Welcome to Cosmetic Tribune and Hygiene Tribune!

Dental Tribune America has some big news to share with you this month. Earlier this year we gave you a little taste of Cosmetic Tribune during the AACD event and Hygiene Tribune during the ADHA event, but now these two new editions are making their permanent debuts as a part of the Dental Tribune weekly. Once a month you’ll benefit from entirely new content that will feature information from experts in the areas of cosmetic and hygiene.

We welcome your feedback, so please do not hesitate to share it with us!

The critical missing element to complete care: where dentistry and orofacial myofunctional therapy meet (Part 1 of 2)

By Joy L. Moeller, RDH, BS, COM

I. Problems that can be addressed

◎ Does your patient complain about chronic headaches?
◎ Does your patient have an open-mouth rest posture?
◎ Have your patient’s teeth moved after orthodontic treatment?
◎ Does your patient exhibit an open bite?
◎ Does your patient complain of temporal mandibular joint dysfunction (TMD) or neck pain?
◎ Is the patient’s tongue always “in the way” when you are drilling, scaling, or examining the teeth?
◎ Does your patient exhibit a scalloped tongue from pressing against the teeth?
◎ Have you noticed oral habits such as thumb or finger sucking, nail biting, lip licking or hair twirling or chewing?
◎ Does your patient lisp when saying the “s” sounds?
◎ Do you see the tongue come forward against the teeth when swallowing?
◎ Is your patient a mouth breather contributing to anterior gingivitis or open-mouth rest posture?

See Complete care, Page 3
NCOHF and ADHA urge all dental hygienists to become tooth fairies

The National Children’s Oral Health Foundation (NCOHF) and the American Dental Hygienists’ Association (ADHA) urge all dental hygienists to participate in the Dental Hygienist Toothfairy Campaign to help eliminate pediatric dental disease. The national program invites all hygienists to “earn your wings” and with a minimum contribution of $25, they can also enter a raffle to win up to 12 pairs of Sybron Orascoptic Loupes, (valued at $1,425 each).

“NCOHF and ADHA are moving aggressively to raise awareness of the widespread nature of pediatric dental disease and most importantly, provide practical solutions,” said Margaret Lappan Green, RDH, MS, past president of the ADHA, and founding chair, Dental Hygienist Toothfairy Campaign. “I hope all dental hygienists and students enthusiastically support the Dental Hygienist Toothfairy Campaign, a fabulous initiative that will bring health and well being to millions of our nation’s at-risk children.”

Pediatric dental disease is the No. 1 chronic illness among our nation’s children and is completely preventable. The potential health-related, societal and economic-side effects are alarming. The U.S. Surgeon General calls it a “silent epidemic” because most Americans have no idea that it is so widespread.

“As most hygienists know, millions of children experience sleepless nights, have trouble eating, and are unable to concentrate and learn in school due to mouth pain,” states Fern K. Ingber, NCOHF’s president and CEO. “We are so grateful to the ADHA for helping to mobilize hygienists who are on the frontline of defense – where care begins.”

For more information on how to be part of the solution, call (704) 350-1600 or visit www.ncohf.org/ADHIToothfairy.php or www.adha.org.
Complete care
From Page 1

- Does your patient grind or clench his/her teeth?
- Does your patient have chronic stomachaches, burping, drooling, hiccups or acid reflux?
- Does your patient have a forward head posture?
- Does your patient have a short lingual frenum or a tight labial frenum?
- When you check for oral cancer on the sides of the tongue, have you found lesions from tongue thrusting causing chronic irritation?

These are all signs and symptoms of an orofacial muscle asymmetry that can be addressed by an orofacial myofunctional therapist.

History of orofacial myofunctional therapy (OMT)

OMT is an area of specialization arising out of orthodontics. The field of OMT is unique because the therapist helps the patient to make major life-enhancing changes, which affect the entire body.

Many dentists during the 1800s and early 1900s recognized that tongue rest posture, mouth breathing and oral habits influenced occlusion. Edward H. Angle — justly termed as some of the grandfather of orthodontics — wrote “Malocclusion of the Teeth,” appearing in Dental Cosmos in 1907, in which he recognized the influence of the facial muscles on dental occlusion. In his research he concluded that mouth breathing was the chief etiological factor in malocclusion.

The first program of OMT began in 1918 with an article written by an orthodontist, Dr. Alfred P. Rogers, titled “Living Orthodontic Appliances.” He was one of the first doctors in the United States who suggested that corrective exercises would develop tonicity and proper muscle function and thereby influence proper occlusion.

In the 1970s and ’80s there were two different organizations representing therapists. Daniel Garlinder and Dr. Roy Langer founded the Myofunctional Therapy Association, and Dr. Marvin Hanson, Richard Barrett, William Zickfusso, and Galen Peachey founded the International Association of Orofacial Myology (IAOM). Currently the IAOM is the main professional organization in the world promoting and developing orofacial myofunctional therapy.

The team approach

Today the field is expanding to include many professions. Through a team approach the patient can experience the best of all worlds and achieve remarkable results. The interdisciplinary approach to patient wellness includes but is not limited to:

- orthodontics
- general dentistry
- speech-language pathology
- dental hygiene
- periodontics
- oral surgery
- ear, nose and throat specialty
- cranial osteopathy
- allergyology
- pediatric dentistry
- pediatrics
- physical therapy
- chiropractics
- gastroenterology
- plastic surgery

Failure to help many patients

Through 30 years of practicing orofacial myofunctional therapy, some questions patients or their parents asked me include:

- Why didn’t someone tell me about this earlier?
- I knew I had a tongue thrust, I didn’t know there was a special person to help me.
- Why didn’t someone tell me my habit of tongue thrusting, thumb sucking or nail biting could be easily eliminated in therapy?
- I have tried multiple splints, functional appliances, medications and occlusal adjustments for my TMD problem. I was even referred to a psychologist for counseling because they told me it was stress related. Why didn’t someone recognize my facial muscle dysfunction and refer me for orofacial muscle therapy sooner?
- This is the third time my orthognathic surgical result has relapsed. Why hasn’t anyone referred me to an orofacial myofunctional therapist?

- My child was traumatized by wearing a “rake” in his mouth to stop his tongue thrust. His speech has gotten worse and he has withdrawn. After the rake was removed, the tongue thrust returned. Why wasn’t I given the option of seeing a therapist who specialized in treating this disorder with exercises?
- My child wore a palatal expander for a high narrow palate. After the expander was removed, the palate collapsed because the tongue was resting down. Why wasn’t I referred to an orofacial myofunctional therapist immediately following the expander being removed?
- I was told I was tongue-tied and needed a lingual frenectomy. After surgery, my tongue reattached.

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scar tissue formed and was worse than before we started! Why wasn’t I told to see a therapist immediately following surgery to prevent re-attachment?

Patients can learn to develop healthy muscle patterns. Healthy muscle patterns, when permanently habituated, can be proactive in preventing or treating:

- orthodontic relapses,
- articulation disorders,
- breathing disorders due to allergies or mouth breathing habits,
- TMD when it is a muscle or habit-related issue,
- digestive disorders from not chewing properly or swallowing air,
- postural problems,
- faster normalization of the facial muscles and neuro-muscular facilitation post orthognathic surgery.

How can orofacial myofunctional therapy help the general dentist?

Orofacial myologists can assist the dentist in many aspects of his or her practice to:

- re-educate muscle patterns that promote a stable orthodontic result.
- reduce the time spent in fixed appliances.

Study OMT!

Joy Moeller will teach a five-day IAOM-approved course on orofacial myofunctional therapy Oct. 19–23, 2008, and a seven-day course (which includes two days of internship) on February 11–17 and June 24–30, 2009 in Los Angeles with Barbara J. Greene, COM, and Licia Cocceani-Paskay, MS, CCC-SLP, COM. For more information contact Greene at bgreene@tonguethrust.com or call (805) 985-6779.
source for dentists.

The best time for the dentist to refer the patient to an orofacial myofunctional therapist is before intervention by appliance therapy. It is always best to do the least invasive treatment first and eliminate habits that are interfering with treatment. This will ensure that the muscles are working with the forces of the appliances. Also, another good time to refer would be before the braces come off, depending on the patient’s facial structure and motivation. We can work together to help the motivated patient achieve amazing results.

To elaborate on the importance of the working relationship between OMTs and the dental community, I have reached out to some of my esteemed colleagues for commentary.

According to Dr. John Kishibay, an orthodontist from Santa Monica, Calif., who is a professor at USC School of Dentistry, “Orofacial myofunctional therapy must be part of the treatment plan from the beginning. This way the patient understands from day one that the muscle adaptation is important for long-term stability. Especially important would be the orthognathic patient.

The patient must learn to use the new space in an ergonomic manner, in both a functional patterning and habit elimination awareness.”

Dr. William Hang, an orthodontist practicing in Westlake Village, Calif., believes that OMT problems are one cause of poor facial development. He says, “Stability will continue to be an elusive, unachievable goal with poor facial balance frequently being the norm of the post orthodontic result. Myofunctional therapy must become the first line of defense in the quest for proper facial development rather than the rescue squad when the orthodontic result is going up in flames. When orthodontists embrace myofunctional therapy, they stop treating symptoms and begin to focus on treating the cause of poor facial development [altered oral rest posture].”

Dr. Jerry Zimring, a practicing orthodontist for 44 years in Los Angeles, believes that attaining proper occlusion is a state of balance between the teeth, the muscles and the bones. He states, “Both my daughter and my grandson were treated with myofunctional therapy with excellent results that would not have been possible without this valuable treatment. I feel strongly that myofunctional therapy should be part of every orthodontic practice.”

Dr. Richard L. Jacobson, a Diplomate of the American Board of Orthodontics who has been in the exclusive practice of orthodontics in Pacific Palisades, Calif., for the past 28 years, stated, “We know that form follows function and function can follow form. Therefore, it is vital to identify those patients that need myofunctional therapy. In these patients myofunctional therapy by a specialist is essential. Treatment is effective and orthodontic stability is enhanced.”

The author would like to thank Karen Macedonio, a Certified Life Coach (and patient), Barbara J. Greene, COM, and Licia Coceani-Paskay, MS, CCC-SLP, COM for their assistance with writing this article. A complete list of references is available from the publisher.

To find a therapist near you, go to www.iaom.com and look at the directory.

Joy Moeller, BS, RDH, COM, is a certified orofacial myofunctional therapist and a licensed registered dental hygienist. She is in the exclusive private practice of OMT in Pacific Palisades and Beverly Hills, Calif. She is currently an elected member of the Board of Directors of the IAOM and is the hygiene liaison. Joy is also a former associate professor at Indiana University School of Dentistry and an on-going guest lecturer at USC and UCLA to ortho, perio and pedo dental residents, and at Cerritos College to hygiene students.

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Webinar schedule

Cone Beams: a new dimension of dentistry, by Dr. Daniel McEowen
October 21 — 7:00 pm E.S.T. — Free

PreXion 3-D Dental Scanners are addressing the rapid shift in dentistry from analog-based 2-D film radiography to digital 2-D and 3-D volumetric rendering. This Webinar will introduce attendees to cone beam technology in general and make comparisons between all current available CBCT units. It will include a live scan, from scanning to processing, until images are available to work with. The objective is to learn to use the PreXion 3-D for general dentistry, endodontics, implantology, oral surgery, oral-maxillofacial surgery and periodontics, and show the ease of use of this unit.
Register at www.dtiinstitute.com/webinar/cone-beam

Increase net revenue, foster employee confidence: the five keys to effective employment relations for the dental office, by Juris Doctor Michael Garth Moore
November 11 — 7:00 pm E.S.T. — $95 fee

Gain familiarity with legal concepts underlying employee claims; learn the processes and practices that reduce turnover of good employees; learn how to reduce anxiety in dealing with employee relations issues; learn the documentation that reduces the risk of unemployment compensation and wrongful termination claims.
Register at www.dtiinstitute.com/webinar/HR

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How well do Dental Tribune publications meet your needs for dental news and information?
- Extremely well
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Successful treatment strategies for anterior total tooth replacement in the thin scalloped periodontal architecture: the ankylos tissue care concept for long-term success

Cech Dr. DiGiallorenzo’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting on December 1, 1:30–2:30 p.m.

“Tissue Care Concept by Ankylos,” PRGF, lasers and piezo surgery. Learn about:
- Diagnosis of patient biotypes and its affect on treatment decisions.
- Immediate or staged?
- Surgical management: incisions, atraumatic extraction, periodontal plastics, bone grading (PRGF), over-correction, site preparation, and 3-D implant placement.
- Prosthetic management: abutment selection, provisionalization, restorative materials and methods.

Earn C.E. credits! Attendance is free for all GNYDM visitors!

For more info and registration, please contact Julia Wehkamp: j.wehkamp@dtamerica.com.

Endodontic irrigation via EndoVac: safety, efficacy and clinical techniques

Although seemingly simple, endodontic irrigation is a highly complex problem that begins with patient safety and ends with clinically efficient and effective results. However, as complex as the problem is, the answer is equally simple. Attendees will learn the answer, while becoming familiar with:

1) Identifying flaws in current endodontic irrigation studies.
2) Listing the principles and ancillary benefits of apical negative pressure.
3) Describing the critical importance of safely using full-strength sodium hypochlorite during endodontic irrigation.

Earn C.E. credits! Attendance is free for all GNYDM visitors!

For more info and registration, please contact Julia Wehkamp: j.wehkamp@dtamerica.com.

CEREC 3-D CAD/CAM: The power of technology in clinical restorative dentistry

Join your colleagues for Dr. Antenucci’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting on November 30, 10:00 a.m.–1:00 p.m.

This lecture will provide a systemic, biologic and evidence-based approach to ensure success in the class 1 to class 4 case utilizing the CEREC 3-D CAD/CAM technology in achieving outstanding results.

CATCH DR. DIGIALLORENZO’S LECTURE AT THE DENTAL TRIBUNE SYMPOSIUM DURING THE GREATER N.Y. DENTAL MEETING ON DECEMBER 1, 1:30–2:30 P.M.

“Tissue Care Concept by Ankylos,” PRGF, lasers and piezo surgery. Learn about:

- Diagnosis of patient biotypes and its affect on treatment decisions.
- Immediate or staged?
- Surgical management: incisions, atraumatic extraction, periodontal plastics, bone grading (PRGF), over-correction, site preparation, and 3-D implant placement.
- Prosthetic management: abutment selection, provisionalization, restorative materials and methods.

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Industry News

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The University of Washington School of Dentistry and the UW Athletic Department held the mouthguard event in July at the university’s dental clinic. Over 130 student athletes visited the clinic to be fitted for the mouth guards. Sixty dental students took impressions of the athletes’ teeth, as faculty members and staff supervised the process and offered tips on the best fit.

For more information on the University of Washington’s mouthguard event, please visit www.uwnews.org.

For more information on Zenith Dental’s full line of products, including StatusBlue and MixStar-eMotion, log onto www.zenithdental.com or call (800) 662-6383.

(Source: Zenith Dental)

New cameras from Canon and Nikon

The newest cameras to enter our line of clinical systems are the Canon Rebel XS and the Nikon D60.

These two cameras represent the least expensive models from each manufacturer.

The new Rebel XS can be thought of as the Rebel XSi’s little brother. The camera dimensions and weights are almost identical. The main differences are the LCD screen (2.5-inch vs. 3.0-inch) and resolution (10MP vs. 12MP). If you don’t mind a slightly smaller screen, you can save a few bucks and still get great photos.

We first talked about the Nikon D60 in our April newsletter and at that time the camera was only available in “kit” form (with the 18-55 mm zoom lens). Nikon is now shipping the D60 as a body only.

Canon is offering rebates on popular camera/lens combinations through Oct. 13, 2008. Purchase a Canon 40D camera and a Canon EF 70-300 f/4-5.6 IS USM lens (together on the same invoice) and save $150 instantly. Purchase a Canon Rebel XSi camera and a Canon EF 75-300 f/4-5.6 III lens (together on the same invoice) and save $100 instantly.

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New cameras from Canon and Nikon

The newest cameras to enter our line of clinical systems are the Canon Rebel XS and the Nikon D60.
Is he a dentist? Is he the mayor? He is both!

An interview with the mayor of Ormond Beach, Dr. Fred Costello

By Robin Goodman
Group Editor

How long have you been a dentist and when did you become mayor of Ormond Beach?

I graduated from University of Iowa in 1974. After serving in the U.S. Air Force for three years, I moved to Ormond Beach in 1977 and entered private practice. I am blessed to have always enjoyed my chosen profession. I am 58 and still practice full time and expect to continue for another 10 years or so. After being interested in and involved in giving back to my community for many years — including serving as president of civic groups and of both the Volusia County Dental Association and Florida Academy of Cosmetic Dentistry and serving on and being chair of both the Ormond Beach Planning Board and Development Review Board — I ran for mayor of Ormond Beach city commissioner in 1999 because the candidate I supported had health issues and was unable to serve. I did not support the vision of the other candidates. I had absolutely no intention to run for office. After serving as a city commissioner for three years, our mayor resigned to run for Volusia County Council and I was faced with the choice to run for mayor in 2002 or serve as a commissioner under the leadership of a mayor with whom I had significant disagreements. I am now in my fourth term and still enjoy the opportunity to shape the future of my chosen community!


dentistry and public service both demand high integrity and commitment to excellence and a willingness to give more than expected in order to accomplish a defined objective. And both are rewarding to those who care more about improving the quality of life for others than about using every spare minute in a financially productive fashion. I am a believer that “to whom much is given, much is expected” and I have been given much so I try to give back more than is reasonably expected. I encourage all dentists to get involved in your local community public service arena, including elected offices. As you give, you will grow and get more out of it than you give to it.

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Work Tel.: (386) 675-1611
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E-mail: costello@ormondbeach.org
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Tooth augmentation

By Sarah Kong and Lorin Berland

This attractive and fashionable woman came to us seeking our assistance to improve the appearance of her smile (Fig. 1). She said, “It’s just not me!” Teeth #5 and #6 were part of a double abutment cantilever bridge for the pontic on tooth #7. Teeth #8 and #10 were implant crowns, and #9 was a porcelain crown (Fig. 2). All the restorative work was done less than two years ago in China. Although it was functional and healthy, the patient felt like her teeth looked old and unhealthily, as they were short, dark, uneven and intruded.

The patient had seen other “cosmetic” dentists who wanted to re-do all her restorations, but she remembered the experience, although necessary, was not pleasant, and more important, she did not want to jeopardize these teeth, crowns and implants. At her initial consultation appointment, we did a mock-up of teeth #8 and #9 to see what her smile could look like if she decided to improve their look by building them out facially and increasing their length.

Then we showed her what her smile might look like with a mock-up to include her lateral incisors, as they were also well (Figs. 5a, 5b). We knew that her low lip line was on our side, as even her fullest smile did not show her gum line. This was an ideal case for a tooth augmentation procedure. She loved the way her teeth looked in the mock-up, but she loved even more the fact that we offered a way for her to preview her options! We also discussed the wear on her lower teeth and recommended veneers on a composite, but she wanted to focus on her upper front teeth at this time.

We presented our patient with her treatment options, and because neither of us was looking forward to re-doing these restorations, we suggested laboratory-fabricated, prepless resin veneers. The resin was chosen over porcelain due to its more flexible properties. The brittle nature of porcelain would have been more likely to cause fractures due to your strengths and staff your weaknesses. In other words, don’t try to do things others can do better; work to improve on what you already do well as that will energize you instead of frustrate you. Your team is an extension, and a reflection, of you … continually improve, elevate, refine and reward your team. My dental team of 12 and our Ormond Beach city employees of about 560 are considered to be outstanding! And we are always striving to get better!

Dentistry and public service both demand high integrity and commitment to excellence and a willingness to give more than expected in order to accomplish a defined objective. And both are rewarding to those who care more about improving the quality of life for others than about using every spare minute in a financially productive fashion. I am a believer that “to whom much is given, much is expected” and I have been given much so I try to give back more than is reasonably expected. I encourage all dentists to get involved in your local community public service arena, including elected offices. As you give, you will grow and get more out of it than you give to it.

Any pearls of wisdom you can share with us from your work in dentistry and politics?

Whether in politics or dentistry, it’s all about making sure they are smiling when you’re done. Do the right thing for the right reason no matter what the consequences. Build on your strengths and staff your weaknesses. In other words, don’t try to do things others can do better; work to improve on what you already do well as that will energize you instead of frustrate you. Your team is an extension, and a reflection, of you … continually improve, elevate, refine and reward your team. My dental team of 12 and our Ormond Beach city employees of about 560 are considered to be outstanding! And we are always striving to get better!

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Letter from the Editor in Chief

Dear Cosmetic Dentists,

Welcome to the second edition of Cosmetic Tribune. Our first edition was dedicated to the annual AACD meeting in New Orleans this year. Starting with this edition, Cosmetic Tribune will now be a monthly publication.

Something we hope you will notice is that our clinical articles will primarily focus on the “Why?” behind the cases presented. This is because we want to share with you, our readers, the entire thought process that was involved with each case. We want to feature our authors’ work and understand why they made the choices they did.

What challenges did the clinician face? Were there cost or time restrictions placed upon the dentist by the patient? Were there any specific difficulties that required a unique solution? There are always different factors that affect why a certain path was chosen for a particular case and that is what we want to share with you.

Of course, these clinical articles will also present the “How?” This will be covered in brief, but still shared as concisely as possible. The reason for such brevity is that we want to concentrate on the pictures that best illustrate the situation.

In the future, Cosmetic Tribune seeks to feature the work of doctors who have “been there” and who can share their insight and unique case studies with fellow practitioners. Further, we want to feature the work of our readers so that we can all learn from one another.

We want to encourage all of you to submit articles on cosmetic dentistry cases you would like to share for future editions. If you are interested in publishing within our pages, please contact Group Editor Robin Goodman (r.goodman@dtamerica.com) and she can give you all the details. Also, if you have any feedback to share, we would both be glad to hear it, so please contact Ms. Goodman or myself directly (dberland@dallascodentalspa.com).

In short, I hope you enjoy the first monthly edition of Cosmetic Tribune and we look forward to hearing from you!

Sincerely,

Dr. Lorin Berland
Editor in Chief
Acredited and a Felllow of the AACD

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Tooth

From Page 1
to the undercuts in the old crowns and cantilever bridge. Also, we had more flexibility finishing the facial contours with resin as opposed to porcelain, especially since we had to over-contour in certain areas to account for blocked out undercuts. In this particular situation, these areas could be adjusted and polished in the mouth far better than porcelain.

Invaluable to the case was the Smile Style Guide, a comprehensive library for smile design (Fig. 4). She has round canines, and since we did not want to change her canines, we looked at the possibilities with round cuspsids. She instinctively chose R-2, square centrals, square-round laterals, and round canines. For the length she selected L-3, the laterals significantly shorter than the centrals and cuspsids (Figs. 5a, 5b).

As with most cases, we were able to show our patient side-by-side images of her smile before and with a mock-up using Dexis software. With this technology, the capability to e-mail radiographs and photographs with a few clicks gave us an almost instant response from our periodontists. The Smile Style Guide, a comprehensive library for smile design (Fig. 4).

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tist regarding our implant concerns before starting her case (Fig. 6).

To begin, we placed Expasyl (Kerr) on the facial gingiva to retract her tissues and liquid dam on the lingual interproximals, especially at the gum line to protect her existing restorations from loosening or coming off with the impressions. Full arch upper and lower PVS impressions, such as Take 1 Advanced (Kerr) or Virtual (Ivoclar Vivadent) were taken along with SuperDent Bite Registration (Ivoclar Vivadent) were taken (Fig. 11). Because the margins of her porcelain restorations were below the gumline, hydrofluoric acid use was avoided to protect her gingiva. In this case, Interface (Apex) was used as an etchant and porcelain primer (Fig. 10). This was followed with Optibond Solo Plus air thinned on the porcelain (Fig. 11).

The four Premise indirect veneers were tried on with A-1 and B-1. Ultimately, B-1 Premise flowable composite (Kerr) was used for the centrals and A-1 for the laterals to cement the restorations. We chose flowable composites rather than veneer cement to fill in any undercuts due to the no prep nature of this case. The veneers were cured with the Kerr Demi Light at all angles. Because it is an LED, there is no heat generated that could result in sensitivity from over curing. The excess composite was removed with an American Eagle Gethro periodontal knife along the gingival margins (Fig. 12) and Axis Qwik Strip interproximally (Fig. 13).

The patient’s previous restorations were taken to her high gum line, which was a bit uneven. Now her gum line appeared more symmetrical after having the resin veneers placed. Though she chose to wait to do her lower teeth, experience shows that she will do them in the future, especially after seeing how beautiful her upper teeth turned out. The patient loved her new smile!

When the case was finished, we took digital images of the patient’s new smile, both full face and close-up. This is a very important step, as patients tend to forget what their teeth looked like prior to the dental work. Being able to see their before and after images side by side helps them to appreciate the work that was involved in improving their smile.

Not only was an esthetic result achieved, the patient was able to keep her original restorations without damaging them. People forget what you say and people forget what you do, but they never forget how you made them feel. Digital communication in this manner serves as a constant reminder. And with a click of a button, they can share the experience with their family and friends (Fig. 14).

Fig. 14: DEXIS hub with patient’s before and after images.

Author info

Dr. Lorin Berland is an internationally acclaimed cosmetic dentist and one of the most published authorities in the professional dental and general media. He is a Fellow of the American Academy of Cosmetic Dentistry, the co-creator of the Lorin Library Smile Style Guide; www.denturewearers.com; and the founder of Arts District Dentistry, a multi-doctor specialty practice in Dallas that pioneered the concept of spa dentistry. The American Academy of Cosmetic Dentistry honored Dr. Berland with the 2008 Outstanding Contribution to the Art and Science of Cosmetic Dentistry Award.

Dr. Sarah Kong graduated from Baylor College of Dentistry, where she served as a professor in restorative dentistry. She focuses on preventive and restorative dentistry, transitionals, anesthesia and periodontal care. She is an active member in numerous professional organizations, such as the American Dental Association, the Academy of General Dentistry, the American Academy of Cosmetic Dentistry, the Texas Dental Association and the Dallas County Dental Society.
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Tobacco cessation intervention: Significance for the RDH!

By Carol Southard, RN, MSN

A

s one of the most accessi-
ble health care profession-
als, dental hygienists are in
a unique position to provide tobacco
cessation services. The more inten-
sive the intervention, the higher the
quit rates, but even minimal tobacco
interventions — less than three min-
utes — increase the proportion of
tobacco users who quit and have a
considerable public health impact.
The United States Clinical Practice
Guideline recommends that all cli-
cians provide every tobacco user at
every encounter with at least mini-
mal tobacco intervention.
The regularly scheduled dental
hygiene visit provides a unique oppor-
tunity to relate oral health findings
to patients and provide cessation
support. The efficacy of even brief
tobacco dependence counseling has been well established and
is also extremely cost-effective
relative to other medical and dis-
ease-prevention interventions. With
effective education, counseling and
support, hygienists can provide an
invaluable service. Helping someone
overcome a tobacco addiction may
be the most broad-reaching health
care intervention a dental hygienist
will ever achieve.

Tobacco use

Tobacco use has long been identi-
fied as the leading preventable cause
of illness and death, a fact estab-
lished by the most substantial body
of scientific knowledge ever amassed
linking a product to disease. Tobacco
claims one life every eight seconds
and kills one in 10 adults globally.
In the United States alone, ciga-
rette use accounts for one of every
five deaths and is responsible for
more than 435,000 deaths each year.
Smoking causes more deaths alone
than AIDS, alcohol, accidents, sui-
cides, homicides, fires and drugs
combined.
Worldwide, 5 million people die
each year from tobacco use. That
number has been projected to dou-
ble by 2020, with more than 70 per-
cent of those deaths occurring in
developing nations.
Smoking is a known cause of mu-
tiple cancers, accounting for 25 to 30
percent of all cases of cancer, and
approximately 170,000 cancer deaths
every year in the United States.
The types of cancer associated with to-
acco use include those that affect the
lung, mouth, nasal passages/nose,
larynx, pharynx, breast, esophagus,
stomach, pancreas, bladder, kidney,
cervix and possibly the colon and
rectum in addition to acute myelolog-
enous leukemia.
In particular, smoking has been
linked to 90 percent of cases of lung
in cancer in males and 78 percent in
females. Smoking also significantly
increases the risk for head and neck
cancers (more than 500,000 peo-
ple are diagnosed with these can-
cers every year). In general, indi-
viduals who smoke one pack per
day increase their cancer risk by
tenfold and individuals who smoke
two packs per day increase their risk
by 25 times that of a non-smoker.
In addition, smoking is a known
cause of at least 25 percent of all heart
disease and strokes, and no less than 90 percent of all chron-
ic obstructive pulmonary disease
(COPD). Smoking is a major cause
of coronary artery disease, cerebro-
vascular disease, peripheral vascu-
lar disease and abdominal aortic
aneurysm, and smoking is the most
important risk factor for COPD. Only
5 to 10 percent of patients with COPD
have never smoked. Once thought
of as an “old man’s disease,” this
disorder has become a major killer
in women as well. The disease kills
120,000 Americans a year, and it is
the fourth leading cause of death and
is expected to be third by 2020.
Smoking during pregnancy caus-
es spontaneous miscarriages, low
birth weight, placental abruption,
bleeding, heart defects, and sudden
infant death syndrome. Babies born
to women who smoke are more likely
to be premature. Women, particu-
larly those older than 35 years of age
who smoke and use birth control
caps, face an increased risk for heart
attack, stroke and venous throm-
boembolism.
Other conditions that affect
smokers include cataracts, macular
See Tobacco, Page 2
Dear Readers,

Welcome to Hygiene Tribune! As Dr. Lindow wrote in a previous issue of Dental Tribune, we need to “recognize that the hygiene team’s contribution is the true backbone of any thriving dental practice.”

To that end, we have launched Hygiene Tribune as a monthly insert for our Dental Tribune weekly.

Our purpose within these pages is to bring to our readers — both dentists and hygienists — information on topics that are of utmost importance to fostering an excellent working relationship between the hygiene team and the dentists they work with. In addition, we would also like to create an open forum that presents the current discussions on contemporary topics.

Although our foray into the world of hygiene begins with a few pages each month, which also makes us very selective of the content we feature — our intention is to increase the total number of pages moving forward.

We look forward to hearing any suggestions you might have for article topics, as well as hearing any general feedback you would like to share with us. Please do not hesitate to write me at r.goodman@dtamerica.com!

Sincerely,

Robin Goodman
Group Editor
Like Polyether, but... Polyeasier!

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