Patients often present to the office with unscheduled emergency conditions that require immediate tooth removal. These situations have become increasingly complex to deal with given the myriad available treatment options, which impact the treatment approach and methodology of both tooth extraction as well as provisionalization.  

Prof. Persson presenting at this year’s FDI World Dental Congress in Stockholm. Photo: DtI.

Daniel Zimmermann: The link between periodontal and systemic diseases is currently the focus of much discussion. How has knowledge of this link influenced the field of periodontology?  

Prof. Rutger G. Persson: In the 1980s, a Finnish group first conducted research on the link between periodontitis and cardiovascular diseases. Later, follow-up studies were conducted by the University of North Carolina at Chapel Hill. In 1997, it was common knowledge that patients with diabetes mellitus tended to suffer from periodontal disease, but we did not know much about how periodontitis influenced diabetes. There were also interesting new studies on periodontitis and its relation to preterm births and cardiovascular diseases.

Before 1820, it was also known that apical infections were linked to rheumatism (focal infections), but this changed at the beginning of World War II because suddenly everybody claimed the link did not exist. Thereafter, the topic was taboo. Now interest is slowly returning, not in terms of focal infection teaching, but in terms of knowledge of microbial conditions in relation to inflammation reaction in periodontitis.

Are you referring to biofilm? Yes. Periodontitis isn’t a simple... See CURRENT, Page 4

Fig. 1a: Emergency presentation of unrestorable crown and root fracture of tooth #8.

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Researchers caution that tooth loss may increase risk of chronic kidney disease in U.S. adults

Study published in the Journal of Periodontology suggests that effects of untreated periodontal disease may be linked to chronic kidney disease. According to the National Kidney Foundation, one out of nine Americans suffers from chronic kidney disease (CKD), and millions more are at risk. A debilitating disease, CKD can affect blood pressure and bone health, and can eventually lead to heart disease or kidney failure.

A recent study published in the Journal of Periodontology (JOP), the official publication of the American Academy of Periodontology (AAP), suggests that edentulous adults may be more likely to have CKD than dentate adults. In the study, conducted at Case Western Reserve University, edentulism was found to be significantly associated with CKD, indicating that oral care may play a role in reducing the prevalence of chronic kidney disease in the U.S. population.

The study examined the kidney function and periodontal health indicators, including dentate status, of 4,055 U.S. adults 40 years of age and older. After adjusting for recognized risk factors of CKD such as age, race/ethnicity and smoking status, the results revealed that participants who lost all their teeth were more likely to have CKD than patients who had maintained their natural dentition.

“The rationale for examining edentulous adults in this study is to observe the long-term effects of periodontal disease on the prevalence of chronic kidney disease,” states study author Monica Fisher, PhD, DDS, MPH. “Periodontal disease is a leading cause of tooth loss in adults; therefore edentulism is considered to be a marker of past periodontal disease in the study’s participants.”

While additional research is needed to fully understand why tooth loss is associated with a higher prevalence of CKD, the destructive nature of chronic inflammation may play a role. Both periodontal disease and chronic kidney disease are considered inflammatory conditions, and previous research has suggested that inflammation may be the common link between these diseases. Since untreated periodontal disease can ultimately lead to tooth loss, edentulous patients may have been exposed to chronic oral inflammation.

According to David Cochran, DDS, president of the AAP and professor and chair of the Department of Periodontics at the University of Texas Health Science Center at San Antonio, treating periodontal disease can do a lot more than save your natural teeth. “Researchers have long known that gum disease is related to other adverse health conditions, and now we can consider chronic kidney disease to be one of them. It is exciting to think that by controlling periodontal disease and therefore helping to preserve natural dentition, the incidence and progression of CKD may be reduced,” Cochran says.

Periodontists recommend regular brushing and flossing and routine visits to a dental professional in order to maintain comprehensive oral health. If gum disease develops, consulting a periodontist is an effective way to determine the most appropriate course of treatment.

Members of the public who wish to learn more about gum disease, locate a periodontist or find out if there are at risk for periodontal disease are being invited to visit perio.org or call (800) FLOSS-EM [(800) 356-7736].

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infection with inflammation. It has communities of microorganisms, which raise interest in terms of inflammation reaction and the microbial burden in fields like cardiology and obstetrics. This means we all have a common interest in the aetiological factors.

What information does current research give us about the microbiological interactions in biofilm?

One first has to understand that this is not simply about a small group of bacteria, but perhaps about the total microbial burden and the immune reaction to this burden. For example, Streptococci are early coloniser bacteria that might play a role in other diseases. In the field of periodontology, we haven’t paid much attention to this thus far.

Do you see a need for improved cooperation between dentistry and medical science?

I am already working with cardiologists and gynecologists at the University of Seattle and with physicians from Sweden and Bern in Switzerland because as a dentist, I have microbiological information they may not have. You see, there is close cooperation in the fields of periodontology, immunology and social behavior.

Despite this cooperation, we may be too late in some cases. Periodontal treatment of a 70-year-old patient will yield no improvement, but we might be able to treat 50-year-old patients with the help of a special diet and improved oral hygiene, or with antimicrobial and anti-inflammatory treatment methods that influence cardiovascular conditions.

I also see a lot of potential in cross-sectional intervention studies. In these studies we observe healthy and sick patients and examine their dental conditions and the way in which these conditions and other medical conditions change because of treatment.

Can you give an example?

One could look at epidemiological studies of Jönköping (a province in Sweden), conducted from the 1970s until today. In 1970, almost 80 percent of the county’s residents had some form of periodontal disease, and a rather small number, about 15 percent, suffered from severe periodontal disease. The first group of people do not have periodontitis nowadays, which indicates a significant change over the last 50 years. However, the group with severe periodontitis has not changed.

Why is that?

In my opinion, because of the Swedish health care system. Patients with periodontal disease underwent treatment, but in the group with severe periodontitis, these methods were not successful.

Current methods in periodontology are not sufficient in my opinion. Mechanical treatments, such as scaling and root planing, are not able to remove bacteria in patients that already have symptoms of disease. It could be that these treatments do the opposite, and cause coronary embolism. In addition, there is immune reaction.

There are two studies, conducted in Australia and the United Kingdom, that observed blood circulation in the arms and found that the level of a certain protein increased shortly after periodontal treatment (between 2 mg/l and 15–20 mg/l). The levels decreased after a while, but they did not return to normal. Therefore, the separation did not result in reduction of inflammation factors and thus wasn’t a success in my opinion. One cannot expect to treat patients with risk of cardiovascular disease or preterm birth successfully because the studies show that the risks basically remain the same.

We generally need more knowledge of the relationship between the role of microorganisms and immune defence systems. In addition, there are socioeconomic and genetic factors that we cannot influence at all. My hope is that politicians put more effort into supporting joint academic research between dentistry and medical science.

Is there a lack of support for such research?

I think there are enough funds available for medical research, but it is very difficult for dentistry to compete with medical science in that respect because it is a smaller discipline. But improved cooperation between medical science and dentistry could reduce the risk of preterm births and cardiovascular diseases.

Another interesting aspect is the relation between tooth implants and periodontal infection or the so-called peri-implantitis.

Implants are very interesting as a replacement for natural teeth, but we do not know much about the mechanisms between peri-implantitis and systematic diseases. We do know that Staphylococcus aureus, for example, sticks on titanium inside biofilm, and causes inflammation, which was proved in medical studies involving titanium prosthetics in hand and joint surgery.

In my opinion, because natural teeth and implants are not the same, conditions for the colonisation of bacteria on implant surfaces are different from those of teeth. It is also much more difficult to clean an implant. The problem is that the industry propagates very high success rates of their products, which is too short-sighted in my opinion.

Why?

In Sweden, for example, all joint implants have to be official. We registered. Therefore, one knows exactly how many implants have been implanted, and how many of those were successful. In dentistry, such a list does not exist, and we therefore do not know how many implants have been successful thus far.

In addition, it must be noted that it takes 20 years for natural teeth to develop periodontitis. The first implants are about 20 to 50 years old, and only now can one see how they have developed. At first, only patients without risk of peri-implantitis received implants; yet, all dentists worldwide can place implants, even if he or she is not qualified. There are certainly other ulterior motives involved here, and it is apparent that some companies deliberately try to get new patients who have received implants at all. There is much potential for mechanical and technical failure. But how does one separate the treated patients from patients who suffer from infections, inflammation and pathogeneses? In this case, analysis was not very accurate.

This issue will continue to be of concern to dentistry. What can be done?

We generally have been using the same implant system for years. About 1,000 implants were placed in the last 10 years, so we have a follow-up time ranging from five to seven years. After such a period, one can conclude how successful treatment was through microbial, ethnological, clinical or socioeconomic studies that determine the success of a treatment.

Multiple center studies could help to identify different mechanisms, and help us choose patients with minimal risk or no risk at all of implant failure. Then we might be able to find methods to treat peri-implantitis. I believe we also have to consider antibiotics and anti-inflammatory compounds. Cleaning implants with hand instruments and toothbrushes at home isn’t enough.

What role can the industry play?

This is a very interesting question. I recently discussed this with a colleague from Stockholm, and we both agreed that fluoride toothpaste, developed mainly by the industry and not by universities, was the biggest development in the 1980s and 1990s. This example shows that research conducted by the industry can be very successful.

Personally, I see no problem in this because implant companies make a lot of money and should be responsible for putting some of it back into research institutes, instead of constantly developing new implant systems. This could lead to a better understanding of the mechanisms of successful implants and implants that fail. It will be up to governments and health authorities to introduce control mechanisms for these processes.
Unrestorable crown and root fractures are often ideal clinical scenarios for immediate implant placement given the frequent lack of overt infection and alveolar bone damage, which is often associated with other emergency conditions such as endodontic and periodontal abscesses. Failure to perform immediate implant placement or site preservation during the emergency visit often leads to a loss of alveolar bone, which greatly impacts dental implant treatment success. When comparing the excellent long-term success rates of implants with the guarded long-term prognosis of a badly fractured tooth requiring endodontic treatment, crown lengthening surgery, and a post and core buildup, extraction and site preservation or immediate implant placement is frequently the ideal treatment approach.

A clinical study of 534 fractured teeth reported a 20 percent failure rate when conventional therapy was performed, specifically, endodontic treatment, post and core buildup and a tooth-supported crown. Immediate implant placement following an emergency extraction should therefore be an integral part of emergency treatment.

Strategies to manage the extraction defect have been previously published providing algorithms to help guide implant treatment procedures, including immediate implant placement following tooth extraction. Guidelines for predictable immediate provisionalization of immediate implant have also been previously established.

A one-year prospective study reported a 100 percent implant success rate and also suggested improved esthetic outcomes are achieved following this approach when compared to extraction alone without implant placement. The ability to quickly and effectively treat these emergency scenarios improves patient satisfaction, facilitates patient management and is a tremendous clinical service.

Therefore, the dental office and team should be well-equipped, or referral guidelines be effectively established, to allow for efficient and predictable dental implant placement during these types of emergency appointments. The following two clinical case reports describe a simple and effective process to treat hopelessly fractured teeth using dental implants and either a bonded restoration as a provisional or a provisional placed immediately on the implant.

**Patient 1**
A 65-year-old Asian female presents for a new patient emergency exam with an oblique crown and root fracture affecting her maxillary right central incisor. The fracture occurred spontaneously while...
eating, involved the entire facial surface of the tooth and extended to the alveolar crest (Figs. 1a, 1b). The clinical crown exhibited severe mobility and was painful upon palpation and percussion. The prognosis was poor and extraction was advised.

Treatment options to replace the tooth were discussed and included a fixed partial denture as well as an implant supported crown. Given the excellent condition of the adjacent teeth as well as the patient’s prior history of having successful dental implant-supported restorations, she elected to have an implant placed.

The crown portion of the tooth was easily removed and, given its excellent condition, was retained to be used as a bonded provisional (Fig. 1c). The tooth root was extracted atraumatically without flap elevation and the socket debridged, irrigated and evaluated with a periodontal probe. The extraction defect had minor horizontal bone loss associated with a reduced periodontium secondary to a prior history of periodontitis, but the adjacent socket walls including the buccal crest were otherwise intact. Therefore the defect appeared amenable for immediate implant placement.

A 4.3-by-16 mm Replace® Select implant (Nobel Biocare™) was placed and utilized the entire length of the alveolus and engaged the nasal floor, in order to achieve effective primary stability (Fig. 1e). After implant placement, the residual socket defect was grafted with a composite anorganic bovine bone matrix (Bio-Oss® Osteohealth®) and a demineralized cortical bone allograft (OraGraft® LifeNet®). Composite was bonded to the fractured surface of the clinical crown in order to develop an ovate surface to maintain soft tissue esthetics. The modified clinical crown was then bonded to the adjacent teeth and served as a primary provisional restoration (Fig. 1d). The patient was then referred back to her restorative dentist the next day to fabricate an immediate provisional supported by the implant. The emergency appointment including the extraction, placement of the implant, grafting of the residual socket defect and bonding of the primary provisional restoration took approximately one hour of clinical time.

Patient 2

A 35-year-old female presented at the emergency clinic of Loma Linda University School of Dentistry and was immediately referred to the Center for Implant Dentistry. She complained of trauma to her maxillary anterior dentition after an alleged assault, a “blow to the face,” two days previously. Upon examination; the maxillary left central incisor was partially fractured at mid root and exhibited grade III mobility (Fig. 2a). The left lateral incisor was tender to percussion
and exhibited grade 1 mobility, but it recorded a negative response with ethyl chloride and electronic pulp testing.

The patient was then scheduled to undergo an emergency procedure at the clinic consisting of atraumatic extraction of the affected tooth and immediate implant placement with immediate provisionalization. The fractured tooth was extracted and the remaining root fracture was removed utilizing a periotome instrument (Fig. 2b). The alveolus was curetted and no bone fenestration was noted.

A Nobel Active dental implant was used to replace the extracted tooth (Fig. 2c). The osteotomy was performed palatal to the alveolus in order to obtain maximum stabilization for the implant.

Fig. 2c: Trauma to the maxillary left central incisor with horizontal root fracture.

Fig. 2b: Periotome and forcep extraction of fractured root.

Fig. 2a: trauma to the maxillary left central incisor with horizontal root fracture.

Fig. 2d: An immediate acrylic restoration is used as a provisional.

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The implant was seated at 35°c stability, which made the clinical situation viable for immediate provisionalization. A prefabricated abutment was placed and hand torqued to provide the support for the acrylic resin restoration. The provisional crown was then relieved from all occlusal contacts (Fig. 2d). Intraoperative radiographs revealed adequate position of the implant in relation to the adjacent dentition and bone implant level.

The emergency dental implant procedure should be considered a viable and often preferable treatment approach to treat emergency situations that ultimately lead to tooth loss such as root fractures. When appropriate, immediate provisionalization or bonding of the fractured crown can be used as a provisional restoration.

References
Distinguished speakers highlight 34th Yankee Dental Congress, Jan. 28 through Feb. 1, 2009

Dental Congress, Jan. 28 through Feb. 1, 2009
Distinguished speakers highlight 34th Yankee Congress (YDC), New England’s largest dental meeting, which will be held Jan. 28 through Feb. 1, 2009, at the Boston Convention and Exhibition Center (BCEC).

The YDC is the fifth largest dental meeting in the country and is sponsored by the Massachusetts Dental Society, in cooperation with the Connecticut, Maine, New Hampshire, Rhode Island and Vermont dental associations. The estimated 50,000 dental professionals expected to attend the convention in Boston next year will not only discover YDC 34’s educational offerings, but will also enjoy world-class entertainment events, top-notch speakers, 450 education courses from which to choose.

On Thursday, the Big Apple Circus Circus To Go! will entertain and delight with acrobats, jugglers, clowns and wirewalkers. Have lunch with author Dennis Lehane, best-selling author of Mystic River and Going, Going, Gone. Friday evening, the YDC presents the first-ever Comedy Night, starring comedians Frank Caliendo and Kathleen Madigan.

YDC 34 highlights by day

Thursday, Jan. 29, 2009
The Scottsdale Center for Dentistry will offer attendees an integrated approach to achieving excellence that incorporates every aspect of success, including patient care, clinical excellence and business profitability. Featuring Drs. Gordon Christensen, George Bailey, Teresa Donovan, Edward McLaren and Jon Suzuki.

Team Development Day: Real World Communications Made Easy is designed specifically for the dental auxiliaries attending the YDC. This day of practical sessions with the Coaching Center will build clinical knowledge and strengthen team relationships. In this participatory program you will learn the basic skills of effective communication with colleagues and patients.

Dr. Joe Camp, an adjunct professor in the department of endodontics at the University of North Carolina School of Dentistry, will present “Mechanical Instrumentation of Root Canals” and “Endodontic Diagnosis.”

Dr. John Sorenson, a diplomate of the American Board of Prosthodontics and founder of the Pacific Dental Institute, will discuss “Optimizing Esthetic Outcomes in Implant Prosthodontics.”

Dr. George Priest, a diplomate of the American Board of Prosthodontics, will present “Young Patients and Implant Esthetics.”

Dr. Terry Tanaka, a clinical professor of graduate prosthodontics at the University of Southern California School of Dentistry, will offer a talk on “Problem Solving for Fixed, Removable and Implant Procedures.”

Dr. Jeffrey Wood, president of the California Society of Pediatric Dentistry and professor at the University of Southern California School of Dentistry, will discuss “Space Maintenance in the Primary and Mixed Dentitions.”

Dr. Rhonda Savage, past president of the Washington State Dental Association and director of Linda L. Miles and Associates, will discuss “Communication and Teamwork.”

Gary Zelosky, who has been presenting to audiences around the world for over 25 years as a life and team coach for business professionals, dentists and teams, will speak on “The Passion-Centered Practice” and “Naked in Paradise.”

Dr. Theresa Gonzales, a diplomate of the American Academy of Oral and Maxillofacial Pathology and a professor at the Naval Postgraduate Dental School, will present “Conducting a Head-and-Neck Examination” and “Redefining Dentistry’s Role in Forensics.”

Dr. Uche Odiatu, a clinical instructor at the University of Pittsburgh School of Dental Medicine and editorial director for Modern Dentistry, will discuss “Determining Risk, Redefining Treatment and ‘An Update in Periodontics — What Every Office Needs to Know’.”

Dr. Ronald Jackson, the director of the advanced adhesive esthetic dentistry and anterior direct resin programs at the Las Vegas Institute for Advanced Dental Studies, will present “The Art of Direct Resin.”

Dr. Roger Levin, a world-renowned consultant, speaker and author, and the founder, CEO and president of the Levin Group, will discuss “Eight Secrets of Highly Successful Practices” and “Double Your Production and Profit.”

Robin Wright, PhD, a nationally recognized communications expert and president of Wright Communications, will speak on “Team Up for Treatment Acceptance” and “Tough Questions, Great Answers.”

Jerome Groopman, MD, the chief of the division of experimental medicine at Beth Israel Deaconess Medical Center and professor at Harvard Medical School, will discuss “How Clinicians Think.”


Dr. Stanley Malamed, a diplomate of the American Board of Dental Anesthesiology and professor of anesthesia and medicine at the University of Southern California, will offer a talk on “Local Anesthetics: Dentistry’s Most Important Drugs” and “Update on Local Anesthetic Techniques.”

Bill Reithman, RDH, a visiting clinical instructor at the University of Pittsburgh School of Dental Medicine and editorial director for Dimensions of Dental Hygiene, will discuss “Determining Risk, Redefining Treatment” and “An Update in Periodontics — What Every Office Needs to Know.”

Friday, January 30, 2009
Loretta LaRoche, founder of The Human Potential Inc. and consultant to Fortune 500 and chair of PBS specials, has starred in four PBS specials and teaches audiences to beat the odds with humor, wisdom and patience. She will present the personal development seminar “How to Prevent Hardening of the Attitude.”

Dr. L. Stephen Buchanan, the director of the American Board of Endodontics and an assistant clinical professor at the University of Southern California School of Dentistry, will discuss “The Art of Endodontics.”

Dr. Gordon Christensen, the dean of the Scottsdale Center for Dentistry, director of Practical Clinical Courses and a senior consultant for Clinicians Report, will talk on “New Aspects of Dentistry for 2009.”
Live from San Diego, it’s AAID!

Surgeries broadcast live are the highlight of this year’s annual meeting

By Sierra Rendon, Implant Tribune Managing Editor

“I thought there was no way they were going to be able to pull it off....

“I think they should do it every year.

“I was really amazed at how well prepared they were — they came right in and the patients were ready to go.”

These were just a few of the glowing comments heard immediately following the first two live surgeries that took place the morning of Oct. 31 at the American Academy of Implant Dentistry’s 57th Annual Meeting at the Manchester Grand Hyatt in San Diego.

The morning started out with two pre-recorded surgical procedures performed at Loma Linda University, from which all of the day’s surgeries were located.

The first pre-recorded procedure demonstrated surgical application of recombinant human bone morphogenetic protein (rhBMP-2) for sinus grafting. Successful repair of a sinus membrane perforation was also demonstrated during this first clinical procedure. The second pre-recorded surgery showed successful implant placement within the BMP-2 graft complex following six months of healing and revealed graft consistency and success.

Next came two live surgeries broadcast side-by-side on a megascreen with Dr. Don Clem moderating. The first was “Radical Vertical Bone Augmentation” with surgeon Istvan Urban, DMD, MD. Broadcast via the Internet, the live surgery demonstrated techniques to achieve successful vertical bone augmentation. With the use of e-PTFE membranes in combination with particular grafts and soft tissue grafts, Dr. Urban demonstrated how to predictably regenerate extremely challenging vertical defects using relatively conservative procedures and minimize complications.

Simultaneously, Alan Herford, DDS, MD, showcased “RhBMP in Implant Dentistry.” Herford said surgical procedures for the treatment of mandibular continuity defects, preprosthetic atrophic alveolar ridge deficiencies, trauma and maxillary clefts have demonstrated extraordinary osseous regeneration induced by rhBMP-2. The application of rhBMP-2 was presented in the live case.

As the two surgeries drew near to an end, audience members were offered the opportunity to present questions that the moderator would ask the two surgeons. About a dozen questions from the audience were asked, creating an even higher level of audience participation from the standing-room only group.

The final live surgery by Joseph Y.K. Kan, DDS, MS, a professor at Loma Linda University, focused on “Surgical Biotype Transformation During Immediate Implant Placement in the Esthetic Zone: You Be the Judge.”

The session began with an explanation of the patient’s history and video from surgical preparation earlier in the day for the implant placement. During this surgery, the audience again was asked to submit any questions for Kan via the moderator, which many participants did, and, later in the session, the audience “voted” through audience response keypads on the question Kan asked regarding the techniques shown in the surgery.

The question was: “How many of you believe this (tissue graft) technique is able to...”
Oral Health America to hold 19th annual gala dinner and auction

Oral Health America, a non-profit organization that has been dedicated to improving oral health for all Americans for more than 50 years, will hold its 19th Annual Gala Dinner and Silent Auction Feb. 26, 2009 at Navy Pier in Chicago. The event will raise funds to support educational and service programs designed to improve oral health.

The Oral Health America Gala, held each year during the Chicago Dental Society Midwinter Meeting, is one of the dental industry’s premier networking events. The “party on the pier” has become so popular that it sells out early. For this reason, organizers are urging attendees to purchase their tickets early to avoid disappointment. The black-tie-optional evening features dinner, dancing and a silent auction. Oral Health America is also seeking event sponsors at the Gold ($5,000), Platinum ($5,000) and Diamond ($10,000) levels.

The Oral Health America 19th Annual Gala Dinner and Silent Auction will take place 6:30–11 p.m. on Feb. 26. Tickets are $285 each ($300 after Feb. 1, if still available); a table for 10 can be purchased for $2,500 ($2,750 after Feb. 1, if still available).

To reserve tickets or to get information on sponsorships or donations please contact Joe Donohue at OHA by calling (312) 836-9900 or e-mail him at joe@oralhealthamerica.org.
Whip Mix wins Manufacturer of the Year Award

On Nov. 7, Whip Mix Corp. was named the recipient of the 2008 Kentucky Manufacturer of the Year Award by the Kentucky Association of Manufacturing (KAM). The Kentucky Manufacturer of the Year Award was created in 2001 to focus attention on the important contributions manufacturers and industry make to their employees, customers, and communities. Nominees were judged on innovation and entrepreneurial leadership, community leadership and policy contributions made to enhance the prosperity of the Commonwealth.

The award was presented at the Kentucky Association of Manufacturers Annual Meeting and Awards Luncheon at the Kentucky Convention Center in Louisville, Ky.

The Kentucky Association of Manufacturers, established in 1911, is the state’s only trade association solely dedicated to the manufacturing industry. KAM’s mission is to enhance the competitiveness of manufacturers by shaping a legislative and regulatory environment conductive to economic growth and to increase understanding among policy makers, the media and the general public about the importance of manufacturing to America’s economy.

Founded in 1919, Whip Mix manufactures Hanau™, Denar® and Whip Mix articulators, dental gypsums, investments, waxes, furnaces, ovens, mixing equipment and model trimmers for use in dental labs and dental offices. Whip Mix Laboratory Services Division offers the Vericore™ System, which utilizes a state-of-the-art CAD/CAM technology to mill custom zirconia copings and bridges. Whip Mix is ISO9001-2000 certified and sells its products through distributors in over 80 countries and maintains an office and distribution center in Dortmund, Germany. For more information visit www.whipmix.com.

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The Optima MX INT uses Bien-Air’s Micromotor MX, which was the leader of the pack in an independent assessment by the ADA Professional Product Review (Vol. 2, Issue 1, Winter 2006). This review confirmed that a Micromotor MX series motor has the highest torque (6 Ncm), the most power, and the most broad rpm range that runs at the exact speeds it is set at.

The control unit utilizes a three-phased voltage delivery that provides the constant torque necessary to support high and slow speed application with only one attachment. This feature directly translates into savings, efficiency and precision. When taken together, the proper torque and an accurate display of slow-speed rpm help decrease the risk of snapping procedures.

In addition, the Micromotor MX is the quietest motor and offers the best light transmission. (If you would like to read a full description of the tests conducted and methods used, please visit the ADA Web site at www.ada.org/goto/ppr.)

Upgrade to the Optima MX INT for $1,950 along with the trade-in of your current system from any manufacturer (MSRP is $3,260, so that’s a 40% savings!), and you’ll get the peace of mind that comes with a three-year warranty.

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Crosstex launches ‘Pink with a Purpose’ to help support women’s cancer initiatives

Crosstex®, a global manufacturer of infection control and preventive products, is proud to help support the fight against women’s cancers with its new Pink with a Purpose® program that launched in August. Now, when dental professionals purchase Crosstex Pink products, a portion of the proceeds will go toward funding breast and reproductive cancer research at Memorial Sloan-Kettering Cancer Center.

“Crosstex has always been interested in helping advance breast and reproductive cancer research, raise awareness and build hope for future generations. This year we’ve decided to be more aggressive and add our voice to help strengthen the cause. This has meant mobilizing every facet of our company, from manufacturing to sales and distribution, and engaging the support of thousands of dental professionals who use our products,” states Andrew Whitehead, vice president of sales and marketing for Crosstex.

In creating this program, Crosstex has produced dozens of its products in pink — offering a broad selection while heightening breast and reproductive cancer awareness. Clinicians can select from face masks, skin care lotions, Premium® Saliva Ejectors and Patient’s Choice® products such as GumNumb® Topical Anesthetic, Sparkle® Prophy Pastes and Zap® Fluorides, to name just a few — all proudly displayed in pink. Several new products were specifically designed for this effort, including the Pink with a Purpose Sterilization Pouch and the Pink with a Purpose Econohack® Towel.

“The Pink with a Purpose program transforms ordinary dental products into statements about compassion and support,” states Whitehead. “Seeing these pink products also makes patients aware that their dental office supports the cause.” Crosstex also will offer promotional incentives to reward dental offices purchasing specified quantities of pink items.

For more information on the Crosstex “Pink with a Purpose” program and other Crosstex products, please call Crosstex International at (888) 276-7783 (toll free), (651) 582-8777 or visit www.crosstex.com.

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The information on many of the forms in a dental office is best collected using pen and paper: new patient information, medical history update, and informed consent and treatment plan authorizations.

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Solution: increased case acceptance and greater profits

By Marla Merritt

For years dental offices have sent patients seeking higher dollar procedures to third-party companies for financing. While this solution provides an option for patients that could otherwise not afford treatment, it presents several challenges.

Challenges presented when using third-party financing

- Third-party finance companies charge as much as 10 percent to the practice. These high fees result in lower profit margins and have left many dentists unwilling to accept anything other than cash up-front for treatment.
- If it sounds too good to be true, it probably is! Third-party finance companies offer attractive “same as cash” or “no interest” options to patients. While these sound like great deals, one late payment will result in retroactive interest charges as high as 24.99 percent. This scenario can leave patients with ill feelings toward the practice.
- A growing number of patients may not qualify for third-party financing. Historically, when our nation enters a downturn in its economy, lenders tighten credit criteria resulting in more credit declinations. Dental practices will likely feel the crunch in the form of lower case acceptance as patients struggle to come up with cash before treatment. Answering this challenge requires a solution that will help the patient pay over time while minimizing the potential risk to the practice and increasing profit margins.

It's time for a paradigm shift

Dental practices have avoided office payment plans for two reasons:

- Fear of non-payment.
- A lack of staff resources for billing and payment collection.

Resolving these two objections allows a practice to have an office payment plan that answers patients' needs and provides a new revenue stream to the practice.

Let's first answer the problem of credit risk. Many consumers cannot afford to pay treatment costs up front, but can comfortably afford payments over time. The trick is to separate which patients can afford and maintain monthly payments from those who are potential collection problems. A practice can solve this quandary by using a credit report with a scoring model to separate patients by risk level.

When exploring avenues for purchasing credit reports, be sure to ask for help deciphering scores or, better yet, a system that will automatically separate the candidates into risk categories. You will also need to assess the cost to the practice by asking if there are annual fees or monthly minimum charges. Once a practice has a good credit evaluation mechanism in place, an office payment plan will not seem so daunting.

Now, let's explore options for an office payment plan. By offering patients the ability to pay over time, a practice opens up new opportunities for case acceptance. Based on credit levels, an office may choose to stretch payment plans over six, 12 or even 24 months to offer a solution that makes costly treatment affordable to a greater number of people. But how much extra work will this create for the staff and how does a doctor know that the staff will stay on top of the collection process?

Many companies are now using automatic drafting to insure payments are received on time every month. These auto-debits can be set up through various software packages or can be outsourced to a payment management company. These options require varying degrees of hands-on staff time. The goal should be to find a solution that requires minimal employee time so they are not burdened with the payment process.

Increase case acceptance and profitability!

With a little research and a shift in thinking, a practice can become much more profitable by putting more patients on the books without losing up to 10 percent of the treatment fee to third-party finance companies. Since the nation's credit crisis has made it more difficult for consumers to receive financing, this could be the solution to maintaining or growing the level of business for the practice during a time that many businesses are suffering. By assessing risk and keeping management costs low, a practice can offer an office payment plan that is a win-win solution for the patient and the dentist.

Marla Merritt is the director of sales and marketing of DentalBanc, a payment management solutions provider. She can be contacted at (888) 758-0584, ext. 8304 or by e-mail at mmerritt@orthobanc.com.

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Nobody cares for your money like you and RG Capital

Robert Graham, founder and owner of RG Capital, had a vision: to create an atmosphere where businesses and individuals would be able to prosper in the financial arena. To date, the company has distinguished itself as one that also specializes in working with dentists and dental professionals. As such, the company has worked with practice management firms for four and a half years and been an official Levin Group Alliance Partner for the last two and a half years.

Founded in May 2004 in Scottsdale, Ariz., RG Capital has a team of 10 advisors. These advisors, Graham included, provide wealth management services with the goal of focusing not only on the process of wealth accumulation, but also informing and educating clients about every step used to reach that goal.

This relatively young company now boasts a management portfolio of more than $450 million and numbers some 1,800 clients spread throughout 30 states. Graham attributes RG Capital’s most recent success to its growing client base within the dental industry. Although it specializes in advising dental professionals, its clients range across a broad spectrum—from professional athletes, such as star defense Adrian Wilson of the Arizona Cardinals, to large corporations and middle-income individuals and families.

RG Capital’s clients benefit from working with a company that maintains the variety of resources one would generally expect from a very large institution. The first step in the company’s personalized service entails identifying a client’s visions and goals. Once the RG Capital advisor understands the client’s visions and goals, the advisor will implement the best strategies, tactics, and tools to help accomplish the best possible outcome.

Dental clients experience the RG Capital SmartPlan approach. The RG SmartPlan centers on tax avoidance strategies, practice tax savings, income tax savings, efficient investing, investment cost efficiency, accumulation strategies, estate planning and asset protection. This holistic approach has given rise to RG Capital’s rapid growth within dentistry. RG Capital was ranked No. 3 within the Top Ten Fastest Growing Advisory Firms.

Probably the most important factor that ensured the company’s success is that from its inception set it attracted a highly experienced group of financial professionals who decided to leave much larger companies due to various mergers and acquisitions. In addition, these advisors shoulder all the responsibility for their individual clients. The advisors’ complete responsibility means there is no “investment big brother” looking over their shoulders and demanding that they push proprietary products that are in the best interests of the company, but not necessarily so for the client.

RG Capital’s independent and open architectural structure allows its advisors to take a client-centered, process-driven approach. The client-centered approach centers on what the client defines as the “best possible outcome.”

“Our investment strategy is based on the values, vision and client’s personal goals; it is what drives our actions. This is in contrast to the cookie-cutter investment approach taught today that categorizes clients’ investment approach based solely on their age,” said President and CEO Robert Graham. Whether one has vast sums to work with or a more modest amount, the key to wealth management is to differentiate between what you want and what you need.

When seeking out a financial advisor to help you down that path, you want one that places accountability and a willingness to educate you about the options offered. Graham values strong customer relationships so highly that he was dissatisfied with the customer relationship management systems on the market. So he created his own that now forms the backbone of innovation, a company for which Graham is recognized as the founder.

The atmosphere RG Capital creates for its clients is one of simplification, accountability and reliability. The company’s personalized service includes well thought out timelines for goal achievement and regular reviews to assess progress and make any adjustments in goals. Whether you own your practice or not, planning your wealth management strategy can be a daunting task. RG Capital has the unique experience and insight you can rely on to help guide you down the path of wealth management that allows you to achieve your short-term and long-term goals.
Esthetic inlays and onlays: the coming of age

By Ronald D. Jackson, DDS, FAGD, FAAcD

There are many prominent teaching clinicians who feel that inlays and onlays (of whatever color) are a grossly underutilized restoration, and that crowns are an overutilized one. I think it is worthwhile to examine some of the possible reasons for this unfortunate situation (for our patients’ sake) and see if the reasons for dentists’ reluctance to incorporate these restorations into their routine services are really valid today.

Reason No. 1: Large amalgam fillings are easier and more affordable than inlays and onlays.

Both terms — easier, affordable — are relative. Whether something is easy or not in dentistry depends on your training and how often you’ve done it. Our first amalgam filling or crown in dent school wasn’t easy either. As for affordable, isn’t that for the patient to decide? People generally buy what they want or what they perceive is in their best interest.

Reason No. 2: It’s just easier to do a crown than an onlay.

Same response as above. However, I will agree that when doing a crown, the clinician isn’t faced with the decision of which cusps to keep and which to remove — you just unthinkingly remove them all. But as practitioners, we have to ask, are we deserving of patients’ trust and their money by only recommending that which we perceive (possibly because of lack of training or practice) as expedient?

Reason No. 3: Inlays and onlays are expensive.

Not anymore than crowns or root canals! We have no trouble recommending these services when they are indicated. Maybe it would be easier for dentists to accept and recommend these restorations if an onlay (gold or tooth colored) was referred to, and thought of, as a partial crown and carried the same fee as a crown.

Reason No. 4: Crowns last longer and are more predictable.

Although longevity is important and ingrained in the dental psyche, it is not the only criteria of value. In the age of adhesive dentistry, respecting remaining tooth structure and esthetics have become components of value as well. Keeping in mind that patients are living longer and want and expect to keep their teeth for a lifetime (something we tell them can be done) means, in most instances, it is best to recommend a crown only when it’s truly indicated.

The name of the game in dentistry today is “bank the tooth structure” for future use. Regarding durability, esthetic inlays and onlays are not new anymore. They have a track record, and it is good.4–9 With today’s materials, longevity is mainly a matter of diagnosis, correct treatment planning and proper execution of technique (Figs. 1–4).

Although not esthetic, well-done gold inlays and onlays are considered to have a proven durability and longevity similar to crowns. If esthetics is not an issue, gold is still the standard and what I always recommend for second molars when a conservative indirect restoration is indicated. However, it’s interesting to note the number of people and the types of people who still desire tooth-colored or non-metal restorations even in these teeth.

Reason No. 5: Posterior direct resin restorations are less costly to the patient and can be completed in one appointment.

It is a fact that more and more patients today are selecting tooth-colored restorations for their posterior teeth,10 and there is no question that well-placed Class I and II direct resin restorations are proving to be viable alternatives to amalgam.11,12 However, the indications for these restorations do have limits.

Generally, when the cavity is large or the tooth is under excessive functional demand (heavy bruxer or clencher), indirect restorations (resin or ceramic) are indicated.

Certainly, when a cusp is missing, many clinicians feel the standard of care is best satisfied by an indirect restoration (Figs. 5–10). After all, there is no question that a laboratory technician working with mounted models at the bench is going to provide a more accurate occlusal morphology, contact and overall contour as well as properly located functional stops of the right intensity than we can by grinding all the blue spots in the mouth. It’s also very difficult to achieve quality contacts in large restorations with poor tooth alignment or spacing.

No matter how good the direct resin materials get, the above situations will usually be better served by indirect restorations in the same way that gold inlays/onlays are considered superior to large amalgams, especially those that replace cusps.

Reason No. 6: Many third-party payment plans don’t pay benefits for esthetic inlays and onlays, but most pay a benefit toward porcelain-fused-to-metal crowns.

In a health care profession, it shouldn’t be necessary to even respond to such a statement, but I will. If a properly informed patient

See ESTHETIC, Page 2
would rather sacrifice healthy tooth structure to save a few dollars or for a perceived greater longevity, well, that’s his or her choice. It may be what that patient feels is best for himself or herself at that time. The operative words, however, are “properly informed” (pros vs. cons) and “his or her choice.” We shouldn’t make the choice for a patient based on an assumption that all patients want the cheapest option or what their insurance will partially pay for.

In conclusion, for many dental practices, offering only low-cost (at least initially), large fillings or expendable crowns where they may not be the best our profession has to offer, is questionable and shortsighted. The bottom line in dentistry today, as it always has been, is to recommend treatment, which according to the clinician’s professional judgment, is in the patients’ best interest. This is usually what the clinician would select if he or she were the patient. The patients may not always want that particular service and decline to have it done, but they always deserve the choice.

The trend in dentistry is clearly toward more esthetic and less invasive. Indirect resin and ceramic inlays and onlays are not only compatible with this trend, but fulfill very nicely the restorative void between fillings and crowns.

**Literature**


**About the author**

Dr. Ron Jackson has published many articles on aesthetic and adhesive dentistry and has lectured extensively across the United States and abroad. He has presented at all the major U.S. scientific conferences. Jackson is a fellow in the American Academy of Cosmetic Dentistry, a fellow in the Academy of General Dentistry and is director of the Advanced Aesthetic Dentistry and Anterior Direct Resin programs at the Las Vegas Institute for Advanced Dental Studies. Jackson maintains a private practice in Middleburg, Va., emphasizing comprehensive restorative and cosmetic dentistry.
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- Dr. Brian C McDowell Fitchburg, MA

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Gordon J. Christensen, DDS, MSD, PhD (Dental Economics October 2008): “Now is the time ... for dentists to patronize companies that produce quality implants sold at a reasonable price.”

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<th>Why should YOU pay more?</th>
<th>Implant</th>
<th>Cover Screw</th>
<th>Healing Collar</th>
<th>Straight Snap Abutment</th>
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Tobacco cessation intervention: pharmacotherapy

By Carol Southard, RN, MSN

A n updated clinical practice guideline released by the United States Public Health Service on May 7, 2008, identified new medication treatments that are effective for helping people to quit smoking. No matter the level of addiction, anyone attempting to quit should consider trying at least one or more of the effective pharmacotherapies.

The goal of cessation pharmacotherapy is to alleviate or diminish the symptoms of withdrawal. The more physically comfortable the smoker is, the more likely he or she will make a serious quit attempt and succeed in permanently quitting.

Assessing pharmacotherapy’s application
Tobacco use is a complex behavior involving the interplay of physiological, psychological and habitual factors that continuously reinforce one another to promote dependence. One way to determine if pharmacotherapy would be helpful is to determine the level of physical addiction. Two hallmarks of dependency include smoking within 30 minutes of arising from sleep and experiencing withdrawal symptoms if a regular pattern of use is disrupted. The cardinal withdrawal symptoms include a craving for nicotine, irritability, anxiety, fatigue, difficulty concentrating and restlessness.

Approved medications
Currently, the FDA-approved, first-line agents for smoking cessation include five nicotine replacement therapy (NRT) products and two non-nicotine medications. All of these medications were found to be effective first-line medications in the guideline’s meta-analyses. There is no question that the odds of a smoker quitting are increased by using a pharmacological treatment.

In addition, multiple combinations of medications were shown to be effective. For the first time, the 2008 clinical practice guideline update assessed the relative effectiveness of cessation medications. These comparisons showed that two forms of pharmacotherapy, varenicline (Chantix) used alone and the combination of a long-term nicotine patch plus ad lib (i.e., as needed) nicotine nasal spray or gum, produced significantly higher long-term quit rates than did the patch by itself. This is “off label” use, but now it is definitively medically sanctioned. (I have been encouraging my own clients to use multiple NRT products for years!)

A reason to smile: New immigrants respond best to oral hygiene campaign
Tapping into the desire to have an attractive smile is the best motivator for improving oral hygiene, and new immigrants are the most receptive to oral health messages, according to a new study in the Journal of Consumer Research.

Authors Shuili Du (Simmons College), Sankar Sen (City University of New York), and C.B. Bhattacharya (Boston University) evaluated the effectiveness of an oral health outreach program that was launched in 2000, according to the U.S. Department of Health and Human Services (2002), there is a “silent epidemic” of dental and oral diseases in disadvantaged communities. They found that focusing on the social benefits of having a beautiful smile was the most effective strategy for improving dental hygiene habits among participants.

“Our findings suggest that, among children from less acculturated families, participation in this oral health program leads to not only more favorable beliefs about the health-related (preventing cavities and gum diseases) and psychosocial (beautiful smile and self-confidence) benefits of oral care behavior, but also an increase in oral care behavior such as brushing, flossing and dental checkups,” write the authors.

The research found that families that had been in the United States longer were less responsive to the program’s messages than new immigrants.

According to the U.S. Department of Health and Human Services (2002), there is a “silent epidemic” of dental and oral diseases in disadvantaged communities, particularly among children of minority racial and ethnic groups. The researchers conducted focus groups of participants in urban areas with large Hispanic populations. Those participants were parents of children in the national oral health outreach program that was launched in 2000, with the involvement of a corporate sponsor, the Boys and Girls Club of America, the American Dental Association, and dental schools.

And here’s good news for the corporate sponsor: The parents who participated in the program said they intended to reciprocate by purchasing the sponsor’s products. “Their intention to reciprocate toward the company is proportionate to their perceptions of how much the program has helped their children and family,” the researchers concluded. (Source: University of Chicago Press Journals)
Dear Readers,

Every time we turn around these days we can’t help but hear about the state of the economy. It is affecting most everything currently, including dentistry. While people are trying to spend less money on things they don’t think are necessary, they might put off dental needs as well. Some patients view dental care as a luxury and not as an essential piece necessary to complete the puzzle of overall health. This train of thought leads to canceled appointments and lost revenue for the dental office. So short of dragging patients in off the streets, what can the dental team do to help patients realize that preventive dentistry is necessary? Education is paramount!

At each professional cleaning and dental check-up appointment, clinicians need to be reiterating the connections between oral health and overall health. Patients need to be taught that bleeding gums are not healthy and may be a sign of much larger problems. Co-diagnosis needs to be taking place with each patient that sits in the dental chair.

Patients understand what they are being told much better if they can see the issue. Who is able to believe there isn’t a problem if they see the issue with their own eyes? If patients understand why they need to return to the office, they are more likely to place the visit on the necessary list rather than the luxury list.

It is time to pull out all the stops so dental offices remain productive through these shaky times. Educate, educate, educate! This is no time to be chat-ting and polishing.

If you have any comments or suggestions on this topic, please feel free to let us know!

Best Regards,

Angie Stone, RDH, BS
Editor in Chief

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**Upcoming Event**

‘Train the Trainer’ workshop on infection control

The United States Air Force (USAF) and the Organization for Safety & Asepsis Procedures (OSAP) will hold their 2009 Federal Dental Services Infection Control Training Course from Jan. 12–15, 2009 at the Crowne Plaza Atlanta-Ravinia Hotel in Atlanta. This four-day “Train the Trainer” course is recommended for everyone responsible for their dental facility’s infection control and safety program. The Federal Dental Services Infection Control Training Course offers a way for dental professionals to verify competency in dental infection control and safety principles. The program will provide the latest information on the implementation and management of effective infection control and occupational health and safety programs for dental settings, emphasizing the infectious diseases and occupational risks associated with dentistry.

The program is geared to federal services dentists, hygienists, dental assistants and laboratory technicians who have been assigned responsibilities in infection control and occupational health/safety, but is also applicable to large civilian dental practices, health maintenance organizations, dental insurers, dental manufacturer sales/marketing staff, dental infection control consultants, faculty of dental schools, dental hygiene and dental assisting programs, and infection control nurses who work closely with dental clinics.

Attendees can receive up to 27 C.E. hours. OSAP and the USAF are American Dental Association (ADA) CERP recognized providers. These credits are also accepted by the Academy of General Dentistry.

For more information, visit the www.OSAP.org Web site. There are also opportunities for companies to exhibit products and services at the product vendor fair. For more information, call (800) 298-OSAP (6727).

OSAP is the Organization for Safety and Asepsis Procedures. Founded in 1984, the non-profit association is dentistry’s premier resource for infection control and safety information. Through its publications, courses, Web site and worldwide collaborations, OSAP and the tax-exempt OSAP Foundation support education, research, service and policy development to promote safety and the control of infectious diseases in dental health care settings worldwide.

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Whether you choose our fashionably Pink selection of Masks, our powerfully Pink Premium® Saliva Ejectors or dozens of other Pink single use dental products for your office, your Pink purchase takes on a far greater purpose.

For more information on our Pink with a Purpose program, or to request our “Pink” catalog, call Crosstex toll free at 1-888-776-7783 or visit www.crosstex.com/pink.

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From Page 1

tion: the Nicotrol Nasal Spray, which appeared in 1996, and the Nicotrol Inhaler that appeared in 1998. The final NRT product to materialize, obtainable without a prescription, is the nicotine lozenge, which has been on the market since 2002.

Research and labeling

Almost all researchers agree that nicotine is not a carcinogen, and there is growing consensus that nicotine derived from medications does not promote cardiovascular disease. All of the NRT formulations are associated with slower onset and much lower nicotine levels than are cigarettes, and, of course, they do not produce carbon monoxide, toxins and carcinogens. The safety and abuse records of NRT have been excellent. The choice of NRT should be individualized — based on preference, past experience, smoking dependence and habits.

The labeling on NRT products still instructs tobacco users to consult their clinician if there is a history of heart disease, ulcers, hypertension or if the patient is pregnant or breastfeeding. However, the only contraindication in the guideline is: severe arrhythmia, serious or worsening angina pectoris, accelerated hypertension.

There is a documented lack of an association between NRT and acute cardiovascular events in persons who continue to smoke while on the patch as well as in those who have had past cardiac events!

The guideline recommends the use of NRT in pregnancy if other therapies have failed. Clearly, the fetus is exposed to significantly less nicotine with NRT than with smoking and, most importantly, is not exposed to carbon monoxide, carcinogens and toxins from cigarettes.

‘Light smokers’

Light smoking has become more common, perhaps due to smoking restrictions and increases in the price and taxation of tobacco products. Many light smokers have a strong dependence even though they smoke relatively few cigarettes. They are less likely to receive treatment than are heavier smokers, but anecdotal evidence shows an increase in success rates for light smokers with the use of NRT. At the other end of the spectrum, higher than recommended doses may be indicated in tobacco users with severe addiction. Failure to respond to NRT products may reflect inadequate dosage, incorrect usage or both.

Other options

Bupropion There are two non-nicotine medications available to tobacco users as well. Bupropion (Zyban), an atypical antidepressant, has been shown to double quit rates. It blocks the reuptake of dopamine and norepinephrine in the central nervous system, which modulates the dopamine reward pathway and reduces cravings for nicotine and symptoms of withdrawal. It is effective in those whether or not the symptoms are current or past depressive symptoms. Combining bupropion with NRT often increases success rates over bupropion used alone.

Varenicline The most recent non-nicotine medication is varenicline (Chantix), a partial agonist selective for a specific nicotine receptor subtype, and it was approved in 2006. The drug’s efficacy is believed to be the result of a sustained, low-level agonist activity at the receptor site, combined with competitive blockade of nicotine binding. The partial agonist activity modestly stimulates receptors, leading to increased dopamine levels that reduce nicotine withdrawal symptoms. By blocking the binding of nicotine to receptors in the central nervous system, varenicline inhibits the surge of dopamine release that occurs immediately (seven to 10 seconds) following each inhalation of tobacco smoke. This effect may help prevent relapse by reducing or even eliminating the pleasure linked with smoking. Evidence suggests that using varenicline can increase successful quitting three times more when compared to placebo.

The hygienist’s role

Dentists have prescriptive powers for all cessation pharmacotherapy. Once the RDH assists the patient in determining which medication may work best, the dentist should be approached for prescriptions as appropriate. Few health interventions have such overwhelming evidence of effectiveness as cessation medications. The seven first-line FDA-approved therapies reliably increase long-term smoking abstinence rates. All approximately double the rate of cessation when compared to placebo.

Smokers cite a health professional’s advice to quit as an important motivator for attempting to stop smoking. With effective education, counseling and support (rather than condemnations and warnings about the dangers of smoking), hygienists can provide an invaluable service.

About the author

Carol Southard, RN, MSN, 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 on smoking cessation throughout the nation. Southard served as the project consultant of the Smoking Cessation Initiative, a national program under the auspices of the American Dental Hygienists’ Association. Recently, Southard joined the staff of the University of Chicago Medical Center as a Study Therapist for the Clinical Addictions Research Laboratory. In addition, Southard was instrumental in launching the Chicago Second Wind: A Chicagoland Smoking Cessation Initiative.

Southard is also a Tobacco Treatment Specialist with the Northwestern Memorial Physicians Group Wellness Institute at 150 East Huron, Ste. 1100 Chicago, Ill. 60611 Tel.: (312) 926-2069 Fax: (312) 926-5444

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