Greater New York Dental Meeting or bust!

By Robin Goodman
Group Editor

Get ready to sink your teeth into the Big Apple in a way that only the Greater New York Dental Meeting can provide. With a myriad of new programs on and off the exhibit floor as well as seminars and workshops, you’ll want to plan your time carefully. Here is a taste of what awaits you.

Witness “Live Dentistry” on the exhibition floor where you can watch procedures that showcase the latest in dental technologies and materials. Also on the exhibit floor, in glass-enclosed areas, you can attend workshops that will present a broad spectrum of up-to-date, hands-on procedures. You can even earn one hour of C.E. credit for walking the expanded exhibition floor, home to more than 1,500 booths overflowing with information and demonstrations on the latest innovations in dentistry.

Also new to the conference this year, Invisalign will host its first national conference. The first annual Greater New York Dental Meeting & Invisalign Expo, featuring eight different programs for the entire dental team. On Nov. 30, there is also the Laboratory Technicians Extravaganza, hosted by Zahn Dental and the Greater New York Dental Meeting. Finally, you won’t want to miss the first annual Dental Tribune Symposium, hosted by Excel Quantronix, which has two separate lasers in one unit: a holmium and neodymium laser. I still have this unit in my office and use it as a backup laser to my newer ones. Lasers can be used by themselves or as an adjunct tool as they are versatile and precise. A simple diode laser can be used to disinfect tooth structure, in crown lengthening, frenectomy, biopsy, periodontal disease and gingival sculpting, etc.

There are lasers like the Perio-lase MVP-7, which are specifically built around a patented soft-tissue technique for periodontalitis — laser assisted new attachment procedure (LANAP). There are hard-tissue (modifies lasers) as well as soft-tissue (modifies lasers) and there are lasers available today that combine both a soft and hard tissue laser in one unit. It all depends on the practice one has, or the one that you want to develop. Bottom line is that you cannot consider yourself a dentist on the cutting edge if you do not have and use a laser as part of your daily regimen regardless of what type of dentistry you practice.

Are you a ‘cutting edge dentist’?

By Robin Goodman
Group Editor

Dr. Martha Cortes, current president of the American Academy of Cosmetic Dentistry New York Chapter and former co-chair of dentistry with the American Society for Laser Medicine and Surgery, took some time to talk about lasers with Dental Tribune.

What is the state of lasers in dentistry today? Dental lasers are state-of-the-art technologies. Every dentist should own one and use it as an integral part of his or her practice, especially as they are much more affordable than they were 15 years ago when I got my first laser; I had the the Duopulse by Excel Quantronix, which has two separate lasers in one unit: a holmium and neodymium laser. I still have this unit in my office and use it as a backup laser to my newer ones. Lasers can be used by themselves or as an adjunct tool as they are versatile and precise. A simple diode laser can be used to disinfect tooth structure, in crown lengthening, frenectomy, biopsy, periodontal disease and gingival sculpting, etc.

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How about lasers and soft tissue such as gum and pulp? I have developed a direct pulp capping technique involving a laser and the immediate placement of a porcelain restoration [CEREC], which has a great success rate as the laser can reach places that antisepsics and antimicrobials cannot reach because of their shallow penetration.
Don’t miss Randy Donahoo’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting at 1:30–2:30 p.m. on Dec. 2.

This course will provide you with an opportunity to see for yourself how the benefits of “heads-up” dentistry can enhance your practice. Experience firsthand the Dental Procedure Scope, a life-changing device that provides increased magnification, superior lighting and more than 4 pm. The Nd:YAG laser device.

The lecture will provide an overview of how Dental Procedure Scopes work, their capabilities and the ease of which they can be incorporated into your daily routine. Learn how they can enhance your practice and put the fun back into dentistry. It’s just a wonderful way to spend your day!

Enhancing your dentistry: Get out of dentistry alive!

Dr. Patel will share a practical perspective of cone beam technology and its multiple uses in “real world” private practice. He will shed light on what the future has to offer and give insight into the impact CBCT technology can have from a business standpoint — return on investment (ROI)!

By the end of the presentation, attendees should:

➢ Understand how 3-D technology can benefit the modern dental practice.

➢ Learn how state-of-the-art 3-D digital dentistry is being done today.

➢ Acquire the tools for implementing 3-D X-ray imaging and software in their practice.

Dr. Patel’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting at 3–4 p.m. on Dec. 1.

Topics to be discussed include the following: caries management by risk assessment; current concepts in endodontology; minimally invasive endodontics; bonded fiber posts; dental lasers; minimally invasive periodontics; current advances in tooth whitening; bonding agents; separating the truth from the hype; and much more. This program will introduce concepts that will change the way you practice forever.

Don’t miss Dr. Jesse’s and Dr. Kaminer’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting at 3–4 p.m. on Dec. 1.

Using 3-D X-ray imaging and planning to increase patient treatment acceptance.

Catch Dr. Patel’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting at 3–4 p.m. on Dec. 1.

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 veut accéder à des colonies bactériennes [biofilms]. Lasers peuvent être utilisés sur le tissu diffusant du fléau à cause de la position correcte et des lasers à droite.

Nd:YAG’s et diodes sont devenus de plus en plus utilisés dans le traitement des bactéries, même si la broche de l’ Nd:YAG, comme le laser, est bien, peut accéder à des zones plus profondes et a une potentialité plus grande de zone degré de thermique distante dans les mains; il ne doit pas être utilisé sur des couches plus profondes de 12 mm. Those interested in the Nd:YAG pour le traitement du cancer qui doivent vraiment regarder le laser dans l’endodontie 3-D de Millennium Dental Technologies comme il est utilisé pour l’instruction/formation dans le laser et LANAP technique.

And for lasers and hard tissue such as tooth and bone?

Erubium lasers are great for disinfection of tooth and for osseous surgery, as they are specifically made for disinfecting and cutting hard tissue. They are also ideal for preparing class I and class V restorations and removal of defective composite materials; however, they cannot be used on metal or porcelains, as these cannot be cut by a laser.

Metals and porcelains must first be removed using the drill; however, once they are removed the laser can be used directly to remove any underlying caries. If the caries are very deep, the erbium laser can be used in a direct/indirect pulp-capping technique with the immediate placement of a CEREC 3-D porcelain restoration. An erbium laser like the Waterlase MD by Biolase can also be used in the direct treatment of root canals as it has laser endodontic tips that are used for post instrumentation for cleaning and disinfecting the canal.

What are your thoughts on a connection between heart disease and periodontal disease?

I love it when patients tell me that they are fit and in good shape except, of course, for the severe gum disease they have. Unfortunately, we have grown up with faulty medical/dental health models that describe the body as distinct and disconnected units, and this shows up in how we view disease and the body. Severe infection in the body is dangerous as it can spread, especially to vulnerable organs.

Periodontitis is a bi-directional manifestation of disease. It can be seen as a manifestation of systemic disease such as diabetes, cutaneous disease, joint disease and osteoporosis. It can also be seen separately from systemic ones as its own complete disease with the great potential of releasing bacterial emboli into the blood system that can travel to the heart, lungs and other major organs. It has been linked to cardiovascular disease since the late 1990s and rightly so, as oral bacteria are not contained but spread and are particularly dangerous for heart patients who are vulnerable to endocarditis, especially before open-heart surgery.

An Nd:YAG laser can reduce microbial colonies that inhabit periodontal pockets by 97 to 100 percent, as the laser is precise, site specific and does not rely on secondary or tertiary effects to kill microbes. It destroys microbes and their colonies on contact without any side effects.

Editor’s Note: Please see Cosmetic Tribune in this edition for a clinical article by Dr. Cortes and her contact information.

“The article is titled, “High-Tech Pulp Capping Using Laser and CAD/CAM, Dental Economics,” and was published by PennWell.
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Endodontic irrigation via EndoVac: safety, efficacy and clinical techniques

Don't miss Dr. Schoeffel’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting at 1:30–2:30 p.m. on Nov. 30.

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:

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

High-resolution cone beam with PreXion 3-D

Don’t miss Dr. McEown’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting at 3–4 p.m. on Nov. 30.

Cone beam computed tomography (CBCT) offers a whole new paradigm to dental radiography. From what were conventional 2-D images, dentists now have the ability to look at the maxillofacial region in any direction, and at any thickness, as well as in 5-D. With the introduction of CBCT the specialist and general dentist alike can now afford to own and enjoy the benefits of this fantastic diagnostic tool. This symposium will cover the basics of CBCT, field of view (FOV), focal spot, flat panel types, processing time and gray scale, and how these affect resolution and image quality. PreXion 5-D high resolution images will be discussed and time spent with real scans showing how these images can be used in planning periodontal treatment, implants, oral surgery, complex endodontic diagnosis, and treatment planning for the general dentist.

CEREC 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 at 10 a.m.–1 p.m. on Nov. 30.

CAD/CAM technology has revolutionized the practice of dentistry with enormous implications for the delivery of patient care that is timely, comfortable, long lasting, beautiful and economical. This presentation is designed to provide not only an overview of the role of CAD/CAM and CEREC in clinical dentistry today, but also provide attendees with practical clinical information on how CEREC literally transforms the practice of restorative dentistry. Numerous clinical cases will be provided along with a thorough discussion of case selection, fabrication and design, delivery and finish. Attendees will leave with a thorough understanding of the clinical application and use of CEREC CAD/CAM technology in achieving outstanding results.

Successful treatment strategies for anterior total tooth replacement in the thin scalloped periodontal architecture: the ankylos tissue care concept for long-term success

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

This lecture will provide a systemic, biologic and evidence-based approach to ensure success in the class 1 to class 4 case utilizing the “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 grafting (PRGF), overcorrection, site preparation, and 5-D implant placement.
- Prosthetic management: abutment selection, provisionalization, restorative materials and methods.

Bone preservation: one of the keys to esthetic success in immediate implant therapy

Don’t miss Dr. Levin’s lecture at the Dental Tribune Symposium during the Greater N.Y. Dental Meeting at 3–4 p.m. on Dec. 2.

Clinicians and researchers have developed recommendations regarding implant positioning, dimensions and numbers, but the area of surgical technique and instrumentation to preserve native bone has been under emphasized. Instrumentation designed to remove teeth without damaging or eliminating pre-existing native tissue is mandatory. The era of using large cumbersome elevators and forceps is dwindling. Surgeons must now appreciate the importance of preserving surrounding bone and maintenance of soft tissue and understand the necessity of modern instruments designed to facilitate, if not enable, esthetically pleasing implant results. The advent of Periotomes, X-Trac forceps and now X-otomes by A. Titan Instruments has simplified these procedures. The presentation will demonstrate the role of these instruments in immediate implant surgery.

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

For more information and registration, please contact Julia Wehkamp: j.wehkamp@dtamerica.com.
Do you value your care?

By Sally McKenzie, CMG

H ave you ever heard of Fritz Knipschildt? I've never met him, but I think I'd like to, for a few reasons. First, Knipschildt is a Connecticut-based chocolatier. Now, mind you, this guy is no ordinary candy maker. No sir. A one pound box of his confections will fetch $2,600. Yes, you read that correctly, two-thousand, six-hundred dollars.

Do you suppose that Knipschildt loses sleep over how much he charges for his award-winning decadent delights? I would guess that he feels quite confident in his fees given his credentials, the time, care and ingredients that must go into each “truly exquisite chocolate experience” as they are described on his Web site. Whenever I come across a story about someone like Knipschildt, I’m always struck by the irony. This gentleman is not afraid to place a significant value on the few minutes of pleasure that he provides in each of his creations. Yet many dentists who provide a lifetime of care and concern for their patients suffer immeasurably whenever they must stand toe-to-toe with a $4 fee increase.

They fret and they worry and they hem and they haw. How will the patients react? Will they balk? Will they leave and never come back? Will they complain about me to their friends, neighbors and random people they meet on the street?

Economic boom or bust, it seems that dentists are always reticent to do anything that might call attention to the issue of m-o-n-e-y. Certainly, where you set your fees is a personal decision, yes, but your business depends on it. Whether you increase your fees, lower them or keep them firmly planted where they are, there are a few steps you want to take to ensure that you are making a carefully reasoned decision, rather than simply reacting to what you perceive to be the current public sentiment.

Keep up with the Joneses

Many dentists will arbitrarily establish their fees without ever checking out what Dr. Jones, Dr. Smith or any of their dental neighbors are charging. Study dental fees in your area and find out where yours stand in comparison. Information on dental fees is available online and through your local dental society. Income and demographic information, which can be extremely helpful in establishing fees, is available through the local chamber of commerce as well as through private companies, such as Scott McDonald and Associates. In addition, a variety of surveys and reports regarding the costs associated with running a dental practice are available through the American Dental Association.

Consider the message your fees send to current and prospective patients. If yours are the lowest in the area, you may be setting yourself up to be a magnet for price shoppers. Similarly, if your fees are the highest, consider if your services are on par with the rates charged. Perhaps you do indeed offer a patient experience and a level of dental care and expertise that warrants the higher rate. Or perhaps you prefer to work with a smaller patient base. That is fine, but you still need some understanding of how your fees compare to the competition.

Make logic, not fear, your guide

Many dentists have not increased their fees in a very long time and have no system for doing so. Consequently, these dentists have trapped themselves in a financial quagmire, many charging only in the 50 th to 60 th percentile for their areas. Undercharging patients by as little as 7 or 8 percent each year translates into thousands of dollars lost to the practice. Undercharging by 40 to 50 percent translates into a serious financial pounding.

The dentist down the street may be charging in the 90th percentile and may be thriving, but many dentists convince themselves that they simply couldn’t charge that because patients will leave or the dentist feels guilty for increasing fees. Or the dentist doesn’t believe that his/her level of care is really worth that price. Yet ours is a culture in which people associate quality with cost. And, like it or not, cheap is often equated with low quality. Certainly, if you’re charging in the 60th percentile today, you don’t want to jump to the 90th percentile next week, but you do need to develop a plan to gradually increase fees over time.

Fee adjustments are simply nec-
See DO YOU, Page 7

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This 27-year-old female was unhappy with the spaces between her teeth. Cases with multiple diastema lend themselves to no-prep cases. In the after pictures, you can see the improvement in shape and size of the teeth. In addition, when viewed from the occlusal, you can see that no-prep veneers do not necessarily have to be bulky in the facial aspect.

Clinical evaluation by Dr. Gaviglio, DDS, FAGD. Fabrication by Glidewell Laboratories.

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sary part of running a high-quality dental practice, which leads me to another question that you need to ask yourself. Are you compromising quality for low fees? Do you continue to forego necessary investments in staff training? Do you bypass updat-ed equipment and more efficient systems because you fear you can’t afford any more than the status quo? Are you compromising your own continuing education opportunities because of the impact on the bud-get? If so, this commitment to being cheap is costing you a fortune in lost opportunity, higher production qual-ity and staff efficiency.

Develop a fee schedule

I don’t need to tell you that the cost of running a dental practice increas-es by an average of about 5% each year. The increases are likely on a record pace. Establishing a sound fee schedule allows you to be fair to your practice and improve care to your patients. Lean years may still be lean, but their impact will be lessened because you will have kept pace with the cost of doing business.

There should be a standard fee for each service. Determine these by evaluating the time required for each procedure, the fixed expenses necessary to run the office, variable expenses including supplies and lab fees, and income required per hour to compensate you, the dentist.

In terms of expenses, they should line up according to the following benchmarks: laboratory expenses, 10%; dental supplies, 5%; tax, 5%; employees’ salaries, 19–22%; payroll taxes and benefits, 5–50%. Identify specific production goals based on the number of days per week you will see patients and the number of hours you will spend on treatment. (More on that in a moment.)

Establish a solid fee for each service and plan to adjust your fees twice a year, 2% then 5% for an annual increase of 5%. Even if you increase your fees only slightly — $4 to $5 per procedure — that will make a huge difference in your bottom line.

Revisit your vision and goals

Step back and take a look at what you want to get out of your career now and in the future. Perhaps you want to save for retirement. Maybe you really want to work fewer hours to spend more time with your family. Perhaps it’s your dream to create a truly state-of-the-art practice.

No matter what your personal/professional desires, they do have a price tag attached. The key is to determine how much your practice needs to produce to enable you to not only to keep the lights on and the staff paid, but to achieve your vision and goals as well. That’s where produc-tion per hour goals come in. Let me explain.

By way of example, let’s say your goal is to break the million dollar mark for practice production, including hygiene. If you take 53 percent out for hygiene, that puts your share of the goal at $670,970. This calcu-lates to about $15,958 per week (taking four weeks out for vacation). Working 32 hours per week means that you will need to produce about $456 per hour.

A crown charged out at $990, which takes two appointments for a total of two hours, exceeds the per hour production goal by $59. It’s unlikely that you re-doing crowns every hour on the hour, but this sur-plus revenue could be applied to any shortfall caused by smaller ticket procedures.

Use the formula below to deter-mine the rate of hourly production, and whether you’re meeting your own personal production objectives.

1. The assistant logs the amount of time it takes to perform specific procedures. If the procedure takes the doctor three appointments, she/ he should record the time needed for all three appointments.

2. Record the total fee for the procedure.

3. Determine the procedure value per hourly goal. Take the cost of the procedure, for example $215, divide it by the total time to perform the procedure, 50 minutes. Take the production per minute value of $4.30, and multiply that by 60 min-utes to get $258/hour.

4. The amount must equal or exceed the identified goal.

Now you can identify tasks that can be delegated and opportunities for training that will maximize the assistant’s functions. You also should be able to see more clearly how set up and tasks can be made more effi-cient. And you’ll be well on your way to achieving your own production goals, whatever those may be.

Finally, as you consider the various steps and suggestions I’ve offered in this article, you might want to mulit it all over a nice glass of wine, perhaps a bottle of 1787 Château Lafite — that is, if you can get your hands on one. One such bottle sold at Christie’s London in Decem-ber 1985 for a mere $160,000. Said to have been from the cellar of Thomas Jefferson, our third president, it was recorded to be the most expensive bottle of wine ever sold.

Certainly, some of you will shake your heads in disbelief at such seem-ingly outrageous sums for consum-ables. But I can promise you that the person who purchased that bottle had great appreciation for the value of his/her investment. My point is that dentists commonly undervalue the care and treatment they provide. Often times the biggest barrier in establishing appropriate fees is not the patients, it’s the dentists who sell themselves and their care short time and again.

About the author

Sally McKenzie, Certified Man-agement Consultant, is a nation-ally known lecturer and author. She is CEO of McKenzie Manage-ment, which provides highly suc-cesful and proven management services to dentistry, and has since 1980. McKenzie Management offers a full line of educational and management products, which are available on its Web site, www. mckenziemgmt.com. In addition, the company offers a vast array of Practice Enrichment Programs and team training. McKenzie is the editor of the e-Management news-letter and The Dentist’s Network newsletter sent complimentary to practices nationwide. To subscribe visit www.mckenziemgmt.com and www.thedentistsnetwork.net. McKen-nie welcomes specific practice ques-tions and can be reached toll free at (877) 777-6151 or at sally- mck@mckenziemgmt.com.
Smiling toward peace

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

Dentists are contributing a massive effort to achieving peace in the Middle East. Ironically, the movement by our colleagues is called “Bridges to Peace.” Led by Dr. D. Walter Cohen, dean emeritus of the University of Pennsylvania School of Dental Medicine and chancellor emeritus of Drexel University College of Medicine, dentists are learning to improve the quality of life for the world’s populous.

The D. Walter Cohen Middle East Center for Dental Education, in collaboration with Henry Schein Cares, the global and socially responsible program of Henry Schein Inc., has launched a pioneering Israeli-Palestinian partnership between Israel’s premier dental school, Hebrew University, and the newly established Faculty of Dental Medicine at Al-Quds Dental University in East Jerusalem.

This partnership is creating forums for dialogue between dental professionals of different backgrounds, faiths and cultures to produce dental professionals skilled in modern dentistry techniques. Students from these schools are sharing classes and reporting information learned on the academic and clinical aspects of our profession. Henry Schein Cares is providing cutting-edge equipment and supplies to train these Israeli and Palestinian dental professionals to assure quality dental care.

Six recipients from this partnership were just awarded the prestigious Tree of Peace award. Stanley Bergman, CEO of Henry Schein Inc., speaking on behalf of the six honorees, after receiving the statuette of the Tree of Peace at the Pierre Hotel in New York City, reaffirmed his commitment to the role of dental medicine in building “bridges to peace.” I personally would like to emphasize two of these recipients. Professor Musa Bajali, dean of Al-Quds Dental School, and Professor Adam Stabholz, dean of the Hebrew University School of Dental Medicine, who deserve special recognition. Using ratiocination they — aided by the efforts of Dr. D. Walter Cohen — helped forge a leap toward global quality dental care.

Dr. A. Finkelstein, while presenting a large sculpture, the Tree of Peace, summarized the hopes of all involved when he sagely prophesized, “Perhaps this tree will grow into a forest. Through this great healing science we will teach the world that we can live in peace in the Middle East and throughout the world.”

As dentists show the world that by working together we can forge bridges to peace, I personally am very proud of my profession.

About the author

Dr. David L. Hoexter (BA, DMD, FACD, FADFE, FICD) is director of the International Academy for Dental Facial Esthetics, an organization that combines physicians and dentists with other related fields in research and relates its finding to clinical practice. He is also clinical professor in periodontics at Temple University, Philadelphia, Pennsylvania.

He was previously clinical professor in periodontics at the University of Pittsburgh. He received his degree from Tufts University, where he was an adjunct professor in periodontics. He is also a Diplomate of Implantology in the International Congress of Oral Implantologists as well as the American Society of Osseointegration, and a Diplomate of the American Board of Aesthetic Dentistry.

Dr. Hoexter lectures throughout the world and has published nationally and internationally. He has been awarded 11 fellowships including FACD, FICD and Pierre Fauchard. He maintains a practice at 654 Madison Ave., New York City, limited to periodontics, implantology and esthetic surgery. He can be reached at (212) 555-0004 or dr-davidlh@aol.com.
Inspiration is what drives us to do incredible things. Inspiration drove people like Michelangelo to paint the Sistine Chapel, Thomas Edison to invent the light bulb and Ludwig van Beethoven to write his Fifth Symphony. Just as these revolutionary thinkers were inspired to bring something great into the world, Henry Schein Practice Solutions sought inspiration, and found it in our customers. With more than 170 user-requested features built in, DENTRIX G4 is the proven solution to making practices successful. Save time, save money and accomplish more with the practice management software that was inspired by you.

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Enamel & Dentin Thermocycling

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Crown Retention to Tooth Surface

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<th>Maxcem Elite</th>
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*Internal and/or independent testing data on file.
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Align Technology and Greater New York Dental Meeting create first Educational Expo at the 2008 Greater New York Dental Meeting

Invisalign® is a revolutionary concept in orthodontic treatment that has taken the country by storm. As of the second quarter of 2008, more than 800,000 patients have completed or are currently in treatment. Invisalign courses have always been immensely popular at the Greater New York Dental Meeting. So when Align Technology decided to hold its first national Invisalign Educational Expo during a dental meeting, they naturally decided to do so during the Greater New York Dental Meeting.

Invisalign is a series of clear, removable teeth aligners that both orthodontists and dentists use as an alternative to traditional metal dental braces. The Invisalign treatment program consists of a series of aligners that are switched out about every two weeks. Each aligner is individually manufactured to exact calculations in order to gradually shift teeth into place. Invisalign is the best way to transform a smile without interfering with a patient’s day-to-day life.

The Greater New York Dental Meeting offers more Invisalign programs than any other dental meeting in the world. During the 2008 meeting they will feature four full days of Invisalign programming, including: Invisalign Clear Essentials I and II; Invisalign Technique and Technology; Integrating Invisalign into the Hygiene Practice; Maximizing the Dental Assistant’s Role in Invisalign; and An Afternoon with the Invisalign Experts. With such a diverse array of educational programs offered, there is something for the entire dental team. All courses will be taught by Invisalign experts, and will take place in the Invisalign Pavilion located on the exhibit floor of the Jacob K. Javits Center in New York City.

The Greater New York Dental Meeting is proud to be an integral part of Invisalign’s first national educational expo, and looks forward to many more years of successful Invisalign conferences. “We have always had a very positive reaction to these programs at the Greater New York Dental Meeting. And with the awareness of Invisalign growing so rapidly, we know this first national conference will be a huge success,” said Executive Director of the Greater New York Dental Meeting Dr. Robert Edwab. “We feel very fortunate that Dr. Edwab and the Greater New York Dental Meeting team embraced the idea, and that they are constructing an Invisalign Educational Pavilion on the exhibit floor,” said Dr. Lou Shuman, vice president of clinical strategic relations at Align Technology. “For years, the Greater New York Dental Meeting has consistently sold out all of our courses. This year, we look forward to providing its membership with a larger array of sessions than ever before, each presented by a leading authority on Invisalign.

The Greater New York Dental Meeting is confident that the conference will be very well attended. In fact, the only real “problem” they anticipate is that these courses are going to be too popular. Seating is limited and is on a first-come, first-served basis, so it is recommended that attendees register early to avoid disappointment.

The first Invisalign Greater New York Educational Expo will run Nov. 50 to Dec. 3, 2008. Come be a part of the excitement and experience all that New York has to offer! Pre-register yourself, your staff and your family at no charge. Registration is currently available on the Greater New York Dental Meeting’s Web site, www.gnydm.com. Click on “Courses and Events 2008” and type in “Invisalign” to obtain more information on specific courses or speakers who will be featured during the 2008 Invisalign conference during the Greater New York Dental Meeting.

For additional information please contact the Greater New York Dental Meeting at 570 Seventh Ave., Suite 800, New York, N.Y., 10018-1806; Tel. (212) 598-6922; Fax (212) 598-6934; Web site www.gnydm.com; e-mail address: info@gnydm.com.

Supporting Comments for the New Extraction Forceps

I have never looked forward to doing extractions in my practice. It can take just a few minutes or more than half an hour if I hear that dreaded ‘cracking’ sound indicating I have broken a crown or a root. Since using the Physics Forceps that sound is a thing of the past. These new forceps don’t rely on brute force, but rather, use the simple concept of leverage. Instead of grasping, pushing, twisting and pulling the clinical crown, this technique employs a slow, steady rotational force that literally rolls the tooth free from the PDL. Seldom do new innovations come along that truly revolutionize the way a dentist approaches a service – this is one!

Faster, easier and better - these are the three magic attributes that I look for whenever I evaluate new products. The GoldenMisch Physics Forceps are by far one of the greatest advancements I have seen in endodontia in my 28 year career. Using these unique instruments greatly reduces buccal bone loss during the extraction, making implant support and esthetic success much more predictable. The amount of time, effort and frustration saved is incredible, especially with challenging teeth. The Physics Forceps are an absolute must for every dental practice and I highly recommend them in my lectures.
Orthodontic specialty programs featured at the 2008 Greater New York Dental Meeting

The Greater New York Dental Meeting has assembled two exceptional panels of world-renowned speakers whose presentations will update attendees on the latest trends and techniques, and who will answer questions regarding some of the most controversial topics in orthodontics. These unique programs will run all day on Tuesday, Dec. 2, 2008 and Wednesday, Dec. 3, 2008 from 9 a.m.–4:30 p.m.

Tuesday’s program is titled International Symposium on Advances in Orthodontics. This seminar will provide brief exposure to some exciting new technologies that will change the efficiency and effectiveness of contemporary orthodontic treatment. Participants will learn how to maximize esthetic results in the clinical practice of orthodontics. Topics covered on Tuesday will include: The Importance of Maxillary Prominence in Orthodontic Treatment to Create Facial Harmony and Facial Aesthetics; Long-Term Longitudinal Evaluation; Technologic Leaps into the 21st Century Aesthetic Orthodontic Practice; The Use of Temporary Anchorage Devices in Efficiently Obtaining Maximal Aesthetic Orthodontic Results; and The Right Force Orthodontic Sensor System.

The program clinicians include: Drs. Michael Arvystas, Jean Pierre Joho, John Lolise, Anthony Maganzini and Robert Sears.

Wednesday’s program is titled Current Concepts to Improve Clinical Outcomes — Learn Them Today, Use Them Tomorrow. Topics covered will include: When Does a Non-Extraction Orthodontist Extract; Evidence-Based Analysis of Current Controversies; Avoiding Orthodontic Errors and Management of These Errors and The Use of Temporary Skeletal Anchorage in Orthodontics; Drs. Anthony Gianelly, R.G. “Wick” Alexander, P. Lionel Sadowsky and Jack Fisher will serve as the featured clinicians. This program is presented by an affiliation with the New York University College of Dentistry, Department of Orthodontics and Orthodontic Alumni Association.

These orthodontic specialty seminars are recommended for orthodontists, general dentists, orthodontic students and orthodontic post-graduate students interested in learning more about current topics in orthodontics. Registration for these courses is currently available on the Greater New York Dental Meeting’s Web site, www.gnydm.com. Click on “Courses and Events 2008” and scroll down to “Orthodontics” to view course synopses and to obtain additional information on specific orthodontic speakers featured at the 2008 Greater New York Dental Meeting.

The Greater New York Dental Meeting is the largest and most highly attended dental meeting in the United States. Figures from 2007 showed some 55,687 registered attendees, which included 16,602 dentists and 4,115 international registrants from 115 countries. Attendance is expected to increase significantly at the 2008 meeting where programs are available for dentists, students and the entire dental team. And remember, there is never a pre-registration fee for attending the Greater New York Dental Meeting.
Caries is a chronic infectious disease affecting both children and adults worldwide. Research within the last decade suggests that caries be treated as a preventable disease with emphasis placed on early detection and minimally invasive intervention to preserve healthy tooth structure.

The advent of fluoridation has caused caries to retreat “underground,” making fissure caries more challenging to diagnose. The “watch and wait” philosophy is not effective, because often enough the decision to treat the tooth is decided after the caries process had been well established. Subsurface decay may then progress to the point of extensive excavation and loss of valuable tooth structure.

Traditional caries detection modes, visual, tactile and radiographic techniques, are quantitative, subject to operator interpretation and can produce varied diagnoses. Treatment and prevention of dental caries requires new strategies by the dental team. The adjunctive use of laser fluorescence by DIAGNOdent® raises early caries diagnosis beyond 90 percent.

What is laser fluorescence and how does it work?

Laser fluorescence is the use of visible light dispersed according to its wavelength. Fluorescence occurs as a result of light absorption when electromagnetic radiation comes in contact with tooth structure. When compared with healthy enamel and dentin, fluorescence increases in the presence of caries because lesions that contain cariogenic bacteria show significantly higher fluorescence than those without. Fluorescence is produced when bacterial complexes known as porphyrins are activated by red light.

What is DIAGNOdent and how does it quantify carious lesions?

DIAGNOdent (KaVo, Lake Zurich, Ill.) became available in 2001 allowing clinicians another clinical option for detection of carious lesions including Class I, II, V, and secondary decay existing at amalgam margins and around certain types of sealant materials. The DIAGNOdent is based on the laser fluorescence principle and emitted light is proportional to the scale of the carious lesion, allowing DIAGNOdent to indicate the severity of the lesion.

It operates at a wavelength of 655 nm. At this particular wavelength, clean healthy tooth structure exhibits little or no fluorescence, and results in very low display readings.

The DIAGNOdent handheld devices (tabletop and pen versions) emit the laser light and can specify the location and extent of the lesion in tooth structure. As the laser light is emitted on the tooth, the two-way handpiece optics permits the electronic unit to simultaneously quantify the reflected laser light energy. This degree of fluorescence is expressed in a numerical value (0–99) and displayed on the digital screen. An audible tone is emitted from the unit allowing the operator to hear changes in the scale values on the display.

Are there any false positive readings when using the DIAGNOdent?

When used properly, DIAGNOdent is over 90 percent accurate. The device has a high degree of sensitivity, making false positives very uncommon. However, false positives may arise when the operator fails to completely remove stain or debris. To ensure this does not occur on patients with heavy stain such as tobacco or coffee stain, pit and fissures should be treated with an air polisher such as the PROPHYflex® and rinsed thoroughly.

When do you recommend using the DIAGNOdent?

It is recommended that DIAGNOdent be used as an adjunct before placing fissure sealants. It can help identify asymptomatic caries when done properly.

What is the Whole Kit and Caboodle?

The Whole Kit and Caboodle is on display at www.photomed.net - 24/7

Canon

The whole kit and caboodle, Everything, and all of it! That describe: PhotoMed. We’ve got everything you need for clinical dental photography. The full digital camera systems feature the best digital camera equipment available. Shown above are the PhotoMed/Canon G10 and the Canon 50D. We also feature clinical systems built around Canon’s Rebel XS, Rebel XSi, EOS 40D and (soon) the SD Mark II. Go to photomed.net for full info on each of these cameras.

We know that no one likes to spend time reading thick user manuals so your camera is delivered assembled, set and tested along with our concise custom instructions. And we include unlimited phone support and loan equipment if needed.

PhotoMed carries all of the accessories you may need: intraoral mirrors, retractors, contrasters, printers, clinical photography books/training CDs (Dr. Chris Or’s new interactive dental photography CD is a great way to train your staff) and recreational lenses from Sigma (the new 18-200 DC OS lens is a nice choice). Visit our website. Give us a call. Come see us at a dental meeting (there’s a complete list of upcoming meetings at: www.photomed.net). We know you’ll like us.

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Caries
From Page 13

will allow for higher potential for sealant success, ensuring that the bonding agent will adhere. Other recommended uses include new patient exams as well as mapping the direction of decay on patients of record, allowing for higher ease acceptance. DIAGNODent can improve the accuracy during caries excavation in conservative preparations where the access allows the tip to reach the floor of the cavity, alerting the operator if decay is still present. Is DIAGNODent able to detect calculus? Yes, DIAGNODent is capable of detecting calculus. Used in conjunction with DIAGNODent laser fluorescence detection technology, the DIAGNODent Perio Probe tip was designed to detect calculus concretions in periodontal pockets up to 9 mm deep. Calculus fluoresces differently than healthy tooth structure; therefore, the probe detects the difference and sends a signal to the digital display while simultaneously emitting an audible tone to the operator, identifying calculus. The probe tip used in conjunction with standard root planing and scaling allows the clinician to preserve tooth structure and reduce operator fatigue. Caries detection is more challenging due to fluoridation and remineralization agents. Conventional methods of caries detection are limiting, causing caries to go undetected much of the time until the lesion has reached an advanced stage. The adjunctive use of DIAGNODent during examination raises diagnostic accuracy beyond 90 percent, allowing subsurface caries to become a historic phase. The quick, easy and safe use of DIAGNODent allows for early and accurate diagnosis of caries, enabling successful prevention and minimal restorative intervention. References

About the author

Donna L. Catapano, RDH, BS, MA, is a dental hygiene graduate from Farmingdale State College in New York and joined their faculty as an adjunct clinical instructor in 2002. Prior to 2002, she worked as an adjunct clinical and laboratory instructor as well as an adjunct lecturer at New York University College of Dentistry. Catapano holds a master’s degree from Hofstra University, where her research focused on the oral-systemic link between gingival inflammation and cardiovascular disease. Another area of research throughout her experience includes forensic odontology. She currently practices clinical dental hygiene full-time in private practice and intends to pursue a doctorate degree in science.

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About the author

Donna L. Catapano, RDH, BS, MA, is a dental hygiene graduate from Farmingdale State College in New York and joined their faculty as an adjunct clinical instructor in 2002. Prior to 2002, she worked as an adjunct clinical and laboratory instructor as well as an adjunct lecturer at New York University College of Dentistry. Catapano holds a master’s degree from Hofstra University, where her research focused on the oral-systemic link between gingival inflammation and cardiovascular disease. Another area of research throughout her experience includes forensic odontology. She currently practices clinical dental hygiene full-time in private practice and intends to pursue a doctorate degree in science.
VELscope photography

By Martin B. Goldstein, DMD

Those of you who purchased LED Dental’s VELscope may have discovered that while it appears to be a very useful tool for assisting in early oral cancer detection, documentation of your findings requires a bit of photo wizardry. Fortunately, a number of photo equipment vendors have taken note of the VELscope and now provide several approaches to capturing the oral cavity through the lens of this diagnostic tool.

It’s worth noting that LED Dental now ships a set of Doctorseyes adapters with its new Vantage VELscope that allow for easy mating with today’s popular SLR cameras. If you’ve a previous model VELscope, this set can be had directly from Mr. Larry Blosser at (800) 200-5394 (www.jlblosser.com). This kit provides an assortment of adapters and a rudimentary list of camera setting recommendations. A certain amount of experimentation will allow you to dial in the settings that are right for your camera.

PhotoMed International offers a somewhat different approach. Their VELscope Photography Kit, which is ordered camera specific, includes not only the coupler, but a simple software application that allows the user to brighten the images for better viewing. (Please note: For an SLR to be appropriate for VELscope photography, it requires an ISO capability of 1600 or higher. Check your camera’s specs!) For more detail on the PhotoMed kit, please visit www.photomed.net and check under “accessories.”

For those who do not own an SLR camera and choose not to do so at this time, an alternative solution is Dental Learning Centers’ Dental-Foto VELscope system with a LoLite adapter currently based upon the Canon Power Shot A650. This camera complete system offers a convenient approach to VELscope photography with the added benefit of video capability. For more information on this system please visit www.dlcenters.com.

Should you already own a Canon Powershot, such as the A650 or a similar point and shoot camera, and wish to use it with your VELscope, a Doctorseyes close-up adapter and coupling ring kit is available from Larry Blosser at (800) 200-5394 (www.jlblosser.com).

I have tried all of the above implementations and have found that each has its merits. Above all, it has been possible to obtain diagnostic quality images with all the options listed. The user need only select the scenario that best describes his or her “camera ready” state as well as budget requirements.

Sweden’s top students receive prestigious award

For the 19th year running, The Hon. Göran Anneroth Student Achievement Award of the Year, also known as the Dentatus-prize, was granted at a ceremony on the opening day of FDI/Swedental 2008 in Stockholm. The prize, which is sponsored by Swedish company Dentatus, is awarded yearly to the top students of the four dental universities in Sweden. This year’s recipients, selected by their respective university for their excellent academic achievements, were Nadya Esfahani, Ivana Franc, Jeanette tee V and Gustaf Wiklund.

In keeping with tradition, the students were also recognized for their achievements during the traditional Dentatus breakfast meeting held on Sept. 25. During the meeting, the newly awarded students had the opportunity to network with several prominent dental professionals from all over the world as well as representatives from the international dental industry.
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The importance of gingival health in a functional cosmetic case

By Martha Cortes

Complete dentistry is the esthetic and occlusal harmonization of the teeth with the gingiva, lips, and face. As dentists, we can directly affect the esthetics of the teeth and gingiva. However, we can also indirectly affect the lips and face by how we design teeth to sit in the oral cavity.

Laser-Assisted New Attachment Procedure™ (LANAP®) is the standard of care for periodontal laser therapy and beyond that of conventional treatment, which amputates, leading to a result that can be less than desirable. LANAP is a patented soft-tissue technique specifically utilizing the Periolase® MVP-7 Nd:YAG (1064 nm wavelength) laser (Millennium Dental Technologies) with the aim of regeneration rather than traditional resection of the gum tissue, which is done solely for pocket maintenance.

The patient, a woman in her early 60s, came to my office because she was having problems with a bridge (lower left) that had recently been repaired; she was unable to chew well. During the discussion she revealed that she was also having problems on the lower right, indicating that the problem was not local but one that involved the bite.

On further examination, it was revealed that she not only had occlusal problems, but she also had moderate periodontitis throughout with bone loss especially impacting the lower anteriors. The patient had worn away her teeth, as a result, suffered from severe malocclusion.

She had large diastemas between the upper and lower centrals with little occlusal guidance. Her temporomandibular joints demonstrated hypermobility while opening and closing. The patient also had ill-fitting porcelain fused to metal crowns on teeth #5-5 and #11, #50, #12 and #21 with metal exposure and a new zirconium bridge with flat occlusion on teeth #16-20. All prosthesis had poor color matching and flat occlusion.

The periodontitis and bone loss were partially due to a traumatic bite that improperly distributed the occlusal forces laterally rather than perpendicularly so that the loading forces were forcing the lower anteriors to splay. In order to inhibit the mechanical progression of the periodontitis and bone loss, and prevent the tooth from splaying further, it was decided to completely restore the teeth to a fully functional platform. The patient was at first intimidated by the idea of a complete smile makeover, and yet she was at the same time ready for this life-changing event. The patient understood that the esthetics would be built functionally so that the occlusion, teeth, arches and periodontium would support each other and thereby help keep the entire oral cavity healthy.

Having a functionally beautiful smile not only affects a patient’s self-esteem, it also has an effect on the health of the head, neck, and body as the patient tends to have better posture and better body integration, because aligned jaws might proprioceptively affect the body in space. Although the patient’s main concern was dental health, the added benefit of gorgeous esthetics appealed to her greatly.

Due to her severe malocclusion, the patient’s habitual centric bite could not be used as the guide for her smile makeover. The proper functional height for the patient’s teeth needed to be found and established. The patient had ground down her posterior teeth and much of the functional forces of mastication were pathologically loading on the lower anteriors, causing them to splay and repetitively injuring the gingiva.

LANAP’s uniqueness allows for the prepping and placing of restorations without having to wait an inordinate amount of time for the gums to heal as the gingiva is not cut and sutured; therefore, healing is quicker and less traumatic and esthetically more pleasing.

The patient was neuromuscularly tested using the K7 Evaluation System (Myotronics) in order to determine where the bite ought to be before restoring. The patient received a fixed orthotic/occlusal device that was worn for approximately six months in order to relax the pathologic forces, arrive at the correct vertical dimension for the patient and gradually retrain the neuromuscular defects. The splint would also help to abate any negative forces affecting the gingiva.

The patient would be restored with an eye toward the correct Shim-bashi measurement and with golden proportion principles in mind. A myocentric position is derived from the orthotic, and the use of a transcutaneous electrical nerve stimulator (TENS) that erases the habitual bite and helps to create healthy neuromuscular conditions, which inhibits its occlusal breakdown.

She was tested again a few months later with the K7 to evaluate the temporal mandibular/neuromuscular complex with the occlusal device determining the health of the new vertical on the entire system. At approximately four months after the mandibular trajectory was found, the upper teeth were ideally leveled with the provisionals to correct the maxillary cant by proportioning the anterior crowns to canine to canine and harmonizing them with the posterior curve of Wilson.

The patient received LANAP on all quadrants using the Periolase MVP-7 laser for pockets that were between 6 and 7 mm, approximately three weeks before the orthotic was fixed to the lower arch. Had this been done conventionally, the patient would have needed to wait at least three months or more for the tissue to heal. Dental lasers are site specific, biostimulative, allow for excellent healing.
hemostasis and are intrinsically anti-septic and bactericidal on contact.

The patient received 28 units made of a pressible ceramic (IPS Empress® Esthetic, Ivoclar Vivadent). The zirconium bridge was not removed as it was new, in good condition and the occlusion and stability could be added directly onto it by building it up. The patient's vertical dimension was permanently raised with the prosthetics throughout, to compensate for the collapsed occlusion. This altered the facial structure and smile by enhancing how the teeth, lips, gums and face work together as a whole. Also, the patient benefited from a healthier oral cavity. Two years later, there was bone regeneration in the lower anteriors (a benefit of LANAP), the pockets disappeared and the patient was enjoying occlusal health with esthetic accompaniment.

Dr. Martha Cortes is a graduate from the University of New York at Buffalo School of Dental Medicine. She is the current president of the American Academy of Cosmetic Dentistry New York Chapter, as well as a past president (1994–1996) and past international chair serving consecutive terms, and an accredited member since 1992. An international lecturer and published author, Dr. Cortes has served two consecutive years as co-chair of dentistry with the American Society for Laser Medicine and Surgery and is a recognized member of the American Society of Dental Aesthetics, as well as a diplomat of the American Board of Aesthetic Dentistry and the International Dental Facial Aesthetic Society and an LVI fellow. Dr. Cortes is a qualified laser educator and former examiner for laser qualifications for the Academy of Laser Dentistry, and has a mastership in laser technology through the Academy of Laser Dentistry. You may e-mail Dr. Cortes at lazersmile@aol.com.

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Publisher
Torsten Oemus
t.oemus@dtamerica.com
President
Eric Seid
e.seid@dtamerica.com
Group Editor
Robin Goodman
r.goodman@dtamerica.com
Editor in Chief Cosmetic Tribune
Dr. Lorin Berland
d.berland@dtamerica.com
Managing Editor Endo Tribune
Fred Michmershuizen
f.michmershuizen@dtamerica.com
Managing Editor Implant Tribune
Sierra Rendon
s.rendon@dtamerica.com
Managing Editor Ortho Tribune
Kristine Colker
k.colker@dtamerica.com
Product & Account Manager
Mark Eisen
m.eisen@dtamerica.com
Product & Account Manager
Kimberly Price
k.price@dtamerica.com
Marketing Manager
Anna Wlodarczyk
a.wlodarczyk@dtamerica.com
Sales & Marketing Assistant
Lorrie Young
l.young@dtamerica.com
C.E. Manager
Julia E. Wehkamp
j.wehkamp@dtamerica.com

Cosmetic Tribune America, LLC
213 West 35th Street, Suite 801
New York, NY 10001
Tel.: (212) 244-7181
Fax: (212) 244-7185

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Bleeding gums linked to heart disease

By Coral Southerd, RDH, MSN

It is a testament to the power of tobacco addiction that 20.8 percent of U.S. adults (about 45 million) are current smokers. Smoking rates in the United States have decreased since the 1964 Surgeon General’s Report linked lung cancer and cigarette use. At that time, an estimated 42 percent of the American population smoke. However, the current prevalence has not significantly decreased since 2004, demonstrating a stall in the previous seven-year decline.

Unfortunately, the incidence is highest in the most vulnerable populations. Those living below the poverty line are 40 percent more likely to smoke than those living above the poverty line. The most powerless populations — the young, indigent, depressed, uninsured, less educated, blue-collar and minorities — have the highest percentages of smokers in the United States.

Tragically, tobacco use must be considered a pediatric disease with more than 2,000 children and adolescents becoming regular users of tobacco each day in the United States alone. Half of all smokers start prior to the age of 14 and 90 percent begin by age 19. Only 10 percent of smokers initiate the habit as adults.

About 50 percent of patients in any given practice are current smokers. Although 70 percent of smokers say they are “interested” in quitting, only 10 to 20 percent plan to quit in the next month. About 45 percent of smokers will try to quit in a given year. The majority of smokers try to quit on their own. For most, relapse occurs quickly. Only half succeed for two days and only a third last one week. Relapse often occurs in the first few months.

Overall, “self-quitters” have a success rate of 10-20 percent. Annual relapse is 40-50 percent. Those who use medication or professional help are more successful. About 30 percent of patients in smoking cessation programs will quit, but only a third will remain smoke-free.

Tobacco cessation intervention: The RDH’s vital role!

The RDH can play an essential role and may be candidate for tobacco treatment team.

As the leader of the treatment team, the RDH acts as coordinator for follow-up, and assists the patient and physician in developing practical strategies for smoking cessation.

Advise to quit.
- Stress the importance of the decision to quit.
- Emphasize the health benefits.
- Set a quit date.

Assess willingness to quit.
- Ask if the patient has previously tried to quit.
- Assess the patient’s confidence.

Assist in quit attempt.
- Provide a quit plan.
- Encourage regular follow-up.

Arrange follow up.
- Schedule appointments for weeks 1, 3, and 6.
- Offer refills at each appointment.

Overall, “self-quitters” have a success rate of 10-20 percent. Annual relapse is 40-50 percent. Those who use medication or professional help are more successful. About 30 percent of patients in smoking cessation programs will quit, but only a third will remain smoke-free.

See TOBACCO, Page 3

These findings suggest why anti-biotics do not always work in the treatment of infectious heart disease and also highlight the need to develop new drugs to treat this disease. We are currently in the process of identifying the exact site at which the bacteria stick to the platelets,” Professor Jenkinson said. “Once this is identified, we will design a new treatment of infectious heart disease.

“The mouth is probably the dirtiest place in the human body,” said Dr. Steve Kerrigan from the Royal College of Surgeons in Dublin, Ireland.

“If you have an open blood vessel from bleeding gums, bacteria will gain entry to your bloodstream. When bacteria get into the bloodstream, they encounter tiny fragments called platelets that clot blood when you get a cut. By sticking to the platelets, the bacteria cause them to clot inside the blood vessel, partially blocking it. This prevents the blood flow back to the heart and we run the risk of suffering a heart attack.”

The only treatment for this type of disease is aggressive antibiotic therapy, but with the increasing problem of multiple drug resistant bacteria, this option is becoming short lived.

“Cardiovascular disease is currently the biggest killer in the western world. Oral bacteria such as Streptococcus gordonii and Streptococcus sanguinis are common infecting agents, and we now recognize that bacterial infections are an independent risk factor for heart disease,” said Professor Howard Jenkinson from the University of Bristol. “In other words it doesn’t matter how fit, slim or healthy you are, you’re adding to your chances of getting heart disease by having bad teeth.”

Researchers at Bristol have been investigating the ways in which the bacteria interact with platelets in order to develop new and improved therapies.

“Most of the studies that have looked at how bacteria interact with platelets were carried out under conditions that do not resemble those in the human circulatory system. We mimicked the pressure inside the blood vessels and in the heart,” Professor Jenkinson said. “Using this technique we demonstrated that bacteria use different mechanisms to cause platelets to clump together, allowing them to completely encase the bacteria. This shields the bacteria from the cells of our immune systems, which would normally kill bacteria, and most importantly also protects them from antibiotics.”

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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.”

During the years I have spent in the dental profession, I have been exposed to a world of endless possibilities. Yet, another opportunity has presented itself. Through the pages of Hygiene Tribune, I am being afforded the ability to reach the minds and hopefully the souls of my dental and dental hygiene colleagues.

I have witnessed time and time again when working with dental teams that dentistry is dentistry and dental hygiene is dental hygiene. Seldom is there a cohesive flow between the two entities. If, however, the team is going to deliver the highest quality comprehensive dental care possible, it is imperative that the whole team understands and appreciates the contributions of each team player. Once this goal is achieved, then and only then, will the team recognize the endless possibilities they have as a team.

Dental Tribune America has recognized this need and is addressing it by incorporating Hygiene Tribune into their Dental Tribune publications. By combining these publications, the entire dental team will benefit from two publications that are distributed simultaneously for the first time. The hope is that the sharing of this newspaper will open the lines of communication between dentistry and dental hygiene.

As editor in chief, I will strive to see that you receive pertinent and credible information from the pages of Hygiene Tribune. I welcome your feedback and will make every effort to address your concerns. It is my hope that operating on this pretense will allow all of Hygiene Tribune and Dental Tribune readers to realize the endless possibilities that lie in front of them.

Best Regards,

Angie Stone, RDH, BS
Editor in Chief

Dental Tribune Symposia at the Greater New York Dental Meeting

Brought to you by

November 30 to December 3, 2008

The Dental Tribune Symposia at the Greater New York Dental Meeting offer an inspiring schedule of continuing education lectures in various dental disciplines. Each scientific lecture will provide an invaluable opportunity to learn about a new field and how to integrate a variety of treatment options into your practice.

We have developed a course schedule that is both diverse and engaging, and which also offers you the opportunity to earn C.E. credits. The symposia sessions are FREE for registered Greater N.Y. Dental Meeting attendees, but pre-registration is recommended.

Schedule

Sun., Nov. 30
Mon., Dec. 1
Tues., Dec. 2
10 a.m.–1 p.m.
10 a.m.–1 p.m.
10 a.m.–1 p.m.
CEREC CAD/CAM: The Power of Technology in Clinical Restorative Dentistry
by Dr. Eugene Antenucci and brought to you by CEREC – Sirona
Using 3-D X-ray Imaging and Planning to Increase Patient Treatment Acceptance
by Dr. Neal Patel and brought to you by Galliesso – Sirona
Details to follow shortly
11:30 a.m.–12:30 p.m.
CAD/CAM Technology: Details to follow shortly and brought to you by D4D Technologies
1:30–2:30 p.m.
Tissue Care in the Maxillary Anterior: Anxieties – A New Paradigm
by Dr. David DiGiallorenzo and brought to you by Tulsa Dental Specialties
Enhancing Your Dentistry: Get out of Dentistry Alone!
by Randy Donahoo and brought to you by MagnaVu
2:30 p.m.
3–4:00 p.m.
High resolution Cone Beam with PreXion 3-D
by Dr. Daniel McCooey and brought to you by PreXion
Minimally Invasive Dentistry in Rapid-3
by Dr. James Jesse and Dr. Ron Kaminer and brought to you by Ultradent Products, Inc.
Bone Preservation: One of the Keys to Esthetic Success in Immediate Implant Therapy
by Dr. Barry Levin and brought to you by A. Titan Instruments
Program details for Wed., Dec. 3 to follow shortly.

Attendee Registration

EARN YOUR C.E. CREDITS HERE! The Greater New York Dental Meeting is an ADA CERP recognized provider

Tell us what you think!

Do you have general comments or criticism you would like to share? Is there a particular topic you would like to read about? Have you written an article about Hygiene Tribune? Let us know by e-mailing feedback@dtamerica.com. We look forward to hearing from you!
cess rate of 4 to 6 percent. Most smokers make three to eight quit attempts before finally succeeding. The good news is that half of all smokers eventually quit. There are now as many former smokers as current smokers in the United States.

How the hygienist can help

An important implication of the above statistics is that dental hygienists need to understand the importance of helping the tobacco user through not just one quit attempt, but rather through several attempts! Another implication is that dental hygienists need to prompt and re-prompt tobacco users to make efforts to quit. Offering consistent treatment intervention will not only help smokers who want to quit, but can also motivate ambivalent smokers to at least try to stop.

The Clinical Practice Guideline for Treating Tobacco Use and Dependence published by the United States Department of Health and Human Services is considered the benchmark for cessation techniques and treatment delivery strategies. The updated 2008 guideline reflects the scientific cessation literature published from 1975 to 2007. As the first 1996 publication recommended, the “5 A’s” — Ask, Advise, Assess, Assist, Arrange — are still considered key components of comprehensive tobacco cessation counseling.

The American Dental Hygienists’ Association (ADHA) has developed a condensed “user friendly” model for the dental hygienist who does not have the time, inclination or expertise to provide the more comprehensive tobacco cessation counseling as recommended by the guideline. “Ask, Advise, Refer.” (AAR) is the ADHA’s national Smoking Cessation Initiative (SCI) designed to promote cessation intervention by dental hygienists. The “Ask, Advise, Refer.” approach integrates the “5 A’s” into an abbreviated intervention that remains consistent with recommended guidelines.

As part of the “Ask, Advise, Refer.” campaign, dental hygienists refer their patients who use tobacco to Quitlines as well as to Web-based and local cessation programs. Dental hygienists can utilize a variety of resources to help their patients quit smoking. The “Ask, Advise, Refer.” program is designed as a program that dental hygienists can easily integrate into their tobacco cessation efforts. See www.askadviserefer.org.

By referring their patients to a Quitline, dental hygienists are incorporating all “5 A’s” (Ask, Advise, Assess, Assist, Arrange) of the Smoking Cessation Clinical Practice Guideline. Quitlines have proven to be one of the more effective methods of promoting smoking cessation. The United States Department of Health and Human Services has recognized the overwhelming success of Quitlines and is dedicated to providing every citizen in every state with this important tool.

Quitline services are easy to access and free to users. Traditionally, tobacco users have had to overcome various barriers in accessing cessation services, including:

- Sporadic availability of programs, both geographically and over time.
- Transportation difficulties.
- Childcare responsibilities.
- Financial cost of participating.

Quitlines reduce these barriers by allowing tobacco users to access service from their own homes at a time that is convenient for them and at no cost. Quitline services have the potential to reach large numbers of tobacco users, including low income, rural, elderly, uninsured and racial/ethnic populations who may not otherwise have access to cessation programs. The main reason Quitlines have proliferated is that there is strong evidence of their efficacy. Dental hygienists are natural partners for Quitlines and can play a major role in increasing their utilization. Dental hygienists who ask all patients whether they use tobacco, advise quitting and refer to Quitlines for comprehensive cessation counseling can have a profound and lasting impact on patient health.

### Strategies for implementing the ‘5 A’s’

#### Ask

- Implement an office-wide system that ensures that for every patient at every clinic visit, tobacco use status is queried and documented.
- Use an identification system that indicates tobacco use status (current, former, never) and level of use (number of cigarettes smoked/cheered per day) on the patient chart.
- Use an open-ended question: When is the last time you tried a tobacco product?
- Not asking about tobacco use implies that quitting is not important!

#### Advise

- Incorporate consistent, clear, strong and personalized advice dialogues when asking every tobacco user to quit: Clear: It is important for you to quit smoking or using chewing tobacco now, and I can help you.
- Strong: As your hygienist, I know that quitting may be the hardest thing you ever do, but it is definitely the most important thing you will ever do for your health.
- Personalized: Continuing to smoke may worsen those oral findings.
- Express concerns for the patient’s health and a commitment to aid with quitting.

#### Assess

- Determine the patient’s willingness to quit and knowledge of quit resources by asking open-ended questions using a one-judgment approach:
  - How do you feel about quitting at this point in your life?
  - Are you aware that there are tools to make the process a bit easier?

#### Assist

- Encourage the patient to set a quit date, preferably within one to two weeks of the clinic appointment.
- Discuss challenges such as withdrawal symptoms, triggers, vulnerable situations, etc.
- Reassure the patient that ambivalence, fear, relatability, etc. are normal, but should not deter the quit attempt.
- Supply information on cessation programs, Web sites, Quitlines, medications, etc.
- Provide appropriate cessation referrals for treatment such as the Quitline, Web site resources or local programs.
- Review the options and help the patient determine what would work best for him/her.

#### Arrange

- Follow-up contact should begin soon after the quit date (preferably within one to two weeks) with a focus on preventing relapse.
- Schedule further follow-up contact as indicated.
- Consider referral for more intensive treatment as indicated.
- If tobacco use has occurred following the established quit date, review circumstances and discuss how to avoid another slip in similar circumstances.

### About the author

Carol Southard, RN, MS, an American Lung Association certified instructor with more than 20 years experience and proven success, is a pioneer in the field of smoking cessation. Southard is a Tobacco Cessation Consultant for Chicago area hospitals and has published articles and presented numerous workshops and seminars for health professionals as well as for community groups.
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