‘HIV tests should be offered in every dental practice’

By Daniel Zimmermann, DTI Group Editor

According to the latest figures from the United Nations organization UNAIDS, more than 34 million people worldwide are currently living with the HIV virus. Because it can take up to 10 years before progressing to AIDS, early testing can be a life-saving factor.

New tests for HIV checks in dental practices have recently been developed. Dental Tribune Asia Pacific met with Dr. Catrise Austin, who maintains a dental practice — VIP Smiles — on 57th Street in New York City, to speak about HIV testing in her practice and how such testing could help to create a heightened awareness of the disease amongst patients.

Dr. Austin, would you tell our readers the reason you decided to offer free HIV tests to your patients?

The idea for offering free HIV tests to my patients arose earlier this year once I had learnt that doctors other than medical doctors can offer HIV testing in their practices. I said to myself: “Why not add another service to our existing checklist of lesions or cavities and give patients the opportunity to know their status in a different setting?” I saw this as a unique opportunity for me as a dentist to diagnose HIV in its early stages.

Unfortunately, the virus is still highly prevalent. In New York City alone, there are 94,000 confirmed cases and it seems that the number of infections is not improving in 2009/2010.

Why should dental offices test for infectious diseases such as HIV/AIDS or tuberculosis in the first place?

My opinion is that HIV tests should be offered in every dental practice because the oral cavity is one of the...
first places that shows signs of HIV infection. You can detect signs of herpes and other sexually transmitted diseases in the mouth as well, and so we look for lesions and other signs or symptoms of the disease. I am currently not aware of other tests that may diagnose diseases other than HIV/AIDS; it would be fantastic if we were able to diagnose everything through the mouth.

How does the test work?
The test is called OraSure Advance and it tests for antibodies in the blood system. It uses an oral swab, which we take under the upper and lower lips and place in a developing solution directly at the beginning of our dental appointments. The results are available within 20 minutes and we can start with normal treatment immediately after 20 minutes and we can start with our dental appointments.

The greatest joy for me is when a patient says that he or she would be the trailblazer and help to make the test the standard of care in dental health.

Is the test optional?
We do not have any positive testing so far.

What happens if a patient tests positive?
We are fully trained and prepared in case a test is positive. If a patient tests positive, we counsel him or her immediately and help him or her call a primary health physician to schedule a confirmatory test.

It is important to note that the test that we offer is a screening test only and not a confirmed test. If a patient does not have a physician, we usually refer him or her to one of the clinics in the New York City area with which we have a partnership.

There are thousands of people in the US and more around the world who are unaware that they are HIV/AIDS infected. Do you think that regular checks in dental practices could help to create more awareness of the disease?

That is something I would like to see happening as more dentists begin administering the test. It is time to recognize that we should be concerned with the patient’s holistic health, not only his or her oral health.

I am the first dentist in New York to offer the test, and I would love to be the trailblazer and help to make the test the standard of care in dental practices around the world.

The greatest joy for me is when a patient says that he or she would have never undergone this test if it were not for me.
‘Dentcubator’ meets in New York

By Daniel Zimmermann, DTI Group Editor

Year after year, dental companies spend millions on the research and development of new products. Nobel Biocare, which is one of the biggest spenders in the dental industry, uses about 4 to 5 percent of its annual turnover for R&D.

However, there are thousands of ideas developed by individual dentists that will never be implement ed because their inventors lack the funds or expertise to market their ideas or are downsized by shrinking R&D budgets in difficult economic times.

For such ideas, there are usually incubators. Introduced in the lab, university and communities that housed many small businesses, incubators have become a significant tool in the business world for assisting early-stage companies.

Their main goal is to accelerate the successful development of entrepreneurial companies through support resources and services such as finding attorneys, funding prototypes and finding distribution channels.

In fact, a study by the University of Michigan found that almost 90 percent of start-up companies stay in business for the long term with the help of incubating programs.

Worldwide there are an estimated 5,000 of these incubator networks, with 1,400 operating in the United States alone. In dentistry, there was no such network until Dentcubator was founded at the Greater New York Dental Meeting (GNYDM) last year.

Originating in Massachusetts from a loose network of renowned dental specialists around the globe, the program has evaluated 48 submissions thus far and aims to support as many as 80 over the course of the next five years.

Panels of dentistry experts — such as Steve Buchanan, Sonia Lutey, John McSpadden, Lorne Lavine, Jörg Strub, Ron Jackson, Ken Ailmert and Tom McCarty — evaluate new ideas on a regular basis.

Dentcubator is a virtual entity, which means that its members meet by phone, e-mail or through Web-based discussions.

Once an idea is submitted through one of the committees, it undergoes a four-week screening process to evaluate its marketing potential. Special emphasis is placed on the ability to re-design a product for emerging markets such as Asia or Latin America.

“By testing each submission for its applicability to emerging market countries, we have the opportunity to offer the products and techniques associated with outstanding oral health care to a broader audience than the typical markets of Western Europe, Japan or the United States,” a Dentcubator representative said during this year’s GNYDM.

Once the idea has been approved for funding, the network provides its services with compensation taken in equity in the ownership of the idea. The process typically takes up to three months to be completed.

After Dentcubator becomes an equity partner, develops and protects the idea, discussions are initiated with the directors of acquisition or R&D departments at global dental companies.

Dentcubator sees itself as a complement to traditional R&D and as an alternative source for funding, development and access to market resources.

“We are under no circumstances in the business of replacing R&D budgets,” the Dentcubator representative said. “We are the nursery that takes the small seed of an idea, grows it and then brings it to market.”

Trident provides funding for new NCOHF grants

By Fred Michmershuizen, Online Editor

Thanks to the generosity of Tri dent chewing gum, the National Children’s Oral Health Foundation: America’s Toothfairy (NCOHF) recently awarded grants totaling $100,000 to four not-for-profit university and community- based dental programs.

“For over 40 years, Trident has been an innovator and leader in oral care advancements, beginning with the introduction of Trident in 1964 as the first cavity-fighting, sugar-free gum,” said Lesya Lysyj of Cadbury North America, manufacturer of Trident.

“Our partnership with NCOHF enables us to continue our commitment to promote good corporate citizenship in the communities we touch by helping to raise awareness and funds to fight oral disease among thousands of children in need,” Lysyj said.

The Trident Toothfairy Grants, which fund critical early childhood oral health treatment and educational training programs, were awarded to:

• Howard University in Washington, D.C.;
• the University of California at San Francisco;
• the University of Illinois at Chicago and
• the Arkansas Oral Health Coalition.

Each institution received $25,000 to help reach thousands of young children and caregivers in their communities.

The facilities are members of the NCOHF’s national affiliate network and are dedicated to delivering comprehensive oral health treatment and preventive educational programs to millions of underserved children and their families.

“Effective oral health practices must be established during a child’s early years,” NCOHF is fortunate that Trident understands the key to eliminating pediatric dental disease lies in comprehensive preventive therapies and educational programs,” said NCOHF President and CEO Fern Inghber.

“These generous grants allow NCOHF affiliates to establish programs that provide vital services and smile-saving oral health care basics for our nation’s youngest generation,” Inghber said.

Visit NCOHF.org

The NCOHF is composed of dental professionals, industry leaders, philanthropic individuals and concerned non-profit agencies.

It is the only independent non-profit national children’s health organization exclusively focused on supporting delivery of comprehensive oral health care for economically disadvantaged children.
Lifeline Express: A journey with the world’s first hospital train in India

By Neil Sikka, United Kingdom

India is a vast and varied country with a population of a billion, of which 70 million are disabled — more than the population of the United Kingdom. I was looking forward to returning to my homeland and to working alongside those on the Lifeline Express.

While the word Delhi may conjure up images of crowding, poverty and sickness, Delhi domestic terminal was like any other European airport — all Jasper Conran-designed hotels, five-star cuisine, designer shops and even a place to grab a coffee and a chocolate muffin. It seems Delhi has changed incredibly since my last visit three years ago.

After a good evening meal (during which I choked over the wine list as luxury items cost three times more than in London; yet everyday living costs less than one third), I caught the red-eye flight from Delhi to Jabalpur in the Madhya Pradesh state, Touching down in Jabalpur revealed a complete contrast.

A solitary, simple, small, plain concrete terminus greeted us, surrounded by a barren and dusty landscape. Jabalpur is just like many other small towns in India: low rise, an army presence and an air of forbearance from all those who go about their daily routine, especially when it comes to the traffic. Most importantly, it has a railway station!

Lifeline Express

Neelam Kshirsagar, general manager of special projects for Impact India, met me and immediately took me to the Lifeline Express. The train, consisting of six or seven bright painted wagons, was parked in the siding where a platform had been specially built.

There were families milling around, waiting their turn for treatment, not worried about the baking platform and extreme heat. A quick tour revealed two operating theatres, three beds in each, with waiting and recovery areas; three large, gleaming, industrial autoclaves; a lecture room; stores; an office; a changing room; a staff room and, finally, the dental room, all wonderfully air conditioned!

I was introduced to Zelma Lazarus, the charismatic CEO of Impact India. She explained that the Life-line Express was here to provide free treatment for all, but it could only be successful with the support and cooperation of the local community.

Local hospitals had been contacted many months prior to arrival, and teams of local orthopaedic, eye, cleft lip and ENT surgeons agreed to give freely of their time.

The local Hirkani Dental College was also supporting the project. The director, Dr. Dhiranwani, and his team would be assisting me for the duration of my visit.

Getting things moving

As only certain types of operations could be performed on the train, all patients had to be screened prior to commencement. The orthopaedic team alone saw more than 3,000 patients, of which 200 were suitable cases.

Lazarus explained that the only way to “get things moving” was to go straight to the district collector. He is the area head of local government and in India holds a position of considerable power and influence.

He agreed to mobilise his network of officials to ensure that all in the town and outlying villages would be aware of the visit. The collector also wanted to meet “the dentist from London,” and so at the duly appointed hour he arrived for the inaugural ceremony of the dental suite.

He assured me that he was committed to spreading the word and promised me many patients for the next day. To prove his point, he brought along the local television station to conduct an interview with me (which was aired that night).

The following morning I was raring to go. I hadn’t been this excited about going to work for years. So at 9 a.m. on the dot, I arrived at the platform ready, willing and able, only to find the place virtually deserted.

Lt. Col. Randhir S. Vishwan (who runs the Lifeline Express) invited me into his office for a cup of tea. In the nicest possible way, he explained that in India when a doctor says he starts at 9 am he never arrives before 10.

As a result, patients never turn up before 10:15. The team from the dental college arrived at 9:30. I had thought they would send a dentist to assist me, but to my surprise two dentists, Dr. Mangesh Ghate and the newly qualified Dr. Pratibha Patel; a hygienist, Amos; and our nurse, Reena, welcomed me.

Ghate explained that as it was my first day they wanted to ensure I was fully supported. He proposed that as it was likely to be very busy, we concentrate on those most in need. Patel and he would initially screen the patients and any non-urgent cases would be asked to return at a later date.

Anyone else would be given a written prescription for treatment. This was of enormous assistance, as my Hindi is terrible and most patients spoke a local dialect (one of 1,300 in India!).

Patients

True to the colonel’s word, at 10:15 the first patients arrived, and by 11 we had a queue of 20 people. We turned the lecture facility into a waiting and post-op room. Extractions and scaling were the order of the day.

Many patients had never visited a dentist in their life and most had travelled enormous distances to be treated.

By lunchtime, I had removed more teeth than I had in the past 10 years. I was thankful for the pristine ultra-sonic scaler, which enabled me to provide some first-time scaling. All those I treated were incredibly grateful and remained stoic despite the considerable pain they had been in (probably for some years).

Some of those I examined had difficulty in opening their mouths and, on further investigation, I noticed clinical changes on the buccal mucosa consistent with submucous fibrosis at the dental clinic.

I remained for the next two days, after which it was time to...
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Scientists from the University of Melbourne, Australia, have announced they have partnered with CSI Limited and Sanofi Pasteur, the country’s largest biopharmaceutical companies, to further develop and commercialize a vaccine for the treatment of gum disease.

The program, which took 10 years in development, involves bacterial strains of periodontal bacteria called Porphyromonas gingivalis that cause periodontitis. According to a U.S.-based research consortium, elevated levels of the organism were found in the majority of periodontal lesions, as well as low levels in healthy sites. In addition, the organism also produces a number of enzymes that have been shown to interact with and degrade host proteins.

Although the bacterium can be eliminated through periodontal therapy, it is often found in recurrent infections. “Periodontitis is a serious disease and dentists face a major challenge in treating it because most people will not know they have the disease until it’s too late and the infection has progressed to advanced stages,” says Professor Eric Reynolds, CEO of the Cooperative Research Centre for Oral Health Science and the head of The University of Melbourne’s Dental School.

“This new approach will provide dentists and patients with a specific treatment.”

Traditional periodontal therapy involves manual scaling and cleaning, and even surgery with instruments or dental lasers, in an effort to contain the bacterial infection. Reynold said the new line of vaccine products will possibly prevent the progression of the disease, rather than managing its symptoms and incurring damaging consequences.

Sanofi Pasteur has an option to an exclusive worldwide license to commercialize the intellectual property associated with these products.

### Australia: vaccine for treating gum disease

**By Daniel Zimmermann, DTI Group Editor**

The Lifeline Express is the world’s first hospital train. To date more than 500,000 patients living in the remote rural interiors of India, where medical facilities are scarce, have been treated. Last year Impact India introduced dental services as a trial measure on the Lifeline Express in Mandsaur in Madhya Pradesh. Patients received free treatment for scaling, fillings, extractions and minor surgeries, and biopsies of a few patients were taken for diagnosis.

This trial project demonstrated that there was an urgent need for dental health care. In order to assist, Dr. Neil Sikka has donated funds to cover the costs of items such as a hydraulic chair, an oil-free compressor, a scaler with handpiece and other essential equipment.

For his next trip, Sikka already has a list of further equipment needed, including syringes and cartridges, sprays for disinfection, tissues and sharps bins.

Many thanks to Claudius Ash for donating 500 much-needed toothbrushes, all gratefully distributed.

For more information on the work of Impact India, visit www.impactindia.org.

### Asia: less than average in health care spending

**By Daniel Zimmermann, DTI Group Editor**

Countries in Asia have been found to spend less of their GDP for health care than most other countries in Europe and the United States.

According to a new health care report by the Organisation for Economic Co-operation and Development (OECD) in Paris, France, only New Zealand provided more money for health care in 2007 than the average of all observed countries. Japan, Korea and Australia, however, spent less than the OECD average of 8.9 percent.

The United States currently spends more on health than any other country — almost two and a half times greater than the OECD average of $2,084 adjusted for purchasing power parity. Luxembourg, France and Switzerland also spend far more than the OECD average.

At the other end of the scale, in Turkey and Mexico, health expenditure was less than one-third the OECD average.

The 2009 edition of the OECD Health at a Glance report also shows that all countries could do better in providing good quality health care. Key indicators presented in the report provided information on health status and the determinants of health, including the growing rates of child and adult obesity, which are likely to drive health spending higher in the coming decades.

The report also had new data on access to care, showing that all OECD countries provide universal or near-universal coverage for a core set of health services, except the United States, Mexico and Turkey.
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I bet you're intimately familiar with those large cabinets you have in your office. You know the ones; they are most likely near the front desk area. They contain page after page of vital information about your dental practice, your procedures and, most importantly, your patients.

They are your patient records and chances are good that they take up a very large space in your practice. Frankly, you could probably do a lot with the area they consume. However, this is practically sacred ground, and those huge files with all the important records about all those patients who come to see you day after day, well those have become a source of comfort and reassurance.

Look at all of them! You must be the most popular dentist in town! Too bad you could gather up about half of them to use as kindling at the next autumn bonfire.

Of every two patients that walk in the front door, there is a good chance that one of them will quietly slip out the back. It's unlikely you'll notice until there seems to be a few too many holes in the schedule or dollars are getting tight.

How to use the 'yearly sticker'

Here's what we see happening in dental practices all over the country. I know that you are certain yours is different, and I wish it were, but nine times out of 10 you're in the same boat with the rest of your dental colleagues, and most of you are paddling up the same creek.

Dentists are often lulled into believing that they have a very active patient base. After all, there are oodles and gobs of charts. One look at the yearly sticker tells you at a glance how many of those patients are active.

Unfortunately, often the yearly stickers are showing you only what you want to see and not the reality.

During our onsite practice consultations, we ask dental teams when they place the yearly sticker on the chart. The typical response is: “Well, of course the sticker would be placed on the chart the first time the patient comes in for any type of care that year.” Bzzz! Sorry, that would be an incorrect answer. Here’s why.

There are any number of patients who are coming in only when it hurts, but they haven’t had an appointment with the oral hygienist since Barack Obama was a small-time legislator in the Illinois General Assembly. Place yearly stickers on the record when the patient comes in for his/her recall appointment.

If the yearly stickers are placed correctly on records, charts can be pulled for inactivity based on the sticker. Most practices will keep a patient’s record in the file for up to two years; beyond that they should be pulled.

In addition, if you are assigning patient records to emergency patients, stop that habit immediately. Emergency patients who have never been to the office for treatment should not be given a patient record because this adds to the illusion of a substantial and loyal patient base.

An annual record audit

The only real means of assessing true patient loyalty is to conduct an annual record audit to ascertain exactly how many patients continue to choose you as their dentist. What? Is that a protest I hear? “But we don’t have time to do chart audits. Our patient retention must be fine because we are so busy we are only allowed to schedule vacations during years in which a solar eclipse can be seen in North America.”

Busy is often an illusion. It’s
‘Busy’ is often an illusion.
The only way to assess true patient loyalty is to conduct an annual record audit.

- Monitor and report on recall monthly during the staff meetings. This is a good opportunity to assess the system, evaluate what is working and what isn’t and seek input from others.
- Tweak your telephone scripts to ensure that you know exactly what to say and how to say it in those phone calls to patients.

Reacquaint patients with you and your practice
Send a direct mail letter to every adult in your active and inactive files who is or was a patient in good standing. Be sure to include something about the importance of ongoing professional dental care and giving patients beautiful smiles.

Explain that you value them as patients and are concerned about their oral health as well as their overall health and well being. Mention new services offered, continuing education accomplishments of the dentist and/or staff, other improvements that have been made in the practice, etc.

The bottom line is that you want patients to feel that they are valued and appreciated by you and your team.

Finally, encourage them to call your office and schedule an appointment today. Assure them that your business team will make every effort to secure a convenient appointment time for them — then make sure that is the case.

Consider setting aside popular appointment times specifically for patients that are responding to the mailing.

If someone calls in response to the mailing and the business team says there isn’t an opening for four weeks (or eight weeks or six months), you’ve just wasted your time and your money and convinced those long lost patients that your practice really is not interested in providing care for them.

While a variety of practice systems likely need to be examined to determine exactly what is causing patients to seek care elsewhere, you can take at least a few immediate steps to slow, if not stop, the exodus.

Modernize your collection system for maximum profit

By Keith Drayer

In today’s economy there are many dental professionals who are faced with the challenge of their accounts receivable. Uncollected receivables turn into pure losses. Yet embracing a systematic approach to collections can help practices collect more funds and on a more timely basis.

One mistake providers make is not recognizing the signs of early default. When a patient doesn’t pay a bill within 60 days, hasn’t set up or is adhering to a payment plan, the patient is telling you that he/she is not going to pay.

Should you use your staff’s time trying to collect these accounts? As a dental provider, you are implementing state-of-the-art methods to treat your patients’ dental needs. You need to be able to pay the most up-to-date methods to keep your practice fiscally healthy.

In the past, collection agencies were the only “act on the block” and viewed as the last resort to collecting your money. They can be expensive and often care little about your relationship with your patients. You had no control over how they treated your patient and you never knew if they collected your money or not.

Often the collector, who is paid on a commission basis, “cherry picked” over your accounts and attempted to collect only the larger ones and did not work the smaller ones.

In addition, many of your accounts that were collectable were deemed too small to work. Thus, you lost money when you didn’t need to. What is needed is a proactive, systematic business model that will work all of your delinquent accounts equally.

Providers must take an approach that will reduce losses as well as speed up cash flow from past due accounts. You need to work with your patients quickly and effectively.

Outsourcing your collection problems to a service bureau can be much more cost effective than working them in-house — and certainly more effective.

Utilizing a third-party collection method that will keep you in complete control of the collection process is a must.

The third-party system should be respectful but firm, and utilize every possible legal tool to collect your money.

The provider who utilizes a systematic third-party approach to collect his/her money will see an increase in the bottom line.

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For additional information, please call (800) 445-2756 or send an e-mail to hsfs@henryschein.com.

Making sense of digital radiography

By Lorne Lavine, DMD

In my last article, we discussed the advantages of digital X-rays and looked at how to develop a positive return on investment, specifically focusing on improved diagnostics, efficiency, reduced exposure times and co-diagnosis.

While many dentists will spend a lot of time evaluating the pros and cons of sensors vs. phosphor plates and the resolution of various systems, many offices still fail to realize the importance of improving their infrastructure to be able to handle digital radiography.

A good digital system won’t do you much good if you’re struggling to make it work on outdated hardware and networks. Here are some key areas that should be addressed while you are also evaluating the digital X-ray systems.

The computer server

The server is the lifeblood of any network. Many dentists fail to understand that the storage needs for digital X-rays are exponentially higher for images than if you just have practice management software data.

The server must have enough memory to allow the server to multitask, should have fast hard drives to push the data out to the workstations quickly, should have an operating system that allows for control over the entire network and include a replacement part policy that delivers new parts in hours, not days.

I currently recommend a Dell T500 server with RAID 1 (mirrored) 500 GB hard drives, 4 GB of RAM, Windows Server 2003 or Server 2008 (if your dental software supports 2008) and a four-hour contract.

One thing to be wary of are new operating systems. For example, while Windows Server 2008 has been out for a year, many dental applications still do not work properly with it. Check with your software and hardware vendors for compatibility issues before you purchase new systems.

The network

Make sure that besides the server, you have proper network infrastructure throughout the office. Digital images are quite a bit larger than practice management data and you’ll need to be running at a speed of a gigabit (1,000 MB) per second.

Make sure all network cards are 10/100/1000 network cards, use a switch (a smarter version of a hub) that can handle the faster speed and use either Cat5e or Cat6 cabling. Cat6 cabling is recommended for new offices because it will be able to handle a faster speed once that becomes the industry standard.

Computers in the ops

These computers typically need to be faster than front desk computers. One area to focus on is the video card. Cheaper computers often ship with the video chip fused on to...
Dealing with stress in the 21st century

By Ros Edlin, United Kingdom

Ask the average man in the street for his opinion as to whether or not dentists experience stress and you will, in all probability, be met with a look of incredulity and a snort of derision. After all, isn’t stress in the dental environment not going to be turned into two or three. You are learning to accommodate to the environment if he or she does not want to pay the price. This situation may carry on for some time, and leave you feeling as if you have received any particular training in, for example, people skills or financial management, it is little wonder that many dentists fall victim to stress-related illnesses, either mental, physical or both.

Stress itself is not an illness but is, according to the Health and Safety Executive (HSE) definition, “the adverse reaction people have to excessive pressure or other types of demand placed upon them.”

The HSE also “makes an important distinction between the beneficial effects of reasonable pressure and challenge (which can be stimulating, motivating and can give a ‘buzz’) and work-related stress, which is the natural but distressing reaction to demands or ‘pressures’ that the person perceives they cannot cope with at a given time.”

The concept of perception is particularly relevant in that, faced with the same situation, a difficult procedure or a demanding patient, one dentist may relish the challenge and yet the other be trembling in his shoes! Also pertaining to the definition of stress are the notions of control and change. It is clear that we function best when we are in control of our circumstances, when we feel we are responsible for our successes or failures due to our own personal attributes. This could also include the responsibility of the welfare of both patients and staff. As is often the case, however, bureaucracy mitigates against this feeling of control, which could result in work-related stress.

The recent NHS Dental Contract for the U.K. is a prime example where it can be argued that dentists have a loss of control of their own destinies. It also illustrates the importance of our concern in the process of change for the best results to be achieved. “Today’s dental environment is not going to change, but we can accommodate to it as an individual. It’s the individual who needs to learn to accommodate to the environment if he or she does not want to pay the price.”

There is no doubt that we all need pressures and challenges in our lives to get us up in the morning and to keep us going. These are critical, and it is little wonder that many dentists experience stress and your perception is that you cannot cope.

“Many dentists won’t even blink when spending $20,000 on digital X-rays, yet they try to save $100 by buying a cheap monitor.”

In conclusion

Digital X-rays are a great option, but dentists need to make sure they take the time, and spend the money if necessary, to ensure a smooth transition by having proper hardware infrastructure.

Dr. Lorne Lavine, founder and president of Dental Technology Consultants (DTC), has more than 20 years invested in the dental and technology fields. A graduate of USC, he earned his DMD from Boston University and completed his residency at the Eastman Dental Center in Rochester, N.Y.

He received his specialty training at the University of Washington and went into private practice in Vermont until moving to California in 2002 to establish DTC, a company that focuses on the specialized technological needs of the dental community.

I personally don’t see much difference between monitors that are 800:1 and, say, 1500:1, but some people claim they can diagnose better with these higher contrast ratio monitors.

Data backup

We’ve talked about this in previous articles, but once you make the decision to go digital with your X-rays, having a good backup protocol and business continuity systems are critical.

If your server goes down and you don’t have this, not only will you not be able to access patient information, you won’t even be able to take X-rays — this can be devastating for a practice.

I recommend a system like the DataProtect system we offer, which combines an emergency server in the office with an automated online backup. Most offices will spend less than $100 per month to have the peace of mind of a great backup without any worries.

The key statistic to evaluate is the contrast ratio, the difference between the whitest white and the blackest black. Ideally, look for a monitor that has a contrast ratio of at least 800:1.

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have been verified to work with this new operating system.

Monitors

I consider this one of the most important decisions that needs to be made when it comes to digital X-rays, and often the most overlooked.

I see many dentists not even blink when spending $15,000 to $20,000 on digital X-rays, yet they try to save $100 on a cheap monitor.

The key statistic to evaluate is the contrast ratio, the difference between the whitest white and the blackest black. Ideally, look for a monitor that has a contrast ratio of at least 800:1.

Another important statistic to evaluate is the contrast ratio, the difference between monitors that are 800:1 and, say, 1500:1, but some people claim they can diagnose better with these higher contrast ratio monitors.

Many dentists won’t even blink when spending $20,000 on digital X-rays, yet they try to save $100 by buying a cheap monitor.'
or going out at lunchtime to listen to music or having a relaxing bath. The importance of relaxation is that it enables you to switch off and recharge your batteries.

**Equally important is physical exercise.** Exercise burns up the excess adrenaline resulting from stress, allowing the body to return to a steady state. It can also increase energy and efficiency. Do find an exercise that you enjoy and that will motivate you to continue doing it.

**Balance your diet.** Eat breakfast, drink sensibly and include lots of water to rehydrate the system. Include complex carbohydrates (whole meal bread, jacket potatoes [with the skin on]) in your diet, to counteract mood swings, and fruit and vegetables to provide vitamin C to support the immune system.

**Manage your time (and yourself) efficiently.** Again, taking a step back and reviewing your working practice is essential. Do you have an allotted time for dealing with emergencies and administration? Are you constantly running behind schedule, causing your stress levels to escalate? Developing leadership and organisational skills will enable you to feel more in control of your working environment.

Ensure that your staff members are properly trained and aware of their individual roles and responsibilities. Encourage a culture of mutual support, whereby asking for help is not viewed as weakness.

Talking over your problems with someone you trust can be such a help. As mentioned previously, some dentists may be excellent practitioners but sadly lacking in interpersonal skills. An ability to listen is a gift. If you feel you need some training in communication, there are plenty of courses available.

By incorporating at least some of these strategies into your everyday life and your working life, you could create an environment that is stress-free and an environment in which it is a pleasure to work. It could make the difference between a good practice and an outstanding one. Who wouldn't want that?

References are available from the publisher.

Ros Edlin is a freelance stress consultant from Hale, United Kingdom. She can be contacted at ros@stresswatch.co.uk.
Same-day inlay/onlay technique

By Lorin Berland, DDS, FAACD

I’m always looking for ways to help my patients get the dentistry they want and deserve. More and more patients are demanding esthetic, reliable alternatives for their old, defective amalgams. They still want to avoid crowns, root canals and multiple visits. This is why I’ve been providing reliable, durable and much appreciated biomimetic same-day inlays and onlays for years.

What is biomimetic dentistry?
Biomimetic dentistry is conservative, preservative dentistry. We treat weak, fractured and decayed teeth in a way that conserves tooth structure and helps preserve strength.

This helps provide resistance to bacterial invasion. It reduces the need to fill or remove teeth and will reduce postoperative discomfort, as well as the need for two appointments, and possible endodontic treatment.

In essence, it is utilizing the latest in dental materials and technology to keep what we’ve got for as long as we can — just as nature intended. Unlike other parts of our bodies, our teeth do not mend on their own.

It is, therefore, imperative to conserve as much natural tooth structure as possible. We strive to do this with same-day inlays/onlays.

This means no excessive tooth removal, no cumbersome temporaries and no time-consuming and uncomfortable second visits.

Biomimetic: to copy/mimic nature
Nature is our ideal model. In order to mimic nature, we must understand what nature looks and feels like.

We need to know how it moves and functions. In other words, we study nature’s properties so that we can better replicate it. We want stronger dental units — teeth and restorations — not just stronger crowns.

Now it is possible to rebuild teeth with newer materials and techniques that more closely simulate natural teeth and hold up better to the hearty demands of life.

Through advances in dental adhesives, we strive to make the compromised tooth whole, using materials that best mimic dentin and enamel. Our patients can testify that biomimetic restorations look and feel much better than traditional dental restorations.

Biomimetic dentistry is conservative
Modern adhesives and bonding technologies are the driving force of biomimetic dentistry.

With traditional dentistry, healthy tooth structure is destroyed and/or removed in order to retain a new restoration.

By using advanced adhesive techniques and properly fashioned inlays and onlays, dentists can help save their patients’ teeth, time and money.

We could say that preservation and conservation lie at the heart of biomimetic dentistry. It is a win-win situation for everyone.

I think every dentist who sees a lot of old amalgams should consider offering these restorations. Most dentists probably have almost everything they need to do so, including the patients.

All that is most likely needed is an indirect composite and curing system, a portable hydrocolloid impression method, silicone injectables for die and model work and disposable articulators. That’s it.

In addition, once a dentist has all that, in addition to same-day inlays/onlays, the dentists will be ready to provide patients with lab-quality transitional and temporaries as well as custom trays on an immediate, low-cost basis.

That means better dentistry. Sound good?

We know it’s the right thing to do. It’s what we would do for ourselves. Gordon Christensen says, “The lack of use of tooth-colored onlays is one of the most frustrating situations I see in current restorative dentistry.”

People hate temporaries. The worst aspect about temporizing inlays and onlays is they always come out when you don’t want them to and sometimes won’t come out when you do want them to at the second, or “bond” visit.

Patients hate having to come back to get numb for yet another uncomfortable appointment.

Moreover, that second visit is what keeps many patients from being proactive about replacing all of their old amalgams. In addition, it’s also what makes it so costly — for your patients and for you.

That’s why if you incorporate these restorations in your practice, your overhead goes down and your profits increase — all while taking better care of your patients.

Same-day inlays/onlays will definitely benefit your patients and your practice.

For a minimum investment in new equipment and materials, and a very short and easy learning curve, you and your assistants can quickly begin to replace defective amalgam restorations and at the same time conserve and reinforce remaining tooth structure — and so much more!

Your quadrant and full-mouth dentistry will definitely increase along with patient satisfaction, referrals and profits.

Look at the benefits for you and your patients:

• No lab bill means reduced overhead costs.
• No costly second appointments means patients appreciate getting it all done the same day.
• No “lost” second appointments.

If you’d like more information on the Biomimetic Same Day Inlay/Onlays 8-AGD credit CD-ROM that outlines the materials, equipment and techniques, please call (214) 999-0110 or e-mail ashley@dallisdentalspa.com.

Fig. 1: Large, broken-down amalgam.
Fig. 2: Immediate post-op, occlusal.
Fig. 3: Immediate post-op, buccal.
Fig. 4: Broken, unhappy tooth No. 19.
Fig. 5: Amalgam and caries removed showing dentinal floor fracture.
Fig. 6: Selfetch primer.
Fig. 7: Final prep.
Fig. 8: Onlay on model.
Fig. 9: Happy tooth, happy patient.
Fig. 10: Same day inlay/onlay CD-ROM cover.

About the author
Dr. Lorin Berland, a fellow of the Aacd, pioneered the Dental Spa concept in his multi-doctor practice in the Dallas Arts District. In 2008, he was honored by the Aacd for his contributions to the art and science of cosmetic dentistry.

For more information on The Lorin Library Smile Style Guide, www.denturewearers.com, a “Full-mouth Rebath in 2 Visits” DVD and the Biomimetic Same-Day Inlay/Onlays 8-AGD credit CD-ROM that outlines the materials, equipment and techniques, please call (214) 999-0110 or visit www.berlanddentalarts.com.
Oral biofilms 101: the basics

By Amit Sachdeo, Michael J. Costello, Angela Gil-Levin, Peter Arsenaault and Robert F. Wright

Biofilms are adherent communities of bacteria, fungi or protozoa living in a self-produced milieu of non-living matrix compounds. Their formation is complex and dependent on bacterial communication, which results in a specialized, pseudomulticellular existence.1,3

In the human body, biofilm formation offers pathogenic microorganisms protection against host immune defenses and antibiotics.1,3 Their development on hard, non-shedding surfaces such as teeth, artificial implants and indwelling catheters is ubiquitous, but they often colonize tissue cells as well. The United States National Institutes of Health estimates that more than 80 percent of human microbial infections are caused by bacteria growing as biofilms.2

Oral biofilms

The dense accumulation of bacteria was first reported by G.V. Black in 1898 in his description of dental plaque.3 Dental plaque remains perhaps the most well studied example of a biofilm.

The human oral cavity has been found to contain more than 700 different species of bacteria. Some of these species have been associated with the pathogenesis and progression of dental caries4, periodontitis4-6, dental implant failures7, dental plaque deposits lead to gingivitis in three weeks or less.8-10

Much research has been dedicated to identify the etiologic bacterial species present in the dental plaques of patients with oral pathologies. Socransky et al.11 were the first to categorize these oral biofilm communities. They used genomic DNA probes and checkerboard DNA-DNA hybridization12 to identify bacteria in health and disease using 13,261 plaque samples. Their study found three bacterial species, Bacteroides forsythus, Porphyromonas gingivalis and Tengatena denticola, to be associated with increased pocket depth and bleeding on probing. These species, associated with clinical measures of periodontal disease, were labeled as the “red complex.”16

Research followed to identify pioneer organisms and uncover the bacterial composition changes in plaque that lead to disease. Ritz9 noted that anaerobes succeed aerobic and facultative species, suggesting that the reduced environment created by the presence of aerobes makes it more favorable for anaerobes to colonize.

Dental restorations

Crown restorations require proper physiologic contours to minimize plaque accumulation and the associated biofilm. Crowns should restore teeth to the natural physiologic contours. Stein and Kuwata coined the term “emergence profile” to describe the contour of a tooth or crown as it relates to the adjacent free gingival margin.17

A crown should have a straight emergence profile to allow for proper home care.18 Crown restorations with cervical over contours cause gingival inflammation and plaque accumulation.19 Even though glazed porcelain and polished porcelain seem to deter plaque, when examined microscopically, they are much more porous than highly polished high noble alloy.20

It was believed that supra-gingival margins were kinder to the periodontium and easier to finish and maintain rather than subgingival margins.21 However, contemporary literature dictates that the location of the margin is not as important as the dentists’ skill in providing a well-fitting margin with a smooth finish.22

Basic principles from fixed prosthodontics regarding minimizing the biofilm should be followed for partial veneer restorations and conventional operative procedures such as amalgams, composite resin restorations and glass ionomer restorations. These restorations should also restore the tooth to the normal physiologic contours, have good marginal integrity and have favorable polished surface properties.

Bonding resin to the surface or liquid polished coatings have been shown to significantly reduce the biofilm thickness on dental restorations.19

The edentulous subject

Most studies to date have examined oral biofilms in the dentate subject, leaving us with limited knowledge regarding biofilms in the edentulous or complete-denture-wearing patient.

A recent study by Sachdeo et al.23 provided the first step in defining the organisms that are associated with the edentulous on both the soft (mucosa) and hard surfaces (denture).

The results from this study showed that periodontal pathogens Aggregatibacter actinomycetemcomitans and P. gingivalis that were believed to have disappeared from the oral cavity after extraction of all natural teeth24,25 were clearly present in biofilm samples from the edentulous patients.

The finding of these periodontal pathogens in the denture-wearing population by Sachdeo et al. is of great concern because if there...
Win a Dream Practice Sweepstakes from P&G

Procter & Gamble Oral Health announced during the Greater New York Dental Meeting that it is collaborating with Levin Group to offer dental practices a chance to win in the Dream Practice Sweepstakes. During the six-months of the promotion, 12 winners will receive a yearlong Levin Group Total Practice Success™ Management Consulting Program. Two dental practices will be randomly selected every month from all entries.

When asked where the impetus came from to offer such a sweepstakes, Associate Marketing Director of P&G Oral Health Ann Hochman replied: “We really want to see professionals thrive, particularly in this economy. We are committed to seeing patients and practices succeed. Healthy offices are tightly linked to healthy patients.”

And, of course, healthy offices are what Levin Group is all about. Dr. Roger Levin explained that winners will receive the entire consulting program as if they had approached Levin Group directly.

So it’s not a diluted or condensed version, but rather the complete consulting program that gives them the best chance of increasing production and reaching total success. “We are delighted to be working on behalf of Procter & Gamble,” Levin said. The Levin Group Total Practice Success Management is designed to help a practice identify objectives in 12 specific areas and to attain each one of them.

The 12 areas include: case acceptance, case presentation, change management, communication, executive coaching, financial planning, goals and Life Map™ hygiene productivity, patient finance, scheduling, team building and vision.

If you are interested in entering the contest, it’s just a few clicks away: visit www.virtuallyplaquefree.com where you can enter every day of the month.

Each month, a winner will be chosen and the slate of submitted entries will be wiped clean to start all over again the next month.

Procter & Gamble Oral Health is highly focused on total patient solutions, and Hochman said the company felt it had to do more for the professional community.

“Our focus is total office health as well as patient health. We are thrilled to partner with Levin Group for the Dream Practice Sweepstakes,” Hochman said.

From its side of this partnership, P&G brings its well-established Pro-Health System — a three-step hygiene regime — to the aid of dental professionals seeking to bring all-day and all-night protection to their patients. 

The second day of the DTSC Symposia started off strong with Dr. Gary Severance and Dr. Lee Culp. In their lecture, “E/A/D Sky: Dentistry’s Destinatation,” the duo demonstrated everything that dental professionals need for the design and fabrication of single unit glass ceramic restorations.

During the next lecture, “Know Your Products & Tools for Today’s Healing Dentistry,” Dr. Gary Goldstein focused on dental therapy, which makes removal of tooth and periodontal structures and less intervention in the healing process possible.

7 Dentists returned after lunch to learn about “OraVerse — In Practice,” as taught by Dr. Steven Glassman. He explained that OraVerse is a local anesthesia reversal agent that accelerates the return to normal sensation after routine dental procedures.

Finally, Dr. Derek Fine ended day two with his lecture, “Awareness in Three Dimensions,” in which he explored the basics of cone-beam imaging and why it is an important adjunct to the modern dental practice.

Day 3

Dr. Renato Leonardo kicked off day three with a presentation on “In-the-Mouth Digital Photography,” introducing the newest digital lasers, which cover the widest range of clinical indications.

Next, the crowd learned from Dr. David Hoexter about “Esthetics Using Cosmetic Periodontal Surgery.” Listeners were surprised, however, when he demonstrated how changing the background of the desired image will enhance it to appear brighter, cleaner and healthier, yet physiological as well.

The day ended strong with Lynn Mortilla’s lecture, “You’ve Taken Implant Training ... What Do You Do Next?” in which she discussed integrating implants into the practice.

Day 4

The fourth and final day welcomed Dr. George Freedman up on the stage for the third time, to present his lecture “ICOM — Innovative Caries Treatment without Drilling.” Among other important matters, Freedman discussed preserving healthy tooth structure and interproximal and smooth surface treatment options.

The second lecture of the day boasted Dr. Barry Levin, who was lecturing at the DTSC Symposia for a second year in a row. In his lecture “Immediate Tooth Replacement in the Esthetic Zone,” Levin discussed immediate temp seating and the immediate sense of security and esthetics it gives the patient.

After lunch, attendees returned to experience Dr. Ron Schefdore discussing how dental professionals are now incorporating blood screening, evidence-based supplementation, laser therapy, DNA testing and physician referrals into their office protocol to improve dental treatment outcomes and improve the overall health of dental patients.

The DTSC Symposia 2009 came to an end with a live broadcast all... continued
Dr. Howard Glazer was one of many speakers at the recent DTSC Symposia.

A runner-up, Dr. Adam Vaghari, will receive one free registration for the Webinar of his choice. “Thank you to all participants who submitted their names in the draw and attended the DTSC C.E. Symposia at the GNYDM this year,” said Julia E. Wehkamp, C.E. director for Dental Tribune.

Lectures available online
For those who were not able to attend these lectures at the Greater New York Dental Meeting, they will be offered online as C.E. accredited Webinars at www.DTStudyClub.com within the next month.

Winner of drawing
All participants who attended a full day of DTSC Symposia lectures were eligible to put their names in for a drawing for one year worth of free C.E. on www.DTStudyClub.com. Dr. Hoang-Anh Nguyen won a year of free C.E. tuition on www.DTStudyClub.com.

Dr. Sachdeo received his doctorate in oral biology and certificate in prosthodontics from Harvard University. He is currently an assistant professor at Tufts University School of Dental Medicine in the department of prosthodontics and maintains a private practice in Boston. Sachdeo’s area of research is studying the composition and development of oral biofilms. His work has been published in the Journal of Prosthetic Dentistry, Journal of Prosthodontics, Journal of Dental Research and various other peer-reviewed journals. Sachdeo has also been the recipient of numerous awards and grants.

A complete list of references is available from the publisher.
The Dental Tribune Study Club is an educational-based online community that inspires new possibilities while creating greater expectations in online learning. Dental Tribune has scoured the world to find dental meetings with a proven platform for education, communication and development.

The following are premier attractions for the international dental community at large and will each feature a Dental Tribune Study Club C.E. Symposia in 2010.

- April 16–18: IDEM — International Dental Exhibition in Singapore
- April 26 & 27: Dental Salon, Moscow, Russia
- June 9–12: Sino-Dental, Beijing, China
- Sept. 2–5: FDI World Congress, Salvador da Bahia, Brazil
- Sept. 23–25: CEDE Poznan Exhibition, Poland
- Oct. 28–31: DenTech, Shanghai, China
- Nov. 28–Dec. 1: Greater New York Dental Meeting, New York City

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

‘Getting started in...’ Webinars Each “Getting started in...” program includes up to five successive Webinars that provide a thorough introduction to the techniques, products and practice management impact in that field of dentistry.

Each Webinar will include a one-hour presentation followed by a live Q&A session between the online audience and the speaker. Participants receive up to five C.E. credits and attendance is free for the first 100 registrants. The 2010 schedule is as follows:

- March 13: Getting Better in Practice Management
- April 3: Getting Started in Orthodontics
- May 22: Getting Started in CAD/CAM
- May 29: Getting Started in Implants
- July 24: Getting Started in Digital Imaging
- Aug. 14: Getting Started in Endodontics
- Aug. 27: Getting Started in Lasers
- Oct. 9: Getting Started in Cosmetic Dentistry
- Nov. 6: Getting Started in Magnified Dentistry

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

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

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

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

Registering as a Study Club member is free and easy. We encourage you to visit www.DTStudyClub.com and join the community. For additional details, please contact Julia Wehkamp at j.wehkamp@dtstudyclub.com or (416) 907-9856.
Curve Dental: simplicity, efficiency, flexibility and fun

By Kristine Colker, Managing Editor

As the story goes, at the age of 16, whiz kid Matt Dorey started and grew a successful IT company that helped dental practices install computers, networks and software. When he was 19, he asked a pivotal question: “If you can shop online, bank online and book travel online, why can’t you manage your practice online?”

Of course, the only answer he heard was, “That’s a wonderful idea, Matt!” So in 2005, Dorey founded Curve Dental, a Web-based company that prides itself on being simple, flexible, efficient, cost-effective and, just as important, fun. Today, Curve Dental sat down with Vice President of Marketing Andy Jensen to find out more about Curve Dental.

What are the main things the company offers to clinicians?
We offer Web-based dental software that delivers three key benefits.

1) The software is simple. It’s Web-based. How difficult can the Web be?
Almost anybody can navigate around the Web and complete many different tasks. Simplicity also means less training. If the dentist is closing his or her practice for two or three days to train the staff, how much is that costing? Software is supposed to deliver a return on investment, not create another barrier to increasing production.

2) Flexibility. Our dental software is an extension of the staff’s lifestyles because it is Web-based. Everyone is shopping online. More and more people are banking online. More than one-third of all travelers are booking online. And the number of online tradecraft is increasing exponentially.
Why? Because people like convenience and simplicity. If you can shop online, bank online and book travel online, you should be managing your practice online, too.

3) Boosting efficiencies. Reducing the amount of time required to accomplish any one task results in an increase in efficiency. The key test is accomplished by asking this one question: “Can I do it faster with paper?” If the answer is “yes” then what is the point of using the software? From charting to scheduling to billing, you’ll see that Curve Hero passes the test.

• Bonus benefit: Outstanding customer service. Our dental software is no better than our customer service. Our software is a subscription service, so we have to exceed our customers’ expectations every month. That’s pressure to perform, and we love to make our customers happy.

How does Curve Dental differ from other dental software/office management companies?
Two differences: First, our dental software is Web-based. People use the Web because it offers a level of convenience, flexibility and simplicity that can’t be found anywhere else. All that’s needed is a Web browser and an Internet connection.
Second, because our software is Web-based, it is more intuitive. Our customers find that charting is much simpler, scheduling is more flexible and generating reports is easier.

When developing the software, we can approach certain tasks with a completely different perspective not generally available to legacy software developers. When you see a demo of Curve Hero, you’ll be very impressed by the less-is-more design.

For those who are used to their office management software not being Web-based, how does Curve Dental’s work?
Anyone who has visited Amazon, Travelocity or their local bank will admit they were able to understand how to use the service with no formal training. Of course, managing a practice is much more complex than shopping online or booking a ticket online; but the concept is still very much applicable. Our customers are completely trained and using the software live with half as much training as legacy client-server software requires.

Medidenta now offers refining and waste disposal

With 65-plus years and counting, the company Medidenta has 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 the company says will serve all the dental community it has served since 1946. Thus, Medidenta is currently offering some new services.

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 PLIS system is very easy. Fill it. Seal it. Ship it. Everything is included, including the tape at a substantial savings.

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 facilitate clinicians’ 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.medi-denta.com.

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.

The company looks forward to serving all your needs today, tomorrow and well into the future.
MonoCem by Shofu

MonoCem, Shofu’s self-adhesive resin cement, has a new and improved formula with complete auto cure in only ½ minutes. The same reliability and superior performance — now faster — makes MonoCem the ideal time-saving choice.

According to Dr. Richard Berry from Medway, Mass., “MonoCem is the easiest, fastest and strongest cement I have ever used.”

With a self-etch, moisture tolerant formula, MonoCem bonds strongly to all substrates — dentin, enamel, porcelain, all-ceramic restoration or metal-based restorations. Easy to clean up, MonoCem has an unlimited working time and 100 percent polymerization.

MonoCem’s dual-cure formula light cures in 40 seconds and now completely auto cures in only ½ minutes. Available in 7 gram syringes, MonoCem has a low film thickness of less than 12 microns, eliminates sensitivity and has a high fluoride release.

“MonoCem self-adhesive resin cement is a very simple to use and very effective cement. It handles well with excellent flow properties and cleanup is easy. MonoCem exhibits all of the ideal properties of a cement used for luting adhesive ceramic restorations.” Dr. Eugene Atenucci from Huntington, N.Y., said.

With a convenient direct-dispensing, auto-mix syringe delivery system, MonoCem offers color stability for long-term esthetics in translucent or bleach white shades for indirect cementation of crowns, bridges, inlays, onlays and posts.

Visit Shofu online, www.shofu.com, for a new MonoCem step-by-step guide. The helpful how-to is a useful tool that clearly illustrates MonoCem’s fast and easy application.
Seiler Instruments

To say Seiler instrument company has a long history with optics would be a bit of an understatement. With over 64 years of history in dealing with the design and manufacturing of optical equipment, Seiler now provides that equipment to the medical, dental, military, architectural, construction and planetarium markets.

Founded in St. Louis, Mo., in 1945 with the knowledge and expertise by a master of fine optics from the Zeiss University School of Fine Optics in Germany, Seiler Instruments began making and repairing small microscopes and survey equipment.

In 1950, the Seiler microscope division was formed to distribute Zeiss (Jena) surgical microscopes in North America, making them one of the first surgical microscope providers in the United States.

Since then, Seiler has become a major provider of surgical and compound microscopes to the dental, ENT, OB/GYN and laboratory markets.

With all of Seiler’s history it is amazing that the word new could be used to describe Seiler, but in 2009 that has been one of the most popular terms around its new building.

Recently, Seiler has moved its home office from a 70,000 square-foot facility to a new 150,000 square-foot facility to better serve its customers.

In addition to their new building, the company has also released two new microscopes for the dental market: the Seiler iQ and the Evolution xR6.

“We took a conventional approach to the redevelopment of these scopes. We directly asked the dentists what they wanted in a dental microscope, they told us and we listened,” said Nicholas Toal, the marketing coordinator for Seiler.

Listening is something that is normally hard to do for a large company these days, but “Seiler knows that customers are the boss, and catering to those customers keeps the boss happy” says Dane Carlson, division manager of Seiler Microscopes.

The Seiler Evolution xR6 is the newly redesigned, new six-step microscope that comes with the new 50 watt metal halide bulb, which is the brightest standard light source in the market with a bulb life of more than 1,500 hours and a standard halogen backup.

Also, Seiler has released the new Seiler iQ that offers the same new light source, but comes in a smaller package with three steps of magnification and a new design. Both models have five different mounting options: floor, wall, high wall, ceiling and table.

To get more information about Seiler, visit www.seilerinst.com.
“I just got back from LVI and my world has changed. I can’t possibly look at dentistry the same way again!”
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Dr. Myers, how did you become interested in practicing dentistry?

As a child, I wanted to pursue a job where I could work with my hands. I was interested in building model ships and airplanes, and thought about pursuing a career as an orthopedic surgeon.

Then, in high school, I dated a dentist's daughter and noticed that he was able to set office hours and have weekends off, unlike the surgeons I knew who spent long hours at the hospital.

Because I appreciated family life, I decided on the dental path. I also enjoyed the hands-on aspect of dentistry. Most medical positions do not have the opportunity to get that close to patients.

How do you keep up with technological advances in dentistry?

I graduated from dental school in 1987, and taught at the Advanced Education in General Dentistry program at University of Missouri in Kansas City for 16 years. When I moved to private practice and built the office, I wanted to make sure that we offered educational opportunities to my colleagues. We built an education center in the basement with an audio-visual and projector system that can seat 40 people for lectures and 20 for hands-on courses.

We try to offer one course per month. We've done courses on the Gendex cone beam and Nobel Guided Systems, and hold a 10-week dental assisting program twice a year.

I may not be a part of the university system anymore, but I still have a love for education because I believe that we all continue to learn during our lives and careers.

What do you do when you are not practicing dentistry?

Music is one of my biggest loves. I enjoy big band music, and play baritone sax in a big band. We try to make it to the Glenn Miller Festival every year at his birthplace in Clarinda, Iowa. I also play oboe and English horn in the local symphony orchestra.

My other loves are my wife, Kathy, 10-year-old daughter, Katie, and 17-year-old son, Glen, who is hoping to follow in my dentistry footsteps. I hope that I have inspired him to a career that he can really sink his teeth into! 

Fortunately, some people can take the small events that increase quality of life for granted — having a conversation, tasting delicious foods and smiling without self-consciousness are daily occurrences that are rote for some, but luxuries for others.

While certain patients can maintain a happy, productive life with standard dentures, for others with special needs, dentists must find alternatives that fit with the patient's lifestyle and budget. Everyone deserves the confidence and self-esteem that a beautiful smile can provide. With the proper equipment and new procedures, doctors can provide patients with function and fashion.

A variety of implant options offer functionality and esthetics. For one of my patients, an implant-retained denture fit her financial and physical requirements. The 64-year-old German woman has basically well-maintained diabetes, occasionally struggling with insulin levels as well as other health issues, such as skeletal back problems.

She had reached a point in her dental history where she would need her few remaining upper teeth extracted and replaced by a denture. She had been researching the possibility of denture implants. She did not want traditional dentures because she gagged quite easily, and the thick base of the denture, plus her German accent, made her speech difficult to understand. In addition, due to her diabetes, she occasionally got painful and slow-to-heal sores on her palate under her dentures.

Technology helped me to achieve the clinical care and physical appearance that this woman needed. Imaging played a big part in my treatment plan. For the diagnostic part, I used a GXCB-500™ medium field-of-view cone-beam unit from Gendex that gave me a three-dimensional view of her dentition (Fig. 1). This imaging method allowed me to determine whether implants were even possible for the patient because I couldn't identify all of the details without determining the width and height of the bone to see if a bone graft was necessary.

She had already stipulated that she did not want a bone graft. With...
Virginia dentist gives two patients new smiles

By Fred Michmershuizen, Online Editor

When Dr. Lisa Marie Samaha of Port Warwick Dental Arts in Newport News, Va., decided to hold a Smile Makeover Contest, she intended to award one patient with free care.

But after reviewing the applications she decided to present two awards, not one.

The practice received many compelling stories, and two exceptional individuals stood out.

As a result, Michael Boyd of Hampton, Va., and Terry Cane of Williamsburg, Va., were selected to receive life-enhancing and life-saving dental treatment that began in October.

“It was such a heartwarming presentation, for all of us,” said Abby Sharpe, who works in Samaha’s practice. “You could really tell the impact it had on our winners. They are both so deserving. “They will both be undergoing tens of thousands of dollars in treatment over the next month or so and are just so excited and appreciative.”

Samaha and her team had specific criteria for the contest winners. When reviewing the candidates, they considered whether the individuals had life-threatening levels of dental disease, or if they had damage severe enough to keep them from sharing a smile with others.

They considered the candidates’ personal economic circumstances. They also took into consideration whether the candidates had devoted their lives to helping others.

Samaha, founder of Port Warwick Dental Arts, prides herself on offering compassionate care resulting in beautiful smiles.

She provides a wide range of esthetic, reconstructive, surgical and comprehensive dental care.

Her practice offers a non-surgical program for periodontal disease treatment that highlights nutrition, specialized testing and state-of-the-art laser therapy.

outs the 3-D scan, I would need to refer the case to an oral surgeon. By just looking, feeling or with a 2-D X-ray of the ridge, there didn’t seem to be enough bone in the area for a successful implant. Besides the bone, on a 2-D pan, her sinuses appeared so big that I didn’t want to chance complications.

I was able to ascertain from the 3-D scan’s cross-sections (Fig. 2) that she had enough bone to place an implant denture. During the surgical procedure, with my intra-oral digital X-ray (DEXIS®), I could check if the implants were properly situated above the sinus level. My mix of imaging options gave me the vital information I needed to complete my treatment plan with confidence.

After imaging, I decided on full-arch implants on teeth Nos. 4, 6, 8, 10, 11 and 14. Because of her diabetes, the implant denture needed to be removable so that she could clean very well around it.

It was very important to the patient that she did not have a prosthesis that looked like a denture. She had all of her natural lower dentition, and we were able to use a combination of shades (A2-A3.5) to maintain a natural appearance.

Trubyte Portrait IPN teeth were used because of their natural shading from gingival to incisal edge. The Locator attachments, like little gaskets, make it easy for the patient to remove her denture for proper hygiene and re-seat it in the right place every time.

After finding out the condition and measurement of her ridge and gums, we decided on six 3.5 Nobel Replace implants of 15 mm in length, I chose the Nobel Guided Surgery protocol (Figs. 3, 4) because I had to be very precise regarding the length of the implant in relationship to her sinus as well as her small amount of bone.

During the surgery, I used my digital X-ray to check the drill lengths and placements very quickly right at chairside (Fig. 5). That’s the beauty of guided surgery and digital radiography — much of the information is determined beforehand, taking away the stressful element of surprise during the procedure (Fig. 6).

Taking into account possible healing issues because of her diabetes and small amount of bone, I didn’t immediately load the denture onto the implants, but instead put on healing caps and let the area heal for a few months.

Dr. Lisa Marie Samaha, center, is pictured with patients Terry Cane, seated at left with framed certificate, and Michael Boyd, seated at right, along with her staff and the patients’ family members.

After healing, the patient toyed with the thought of having the tissue around the implants removed to see if the implants sat more securely. She tried to remove the tissue with only the implant in the mouth but the tissue would not come off so easily. So, we decided to go ahead with the completed implant denture.

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For denture cases, it is important to keep current on new methods and technologies and for patients to understand their options and improve outcome through proper care.

With digital imaging and 3-D technology, I can better educate my patients by pointing out their particular areas of concern on the large computer monitor.

For extra insight, a Web site called www.denturewearers.com offers helpful information and tips for dentists and patients about the various denture-related options, denture care and how different medical conditions such as diabetes, heart disease and oral cancer affect denture choices.

Being apprised of the facts and researching the choices, such as the patient and I did, facilitates treatment acceptance and success.

For this patient, the implant eliminated the palate of the denture, which had caused much of her gagging, speech and soreness problems. Besides functioning very well, her beautiful teeth give her the encouragement to speak with confidence and smile with teeth showing instead of pursed lips (Fig. 7).

Moreover, she has a renewed pleasure in eating because she can utilize the taste buds on her palate again.

Giving patients their smiles back always leaves a really good taste in my mouth too.

Dr. Terry Myers completed his residency in advanced general dentistry and served as an instructor in the Advanced Education Program and director of the faculty practice at the University of Missouri-Kansas City School of Dentistry.

He is a fellow in the Academy of General Dentistry, and a member of the Academy of Cosmetic Dentistry as well as the Dental Sleep Disorder Society.

Myers is on the board of directors at Research Belton Foundation and is a participating provider for the dental care program to improve children’s dental care. His private practice is in Belton, Mo. He can be reached by e-mail at office@keystone-dentistry.com.
You have the freedom to be something better

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— Franklin D. Roosevelt

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What is a laser? How does it work? How long have lasers been in use in dentistry? How do they benefit our patients? How are lasers integrated in dental hygiene? Are there any disadvantages to the use of a dental laser?

These and more were the questions I had when I first became interested in using laser technology. In short, this technology has simplified my dental hygiene day.

I now have more time in my hygiene treatment regime to introduce comprehensive restorative dentistry, granting my clients the dentistry they want and deserve along with the ability to preserve their investment.

What is a laser?

The word laser is an acronym for ‘light amplification by stimulated emission of radiation.’

We can thank Albert Einstein for theorizing that photoelectric amplification could emit a single frequency, or stimulated emission, which explains how a laser operates. Light is a form of energy that exists as a particle, called a photon, and travels in a wave. A photon wave has three basic properties.

Amplitude: The vertical measurement of the height of the wave, from the zero axis to the peak, which describes the energy of that wave. For convenience, energy is measured in millijoules, or thousandths of a joule.

Wavelength: The horizontal distance between any two corresponding points on the wave. In dentistry, we use wavelengths that range between 450 nm and 10,600 nm.

Laser light is distinguished from ordinary light in that it is monochromatic, it can be visible or invisible and each wave is coherent, or identical in physical size and shape. Laser energy is nonionizing radiation.

Lasers were introduced to dentistry in 1969 and are capable of cutting or identical in physical size and shape. Laser energy is nonionizing radiation.

Lasers were introduced to dentistry in 1969 and are capable of cutting or cutting and ablating layers of calcified tissue with minimal thermal effects.

Because of the unique absorption properties, all wavelengths have different penetration depths within the tissues. The erbium and CO2 lasers are absorbed on the surface of the target tissue where the diode and Nd:YAG lasers can reach several thousand microns deep into the tissues.

Lasers in daily practice

With the integration of lasers, I have the ability to achieve a higher level of health for my patients. The first laser I use in my clinic is the 655 nm wavelength laser to detect subgingival and supra-gingival calculus with the laser perio tip attached (Note that the DIAGNODent uses a standard tip for caries detection and a separate tip for periocul caries detection, so two tools, in one, just by changing the tip). Calculus has never been easier to detect, making my clinical calculus time minimal (Fig. 1). My patients leave with less sensitivity, trauma and discomfort.

Secondly, I use my diode laser to reduce the bacteria and pathogens within my client’s sulcus or periodontally infected pocket by simply taking a small optic fiber, almost half the size of a periodontal probe, and shining photonic laser energy into the sulcus.

This is what we do in the laser hygiene community call laser decontamination, or laser bacterial reduction (LBR), which is the reduction of the bacteria and pathogens within the sulcus. I then proceed with the use of ultrasonics and hand instruments for biofilm and calculus removal from the hard tissues, finishing with the use of the diode laser for laser degranulation (curettage), so again entering a diseased periodontal infected pocket with the same optic fiber. I am able to selectively remove granulation tissue produced by infections and inflammatory diseases like periodontitis.

Today hygienists have the ability to simply and selectively remove bacteria living in our clients’ mouths.

Research shows, 96 percent of the germs that are found in the periodontal pocket are pigmented and can thus be selectively destroyed by the laser.

By simply shining photonic laser energy into our clients’ sulcular tissue, we can safely and effectively lower the bacteria in our clients’ sulcus for up to 56 days. Additionally, the light energy through biostimulation can speed up the process of wound healing and similar regenerative processes.

For a finale, I end my client’s appointment with the same 655 nm wavelengths for laser caries detection, again the KaVo DIAGNODent. I can give my clients the necessary information to diagnose decay in our patient’s teeth for a higher gold standard of minimally invasive dentistry. Treating caries at its earliest inception preserves our patients’ natural enamel for their lifetimes.

My newest laser purchase has been the KaVo GENTLEray 980nm Premium. This laser has water irrigation. Water irrigation offers less tissue trauma, along with 12 watts of gentle micro-pulsing energy.

Pulsing allows the tissues to thermally relax and cool before each additional pulse. Each pulse is taking to use gentle water irrigation.

I personally use Closys to irrigate while lasing the tissues, producing an antimicrobial irrigation along with water cooling.

This is the only diode laser of its kind available. I am thoroughly enjoying the healthy rewards this laser has offered my clients.

Having worked with and instructed on diode lasers of wavelengths from 808 nm to 1,064 nm wavelengths over the past eight years, I highly recommend the benefits the 980 nm wavelength has to offer my clients.

This wavelength is also absorbed more readily in water vs. the other diode wavelengths.

Any disadvantages?

A perceived disadvantage of some practices is the initial cost. However, with proper training and laser integration (I consider this to be my specialty), the ROI (return on investment) can be less than three months.

The bottom line

I love working with dental offices throughout the country, assisting them in the integration of laser technology, offering their clients’ this new gold standard in technology.

The offices I have worked with are seeing improved health for their clients. In conjunction, they are seeing their hygiene departments run at a profit.

I highly recommend that if you are going to use laser technology, you seek out education. The Academy of Laser Dentistry (ALD) is an
Are children receiving prompt cleft lip/palate treatment?

The timely repair of orofacial cleft (OFC) can greatly improve a child’s medical and psychosocial well-being. The American Cleft Palate-Craniofacial Association (ACPA) has set forth guidelines for the optimal time by which primary repair surgery should be received, broken down by type of OFC.

A retrospective study, published recently in The Cleft Palate–Craniofacial Journal (Vol. 46, Issue 6, Nov. 2009) was conducted to determine whether children with OFC receive primary repair surgery within the time recommended by these guidelines.

The study, conducted in North Carolina, found that most children in that state are undergoing primary repair surgery by the recommended age. The study involved vital statistics, birth defects registries and Medicaid files for resident children with OFC born between 1995 and 2002.

The many variables analyzed fell into five broad categories: maternal, child and system characteristics, perinatal care region and place of residence.

The findings suggest that most (78.1 percent) North Carolina children with OFC received primary repair surgery by the time recommended by the APCA guidelines.

Percentages varied among cleft lip (about 90 percent), cleft palate (58 percent) and cleft lip and palate (89.6 percent). According to the authors of the study, “Children whose mothers received maternity care coordination, received prenatal care at a local health department, or lived in the southeastern or northeastern region of the state were more likely to receive timely cleft surgery.”

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Results: 406 children in North Carolina with OFC were continuously enrolled in Medicaid during the first two years of life. Overall, 78.1 percent of children had surgery within 18 months. About 90 percent of children with cleft lip (CL), 58 percent of children with cleft palate (CP), and 89.6 percent of children with cleft lip and palate (CLP) received timely cleft surgery; the mean age at which surgery occurred was 5 months. Children whose mothers received maternity care coordination, received prenatal care at a local health department, or lived in the southeastern or northeastern region of the state were more likely to receive timely cleft surgery.”

The populations least likely to receive the surgery in a timely manner were African-American/non-Hispanic and those in the southwestern region of the state. This is most likely due to the distance to the craniofacial center and the services provided by the different centers.


References

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