone grafting before, during and after implant placement and pharmacology will be discussed.

Implant prosthodontics for fully edentulous patients, high-water design, bar-overdenture, CAD/CAM designs, etc., will highlight the prosthetic portion of this session.

Session three topics

This session will focus on sinus lift through the lateral window, ramus block graft and chin block graft as well as the J-Bloc grafting procedures. PRP and other advanced bone grafting materials such as rh-BMP2/ACS granules with titanium mesh.

The final graduation examination and certification ceremony will conclude this comprehensive implant training program.

For more information or to register, please contact Jennifer Bettencourt at (858) 496-0574 or visit www.implanteducation.net.

One plus one is three

EMS packs sub- and supragingival air polishing plus scaling in just one unit

What may appear somewhat paradoxical at first turns out to be rather logical when viewed more closely. In order to enable the practitioner to perform sub- and supragingival air polishing as well as scaling while using just one unit, EMS in Nyon, Switzerland, once again has demonstrated its commitment to innovation.

With its new Air-Flow Master Piezon, EMS delivers the right tool to each prophylaxis professional from diagnosis to initial treatment and recall. Following the success of the Piezon Master 700—a virtually painless treatment for the patient and very gentle on the gingival epithelium—the new Air-Flow Master Piezon delivers unequalled patient comfort.

Credited with such performance while achieving smooth tooth surfaces, is the linear oscillating action aligned with the tooth surface and delivered by the original Swiss instruments from EMS. Another plus is the optimal visibility of the treatment site due to the new handpieces with an LED light.

Air-Flow Perio kills biofilm

The Air-Flow Master Piezon is an effective tool to combat periodontitis or periimplantitis. The professionals at EMS are convinced that they are able to get to the root of such harmsful deposits, quite literally, thanks to the integrated Original Air-Flow Perio 1 nozzle.

To learn more or to register, visit www.ems-dent.com

Catapult your career as a dental office manager

The American Dental Managers Conference is Oct. 22 and 25, back by popular demand at the fabulous Las Vegas Hilton. This conference is the premier educational and networking event in the country for dental office managers and practice administrators. The two-day event focuses exclusively on dental practice management.

“Our attendees are the best of the best in their field,” said AADOM President Heather Colicchio. “This conference has grown year over year. We are thrilled with the caliber of speakers, attendees and exhibitors that come to our conference.”

Tracks will be offered for both the experienced business manager, as well as novice office managers. In addition to announcing the 2010 Office Manager of the Year, this year will include a pre-conference “Best Practices” workshop facilitated by Katherine Eitel.

The AADOM is also honored to be inducting its charter class of those who have completed the AADOM fellowship program. This ceremony will take place on Saturday, Oct. 23.

Beverly Wilburn, a past attendee stated “Take your management skills to a higher plateau. If you want to catapult your career as a manager, this conference gives you the tools you need to do just that.”

Dentists agree that sending their office manager to the AADOM conference is a wonderful opportunity to make an investment in the business of their practice. This year’s conference has been approved for up to 9 C.E. credits toward AADOM fellowship.

To learn more or to register, visit www.dentalmanagers.com.
The Future of Dentistry
What's In, What's Out: Materials and Methods to Keep You on the Cutting Edge

Complacency
This Lane
Achivers
Merge Right

MOTIVATION
SOLUTIONS
SUCCESS
This EXIT
10 Miles
25 Miles

Just because the economy is unstable does not mean that your practice has to be.

LVI will steer you in the right direction!

Now is the time to take the driver's seat and invest in yourself and your future.

Recession-proof your practice with an education from LVI.

Bring a new enthusiasm to yourself, your practice, your team, and your patients!

You can have the practice of your dreams, and we can show you how.

Rohnert Park, CA
September 24-25

Calgary, AB
September 24-25

Lincolnshire, IL
September 24-25

Portland, OR
September 24-25

Hilton Head, SC
September 24-25

Sudbury, ON
October 1-2

Edmonton, AB
October 1-2

Omaha, NE
October 1-2

Sioux Falls, SD
October 8-9

Toronto, ON
Palo Alto, CA
San Diego, CA
Stockton, CA
Moncton, NB
Littleton, CO
Madison, WI
Kansas City, MO
Minneapolis, MN
October 15-16
October 15-16
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October 22-23
October 22-23
October 22-23
October 22-23
October 29-30
November 5-6

Carlsbad, CA
Pittsburgh, PA
Seattle, WA
Kitchener, ON
November 12-13
November 19-20
November 19-20
November 26-27

Houston, TX
February 4-5

Park City, UT
February 11-12

Lubbock, TX
March 4-5

Shreveport, LA
April 1-2

LVI is bringing 11 CE credits TO YOU with The Future of Dentistry in your area!

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ADA CERP® Continuing Education Recognition Program

LVI Global is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in maintaining the highest standards of dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it accept acceptance of credit hours by boards of dentistry. LVI Global indicates this activity for 11 continuing education credits.

Sponsored by

Traditionally, cosmetic dentistry has always been faced with the challenge of treating poorly aligned teeth. Treatment options available for mildly and moderately crowded teeth include orthodontics and restorative dentistry. Many patients have chosen the restorative approach, for example porcelain veneers, over orthodontic techniques because longer treatment times combined with either unsightly labial wires and brackets or the expense of “invisible” braces.

In cases in which patients choose to have crowded upper and lower anterior teeth treated with veneers, it is extremely challenging to prepare teeth conservatively, owing to their anatomy and the minimum thickness of porcelain required. A difficult balance has to be found between over-preparing the teeth and placing over-contoured restorations. However, owing to the excitement and emotion created by the effect of popular large smile makeovers, aggressive tooth preparations, in which teeth are prepared to stumps, seem to have been accepted as normal practice, simply because there has been no alternative that could achieve the patient’s objectives in a sufficiently short period.

Inman Aligners are now offering a minimally invasive alternative to patients in the U.K. With only one appliance, most Inman Aligner cases can be completed in six to 16 weeks. In anterior crowding cases, Inman Aligners have proven to be much more time and cost effective than invisible braces or conventional fixed and short-term orthodontics.

To date, I have treated about 1,000 cases and have found that case acceptance has been close to 100 percent, simply because many patients much prefer a removable solution that fits their lifestyle more easily. Treatment can also easily be combined with simultaneous bleaching and final edge-honing for quick and non-invasive, dramatic results. From this, a new procedure has arisen in cosmetic dentistry — alignment, bleaching, bonding — which will be covered in the second part of this series. The cases presented in this article will outline some case types that can be treated.

**The Inman Aligner**

For over 30 years, spring aligners were used to correct minor tooth movements. Early designs were developed for minor tooth movements and to treat slight rotations. Previous spring aligners were useful, but several problems always limited the amount of tooth movement achievable. Their active components were made from stainless-steel wire, which is relatively inflexible and lacks any innate springiness.

As a result, traditional removable appliances required periodic reactivation, leading to short-lived force application that limited the speed of tooth movement, owing to the need to allow the bone around the roots of the teeth being moved to ‘rest’ between successive activations. In addition, the direction of force application with traditional springs was less easy to control, leading to a mousetrap-like force that tended to unseat the appliance.

These factors limited the degree of correction that could be accomplished. For larger movements, single appliances were insufficient to complete the movement.

In developing the Inman Aligner, Donal Inman CDT created a patented design that takes advantage of the gentle, steady and consistent forces generated by NiTi. The design relies on piston-like components driven by NiTi coil springs. Inman designed lingual and labial components to function or move in parallel to the occlusal plane, eliminating the mousetrap-like unseating forces and allowing actual physiological movement of teeth. Inman Aligners are ideally worn for 16 to 20 hours a day. Studies have demonstrated that the removal of orthodontic forces for four hours a day massively reduces the risk of root resorption and that risk of root resorption is lower in removable versus fixed appliances.

A standard Inman Aligner as described in the following cases consists of both lingual and labial components. The forces have the effect of squeezing the teeth into alignment. The components can be used in isolation to retract teeth with a more steady force, requiring less adjustment than a standard labial bow retractor. In Case III, a unique approach that incorporates an expander on the Inman Aligner is described.

**Patient selection**

Case selection for the Inman Aligner is critical. The following criteria should be met before treatment proceeds:

1. Cases should require movement of incisor and/or canine teeth only.
2. Root formation of the teeth to be moved must be complete.
3. Crowding or spacing should be less than or equal to 3 mm. Arch evaluation must be performed to determine the amount of space required. Cases with over 5 mm of crowding require additional space.
AACD credentialing program opens to all dentists, dental laboratory technicians

The American Academy of Cosmetic Dentistry (AACD) offers cosmetic dentistry’s most recognized advanced credentialing program for dentists and dental laboratory technicians. In August, the American Board of Cosmetic Dentistry, the credentialing authority of the AACD, announced that all dentists and dental laboratory technicians are now eligible to pursue AACD Accreditation regardless of their membership status within the AACD.

This visionary and historic change underscores AACD’s dedication to inclusiveness and standards of excellence, thus providing patients greater access to Accredited dental professionals who have demonstrated a very high level of clinical skill and ability in cosmetic dentistry.

The AACD is the world’s largest non-profit membership organization focused on providing cosmetic dental information, knowledge and credentialing for the dental profession and the public.

“Everyone wins when standards are held high and support and training is made available to many,” said AACD Accredited Fellow Member and ABCD Board Member Bradley J. Olson, DDS. “The Accreditation process is an opportunity for dentists and dental laboratory technicians to truly gauge their skill set and expand their skills to a higher level.”

Accreditation in the AACD serves to set standards for excellence in cosmetic dentistry. Accreditation is a three-part process, consisting of a written examination, submission of clinical case examinations for evaluation, and an oral examination.

Requirements for Accreditation candidates will be identical for members and non-members. Non-members will be required to follow the AACD advertising guidelines, and will be subject to a different fee structure than AACD members.

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 6,000 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.

For more information regarding the AACD and the Accreditation process, visit www.aacd.org, send an e-mail to pr@aad.org, or call (800) 545-9220.

Fig. 5: Occlusal view before treatment.

Fig. 6: Occlusal view after 13 weeks with an Inman Aligner.

Fig. 7: Smile view before treatment.

creation techniques, as pioneered in the U.K., which should only be attempted with training. It is quite possible to treat cases with 3.5 mm crowding easily and predictably in less than 16 weeks.

4. Cases should have fully erupted posterior teeth to facilitate retentive clasps, with a reasonably well-aligned arch form to facilitate the path of insertion of the appliance.

5. Cases should be stable and preferably free from periodontal disease.

6. Patients must agree to wear the Aligner for about 20 hours a day and be responsible for good appliance and oral hygiene. Should the patient wear the Aligner for 14 hours a day only, treatment will still be successful.

Model evaluation/Arch analysis with Spacewize

Arch analysis should be performed before any Aligner case is attempted in order to ensure that the case is suitable and, if not, what additional space creation techniques will be needed to allow the Inman Aligner to work. The extent of crowding present is calculated by measuring the sum of the mesial-distal widths of the teeth to be moved. This distance is called the required space or the teeth. If canines and incisors are to be moved, this distance will be measured from the distal surface of one canine to the distal surface of the other canine.

Using an orthodontic retaining or jeweller’s chain or a polishing strip, the ideal arch form is then measured from the distal of each canine in alignment with the ideal arch form following orthodontic correction. Critically, the arch needs to pass through the suggested position of the contact points and not the incisal edges. This is described as the available space or the curve.

It is possible to perform this task more quickly and just as accurately with software such as Spacewize. Just one simple occlusal photograph is required, which can be taken chairside. One tooth needs to be measured for calibration. A curve can be digitally established and this is normally easier when observing the patient’s aesthetic requirements and occlusion directly. The extent of crowding is immediately calculated using such software.

Laboratory requirements

Accurate upper and lower impressions are taken, preferably two of the arch being treated. Simple alginate can be used if cast quickly. A bite registration and prescription should be completed and sent to a certified Inman Aligner Laboratory. The technician should be informed of the amount of crowding calculated. The teeth to be repositioned should be noted clearly. The prescription should provide full details to the technician regarding the teeth to be moved, the area they are to be moved to and the distance they are to be moved. A Spacewize trace of the ideal curve can also be submitted.

Interproximal reduction

Interproximal reduction (IPR) is begun at the fitting appointment using abrasive strips or discs. The model analysis will have already calculated the extent of IPR required.

Many authors acknowledge that the reduction of half of the interproximal enamel on the mesial and distal of each incisor tooth is a safe technique. This equates to 0.5 mm per contact point, creating 2.5 mm of space between the canines. In some cases, the distal of the canine and mesial of the premolar can be reproxi- mated allowing for a total of 5.5 to 4.5 mm. These cases will require more experience in using the system but offer a number of possibilities for clinicians once trained to use the system correctly.

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kept. An in-surgery fluoride rinse or application of topical fluoride is recommended after any enamel reduction procedure. El-Mangouy et al.10 and Radlanski11 have demonstrated that there is no increased risk of caries after IPR, provided surfaces are smoothed correctly. Heins et al.10 and Tal11 have demonstrated that there is no increased risk of periodontal disease after the decreased interproximal space.

Critically, Inman Aligner treatment uses progressive, anatomically respectful IPR. While the extent of IPR required is already known, it is never carried out in one treatment. In order to ensure minimal risk, IPR (0.15 mm per contact point) is carried out only in small increments. The patient is sent away with the Aligner.

Owing to the Aligner forces, the gaps can never elongate to very large proportions. Interproximal reduction is performed at each appointment only as needed, using strips or discs, which ensures the stripping is far more anatomically conservative than would be the case using burs. This significantly reduces the risk of excess space formation, gouging or poor contact anatomy.

Lingual/labial anchors

Composite resin just incisal placed either incisal or gingival to where the bows contact will help them to function more efficiently. This can also be used for the labial surface, especially in cases in which teeth are being retracted. Strategic placement is vital for success and can be very helpful in the treatment of rotated teeth and the extrusion of teeth.

Appliance adjustment

The forces can be varied by adjusting the spring components or replacing the springs for larger, longer springs. Generally, adjustments are not necessary, except in more complex cases, for which training is required to understand the correct spring types and compression rates to use.

Case No. 1

The 25-year-old female patient complained about the appearance of her lower anterior teeth. She gave a history of orthodontic treatment in her teenage years, having a fixed appliance for three months only. She had noticed her lower four incisors starting to become crowded again. Treatment options discussed were invisible braces, conventional fixed brackets or an Inman Aligner.

The amount of space required for reduction was calculated as 3.5 mm. Interproximal reduction was performed using diamond strips (Brasure). A reduction of 0.15 mm at each contact point was achieved at the fitting appointment. This was verified with a little more space. (Incorporated was seen three weeks later and a further 0.15 mm reduced at each contact point.

The teeth were aligned in just over nine weeks. The Aligner was left in for one month to stabilise the tooth positions. Tooth whitening was undertaken for two weeks during the last two weeks of treatment. Simultaneous bleaching is a significant advantage in removable systems and helps patient motivation.

Finally, an orthodontic retention wire was bonded in place on the lingual surfaces, ensuring the patient could still use super floss for hygiene.

Case No. 2

A female patient presented complaining mainly about her rotated upper right central tooth. She was considering veneers to redistribute the space over the four front teeth. This would have meant that she would undergo three aggressive preparations and one invasive preparation with endodontic treatment of the upper right central tooth.

Space calculation with model analysis indicated that treatment would be possible with an Inman Aligner. Because of the relatively low cost, the patient selected this option, understanding that we would not be able to achieve Golden Proportion, owing to the width and length of her lateral teeth.

A midline screw was incorporated to allow for a small amount of operator-controlled expansion to provide extra space in cases with very constricted space. Up to 2 mm of space can be created by expansion, which has the effect of pushing the cuspid away from the lateral.

After alignment, this expansion will just relapse. It is a temporary technique to create sufficient space to align the anterior teeth. After alignment, the expander can even be unwound if required.

Treatment took 15 weeks with three sessions of IPR. A total of 5 mm was stripped and 1 mm was gained with the expander. The teeth were retained using orthodontic gold chain bonded from canine to canine. An upper Essix Retainer was also worn nightly as back-up for retention.

Case No. 5

The patient in this case originally presented for porcelain veneers on her upper anterior teeth. The preparations would have required root-canal treatment of two of her incisors in order to achieve adequate emergence profiles.

Essix Retainer

This retainer is a thermo-formed, clear, thin appliance that is easily made and very comfortable for patients. The recommended post-operative regimen for Inman Aligner treatment is to wear the retainer at night for 18 months and after that for two nights a week indefinitely.

Conclusion

With the Inman Aligner, patients previously rejected orthodontics due to the time and fixed brackets of traditional orthodontic techniques or the expense of more recent invisible braces, could, if they chose a simple, achieve anterior tooth alignment far more quickly with a simpler, single appliance.

Inman Aligners are suitable for alignment of incisors and canines with up to 5 mm of crowding — 5.5 mm once the treating clinician is trained in using the system — and represent a very conservative and potentially revolutionary alternative to radical tooth preparation for achieving tooth alignment using porcelain restorations.

The Inman Aligner allows for a rapid and aesthetic alignment at low risk and cost to our patients. The patient is able to preview the staged changes of alignment, perhaps followed by bleaching and bonding.

As a result, the Inman Aligner is profoundly changing the approach to cosmetic dentistry by those using it with the advanced techniques of dome effect, combined expansion and strategic anchor placement in the U.K. and Europe. This new approach to cosmetic dentistry in the U.K. has been confirmed by figures from the British Academy of Cosmetic Dentistry (BACD). The 2008 study of data from 200 BACD members demonstrated a massive 545 percent increase in orthodontics used in cosmetic cases but no increase in the use of veneers.

Of this increase, 250 percent was solely due the use of the Inman Aligner in cases in which patients would not otherwise have worn their teeth treated, owing to the time cost of fixed braces and no desire to have appliances adhered to their teeth. Many of these patients were those who would have opted for aggressive preparation of their teeth for veneers, before the Inman Aligner.

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Dr. Tif Qureshi is vice president of the British Academy of Cosmetic Dentistry. He presents hands-on courses and lectures on the Inman Aligner worldwide.

For information on U.S. course dates and training, please go to www.straight-talks.com or www.inmanaligner.com. Alternatively, contact Caroline Cross on +44 207 255 2559 or at info@straight-talks.com.

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