ADA continues to monitor proposals for health care reform

By Fred Michmershuizen, Online Editor

As Congress prepared to adjourn for its summer recess, the American Dental Association was taking a wait-and-see approach to pending health care reform legislation.

“The dental provisions they contain can best be described as the good, the bad and the undecipherable,” ADA President Dr. John S. Findley told ADA News, the association’s official publication. “Our most pressing concern is with the proposal for a government-run insurance plan that would compete with private insurers in the marketplace and private plans offered in the so-called ‘exchange.’”

Findley said that a proposal to require dental coverage for children would need clarification before the ADA would support it.

“ar whole concept of a public plan remains troubling, and we would oppose any plan that required dentists to participate, directly or indirectly dictated fees for the private market or would lead to a government-run system,” he said.

The ADA has continued to make its message clear through dialogue with members of Congress and the administration, following the approval of policy by the ADA House of Delegates at the 2008 annual session in San Antonio.

“The ADA does not support a single-payer system because we believe it would stifle access and innovation and reduce the quality of patient care,” said Findley, who pointed out that the association’s efforts in the nation’s capital are ongoing.

“We are pursuing amendments to improve the dental provisions,” he said.

Findley said that flatly opposing the whole thing is not an option.

“If we aren’t highly visible in the process, we open the door to other groups who will claim to be the voice of the oral health community and attempt to dictate what kind of dental provisions get included,” he said. “As the saying goes, you are either at the table or on the menu.”

According to the ADA, the proposed legislation should be rewritten to enhance Medicaid reimbursement. Without it, Findley said, there would be “no significant access improvements for the poor and other vulnerable populations.”
The Eco Dentistry Association (EDA), an international association of dental professionals, was launched in May by the creators of the country’s first green dental office to give colleagues access to eco-friendly practices and consumers the power to encourage their dentists to adopt earth-friendly methods.

- If every U.S. dental office installed a device capturing mercury-containing waste, at least 7,400 pounds of toxic waste would be kept out of the nation’s water supplies each year.
- By switching to reusable and non-toxic disinfection methods, the dental industry would prevent 680 million disposable chair barriers, light handle covers and patient bibs, and 1.7 billion instrument sterilization pouches from ending up in landfills yearly.

The Eco Dentistry Association offers dental professionals practical tips on reducing waste and pollution and conserving resources, such as using cloth wrappers instead of disposables to sterilize dental instruments, installing energy efficient lighting, properly disposing of mercury-containing dental waste, and incorporating planet-friendly building and office methods, such as nontoxic paint and recycled copy paper. It provides the public with information about digital X-ray systems that reduce radiation exposure by up to 90 percent, educates them about keeping dental appliances free from the hormone-disrupting chemical, bisphenol-A, found in many plastics, and 1.7 billion instrument sterilization pouches from ending up in landfills yearly.

Soon after launch, the new planet-friendly organization had grown to 40 eco-conscious members in 20 states and Canada. The group’s members hail from all over the country, including places like Waxahachie, Texas; Beachwood, Ohio; and Fort Bragg, N.C.

The organization is the brainchild of Dr. Fred Pockrass, a dentist, and his lawyer-turned-entrepreneur wife, Ina Pockrass. Six years ago, the couple created the model for eco-friendly dentistry, and they operate their own successful dental practice and conservation stewardship. Dr. Fred Pockrass and his wife, Ina, operate the first certified ‘green’ dental practice and are also founders of the Eco Dentistry Association.
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Align Technology and Ormco end patent dispute, plan to collaborate

Align Technology, manufacturer and marketer of Invisalign, has reached a settlement with Ormco, a subsidiary of Danaher, to end all pending litigation between the parties and to begin a new strategic collaboration.

As part of the settlement, Align will make a cash payment of approximately $15 million to Ormco and issue approximately 7.6 million shares of Align’s common stock to Danaher, that after issuance will be equal to approximately 10 percent ownership interest in Align.

The value of the shares is approximately $77 million (based on the closing price of Align’s common stock on Friday, Aug. 14).

Align and Ormco have also agreed upon an exclusive collaboration over the next seven years to develop and market an orthodontic product that combines the trademarked Invisalign system with Ormco’s trademarked Insignia orthodontic brackets and arch wires system to treat the most complex cases.

Each party will retain ownership of its pre-existing intellectual property, and each party will be granted intellectual property licenses in their respective field for jointly developed combination products.

“We are pleased to resolve this ongoing litigation with Ormco and to begin a new relationship that meets our shared goals of providing innovative products and excellent service to our orthodontic customers,” said Thomas M. Prescott, president and CEO of Align Technology, in a news release.

“This collaboration with Ormco, a fellow innovator in digital orthodontics, gives us the ability to compete for a segment of the market that is difficult to treat with traditional orthodontics, and accelerates our long-term plan for a combination product.”

(Source: Align Technology and Danaher Corp.)

Local anesthesia is truly effective only when injected

A painful truth in dentistry today is that for most dental procedures, local anesthesia is truly effective only when injected. The problem, of course, is that both the insertion of the needle and the injection of the anesthetic fluid itself can cause discomfort.

Dentists have been using topical anesthesia to reduce the pain involved in needle insertion and fluid injection for decades, and they have tried to use finer-gauge needles in the belief that they cause less pain. However, recent research has shown that needle gauge has no effect on perceived pain level.

Topical anesthesia can be useful for minimizing the pain associated with needle insertion, but it has not been proven to address pain associated with the actual injection of the local anesthetic solution.

A recent study in Anesthesia Progress examined the effectiveness of topical anesthesia in reducing pain associated with needle insertion separately from the pain associated with injection of the anesthetic. Results were investigated after different intervals (two, five and 10 minutes) to determine the time for optimal efficacy of the topical anesthetic.

In a double-blind, placebo-controlled study, responses from 85 people showed that the topical anesthetic was statistically and significantly more effective compared to the placebo for reducing the pain caused by needle insertion alone at all time points (two, five and 10).

However, it had no effect on perceived pain intensity associated with injection of the local anesthetic solution at any of the time intervals.

At all time lengths, patients reported the same degree of pain from anesthetic solution injections in topically anesthetized and placebo locations.

Therefore, the minimum two-minute period appears to be sufficient for the topical anesthetic application, as a five- or 10-minute delay has no added benefit in reducing the pain of needle insertion.

To read the entire study, “Effect of Time on Clinical Efficacy of Topical Anesthesia,” visit www.allenpress.com/pdf/anpr-56-02-03.pdf.
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Journées Dentaires de Nice shines once again

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

The Journées Dentaires de Nice dental meeting gathered in Nice, France, in June — as it has for every other year since 1976 — to exchange information on all phases of dentistry, as well as to give exciting up-to-date presentations on futuristic possibilities in our profession.

In June, the sun reflects on the French Riviera like no other place on Earth, making it a perfect location for practitioners to sparkle with the knowledgeable exchange of dental presentations.

Participating supporters from the Chicago Midwinter Dental Meeting and the Greater New York Dental Meeting were there in full force, sharing information with colleagues from France and the rest of the world.

An added glow this year was a warm reception at a beautiful mansion and garden on the sea. There, the mayor of Nice awarded personal citations and medals to a select few who enhanced this wonderful cultural exchange.

Dr. Robert Edwab, executive director of the Greater New York Dental Meeting, was one the recipients. Edwab extended an invitation for all to come, share and participate in the Greater New York Dental Meeting in November, which attracted more than 55,000 attendees from around the world last year.

Since its inception, every Journée Dentaires de Nice has had a special auditorium devoted solely to implants and implant-related presentations. While many meetings these days have sessions related to implants, this group had the foresight and fortitude to offer them years earlier than any other meeting.

Dr. Gerard Scortecci is the chairman of the implant section of the Journées Dentaires de Nice, and has been for many years. He has done a formidable job with masterful presentation choices that are devoid of the political or commercial pressures that sometimes surround such organizations.

Scortecci is a wonderful practitioner, author and modest colleague who endeavors to give a forum to practitioners, as well as implant manufacturers, to elucidate new procedures, products and regenerative materials so that participants can best serve their patients. He is to be congratulated on his achievements and impartiality.

During the Nice meeting, the exhibits were presented in a neat and orderly fashion, making it easy to find the new products as well as making them accessible to all.

Dr. M. Kaduch and M. Burdin have worked exhaustively over the years to cultivate a wonderful meeting with a unique personality that incorporates all of the style and class the French Riviera is known for.

I have attended this congress several times, and I hope this gem of a biennial meeting continues to flourish and sparkle under the French Riviera’s sun.

**About the author**

David L. Hoexter is director of the International Academy for Dental Facial Esthetics, and a clinical professor in periodontics at Temple University, Philadelphia.

He is a diplomate of implantology in the International Congress of Oral Implantologists as well as the American Society of Osseointegration, and a diplomate of the American Board of Aesthetic Dentistry.

Hoexter lectures throughout the world and has published nationally and internationally. He has been awarded 11 fellowships, including FACD, FICD and Pierre Fauchard. He maintains a practice at 654 Madison Ave., New York City, limited to periodontics, implantology and esthetic surgery.

He can be reached at (212) 355-0004 or drdavidlh@aol.com.
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Fiscally fit in 2009

Tax breaks and limited-time laws make 2009 the right time to invest in your practice

By Keith Drayer

The American Recovery and Reinvestment Act of 2009 was signed into law on Feb. 17 with some of the best benefits having limited remaining time eligibility.

Small business owners have limited time in 2009 to benefit from the most lucrative tax incentives for acquiring technology and/or equipment.

If your practice is ready to buy equipment or software, the tax incentives for doing so are better than ever. These benefits will expire, or be reduced, as of Jan. 1, 2010.

The American Recovery and Reinvestment Act accompanied by lower interest rates make this a strategic time to invest in your practice to meet the demands of today’s health care industry.

Because of these beneficial conditions, installing equipment and technology in 2009 can create a cash flow win-win for health care practitioners “in the know.”

Can you deduct $250,000?

For the 2009 tax year, many small businesses may potentially deduct up to $250,000 if the equipment or software is placed in service.

This valuable break is the Section 179 depreciation deduction privilege, and it is an exception to the general rule that you must depreciate equipment and software costs over several years.

Section 179 is an annual “use it or lose it” accelerated deduction benefit that optimally lowers taxable income.

The bonus depreciation is allowable for regular and alternative minimum tax (AMT) purposes for the tax year in which the property is placed in service.

Property eligible for this treatment includes:
- Property with a recovery period of 20 years or less (almost all dental equipment).
- Standard software/practice-management software.

What type of financing is eligible?

Utilizing a finance agreement or capital lease to acquire technology or equipment will qualify for this benefit, while true leases or fair market value agreements will not.

If you use a finance agreement to acquire your equipment and you have deferred payments, you may file your tax returns and achieve the benefits before you have made any payments.

Avoid last-minute decisions

Don’t wait too long to acquire technology or upgrade your office.

Although it is true that you can have equipment placed in service by Dec. 31 to take advantage of the incentives, waiting too far into the year may mean that you will settle on your selections because of diminished year-end choices.

Now is the right time to meet with an equipment or technology specialist and discuss acquiring the optimal production-enhancing technology and equipment that will help your practice stay fiscally fit.

Don’t forget bonus depreciation

Your practice may generally claim first-year bonus depreciation deductions equal to 50 percent of the cost that is left over after subtracting allowable Section 179 deductions (if any).

If your business uses the calendar year for tax purposes, you only have until Dec. 31 to take advantage of the generous $250,000 allowance.

Don’t wait to see if 2010 will provide the same opportunity. Act now and take advantage of all the benefits available through this current legislative windfall.

Annual Internal Revenue Code Section 179 Example

<table>
<thead>
<tr>
<th>Calculations</th>
<th>Equipment not more than $800,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Equipment price</td>
<td>$500,000</td>
</tr>
<tr>
<td>B. Section 179 deduction</td>
<td>$250,000</td>
</tr>
<tr>
<td>C. 50%, bonus depreciation</td>
<td>$25,000</td>
</tr>
<tr>
<td>(A - B x 0.10)</td>
<td></td>
</tr>
<tr>
<td>D. 2009 MACRS deduction</td>
<td>$5,000</td>
</tr>
<tr>
<td>(A - B - C x 0.20)</td>
<td></td>
</tr>
<tr>
<td>E. Total first year tax deduction</td>
<td>$280,000</td>
</tr>
<tr>
<td>ENERGY SAVING REBATES</td>
<td></td>
</tr>
<tr>
<td>F. Combined federal and state tax bracket</td>
<td>$106,400</td>
</tr>
<tr>
<td>G. Total 2009 tax savings as a result of capital expenditure (E x F)</td>
<td></td>
</tr>
</tbody>
</table>

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About the author

Keith Drayer is vice president of Henry Schein Financial Services, which provides equipment, technology, practice start-up and acquisition financing services nationwide.

Henry Schein Financial Services can be reached at (800) 855-9495 or hsfs@henryschein.com.

Please consult your tax advisor regarding your individual circumstances.
Keep the economic crunch from biting your practice

By Sally McKenzie, CMIC

As many of us have observed or experienced firsthand, the economy isn’t doing so great these days. Patients are delaying treatment. They are looking for lower cost options. If patients perceive an appointment isn’t particularly necessary, chances are they will find an excuse to cancel or reschedule. Consequently, practices are scrambling to fill cancellations, and no-shows are on the rise.

This is all the more reason why patients need to understand that dental care isn’t a matter of personal preference, nor is it an option to be exercised when they have a little more discretionary income. Rather, oral health is essential to the patient’s overall health and wellbeing.

It’s up to the dental team to use every opportunity to educate patients that dentistry isn’t about just brushing and flossing; it’s about controlling diabetes, helping to prevent heart disease and respiratory ailments, as well as helping to ensure that pregnant women carry their babies to term.

First, check the messages that you are sending to patients. If you are minimizing the need for care, you are doing your bottom line no favors. Hygienists must take the time to verbalize exactly what they see clinically.

In addition, at the end of the appointment, remind the patient about the findings, such as the pocketing on the lower left that is more of a concern now than it was at a previous appointment. In turn, the dentist must be singing from the same songbook. If she/he walks in and says, “Everything looks great. See you in six months,” not only will both of you lose credibility, you’ll virtually ensure production shortfalls for both dentist and hygienist. If everything does not look great, emphasize the importance of addressing concerns.

Follow up or fall down

Follow up with patients who delay care. In too many cases, patients forgo or delay treatment because they really do not understand the importance of pursuing treatment. In between appointments, continue to educate patients.

Too often dentists will tell a patient something once or twice and believe they’ve done their part to educate them on the matter. Take a page from McDonalds’ — everyone in the country knows what a Big Mac is, but that doesn’t mean they stop telling us, at every opportunity, how delicious they are.

Patients are inundated with hundreds of competing messages every day, which means that for the message to have impact, it must be repeated multiple times and in multiple ways. You can’t just send out the newsletter or the postcard and expect to have it increase hygiene days.

You have to continue to reiterate the message many times and on multiple levels. Telling patients something once or handing them a brochure isn’t ongoing patient education.

What’s more, patients need to understand how they will benefit, so make that an integral part of your message. It’s essential that patients recognize that the dental practice is an essential stop on their journey toward overall good health. It’s up to you to bring them along.

Pursuing treatment should be easy

Next, make it practical for your patients to pursue treatment. This may be a good opportunity for you to review your financial policy and guidelines. It should be neither too lax nor too severe. A policy that is too lenient can create undue financial strain on your practice. A policy that is too strict can cause patients to forgo necessary and elective dental procedures.

The plan should encourage patients to pursue dental care and pay for that care promptly. Consider these possible options:

• If you choose to allow patients to make installment payments, determine how long you are willing to wait for payment. For example, perhaps you will allow all patients under one procedure that costs over a specific amount to pay for the treatment in three installments over a three-month period.

• If the timeframe can be longer or shorter depending on your own preferences. However, it must be finite and it should only be extended to patients undergoing more costly treatment.

• Accept all major credit cards, and in lieu of allowing patients to carry large balances on their accounts, encourage them to pay with credit cards.

• Explore the availability of patient financing companies, such as CareCredit. Some patient financing companies will allow patients to pay over 12 months or longer; however, the dentist receives payment immediately.

• Encourage patients to build a credit on their account before the treatment begins.

Consider offering those patients who are pursuing more costly and more comprehensive dental care a slight adjustment in the fees, such as 5 percent, if they pay for the procedure in full upfront.

Expect patients that have insurance coverage to pay their portion of the fee at the time the dental care is provided.

Always ask for payment

Even during challenging economic times, business staff must continue to ask for and expect payment from patients at the time of service. Keep a few points in mind at the time of collections to ensure that patients fully understand the level of care they have received for their investment.

When asking for payment, explain the services provided and make it easy for the patient to pay. For example, offer the patient financing options.

Avoid asking patients if they would like to pay today. Rather, ask patients what form of payment they would like to pay with today — cash, check or charge? This reinforces the payment expectation and enables patients to determine which form of payment will be best suited to them.

Be prepared with specific scripts that the staff can use when discussing payment options.

For example, if the patient says, “I can make monthly payments for the next 12 months,” the front desk person should say, “Mrs. Jones, we would be unable to accept monthly payments for that duration because this is a small business and we are unable to extend credit for that amount of time.”

However, we do have a relationship with a patient financing company (provided such an arrangement exists) that will offer you an interest-free loan. I just need a little more information.”

This approach helps patients understand why the practice cannot extend no-interest loans, yet it provides a reasonable financial option for patients to pursue.

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.dentistnetwork.net; the e-Management Newsletter from www.mckenziegml.com; and The New Dentist™ magazine, www.thenewdentist.net. She can be reached at (877) 777-6151 or sallymckenzie@mckenziegml.com.
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- Fibroma removal
- Frenectomy
- Frenotomy
- Implant recovery
- Incision and drainage of abscess
- Leukoplakia
- Oporculectomy

- Oral papillactomies
- Pulpotomy and Pulpotomy as an adjunct to root canal therapy
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- Soft Tissue crown lengthening
- Treatment of canker sores, herpetic and aphthous ulcers of the oral mucosa
- Vestibuloplasty

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- Light activation for bleaching materials for teeth whitening

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- Laser soft tissue curetage
- Laser removal of diseased, infected, inflamed, and necrosed soft tissue within the periodontal pocket
- Removal of highly inflamed edematous tissue affected by bacteria penetration of the pocket lining and junctional epithelium.

*Expires on October 31st
Dental Informatics: the right time to invest in training and research?

By Titus Schleyer, DMD, PhD

These days, technology appears to touch most aspects of our lives, and dentistry is no exception. The plethora of possibilities and questions is seemingly endless. Should you invest in chairside computers, paperless records and/or digital radiology? Does it make sense for patients to have Web-based access to their appointments and dental record information? What is Health Information Technology (HIT) and what are the implications for your practice? Can computers really make you a better dentist and help improve your practice?

The last question is one worth pondering. If we look at all investments in our practices, we make them for two reasons: to improve patient care and outcomes, enhance efficiency, or both. Health information technology (HIT) is no different. One important question, however, is that it is often hard to gauge the true balance between costs and benefits.

Evidence for the benefits of information technology (IT) in dentistry can be found, but it is largely anecdotal. Practitioners report easy and nearly ubiquitous access to patient information. Electronic reports allow tracking of patient completion of treatment plans and even health outcomes. Digital information can be e-mailed and shared with patients and colleagues, for instance, to increase patient compliance or to get payment in the mail to us when you get home, we would greatly appreciate it.”

Financial negotiations should be delegated to a trained financial coordinator. The dentist is the clinician, the primary income producer and the chief executive officer. However, he/she is not the financial coordinator, and engaging in this role is often both inefficient and awkward for dentist and patient alike. It also can undermine the profitability of the practice.

Delegated financial discussions to trained members of the team. Those individuals most capable of succeeding in this position are typically assertive, tactful, confident and goal-oriented. You may have excellent members of your team who are loyal, kind and truly dedicated to your practice. However, they may be entirely too passive or very uncomfortable asking patients for payment. It is not a job that just anyone can step into.

Some people are simply not suited for this responsibility. Pay attention to the personality type of the individual responsible for collections and secure training to ensure success.

From time to time, as the dentist, you will feel that certain exceptions should be made to the policy for specific cases. Certainly, as the business owner, that is your prerogative. However, you should be judicious in making those exceptions. Special arrangements that become common practice usually end up as part of the financial coordinator and can quickly render financial policy useless.

Educate patients fully so that they understand the financial impact and the overall value of the care you provide. Review your collections policies, train those who discuss financial arrangements with patients and ensure that patients fully understand the options available.

Before you begin, you will be well past the current economic crunch, and you will have kept your patients in your practice and your bottom-line intact.

The National Institute of Dental and Craniofacial Research (NIDCR), funds dental informatics training to qualified applicants for free (no kidding!). The NIDCR funds provide a stipend, tuition, fees and health insurance support, travel subsidies and a state-of-the-art computer.

These positions are highly sought after and admission is very competitive. Additional information about the program is available at di.dental.pitt.edu/postgrad.php.

For any questions, please contact the program director, Dr. Titus Schleyer, at titus@pitt.edu.
Orthodontic surgery and esthetics

By Prof. Nezar Wattad & Prof. Josip Bill, Germany
Dr. Ori Blanc & Dr. Benjamin Schliomi, Israel

Orthodontic surgery and esthetics

Orthodontic treatment generally follows esthetic, functional and prophylactic objectives, where individual aspects of isolated cases are accorded varying importance as they arise. Increasing esthetic expectations and awareness of modern dental treatment options disseminated by the media have resulted in increased interest and greater willingness of adults to consider orthodontic treatment. Thus, esthetic orthodontics is primarily adult orthodontics.

A peculiarity of orthodontic treatment in adults compared with pediatric or adolescent orthodontics is the age-associated involution of the connective tissues that leads to a reduction in cell density, thickening of the fibre bundles, delayed fibroblast proliferation and reduced vascularization. These are the causes of slower dental movement and delayed tissue and bone reactions. Absent sutureal growth, the age of the periodontium, specific periodontal diagnoses and tissue atrophy also make treatment in adults particularly challenging.

As a rule, esthetically-oriented adult orthodontics therefore has an interdisciplinary inclination. Occlusion, function and esthetics are considered to be equivalent parameters in modern orthodontics, and particularly here in combined orthodontic-maxillofacial surgical treatment. This was achieved through the optimization of diagnostic tools and further development and increasing experience in orthopedic surgery.

Nowadays, treatment of adult patients with dental malposition and mastication impairment is one of the standard tasks of the orthodontist. If the discrepancies in spatial allocations of the upper and lower dentition are particularly pronounced, and where the cause is primarily skeletal and not only dentoalveolar, conventional orthodontic therapy is limited and combined orthodontic-surgical therapy is indicated for remodeling of the jaw bases.

Treatment for a skeletal dysgnathia (Class III) using combined orthodontic-maxillofacial surgical correction is discussed in this article.

Chronological development of maxillofacial surgery of the mandible

The first orthodontic-maxillofacial surgical procedure on the mandible described in the literature was that of the American surgeon Hullihen in 1848.13

This procedure was a segmental osteotomy of the anterior mandible (a posterior shift [retrusion] of a protruding mandibular alveolar process following a burn injury).

Toward the end of the 19th century, the method of orthodontic-maxillofacial surgical correction of dysgnathias by surgical retrusion or protrusion of the mandible was revisited. Jaboulay14 described resection of the Processus condylarism and Blair osteotomy on the Corpus mandibularis.

The continuity resection in the horizontal branch by Blair was the first surgical prognathism procedure. The patient first visited the dentist Whipple in St. Louis in 1891 and was then referred to the most renowned orthodontist of the day,
Dr. Edward Hartley Angle, who ultimately recommended the surgical procedure mentioned above. Six years later, the procedure in this osteotomy on the Corpus mandibulae was also published by the Hamburg surgeon Floris. Parallel with this development in the U.S., von Auffenberg in Europe conceived a step-by-step osteotomy for correcting a mandibular retrusion, which was performed by von Eiseling in 1901.

The era of orthodontic surgery in Europe began only after World War I. The experience gained there led to a substantial extension of the indications for orthodontic-maxillofacial surgical procedures, as well as to the transfer of this surgical technique to the area of elective procedures. In the early 1920s, Bruhn and Lindemann set transversal osteotomy of the Ramus mandibulae as the standard method at the time for the surgical correction of mandibular prognathism. This method, which continued to have many adherents well into the 1960s, is today known as the Bruhn-Lindemann procedure.

In 1955, Wassmund, who saw its drawbacks in a possible dislocation of the proximal segment by the muscles inserted there, described a modification of the Bruhn-Lindemann surgical technique. In the early 1950s, a new era in orthodontic surgery of the mandible was begun with Kazanjian’s resumption of the technique of transverse oblique severing of the ascending ramus, first performed by Perthes in 1922. Shuchard modified this method in 1954 by enlarging the bony insertion surface, and in 1955 Obwegeser introduced sagittal splitting at the horizontal ramus of the mandible. He shifted the buccal osteotomy line obliquely from the last molar to the posterior margin of the jaw angle.

In 1959, Dal Pont moved this buccal osteotomy line from the last molar to the inferior margin of the mandible. Since then, this method of sagittal split at the mandible has been called sagittal split according to Obwegeser-Dal Pont (Fig. 1). Epker developed the incomplete sagittal split into a routine method.

Clinical case presentation
History and diagnosis
A 25-year-old patient presented on his own initiative. He complained of functional (impairment of mastication and jaw joint pain) and esthetic impairment (sunken face with facial asymmetry). He had undergone orthodontic treatment between the ages of 8 and 15 and reported pain in the area of the anterior mandible.

The lateral image showed a retrusive lower face inclined forward with mid-facial hypoplasia — regio infraorbitale — a flat upper lip and an elongated lower face compared with the mid-face — 47:53 percent instead of 50:50 percent (Table I; Fig. 2a). Owing to the negative sagittal overjet, there was a positive lower lip step. The frontal image shows mandibular deviation (laterognathia) to the right, which can be traced to growth asymmetry in the jaw (Fig. 2b).

In addition, there was a Class III dysgnathia angle with conspicuous mandibular midline deviation to the right, frontal and right lateral crossbite, anterior mandibular labial tilt and a steep anterior mandible. Tooth 26 had been missing for some time (Figs. 3a–e). FRS analysis (Table I and II) clearly shows the strongly sagittal and relatively weak vertical dysgnathia both in the soft-
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Therapeutic objectives and treatment planning

The objectives of this combined orthodontic maxillofacial surgical treatment were:

- the establishment of neutral, stable and functional occlusion with physiological condylar positioning;
- the optimization of the facial esthetics;
- the optimization of the dental esthetics, considering the periodontal situation;
- the assurance of the stability of the results achieved;
- meeting the patient’s expectations.

The improvement of the facial esthetics not only in the sagittal axis in the region of the lower face (the mandibular region), but also in the region of the mid-face (hypoplasia) and in the transverse axis should be noted as specific treatment objectives. The change in the region of the mid-face was intended to affect the upper lip and the upper-lip vermilion.

These treatment objectives were achieved by two procedures:

- a dorsal extension of the mandible with lateral sweep to the left for correction of the sagittal and transverse defects, as well as occlusion and the soft-tissue profile;
- bone augmentation in the mid-face for harmonization of the face.

It would not have been possible to achieve the desired treatment objectives with respect to function and esthetics using orthodontic procedures alone. The parameters indicated a growth pattern with an anterior course: the vertical grouping of the soft-tissue profile showed a disharmony between the mid-face and the lower face (G’-Sn:Stm-Me’; 47:55 percent). This was relatively weakly expressed in the bony structures (N-Sna:Sna-Me; 44:56 percent).

In the region of the lower face there was also mild disharmony (Sn-Stm:Stm-Me’; 51:69 percent). Complementary assessment of the mandible showed that the area from the subnasal-labral inferius to the soft-tissue chin (Li-Me’), which should have been 1:0.9, was shifted in favor of the Li-Me’ part (0.9:1; Fig. 4). The panoramic image showed a lucency of teeth 31 and 41. A root canal procedure followed by root apex resection was thus performed (Fig. 5).

Therapeutic procedure

Correction of the pronounced dysgnathia was achieved in six phases:
- Splint therapy: a flat bite guard was installed for six weeks in order to determine the physiological condylar position or centrics before the final treatment planning. By doing this, the forced bite could be demonstrated to its full extent.
- Orthodontics for forming and adjusting the dental arches relating to each other and for the simultaneous correction of the skeletal dysgnathia (Figs. 6a–c).
- Bone augmentation in the mid-face region was completed using autologous bone.
- Splint therapy for determining the condylar position. This was performed in the four to six weeks prior to the surgical procedure. The objective was registration of the jaw joint in a physiological position (centrics).
- Oral surgery for correction of the skeletal dysgnathia: after model operation, determination of the transposition path and production of the splint in the target occlusion, the surgical mandibular translocation using sagittal split according to Obwegeser–Dal Pont was performed. Augmentation in the midfacial region was completed using autologous bone.
- Orthodontics for fine adjustment of occlusion.
- Retention: 3-3 retainers were cemented in the mandible.

Mandibular and maxillary plates were used as the retention appliance. Prosthetic care was provided after six months.

Results

Figures 7a to 7e show the situation after the conclusion of treatment, and after extraction of tooth 31 and subsequent prosthetic treatment: neutral occlusion and correct midline with physiological sagittal and vertical bite.

The extraoral images show a harmonious profile in the vertical as well as in the sagittal axis (Figs. 8a, b). The oral profile is harmonious.
Figs. 6a–c: Situation after orthodontic preparation for the surgical procedure.

Figs. 7a–e: Occlusion at the end of treatment; there is a neutral stable occlusion with physiological anterior bite in the sagittal and vertical axes and a correct midline (a–c). Monitoring images of the upper and lower jaws. A ceramic bridge was made in the lower jaw (d, e).

---

**Parameter** | **Mean** | **Before Treatment** | **After Treatment**
---|---|---|---
G'-Sn/G'-Me' | 50% | 47% | 50%
Sn-Me'/G'-Me' | 50% | 55% | 50%
Sn-Stm/Stm-Me' | 55:67% | 51:69% | 55:67%
Sn-Li/Li-Me' | 1:0.9 | 0.9:1 | 1:1

**Table I: Proportions of soft-tissue structures before and after treatment.**
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Figs. 8a, b: The extrorad treatment results. The sagittal, vertical and transverse were corrected.

Fig. 8c

Figs. 8c, d: Change in the oral profile: pre-op and post-op.

Fig. 9: The cephalometric image after conclusion of treatment shows a harmonious ratio between the skeletal structures, as well in the sagittal axis and the vertical axis, and harmonization in the soft-tissue profile between the upper and lower face.

Fig. 10: Orthopantomogram after conclusion of orthodontic treatment and before prosthetic care.

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Walt Disney World Dolphin Resort – Orlando, Florida
Case report: oral rehabilitation of severely worn dentition

By Dov M. Almog, DMD, Michel Ferrara, DDS & Youngman Chun, DDS

Tooth wear occurs as a natural physiologic process. The average wear rates on occlusal contact areas are estimated to be 29 µm per year for molars and about 15 µm per year for premolars (1 micrometer = one thousandth of a millimeter).5 Pathologic wear occurs when the normal rate of wear is accelerated by endogenous or exogenous factors.6 Tooth wear caused by parafunction is estimated to progress some times faster than physiologic wear.3 Tooth surface loss has been classified into the following types:

1) Erosion: loss of tooth surface by chemical processes not involving bacterial action.
2) Attrition: denoting tooth surface loss by wear of the tooth surface or restoration caused by tooth-to-tooth contact during mastication or parafunction.
3) Abrasion: loss of tooth surface caused by abrasion with foreign substances other than tooth-to-tooth contact.4 Another classification divides tooth wear into two categories: mechanical wear caused by attrition or abrasion, and chemical wear caused by erosion.5 A differential diagnosis is not always possible because often there may be a combination of these processes occurring.1–3 Etiologic factors include bruxism, harmful oral habits, diet, gastroesophageal reflux disease, occupation, eating disorders, xerostomia and congenital anomalies such as amelogenesis imperfecta and dentinogenesis imperfecta.1–12 Clinical parameters have been suggested to aid in diagnosing the type of tooth wear and determining its cause.3

Loss of the vertical dimension of occlusion (VDO) caused by physiologic tooth wear is usually compensated for by continuous tooth eruption and alveolar bone growth. In situations where tooth wear exceeds compensatory mechanisms, loss of VDO occurs.

The determination of the VDO can be achieved with several methods, such as phonetics, interocclusal distance and swallowing.4 In situations where loss of tooth structure has occurred and VDO is still acceptable, treatment may include crown lengthening, orthodontic movement with limited intrusion, surgical repositioning of a segment of teeth and supporting alveolar bone, and placement of crowns and fixed partial dentures.8

In situations where loss of VDO has occurred, the cast overlay removable partial denture (CORPD) may be a treatment option.13–15 This treatment option has been suggested to be efficient and cost effective, with the final outcome pleasing to the patient.13–15 Potential disadvantages of the CORPD prosthesis include compromised esthetics when the dentures are removed; development of caries or periodontal disease as a result of poor oral hygiene; porcelain or resin veneer fracture or discoloration; and possible dissatisfaction with a removable prosthesis.

This clinical report describes the use of maxillary and mandibular CORPD consisting of anterior porcelain veneers and posterior cast overlays in the treatment of a patient with severe tooth wear due to attrition and erosion, including follow-up over three years.

![Fig. 1: Panoramic.](image1)

![Fig. 2: Intraoral.](image2)

**Case report**

A 65-year-old African-American male veteran, the subject of this case report, presented us with a noteworthy case of worn dentition. The veteran was referred to our dental service for prosthodontic treatment consideration. The medical and dental histories were recorded, and a full-mouth-series (FMS) of radiographs and Panorex (Fig. 1) were taken.

The relevant medical history included hypertension, tobacco

![Image 390x597 to 660x749]
use and post traumatic stress disorder (PTSD). The clinical examination revealed severe tooth wear extending to the cervical level of the teeth in some areas, attributed primarily to amelogenesis imperfecta.

Clinical determination of the VDO was achieved with the following methods: phonetics, interocclusal distance, swallowing, lip competence and facial appearance. Following careful assessment, it was determined that a 7-millimeter loss of VDO was caused by a combination of attrition, erosion (Figs. 2, 3a, b).

The patient’s chief complaint noted a desire to improve esthetics (“poor appearance”), function (“would like to chew better”) and eliminate tooth sensitivity (“my teeth are sensitive”). Impressions of both arches were made using stock trays and irreversible hydrocolloid (Deltrate Plus, DENTSPLY Caulk, Milford, Del.), and poured in stone (Quickstone, Whip Mix, Louisville, Ky.). The diagnostic casts were articulated in a semi-adjustable articulator (Hanau H2, Hanau Teledyne, Buffalo, N.Y.), using a centric relation record and a face-bow transfer.

During the following visit, treatment options were discussed with the patient, including crown lengthening, root canal treatments, implants and fixed restorations.

After reviewing photos of other similar cases and considering the invasiveness, life expectancy of fixed restorations, amount of time and cost, the patient elected to have CORPDs using cast frameworks, acrylic teeth and a couple of posterior teeth with metal occlusal surfaces in order to maintain the prospective VDO. The patient was also started on 0.4 percent stannous fluoride once a day (Accelean, Home Care Gel, Henry Schein, Melville, N.Y.) in order to prevent further decalcification of his teeth.

Shortly after, maxillary and mandibular transitional overdentures were fabricated. The new diagnostic VDO and the plane of occlusion were established based on anatomic landmarks and averaged values. These overdentures fit tightly over the teeth and soft tissues, enabling evaluation and adjustment for phonetics, esthetics and occlusion.

The transitional VDO devices were worn for approximately eight weeks, during which time occlusal adjustments were made weekly, and occlusion was modified based on phonetic and esthetic principles as well as patient comfort and ease of function.

In the meantime, the diagnostic casts were surveyed to determine the most suitable path of insertion of the definitive prostheses. Each cast was placed in a horizontal position and slowly lowered posteriorly on the surveyor until undercuts at the disto-buccal of the bicuspids and molar regions were of sufficient depth (0.25 mm). A slight undercut in the anterior region allowed for use of a rotational path of insertion.

The information from the diagnostic casts was now replicated intraorally. Unsupported enamel was recontoured and polished. Guide planes were placed on any remaining proximal tooth surfaces. Because of the severe wear of many of the teeth, a natural undercut for adequate retention could not be located. Therefore, existing enamel surfaces were slightly modified to create 0.25 mm undercuts.

Dentin exposure was managed with a thorough maintenance program. Rest seat preparations were not needed because the entire occlusal surface of all the teeth served as rests under the cast framework.

Definitive casts were obtained using a polyether impression material (Permadine-Penta II and Permadyne Grant 2:1, 3M ESPE, St. Paul, Minn.) and custom trays (Triad VLC Materials, DENTSPLY International, York, Pa.), and mounted in centric relation. The incisal guiding pin was then adjusted for a 7 mm increase in VDO.

Once the path of insertion was established for both casts, the undesirable undercuts were blocked out with wax, and the casts were duplicated and poured in a refractory investment (Hi-Temp, Whip Mix Corp., Louisville, Ky.). The refractory casts were also mounted in the articulator using a cross-cast mounting procedure between the definitive cast and the refractory casts.

The frameworks were waxed using a thin layer of wax (Flexseal Patterns, DENTSPLY Trubyte/Austenal, York, Pa.) over the teeth, to be included in the prosthesis. A couple of the posterior occlusal surfaces were waxed to occlusion. The wax patterns were cast in a chrome-cobalt alloy (Vitallium, DENTSPLY Austenal, York, Pa.). The cast frameworks were then finished.

The frameworks were evaluated intraorally for fit, occlusion, retention and stability. A
new maxillo-mandibular record was made with the frameworks in position, and the definitive casts were mounted on the articulator.

The frameworks were returned to the laboratory for acrylic teeth in the esthetic zone. Although the esthetic zone in the CORPD can be fabricated either with composite or porcelain veneers, in this patient, acrylic teeth were used (Ivoclar Vivadent, Schaen, Liechtenstein) (Fig. 4).

At the patient’s next visit, the CORPDs were inserted (Figs. 5a, b). Following postoperative directions on how to properly insert the protheses, the patient was provided with instructions on adequate oral hygiene and caries and erosion prevention. These included the application of 0.4 percent stannous fluoride once a day. The veteran was also instructed to take the CORPDs out at night. After two post-insertion visits that included minor adjustments, the patient was placed on a six-month recall.

One year and four months after insertion, the patient presented to the dental emergency clinic with discomfort associated with tooth #8. According to the patient, he had stumbled and clenched his teeth together, resulting in a root fracture of tooth #8, following which he was referred to the oral surgery department for a surgical extraction. After removal of tooth #8, a minor acrylic reline was done in the respective underline region in the maxillary CORPD.

Conclusions

This clinical case report demonstrates that the use of CORPD can be a viable, non-invasive and relatively inexpensive choice of treatment for a patient with severely worn dentition who expresses concerns about treatment invasiveness, long-term durability and cumulative costs for the long-term oral rehabilitation and maintenance.

Editorial note: A complete list of references is available from the publisher.
Meeting in San Francisco offers plenty to learn, buy and do

By Fred Michnersonshuizen, Online Editor

For dentists on the West Coast, Northern California is the place to be this September, as it is the setting for “CDA Presents The Art and Science of Dentistry” — to be held Sept. 10–13 at the Moscone West Convention Center in San Francisco.

The California Dental Association meeting (formerly known as the “Scientific Session”) offers attendees the chance to learn from dynamic speakers and technical exhibits, and to fulfill continuing education requirements.

In the exhibit hall, attendees will be able to explore cutting edge products and services. The meeting also offers plenty of opportunities for networking with colleagues and friends, all amid the exciting attractions of San Francisco.

Things to learn

The four-day meeting will feature dozens of informative classes and workshops for dental professionals. Whether you want to expand your practice, increase productivity or even learn a new technique, you are sure to find intellectual stimulation in the lecture halls.

There are too many courses to list them all, but highlights include the following:

- David A. Garber, DMD
  Accelerated Esthetic Restorative Dentistry: Choices, Alternatives and Options; Saturday lecture, 9:30 a.m.–noon; 1:30–4 p.m.

- James R. Dunn, DDS
  Esthetic Restorative Treatments and the Visual Communication Tools Needed in a Contemporary Practice; Sunday lecture, 8:30 a.m.–12:30 p.m.

This class will review the materials and techniques available for bleaching, minimal intervention with glass ionomers, direct composites, bonded ceramics, periodontal alterations and implant restorations.

- Ronald Jackson, DDS, FAGD,
  AFAACD, DABAD
  Giving Your Patients Something to Smile About: Composite Artistry; Friday lecture, 9:30 a.m.–noon; 1:30–4 p.m.

- John O. Burgess, DDS, MS
  Restorative Materials Update; Friday lecture, 10 a.m.–12:30 p.m.; 2–4:30 p.m.

This fast-paced course by Dr. Burgess will advance your dental practice by improving your use and selection of dental materials, and will provide useful information that can be used during your next clinic day.

- Debbie Castagna and Virginia Moore
  Rejuvenate Your Practice — It’s Easier Than You Think, Friday morning lecture, 9:30 a.m.–noon

The comprehensive New Patient Experience: From “Thank You for Calling” to “When Can We Start?”, Friday afternoon lecture, 1:30–4 p.m.

- Joseph A. Blaes, DDS
  AFAACD, DABAD
  Accelerated Esthetic Restorative Dentistry: Choices, Alternatives and Options; Saturday workshop, 9:30 a.m.–noon (repeats 1:30–4 p.m.)

In this hands-on workshop by Jackson, participants will have the opportunity to use 4 Seasons (Ivoclar), a state-of-the-art, naturally shaded composite system. Exercise will include placement of an invisible Class IV.

- John O. Burgess, DDS, MS
  Temporization Made Easy, Friday workshop, 9:30 a.m.–noon (repeats 1:30–4 p.m.)

During this four-day meeting, Burgess will advance your dental practice by improving your use and selection of dental materials, and will provide useful information that can be used during your next clinic day.

- Debbie Castagna and Virginia Moore
  Rejuvenate Your Practice — It’s Easier Than You Think, Friday morning lecture, 9:30 a.m.–noon

The instructors will inspire you with their insight into topics and issues you face every day, including staff meetings and solutions to decrease no-shows and cancellations.

The Comprehensive New Patient Experience: From “Thank You for Calling” to “When Can We Start?”, Friday afternoon lecture, 1:30–4 p.m.

In this session, Castagna and Moore will teach practitioners how to provide the new patient with an exceptional experience.

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For even more on the CDA’s San Francisco meeting, including daily schedules, product news and live coverage of all the seminars, exhibitors and social events, be sure to pick up Dental Tribune’s special CDA San Francisco editions, published each day of the show. See you there!

Going to San Francisco?

For even more on the CDA’s San Francisco meeting, including daily schedules, product news and live coverage of all the seminars, exhibitors and social events, be sure to pick up Dental Tribune’s special CDA San Francisco editions, published each day of the show. See you there!

Chairside techniques using direct composite and indirect porcelain restorations that are indistinguishable from natural tooth structure.

Joseph A. Turbyfill, DDS and Walter E. Turbyfill, DMD

Dueling Dentures Match at Ringside, Friday morning lecture, 9 a.m.–12:30 p.m.

Each speaker will present several cases utilizing different approaches to treating the edentulous patient. Learn from two remaining “giants” in removable prosthodontics.

Exquisite Complete and Implant-Retained Overdentures Calibrated for the General Practitioner, Friday afternoon lecture, 1–3:30 p.m.

This presentation by Dr. Massad and Dr. Turbyfill will cover the most important aspects of complete removable dentures reloaded to include implant-retained overdentures.

The Ultimate Prosthetic and Implant Impressioning Experience, Saturday workshop, 8:30 a.m.–12:30 p.m.

This participation course taught by Massad and members of his teaching team will allow each attendee to learn and experience the best methods for impressioning of prosthetic patients for the complete, immediate denture and the implant restoration overdenture.

John D. West, DDS, MSD

21st Century Endodontics: What Every General Practitioner Should Know, Saturday lecture, 10 a.m.–2 p.m.

This program will provide you with the knowledge, skill and thought process to make endodontics the most enjoyable, energizing and profitable procedure in your treatment day.

Mastering Safe, Simple and Super Efficient Endodontics, Sunday workshop, 8:30 a.m.–12:30 p.m.

This program by Dr. West teaches the clinical pearls of successful endodontics. This highly popular technical class is designed to have you beaming with newfound endodontic freedom and to change your endodontic experiences forever.

Edwin J. Zinman, DDS, JD

The ABCs of Informed Consent, Thursday, 9:30 a.m.–12:30 p.m.

This lecture will illustrate how informed consent principles should be applied to periodontal therapies, such as the laser-assisted new attachment procedure, and included as routine agency of a case presentation. This is a corporate forum sponsored by Millennium Dental Technologies.

David Gates, DDS

Invisalign Clear Essentials I, Saturday

This course is designed specifically for the general practitioner and team members who wish to incorporate the Invisalign system into their practice. There is a $1,695 fee for this course. Tuition covers the dentist and up to four team members.

Things to buy

Meeting attendees will have the opportunity to keep up with the latest technology and trends in the exhibit hall, which will feature more than 400 exhibiting companies showcasing the latest in dental products and services. You can stay ahead of the curve by checking out the new products being launched. The exhibit halls are located on the first and second levels.

The exhibit hall hours are as follows: Friday and Saturday, 9 a.m.–5 p.m.; Sunday, 9 a.m.–2 p.m.

A grand opening ceremony will be held Friday at 9 a.m. Family hours are daily from 9 to 11:30 a.m.

Also on the exhibit floor, be sure to check out The Spot—a lounge for learning, networking and fun. This new interactive area is a place to learn, network and have fun. At The Spot, you can see new products, plan your office renovation, check your e-mail or enjoy a cup of coffee and relax with friends. You can even earn C.E. credit!

The Spot is located on the second level of Moscone West. Hours are: Friday and Saturday from 9 a.m. to 2 p.m., and Sunday from 9 a.m. to 2 p.m.

Things to do and see

For those who want to venture away from the exhibit center, a number of special events are planned. Highlights include the following:

California Academy of Sciences

On Friday evening, a bus trip to the California Academy of Sciences in Golden Gate Park is scheduled. The excursion will offer participants the chance to explore a tropical rainforest, experience the penguins of the African Hall and watch aquatic life in a coral reef exhibit. Nearly 10 years and $500 million in the making, this new academy is billed as a masterpiece of sustainable architecture that blends seamlessly into the park’s natural setting. It features hundreds of innovative exhibits and thousands of extraordinary plants and animals.

To participate, gather at 6:15 p.m. in front of the Moscone West Convention Center to load the buses. Buses will depart at 6:30 p.m. and will return beginning at 9 p.m. Appetizers will be served. There is a fee of $85 to participate.

Sunday Brunch

8:30–10 a.m.

CDA is offering a Sunday morning brunch for members and their staff. This special event featuring delicious food will provide attendees the opportunity to socialize with friends, colleagues and exhibitors. The exhibit hall will open before C.E. courses begin, allowing brunch attendees time to enjoy the food and take advantage of Sunday-only exhibit floor specials.

The menu will include full brunch, coffee and orange juice. Get your tickets early. On-site tickets will be available on a limited basis. Perhaps the best thing is the price—just $5 per person.

Children’s Program

Children 10 and younger are only permitted on the exhibit floor from 9–11:30 a.m. each day. To give kids something to do during other times, a children’s program is being offered by KiddieCorp each day at Parc 55 Hotel. Age-appropriate activities are selected for the children who join them during the meeting. For more information and to register, visit kiddiecorp.com/cafalikids.htm.

San Francisco

Of course, the city of San Francisco is famous for its scenic beauty, cultural attractions, diverse communities and world-class cuisine. This very walkable city is dotted with landmarks recognized throughout the world: the Golden Gate Bridge, cable cars, Alcatraz and the largest Chinatown in the United States.

A stroll of the city’s streets can lead from Union Square to North Beach to Fisherman’s Wharf, with intriguing neighborhoods to explore at every turn. Views of the Pacific Ocean and San Francisco Bay are often laced with fog, creating a romantic mood in this most European of American cities.

For more information

Complete show schedules, registration information, evaluations, archives of past events and timely information about future events, and exhibitors and speakers lists are available from the CDA. For more information, visit www.cda.org/sf09.
Collaborative software connects dental professionals on a global scale

By Robin Goodman, Group Editor

At the end of June, Modulus Media — a Toronto-based technology development and marketing company — announced the release of www.DentalCollab.com. Company founder Shane Powell sat down for an interview to highlight what this unique service has in store for the dental community.

DentalCollab.com is a prime example of “cloud computing,” but what does cloud computing mean?

We use cloud computing services all the time, such as Twitter, Facebook, SalesForce.com, LinkedIn. DentalCollab.com is a software program that runs on the Internet through your Web browser. It doesn’t care whether you are using a Mac or a PC, if you are a technological wizard or a regular computer user. All you need is an Internet connection. It simultaneously scales to meet the demands of each individual user, so you don’t have to worry about costly software and hardware upgrades. It’s all upgraded automatically, and for free.

Can you trust this online “cloud” with your information and, more importantly, your patient’s information?

Just as you trust online banking with your finances, FaceBook with your personal information, and Gmail with your e-mail correspondence, DentalCollab.com has built a security system that protects your data. At rest or at play, your data is being secured with 256-bit encryption — just like what the banks use — 24/7 system monitoring and redundant storage. Yes, it’s secure and yes, it can be trusted.

Why isn’t all of our day-to-day dental software running in the “cloud?”

Most dental software was built to run directly on your personal computer. This includes everything from your word processing to your practice management software. You can imagine that it’s not easy, or cheap, to “rewrite” software to run in the “clouds,” also known as the Internet.

The vast majority of dental professionals have been using their practice management software for years. Because of this, there are massive numbers of users that are ostensibly tied to their desktop computers. What’s the ideal solution? It’s simple. Continue using your desktop-based software and use DentalCollab.com to bridge your offline practice with the online global dental community.

Significant examples of software trending to the clouds include: Microsoft Office Live bringing its office products into the online cloud; Google Docs, its online office suite was the catalyst for Microsoft to start bringing its office products into the online clouds.

What about all the other programs dentists are currently running on their practice computers, does all this have to be replaced?

DentalCollab.com doesn’t replace your desktop software; it will extend your reach. DentalCollab.com actually caters to the practices that need a collaboration tool, an online workspace, an information hub that can be securely accessed and easily shared online. Connect with your team, specialists, referrals, any other dental professionals or groups of professionals from around the globe.

Most dental offices are using legacy software that does a great job of managing their day-to-day practice, but it ties them to their desktop computer. We all know it isn’t practical to replace your practice management software; therefore DentalCollab.com acts as the intermediary, intuitively extending the reach of your offline applications, or “in the clouds” as we say.

How exactly does DentalCollab.com’s cloud computing service help dental professionals?

Now that dental professionals know that they can still use their existing software, they can relax. DentalCollab.com is designed to be super easy to use. Taking this approach, we offer a much shorter learning curve to effectively collaborate online. It’s quick and it’s easy to get started, and exceptionally versatile.

There are tremendous benefits for enhancing patient care through extending one’s expertise through a professional network of local specialists, as well as dipping into the vast global talent pool.

Benefits include: open up treatment mentoring with industry experts worldwide; better manage your referrals by inviting labs, specialists, etc.; request second opinions, something insurance companies love; provide patients with access to their treatment plans, X-rays and follow-up information.

Can you tell us more about the Treatment Workspace and how one navigates around it?

Actually, think of it as your “collaborative” Treatment Workspace. It’s as easy to use as a blog’s and wiki’s, but with specific functionality built in for dental professionals. Apart from the intuitive interface, users also benefit from sharing their workspaces with other professionals within their network. This is where the magic begins and you start connecting and really working together.

How secure is DentalCollab.com?

Isn’t the information just “out there” for anyone to grab?

The world’s information is being transferred to the Internet. It’s alarming how much you can learn about someone nowadays. We trust popu-
lar online services such as Facebook, Salesforce.com, Gmail, and Hotmail without batting an eye. Compared to DentalCollab.com, their data is less secure.

We have built a closed network around each user’s account. If you don’t specifically invite people to access a Treatment Workspace, they can’t get in. It’s as simple as that.

How can DentalCollab.com actually save time and money?

Time savings is realized through improved organization and better communication between team members, suppliers, referrals and even sales representatives, thus saving you time and headaches. Whether you are learning new procedures, training with new instrumentation, or sharing your own particular expertise, DentalCollab.com is perfectly suited for learning and mentoring.

Enhanced patient health has tremendous short- and long-term benefits for your practice. No longer are you limited to your local specialist. With DentalCollab.com you can access world-class opinion leaders to enable you to make the best decision possible. A happy patient means more referrals.

Your insurance company will love you. Managing your second opinions through your Treatment Workspace means that you automatically maintain a secure history of all your collaborations. Think of it as record-keeping insurance that helps to protect you against patient problems.

e-Consultations are becoming a requirement as many patients have less and less time. Common treatment planning and follow-ups can be done over the Internet. Securely invite patients to view their complete treatment plan past, present and future.

How is charting handled?

We’re enabling you to connect any of your existing software with the online DentalCollab.com network. Quickly upload, organize and share your charts, x-rays, photos and all related files. Once you start working with the system, you won’t know how you did without this fabulous resource tool.

1) Log-in to your account.
2) Manage Patients: As easy as filling out a form. Invite patients to view their treatment information anytime.
3) Create Treatment Workspaces: Upload x-rays and supporting files, create treatment plans, set priorities and organize your tasks between collaborators.
4) Invite Collaborators: Invite office staff, doctors, specialists, mentors, sales support staff from manufacturers and patients. Any of these invitation-only “treatment collaborators” can review/edit treatment plans, provide a second opinion or simply provide a follow-up e-Consultation.
5) How to Manage Collaborators: Revolve access at any time, subscribe to daily, weekly, monthly reports and schedule reminders.

DentalCollab has a solid developmental roadmap. Looking into the future we see many opportunities for extending our functionality. However, it’s important that we develop in the right places.

We welcome your feedback and have set up a special offer. Enter code “DTCLOUD” for one free month’s access. You’ll see why we believe that collaboration makes the world a better place.

Please visit DentalCollab.com or e-mail sales@dentalcollab.com for more information. 

So would you walk us through a visit to the site and what a dentist would see once he begins using DentalCollab.com?

Once inside, you’ll see right away how easy it is to create a patient file, create a new Treatment Workspace and invite collaborators to join in.

1) Log-in to your account.
2) Manage Patients: As easy as filling out a form. Invite patients to view their treatment information anytime.
3) Create Treatment Workspaces: Upload x-rays and supporting files, create treatment plans, set priorities and organize your tasks between collaborators.
4) Invite Collaborators: Invite office staff, doctors, specialists, mentors, sales support staff from manufacturers and patients. Any of these invitation-only “treatment collaborators” can review/edit treatment plans, provide a second opinion or simply provide a follow-up e-Consultation.
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DentalCollab founder Shane Powell
Shofu recently introduced BeautiBond™, a seventh-generation bonding agent with an exclusive chemistry, as the newest addition to its family of restorative materials.

BeautiBond's unique dual adhesive monomers work independently to produce equal bond strengths to both enamel and dentin. Available in convenient unit doses for easy, one-step, one-coat application, BeautiBond has a low film thickness of only 5 microns.

BeautiBond's enhanced bond strength rivals that of leading sixth-generation adhesives, but with the convenience of a seventh-generation material. The light-cure, self-etching adhesive produces a durable, reliable bond and is ideal for a wide range of applications.

With excellent biocompatibility and bonding durability, BeautiBond is an all-in-one adhesive that enables etching, priming and bonding in one simple step.

Yet, with many dentists unsure of advances in adhesive technology, Shofu and Dr. Howard Glazer hope to clarify any questions with a new technique video available on Shofu's Web site. Visit shofu.com to view this informative video and learn more about the advantages of seventh-generation bonding agents. Available to view, download or share, the video provides useful technique tips.

In addition to the technique video, Shofu offers a variety of other resources, including a step-by-step animation that is an easy and convenient way to learn more about BeautiBond. Information about interactive Webinars featuring key opinion leaders, such as Dr. Mark Latta, reviewing recent scientific updates on bonding agents is also available at www.shofu.com.

Another key opinion leader has...
Dentistry grown up: utilizing sedation to care for children

By Alex Harris & Michelle Hannah

While adults can be like children at the dentist, the reverse is not true. There are many distinctions between adults and children when it comes to dentistry. Failure to recognize these distinctions can result in significant harm and even death. Specific training in pediatric sedation is essential for treating children.

Each child must be treated according to his or her unique characteristics. Fears, age, weight, medications, supplements and allergies are just a few factors that must be considered. Special considerations should be made for children who are autistic, hyperactive, obese, asthmatic or prone to seizures. An understanding of pediatric anatomy, physiology and psychology provides the framework for safe and effective sedation.

Using oral sedatives and/or nitrous oxide to properly sedate children can not only be effective for the procedure at hand, but can help lay the foundation for lifelong comfort with the dentist. Even older pediatric patients who have previously had negative experiences are able to develop new comfort and resolve dental anxiety.

Fear of needles (belonephobia) and other dental-related fears often begin in childhood. Even very young children can be emotionally scarred by a painful dental experience. Though these young children may be unable to understand why they are experiencing pain, the cognitive association is formed and a lifelong fear develops.

Oral sedation can help resolve these issues. Tense moments of fear and strain transform into a relaxed calm. The calm presents the opportunity to complete more high-quality dentistry in less time, creating better patient comfort and more practice profitability.

Sedation is not only a tool to help anxious patients, it can also increase patient safety. A squirming child afraid of the dentist and the sharp metal instruments used is a recipe for disaster. However, when properly sedated, a child’s procedures can be completed quickly and safely.

Isolated cases of health emergencies represent a small possibility that dentists should be prepared for. Acidosis and cellular death develop much more rapidly in children during cardiac arrest as they lack the oxygen reservoir that adults have in their tissues and blood. The cells in a child’s heart die quickly, and thus timing is of the utmost importance. A dentist must know how to immediately and properly act in a medical emergency should one occur.

Proper training in pediatric oral sedation, anatomy and the psychology of children can be found at the Pediatric Oral Sedation Dentistry course offered by DOCS Education. The course teaches safe, effective and predictable oral sedation techniques, as well as safety procedures specific to children. The differences between children and adults are immense. Proper knowledge and pre-

also weighed in on BeautiBond. Dr. George Freedman reviewed BeautiBond recently in his “First Impressions” column. BeautiBond will also be discussed in upcoming lectures by both Dr. Freedman and Dr. Glazer at the upcoming ADA meeting and the Greater New York Dental Meeting this fall.
Medidenta now offers refining and waste disposal

With 65 plus years and counting, the company Medidenta has truly withstood the test of time and earned the trust of dental professionals around the world.

The company has recently acquired a precious metal refining and waste disposal operation, which will now provide the entire dental community a service that will be unsurpassed in integrity and value, bar none.

Since 1944, Medidenta has morphed into a boutique of dental products where it dares to be different.

Some of its products from the 1940s included copper bands, prefabricated jacket crowns and posts that sold for 15 cents each. And yes, the original product line even included Karat, a pure gold filling material, not to mention genuine silver points for root canal obturation, which in fact was the endodontic standard of care in the ‘50s and ‘60s.

Some of these items can be viewed on the “Nostalgia” section on the company’s Web site, www.medidenta.com. Medidenta’s product line has been synonymous with value because of “direct to the dentist” pricing.

The company’s most significant breakthrough came in 1969 when Medidenta introduced the Gromatic®, the first automated device for root canal therapy; however, its start was with precious metals used in dental appliances and root canal therapy.

In July 2007, Robert Achtziger, an employee of Medidenta since 1975, became the sole owner, president and CEO. He has implemented many changes, from streamlining and improving customer service to increasing the research and development budget, which will result in some major dental product introductions in the coming months.

Through personal hobbies and friends, Achtziger has developed a deep-rooted commitment to environmental issues facing our world.

“Precious metals are a natural resource of our Earth. Our planet has indeed experienced significant advances in technology, but not without a price because our environment is exhausting and neglecting its natural resources, and this will take an effort by all to save and conserve our natural resources for future generations,” Achtziger said.

While some corporations have only just begun to initiate conservancy and recycling procedures, Medidenta has already integrated these measures in its daily business operations, knowing it’s extremely desirable to implement environmentally conscious changes within the dental community it has served since 1946.

As mentioned, Medidenta is announcing it has acquired a refining and waste disposal operation that will now be integrated into Medidenta’s respected product and service line.

This division will encourage recycling and create initiatives, internally and externally, that are kinder to the environment and enable dental offices to earn top dollar on precious metal scraps that are refined and recycled.

When Achtziger was asked, “Why refining and precious metals and recycling?” his response was, “Some of Medidenta’s roots are with precious metals, and the overwhelming majority of our product line is, in fact, recyclable so this was a natural fit for us.” Thus, Medidenta is currently offering some new services.

Refining precious metal scrap Medidenta can now smelt and assay scrap to determine the precious metal content, and pay the dental professional the highest dollar amount within a week. As a bonus, the practitioner will receive valuable discount coupons for other products listed in the Medidenta catalog.

In-office amalgam separator

The BOSS Amalgam Separator offers up to three years of safety, convenience, simplicity and environmental compliance for the ultimate protection for the entire dental office.

Dental waste Dental offices can now forget about expensive long-term contracts for disposal of dental waste. The company’s Sharps PLUS system is very easy: Fill it. Seal it. Ship it! Everything is included, including the tape, at a substantial savings.

Why Medidenta?

In an era of financial uncertainty and mistrust of public conglomerates, dental professionals have a trusted name like Medidenta.

This family-run company that has served the profession for more than 65 years can now recycle products and dispose their scrap and waste. This service offers a profit center for the entire staff because even old jewelry can be turned into instant cash!

Medidenta is the home for direct pricing and huge incentives. Take advantage of Medidenta’s refining service and qualify for a bonus 10 percent off products, including current incentive programs available at www.medidenta.com.

Customer satisfaction is Medidenta’s main priority

The company wants your www.medidenta.com experience to be rewarding and pleasant. The Web site allows you to explore in more detail the new refining and recycling services and browse the general product catalog filled with time-saving, cost-effective products used in your everyday practice.

You can browse the Web site 24/7, and the company looks forward to serving all your needs today, tomorrow and well into the future.™

Medidenta is a family-run company with a 65-year history.

AD

Mojo Veneer Cement shifts confidence, not shade

Give your patients their mojo back with the cement that leaves shade shift behind and helps you create a seamless, natural-looking smile. Pentron recently introduced Mojo® Veneer Cement, the latest in adhesive technology from Pentron Clinical.

Mojo Cement is a light cure, esthetic cementation system that is designed for use with porcelain, ceramic and composite veneer restorations. This ideal cement offers two very important features: try-in gels that consistently match the polymerized cement and no detectable shade shift.

The simple, highly versatile shade system is designed for a simple warning or brightening of the veneer allow this material to be used with a wide range of veneer cases, while offering the least amount of detectable shade shift available. The corresponding water soluble try-in gels, included in the comprehensive kit, allow for a perfect match to the cured cement. Mojo Cement lets you give your patients the self-confidence they deserve.

Pentron Clinical is an established leader in the dental industry, offering a wide variety of products to suit your restorative needs. As a pioneer of dental adhesive technologies, Pentron Clinical continues to demonstrate its commitment to advancing dentistry one innovation at a time.

The company’s portfolio of trust ed, quality dental products includes: Fusio® Liquid Dentin, Breeze® self-adhesive resin cement, Lute-It® page 29A


Dentist helps girl with health challenges

By Fred Michmershuizen, Online Editor

Sometimes dental treatment can be a matter of life or death. Just ask Dr. Brian Nylaan of Grand Rapids, Mich., who recently used his skill, expertise and compassion — plus an invaluable piece of equipment — to treat a special patient with unique needs.

Born with spina bifida, Catherine had been neglected. By the time the 11-year-old wound up in foster care, her internal organs were dangerously compressed. Her condition had become so dire that doctors feared she would not survive unless they could perform surgery. But before they would operate, the surgeons insisted Catherine’s numerous dental infections be treated.

The problem was that Catherine, who had been heavily traumatized her whole life, would not let anyone near her mouth even for a cleaning, let alone for extractions or fillings. With no dental treatment there would be no surgery, and with no surgery she faced risk of death.

Luckily for Catherine, she was in good hands with a compassionate dentist, Nylaan, who knew that anything painful would be out of the question, first had his senior hygienists take all the time they needed to clean her teeth. Upon examination, he found several teeth that needed to be extracted. Knowing that a traditional mandibular block injection was out of the question, Nylaan used the Single Tooth Anesthesia (STA) system fabricated by Scientific to keep his patient comfortable.

“I had one thing going for me — one of her teeth was starting to hurt,” Nylaan told Dental Tribune. “I looked at her, I got down on my knees, and I said, ‘I have this “nummy pen” here. It makes sounds and you will hear 10 helis. As I continued to work, she became more cooperative and the look on her face started to change a little bit.’”

He was able to remove seven teeth for Catherine, who went on to receive the spinal surgery. It was a success, and today Catherine is much happier and healthier. She loves animals, she plans to someday become a veterinary assistant.

Henry Schein exclusive distributor for Dentatus narrow body implants in North America, Australia and New Zealand

Agreement expands Henry Schein’s offering to cover full breadth of dental implants

Henry Schein (NASDAQ:HSIC), the largest distributor of health care products and services to office-based practitioners, and Dentatus, an innovative designer and manufacturer of precision high-tech dental products, recently announced a five-year agreement establishing Henry Schein as the exclusive distributor of the Dentatus Atlas narrow body implant system in North America, Australia and New Zealand. Through this agreement, Henry Schein will now be able to offer dental practitioners the full breadth of dental implants.

“In this important and growing market, the Dentatus Atlas system stands apart and is distinctly different from other systems, with clear benefits that shorten healing time and increase patient comfort,” said Stanley Bergman, chairman and CEO of Henry Schein.

“In North America alone, we estimate the edentulous population who could benefit from this technology to be approximately 50 million people, with projected 6 million new edentulous patients per year. We look forward to working closely with Dentatus to offer these important new products to our North American, Australian and New Zealand dental customers.”

The Dentatus Atlas implants surrounded with the Tuf-Link Resilient Denture liner provides secure retention and cushioned patient comfort. The implant’s low profile eliminates the need to drastically reduce the denture, and its small diameter allows placement where significant bone loss has occurred without bone augmentation.

The Atlas flapless surgical procedure, which is significantly less expensive than a conventional implant procedure, shortens healing time and reduces discomfort.

The procedure requires no surgical incision and no sutures — both of which are typical for wider, more conventional implants — and it can be performed using only local anesthesia in the general dentist’s office in just 45 to 60 minutes.

The patient can walk out of the office wearing his or her refitted denture right away.

With Dentatus Atlas implants, dentists have the ability of any age can experience healthier and better looking smiles with comfortable and fully functioning dentures. After undergoing the procedure, patients are able to keep their dentures in place while sleeping, brush them in the morning and treat them like natural teeth.

Dentures can be easily removed and reseated without any stress. Patients are able to laugh, smile, maintain a nutritious diet and eat their favorite foods with confidence.

Dentatus Atlas implants provide patients with substantial relief from the pain and discomfort they previously endured with ill-fitting dentures, while stimulating the jawbone so less bone is lost. Dentures fit more comfortably and properly support facial features that may have been previously lost, enhancing a patient’s self esteem.

“In Henry Schein, we believe that we have found a sophisticated distribution partner that can compellingly communicate the significant benefits of the Dentatus Atlas system to dental practices,” said Bernard Weissman, president of Dentatus USA.

“The company’s track record of success in growing technology-driven products is impressive, and we look forward to a close collaboration that will strengthen the position of this innovative implant system in these important markets.”

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