More than 550 exhibitors to be at ADA meeting

"America’s Dental Meeting" is Oct. 9-14 at the Henry B. Gonzalez Convention Center in San Antonio. The “Alamo City” will welcome thousands of dental professionals, families and friends for the 2014 American Dental Association annual session.

The meeting features more than 300 continuing education courses, C.E. options before and during the official dates, more than 550 companies and organizations represented in the exhibit hall, the second ADA Mission of Mercy charitable dental event, a variety of special events, networking opportunities and the annual House of Delegates meeting.

You can find detailed descriptions of the continuing education courses, the listing of exhibitors and information on special events, hotels, attractions and registration in the preliminary program available through the meeting website, www.ada.org/session.

Meeting-goers will also be able to use the online schedule builder eventScriber to plan their schedules.

Among the meeting’s many highlights, President George W. Bush is scheduled to deliver the keynote address at the “Opening General Session and Distinguished Speaker Series,” Oct. 9, 9:10-30 a.m., at the Alamodome.

Plan out your exhibit hall visit

Hours for the exhibit hall, in the convention center, are: 10:30 a.m.–6:30 p.m. on Thursday, Oct. 9; 8 a.m.–5:30 p.m. on Friday, Oct. 10; and 9:30 a.m.–3 p.m. on Saturday, Oct. 11.

With more than 550 companies on the exhibit hall floor, it might be worth planning out your visit in advance. To help, the ADA 2014 exhibit hall floor plan is available at www.ada.org/session, enabling you to search for exhibitors by name or product category. You also can

See ADA, page A4
Recollections of seasons past and present

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

Reflections this time of year may evoke a simulacrum of dental meetings with innovations, such as the presentation of new techniques (revived and modernized from dental cosmos publications) or new-again computerized mechanisms to treat patients.

Perhaps it may evoke the excitement of seeing our kin and colleagues once again, while laughing over past experiences. Usually, large gatherings of dentistry are destined to place in large, new convention centers. We may recall previ-ous meetings held in large hotels, warmer and more personal, and reminiscent of some personal history. Now, large dental conventions command large convention halls, acquiring more economic support. These convention centers have different size rooms that are adaptive to different crowds, computerized luxuries that detail all that we need to know without asking questions, and details of where and who will be presenting, and which group is actually meeting and at what time. Still, they are impersonal and all-consuming.

I inquire, while reading the myriad list of organizations at our meeting. “Where did all of these initials come from?” Societies, study clubs and state organizations—state ones next to national, adjacent to international, with so many initials.

While the daylight disappears earlier, there is a slight coolness in the air, and the excitement of seeing friends grows once again. I think of hugging a classmate, a teacher, a lost colleague, and it brings a smile as a leaf starts to descend. Once again, I think of hugging a classmate, a teacher, a lost colleague, and it brings a smile as a leaf starts to descend.

The article ‘Alphabet Soup’ I had written previously with enthusiastic reception, is being reborn in this edition and perhaps will be published annually until the oculus rift dental meeting inundates our dental assemblies.

Alphabet soup

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

A dilemma. We now have so many dental groups that we have almost run out of letters of the alphabet. As group after group abbreviates its name, we are at a loss to tell one from another without a scoreboard. Either we need a new alphabet or more exotic sound-dental organizations with as yet, unused letters. History relates its alphabet beginnings to Mesopotamia, where early transcribers used grouped lines on a ball, or gourd-like container. These scratches of lines became the beginnings of written communication.

Flashing forward to mobile communications of today, where time pressures have abbreviated words, and we have a lingo all of its own. Abbreviating is a modern necessity.

To begin with, you cannot tweet—under twittering rules—over a certain word limit. There is a definite division, albeit not always a clear one, between the Baby Boomers and the Baby Stewards. Fortunately, having a college-aged daughter has given me a little head up in this language. For example, CUL means “see you later” and POS means “parent over shoulder.” Everyone is in a rush—but to where? Tired thumbs? And communication stands in line behind speed.

There is a definite division, albeit not a sharp one, between the Baby Boomers and the computer generation, sometimes alluded to as “nester.” Whereas Baby Boomers enjoy direct personal communication, nesters prefer computer communication. Abbreviations then become even more important.

We are running out of letters to distinguish the plethora of dental organizations. A rebus should represent a meaning, or a riddle perhaps. The ADA, for example, stands for American Dental Association. But, it could also represent the American Dermatological Academy.

At least the GNYDM, representing the largest dental meeting in the U.S., has unique letters in its title and will not be confused with any other group. There is also the ERA mini implant, not to conflict with the ERA in baseball. By the way, has anyone ever seen a maxi implant? Between the Aacd, ASDA, Aade and Aaid, one wrong initial and you’re in the wrong state or country and have to pay new dues. The ESC, Eastern Society of Cariology, must not be confused with the ESC, European Society of Cardiology. The idea of written language is to give unique connotation to words. Abbrevi- ating these words with initials not only obviates the communication, but makes it confusing. Abbreviations have become the teratogen of communication.

To help ameliorate this confusion I am proposing a Hoexter’s Index (HI), which will not only speed up communication, but will satisfy tetchers and texters alike. I propose that we assign a color to every dental specialty. For example, I suggest burgundy for general practitioner, red for periodontics, green for implants, yellow for oral surgery and (maxillofacial), orange for endodontics, blue for esthetics, black for pathology, gray for dental materials, pink for orthodontics and pedodontics, and brown for prosthetics. This way, each respective group would be required to use that color in its initials. When publicizing an AO meeting, we would recognize that an AO meeting was for the Academy of Osteointegra-tion, an implant group, as compared to an AO meeting which would be for Al-phama Omega, a dental fraternity group. Also, we would know that AAP represents the American Academy of Periodontics, which would not be confused with the AAP, or the American Association of Prosthodontics. Unfortunately, unless we have a color chart, we will be just as confused, but it will be much more colorful. This is only a suggestion, and any thoughts or other solutions would be received and considered for publication as well.

Tell us what you think!

Do you have general comments or criticisms you would like to share? Is there a particular topic you would like to see articles about in Dental Tribune? Let us know by sending an email to feedback@dental-tribune.com. We look forward to hearing from you!

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Winter Clinic: New home for big day

The 77th Annual Winter Clinic is on the move, with its 2014 meeting day scheduled for Friday, Nov. 14, at the Toronto Sheraton Centre. The new venue presents a great opportunity to add an evening or even the rest of the weekend in downtown Toronto to the end of the single-day conference. The Sheraton Centre is connected to the financial and entertainment districts by way of the PATH, a 16-mile underground network of shops and services. A wide selection of shopping destinations, the Mirvish Toronto theatres, world-class dining and major Toronto museums are steps away. Among the attractions: Art Gallery of Ontario, Royal Ontario Museum, Hockey Hall of Fame, Harbourfront, Casa Loma, Ontario Science Centre, Niagara Falls, Casino Niagara, Casino Rama, Ontario Place, Air Canada Centre, Rogers Centre (formerly SkyDome), Eaton Centre, Holt Renfrew and Yorkville Shopping District.

Broad spectrum of topics

The Winter Clinic is the largest one-day dental convention in North America, attracting dental professionals who come to learn from world-class speakers and explore and save on products and services. This year’s clinical program covers a broad spectrum of topics and includes an examination of the way digital technology is transforming the workflow in the dental office, demonstrations of cutting-edge tools and equipment, specialized techniques for prosthetic tooth repositioning, the use of lasers in periodontal therapy, a discussion of current views on the use of X-rays as a diagnostic tool, advice on the latest legal requirements for health and safety in the dental office, and how to meet the demands of your modern dental practice through healthy habits and humour.

You can bring the whole team to share the knowledge. The single-day event features 24 separate programs in contemporary dentistry, offering something for all.

(=Source: Toronto Academy of Dentistry)

For more information or to register for the annual session, visit the ADA’s meeting website at www.ada.org/session.

(=Source: American Dental Association)

The single-day Toronto Academy of Dentistry Winter Clinic, Friday, Nov. 14, has a new home: Toronto Sheraton Centre. Photo/Provided by Starwood Hotels & Resorts Worldwide

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MEETINGS

Dental Tribune U.S. Edition | October 2014
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Microscopic dentistry event features hands-on opportunities benefitting all dental specialties

Experienced AMED members and novice visitors alike are invited to Nov. 14–16 meeting

The Academy of Microscope Enhanced Dentistry’s 13th Annual Meeting and Scientific Session, “Pathways to Perfection,” runs from Friday, Nov. 14, through Sunday, Nov. 16, at the University of Maryland, Baltimore Southern Management Corporation Campus Center. Hands-on courses will be at the University of Maryland School of Dentistry.

Meeting and registration details are available at www.microscopedentistry.com. A variety of lectures and courses are on the agenda, aimed at experienced microscope users and those who are simply interested in learning more about it. Among the offerings:

• “New Frontiers in Periodontal and Bone Regeneration,” presented by Mark A. Reynolds, DDS, PhD, MA.
• “Dental-Labial Harmony through Cosmetic Dentistry and Injectables,” presented by Laurence Rifkin, DDS.
• “Microsonic Management of Calcified Canals,” presented by Noushad Rahim, BDS, MDS, MF GDP, MF DF RCS Eng.
• “Protocol of Preparation for Full Crowns and Veneers with Microscope — Full Mouth Micro Invasive Rehabilitation,” by Nazariy Mykhalyuk, DMD.
• “Ultrasonic Preparations. Myth, Magic, and Magnification,” presented by Jeff Hamilton, DDS.
• “Microscopically Guided External Sinus Floor Elevation (MGES) — A New Microsurgical Protocol in Oral Implantology,” by Behnam Shakibaie, DMD.
• “Minimally Invasive Interventions for Working with a Microscopic View.”

Working with a microscopic view. Photo/Provided by Assad Mora, DDS, MSD, FACP

Esthetic Dentistry,” presented by Masayuki Okawa, DDS.
• “Microscope Enhanced Restorative Dentistry: A Prosthodontic Perspective,” presented by Keith Boenning, DDS.
• “Techniques of Micro Suturing,” presented by Arnold Sindler, DDS.

(Source: AMED)

The 2015 Yankee Dental Conference 40th year celebration, Jan. 29 through Feb. 1, at the Boston Convention & Exhibition Center, will include celebratory activities in the exhibit hall, Jan. 29 through Jan. 31. There also will be the usual abundance of C.E. credit opportunities.

• On Thursday, Jan. 29, registered attendees will receive $5 in Yankee Dining Dollars to be used toward any food or beverage purchase on the exhibit hall floor between 11:30 a.m. and 2 p.m. Then in the afternoon, you can enjoy a complimentary 40th birthday cupcake.
• The Fabulous at 40 Reception, 4–5 p.m., Friday, Jan. 30, provides an opportunity to enjoy complimentary wine or beer and snacks while socializing with colleagues and browsing the show floor.
• On Saturday, Jan. 31, the exhibit hall hosts the 15th Annual Chowder Tasting at noon in the food court. Attendees will be able to sample award-winning chowder from Levy Restaurants, Hilton Back Bay, Seaport Hotel, Hyatt Regency Boston and Starwood of Boston.
• There will be multiple daily chances to win rewards by shopping in the exhibit hall. Spending $5,000 enters you to win an AMEX gift card. Also, Mystery Shoppers will reward random exhibit-hall shoppers with gift cards. And there will be opportunities to win free registration to YDC 2016.
• The Lounge provides an opportunity to take a quick break while charging your phone or tablet and having a bite to eat.
• The High-Tech Playground provides the opportunity to test drive the latest in dental technology. Demonstrations featuring state-of-the-art devices and services will take place each day. The idea is to let attendees try out products free of sales pressure and watch presentations before serious shopping on the exhibit hall floor.
• At the Live Dentistry stage, you can learn from some of the profession’s top clinicians as they perform actual procedures. Exhibit hall hours are 9:30 a.m.–5:30 p.m., Jan. 29 and 30 and 9 a.m.–4 p.m., Jan. 31.

(Source: Yankee Dental Conference)
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By Dr. Bob Clark, Founder, DrQuickLook

As a practicing dentist of more than 34 years, I want to buy products that have an impact on my practice. As inventor of DrQuickLook™ products, I am asked about how these intraoral cameras are used in my practice. I recently transitioned to our latest and greatest units — DrQuickLook SD Basic and SD Plus. I thought I would try to relate my office usage to some issues that come up all too often in the practice. See if any of these ring a bell!

"My cap fell out." How many times have you heard that refrain? And how many times was it truly a cap having fallen out? More likely it fractured at the gumline and the understructure you spent so much time fabricating is now level with the gumline. You can either tell the patient the circumstances and recommend extraction or try to perform some heroics to salvage the crown and the tooth for an unknown period of time. Either way, the patient is going to think that there was a whole lot of tooth and you just wanted to charge them an extraordinary amount for what you did. So what’s the answer? Easy — DrQuickLook SD Basic or our SD Plus model.

When that case walks into my office, the patient visit will begin with a clear look at the inside of the crown then a look at the remaining tooth structure. I don't mean one look — I mean several views to show everything and leave no stone unturned. Images of the internal crown and the tooth structure are saved for future review. Even if you show the patient everything — and I mean everything — you know in your heart that they will come back with the thought that the tooth really wasn’t that bad. I love the Quick Draw feature on the SD Plus model here because it allows me to highlight the really critical parts of any image. Yes, I save them too. So here’s to sleeping better at night and making sure your patients see what you see! I'll make a confession here. I don’t take the images or do the transfer personally. DrQuickLook SD products are so easy to use, my staff does all the work.

Taking before and after images of a restorative procedure is a great idea. But one thing has been left out, and it’s the most important one: It’s the “middle image.” Once an old amalgam restoration has been removed, we often see recurrent decay and lots of fracture lines. The patient, however, thinks that once the filling is out, the tooth is pristine again — just like new. How far from the truth is that!

I always have the assistant take an image before I enter the operatory. When the filling is out I grab my DrQuickLook SD Plus and within 10 seconds have a couple of images of the grisly remains. I then restore the tooth with a beautiful new restoration. Before I leave the room I like to personally show the patient the “middle image(s)” and highlight the problem areas — fractures, thin remaining enamel or maybe an exposure — with our Quick Draw feature. Drawing on the images is powerful and will focus the patient. I then recommend further treatment (usually a crown if needed or comment on potential issues (usually a root canal). Once I exit the operatory, the assistant shows the patient the final restoration and compares it to the original. Transparency. Clarity. The patient knows everything I do. They know what they are paying for. All the images — including the ones I drew on — are saved for a time when the patient has curiously forgotten how bad things looked.

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3 online tips that will increase appointments

By Diana P. Friedman, President, CEO
Sesame Communications

In today’s connected world, your future patients depend on the Internet to manage almost every aspect of their lives. However, the tremendous expansion of the Internet makes reaching and engaging with them a constant challenge. According to business intelligence firm Domo, every minute 571 new websites are created, more than 100,000 tweets are sent, and Facebook users share 684,478 pieces of content.1

Here are three ways to ensure your practice rises above the persistent noise to connect with prospective patients and convert them into new patient appointments.

1. Tailor your website for an amazing patient experience: In the connected world, prospective patients will form an immediate opinion of you and your services based on what they see and experience online. To ensure your website will drive new patients to choose your practice, ask yourself the following questions:
   - Do I have a functional website? If not, your practice is invisible to the connected world.
   - Does my website appeal to patients? Make sure your website reflects the vision of a developer who has taken a research-based approach to designing sites with prospective dental patients in mind.
   - Is my website optimized for mobile devices? As of January 2014, 87 percent of smartphone users accessed the Internet using their phones. If your website does not automatically optimize, your prospective patients will likely head to a competitor.

2. Make SEO a priority: Once you have your website in order, you need to make sure prospective patients can find it. Eighty percent of traffic to a website begins with a search query, and 61 percent of searchers consider local results to be more relevant than standard search results.3 This makes search engine optimization (SEO) efforts a must. A key here is to use a firm well versed in local SEO strategies within the dental industry to achieve lasting results.

3. Energize your social media efforts: According to a recent study, Internet users spend more time on social media than any other Internet activity.4 Embracing a social media presence enables you to spend time effectively forging genuine relationships with prospective patients. In terms of where to invest in social media: Facebook, YouTube and LinkedIn are three places where you should focus your efforts. If your practice wants to attract more new patients, it is important that you be active and engaged on these three social media channels.

Final thoughts

The Internet is your best source for reaching prospective patients — and focusing on these three strategies will help your practice create connections that convert into new patient appointments.

References
2. www.pewinternet.org/2012/11/08/mobile-health-2012/
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Dental
A BruxZir solid zirconia veneer case

By Michael C. DiTolla, DDS, FAGD

Glidewell Laboratories’ weekly online series “Chairside Live” has given us a great opportunity to communicate with clinicians across the nation and educate them on topics that they’re actually interested in learning. If you haven’t yet had the opportunity, episodes can be viewed on demand at www.chairsidelive.com or on YouTube and iTunes.

In the Case of the Week from Episode 105, I wanted to try something that I really hadn’t done before. I’ve done some anterior BruxZir® restorations, and they turned out well, but I had yet to do an anterior crown case in conjunction with a BruxZir veneer. This is going to be a straightforward case on teeth #8 and #9 with a BruxZir crown and a BruxZir veneer adjacent to it.

Case presentation

This patient had a pre-existing PFM on tooth #8 that was a poor esthetic match (Fig. 1). Because of the patient’s deep overbite, I liked the idea of using a BruxZir crown for tooth #8 because I could keep it almost as thin as that PFM was on the lingual. I also planned to have the lab fabricate a BruxZir veneer for tooth #9, which happened to be facially deficient anyway. I anesthetized the patient and took off the crown. The prep had been endodontically treated, and it looked like a good gold post was placed in the incisal edge. We placed the first cord (size 00) and then prepared the gingival third of the tooth. Because the tooth already had a PFM, I didn’t have to do a ton of reduction, it was more about where I did the reduction.

While reducing, I exposed a little bit of dentin, so I covered it with a self-adhering composite resin and then finished smoothing off the prep (Fig. 2). I placed the top cord (size 3), which upon removal left us a wide open sulcus that would be simple to impress.

Six days later, we took off the temporary and tried in the final restorations, which the patient approved. We cemented the crown with Ceramic® Crown & Bridge cement (Dona Dental, Newport Beach, Calif.). The thing I love about Ceramic cement is that it bonds on its own to zirconia without requiring you to decontaminate the internal surface of the BruxZir crown or use a zirconia primer Plus, the cement will typically clean up in just one piece (Fig. 3).

With the crown placed, I then turned to the veneer. After try-in, I decontaminated the internal portion of the BruxZir veneer by sandblasting it for 15 seconds. I then placed a layer of Z-Prime Plus and air thinned it, and then placed a layer of bonding agent and air thinned it. I isolated the two adjacent teeth with mylar strips and then etched with phosphoric acid, rinsed, placed the bonding agent, air thinned it, placed the veneer with the light-cured resin cement inside and cured it. You can definitely light-cure through solid zirconia. Try it yourself when you receive the case.

Here’s the patient with the crown and veneer in place (Fig. 4). It looks pretty good, considering those are BruxZir solid zirconia restorations with no ceramic on the facial. BruxZir continues to look better because of the increased translucency of the material. I’m now feeling more confident that if I’m placing a crown on a single anterior tooth that I can place a BruxZir veneer on the tooth next to it. As long as #8 and #9 match, we have a chance of having a nice smile.

Wykle Research offers Calasept Endo line

Wykle Research offers Calasept Endo products, which it distributes for Nordiska Dental of Sweden, the manufacturer of Calasept and Calasept Plus.

Calasept Irrigation Needles are high-quality, double-side-vented, luer-lock irrigation needles that optimize the cleansing of canals, creating a “swirl effect.” The needles are available in 27 g or 31 g, in packs of 40 needles.

Features include the following:
• Bendability
• Luer-lock hub
• Sterile and disposable
• Designed for ease in cleaning roots
• High-quality stainless steel

Calasept Irrigation Syringes are 3 ml luer-lock, single-use syringes. They are color coded to eliminate risk when using multiple irrigation liquids. They are available in packs of 20 syringes, 10 white and 10 green.

Features include the following:
• High-quality, three-part syringe
• Color coded
• Luer lock

These products complement Wykle’s popular Calasept line, which includes Calasept and Calasept Plus calcium hydroxide paste for temporary filling of root canals, sold in packages of four syringes with 20 needles. Calasept EDTA is 17 percent EDTA solution. Calasept CHX is 2 percent chlorhexidine solution for irrigation. Both solutions are packaged with a luer adaptor for easy filling of syringes.

For more information, contact Wykle Research at (800) 859-6641 or visit the company’s website at www.wykleresearch.com.

(Source: Wykle Research)
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Many dental products are used only once, including mixing tips used to prepare cements, impression materials and temporary crown-and-bridge (C&B) material. Following application, the mixer and any material left inside is discarded. To help dentists work more efficiently and sustainably, Switzerland’s Sulzer Mixpac has enhanced its tried-and-tested mixers: The new T-MIXER™ is significantly shorter, so material can be mixed even more quickly. For example, the new blue model saves about 0.4 ml of material per C&B application compared with its predecessor. If a dentist performs an average of four C&B sessions per day, this adds up to 350 ml of savings every year, which is equivalent to seven 50 ml C&B cartridges. Assuming average costs of $100 per temporary C&B material cartridge, the new T-MIXER helps cut annual material costs by approximately $700. And the mixing result is even better. A T-MIXER’s endorsement by The Dental Advisor1 affirms its clinical evaluation. This product enables dentists to not only improve the health and well-being of their patients, but also make their business more efficient, according to the company.

Learn more about Sulzer’s T-MIXER product family from your specialty retailers and by viewing a short film at bit.ly/T-Mixer.

(Source: Sulzer Mixpac)

### Reference

1. The Dental Advisor, published by Dental Consultants Inc., clinical evaluations of products.
THE 1ST INTERNATIONAL SYMPOSIUM ON
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PRE-SYMPHOSUM
THURSDAY, OCTOBER 23, 2014

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October 23–25, 2014
Renaissance Orlando at SeaWorld, Florida

Jonathan Ferenz, Scientific Chair

Speakers
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Markus Blatz        Paulo Kano
Lawrence Brecht     Carlo Marinello
Marcelo Calamita    Walter Renne
Lyndon Cooper       Irena Sailer
Lee Culp            Nelson Silva
Vincent Fehmer       Eric Van Dooren
German Gallucci     Peter Wöhrl

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HENRY SCHEIN DENTAL
Hard to achieve orthodontic stability? Answer may be blowing in the wind

By Dr. Daniel Hanson, BDS
Sheffield, UK

The majority of children today exhibit some degree of malocclusion,1,2 and it has been well documented that this is related to soft tissue dysfunction.3 In fact, it is now so well accepted that the muscles of the tongue, lips and cheeks play a major role in tooth position and jaw development that there are contemporary pre-orthodontic clinics around the world using myofunctional philosophy to treat children between the ages of 5 and 15 (Myobrace® Pre-Orthodontic Center).

Despite these evolutionary myofunctional treatment systems achieving outstanding results, a small percentage of cases that prove difficult to treat remains. This raises questions regarding what is causing these stubborn cases as well as how best to treat them when all obvious poor myofunctional habits, such as digit sucking, tongue postural issues and dysfunctional swallowing patterns, have all been addressed in the myofunctional sense. It appears that answers may be uncovered by examining the child’s airways and breathing patterns.

Relevant literature explains how mouth breathing is a significant factor in the aetiology of malocclusion.3-5 In short, when mouth breathing occurs, the tongue moves down in the mouth to allow the passage of air above it. Furthermore, an open mouthed posture can affect the direction of growth as the muscles pulling on the jaws are affected. However, the real details of why children habitually mouth breathe are not so well documented.

Breathing dysfunction factors

Factor 1: Tongue and head posture. Breathing through the mouth causes the tongue to lower and also alters the head posture. This low tongue posture then leads to reduced maxillary growth6,7 and increases in vertical growth (Figs. 1a, b).

Factor 2: The Bohr effect and cellular hypoxia. It is important to be mindful that breathing dysfunction includes more than just mouth breathing. It also includes habitual hyperventilation, which means the patient will constantly be breathing an excess of air. This will then cause the bond between haemoglobin and oxygen to be weakened (Bohr effect), and while blood oxygen saturation can be normal, oxygenation at a cellular level may be reduced due to poor oxygen release from hemoglobin.

As a result, cells become stressed, and this cellular hypoxia can lead to dysfunction on a cellular level (Fig. 2).

My observations as a breathing educator and dentist practicing myofunctional orthodontics is that in addition to malocclusions, patients with poor breathing patterns also tend to have sinus congestion, asthma, hayfever, enlarged adenoids or tonsils as well as ADD, Asperger’s and other syndromes on the autism spectrum.

Factor 3: Becoming locked into a cycle of habitual hyperventilation. Patients who habitually hyperventilate become accustomed to breathing greater than the physiologic norm (> 35L/min at rest). It is hypothesized that habitual hyperventilation causes the trigger point at which the brain detects a level of CO2 sufficient to prompt the breathing reflex to become too low, and patients become sensitive to healthy CO2 levels, causing them to breathe an excess of air. Because such patients can get locked into this cycle of habitual hyperventilation, they may need extra help breaking the mouth-breathing habit.

What can help these patients?

An increasing number of dental professionals are focusing on innovative techniques to help patients break their cycle of habitual hyperventilation. These techniques involve a combination of breathing and airway awareness exercises intended to assist the patient to become accustomed to breathing smaller, healthier volumes of air. As a result, these patients learn to breathe less (retain more CO2), and more O2 is released to their cells and tissues. Additionally, airways remain clearer, patients often become healthier, and tongue posture improves when mouths remain closed.

These techniques are used by Myobrace Pre-Orthodontic Centers to treat the difficult 5 percent of cases where the patient does not adapt to a better breathing habit using Myobrace appliances along with myofunctional and breathing activities alone.

To predict which patients may require help correcting their airway dysfunction, they can be divided into three groups during treatment planning. It is important to note that the groups remain flexible:

Group 1 — Unlikely to require assistance (5 percent of patients) no asthma, no Hi of ENT, no medications, no regular illness.

Group 2 — May possibly require assistance (30 percent of patients) previous asthma, previous ENT; medications, regular illness.

Group 3 — Likely to require assistance (5 percent of patients) current asthma, current ENT; multiple/several medications, constant illness.

Patients classified into Group 1 and 2 are likely to change their airway dysfunction after treatment with the Myobrace System7,8, which encourages correct breathing. However, patients classified into Group 3, and in some instances those in Groups 1 and 2, are likely to require additional assistance.

Identifying habitual hyperventilators

Generally, habitual hyperventilators show:

- Mouth breathing, lips apart at rest.
- Shoulder/upper chest breathing at rest.
- Audible breathing at rest.
- Medical history of enlarged tonsils and/or adenoids, asthma, hay-fever, recurrent respiratory infections, snoring, teeth grinding or sleep apnea.
- Narrow upper arm form.
- Forward head/shoulder posture.

Conclusions

It is clear a correctly functioning tongue acts as a natural retainer, but when a patient habitually breathes through his or her mouth, the tongue is prevented from functioning in this correct way. In contrast, when the mouth remains closed and the tongue sits correctly, increased orthodontic stability can be expected.

Furthermore, when a patient maintains a closed-mouth posture and high-tone posture, treatment time can be expected to lessen as forces exerted on the teeth and jaws will work favorably. Finally, it has been well-documented mouth breathing is not in the best interests of health, growth and correct development.9,10 Therefore, it is reasonable to assume encouraging correct functional breathing patterns will have a much more far-reaching effect than just correcting crooked teeth and jaws.

Simple fixing the teeth and jaws is potentially missing a huge piece of the puzzle at the expense of possible health gains and future orthodontic stability.

References available from the publisher.
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Prosthesis rehabilitation achieved despite need to use damaged spherical abutments

By Carlo Borromeo, Dental Technician, Italy

For more than 20 years, the 70-year-old female patient had used a total upper prosthesis along with a lower prosthesis that was supported by two spherical metal abutments attached to retentive titanium. She came to the clinic for restoration of the two prostheses, both of which had been extensively damaged by many years of use. Additionally, the attachments, constructed of gold, had lost all retention ability. In the initial exam, extensive damage was noted with the attachment spheres (Fig. 1).

But to contain costs, the patient requested that the spheres not be replaced. So the spheres’ diameters were measured, and an individual impression carrier was constructed to obtain the definitive impression and the registration.

Once the teeth montage was completed, function and esthetics were established (Fig. 2). Lingual and vestibular (Fig. 3) silicon masks were built. The silicon masks provide useful indications in choosing the proper box for the retentive caps and for evaluating if there is enough space to build a metal structure to make the prosthesis more stable and resistant.

It was decided to use Rhein’83 elastic caps, which proved to be perfectly compatible with the spherical abutment diameters and enabled personalization of the prosthetic by creating elastic retention suitable to this specific case.

The reinforcement structure was constructed by using wax in the space between the tissues. The retentive caps were adapted over the spherical abutments and surrounding area, enabling isolation of a defined space where the two castable boxes for caps positioners could be placed.

See PROSTHESIS, page A19
in position (Fig. 4). After the Ot Box Classic boxes were placed in position, the available space was measured to complete the procedure with the lingual and vestibular masks (Fig. 5). The Ot Box Special boxes were then tested together with the masks to determine if adequate space remained available.

Once it was decided to use the Ot Box Special with the connectors, the castable components were connected with resin to create the structure using the silicon masks (Fig. 6). After the structure was completed, sprue followed, keeping the structure over the model (Fig. 7).

The sprue procedure was completed using castable pivots and a special metal stabilizing bar. Removal of the special bar from the model was completed after a fusion and investment procedure. The structure was cleared from the investment (Fig. 8). Then, to verify that the procedure was successful, a test was run over the model (Fig. 9). The structure was cleaned and modeled, and the retentive components were inserted and tested over the model (Figs. 10, 11). The masks were used again to reconfirm that the available space was sufficient (Figs. 12, 13). Modeling proceeded once the opaque process was completed (Fig. 14).

Use of the Rhein'83 special tool for the retentive caps insertion enabled a simple and safe insertion of the proper prosthetic components (Figs. 15, 16). The general structure was now completed and ready to be delivered to the clinic (Fig. 17). Once the test inside the oral cavity was completed, the pink retentive caps were replaced with the reduced-diameter green caps (Fig. 18) to improve the retention — providing optimal stability to the prosthesis and a better sense of comfort to the patient.

As mentioned, the initial situation was functionally compromised by the retentive components. But the quality of the repair materials enabled optimal final results, both esthetically and functionally. Time and costs were reduced thanks to proper use of the Rhein'83 solutions. The castable cap boxes were fundamental for the procedure and for the construction of the bar. The components satisfied the patient’s and dentist’s expectations. Proper use of the Rhein’83 components added a relevant value to the dental laboratory work.

CARLO BORROMEO founded Dental Laboratory Borromeo in Italy in 1988, specializing in the construction of prosthesis for implants using CAD/CAM. He collaborates with Nobel Biocare Procera, Dental Wings, Rhein’83 and other companies to improve his expertise with their materials. He is a highly published industry author and presents and participates in many dental lab courses and conferences.
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Fall for Smiles campaign spreads message about the importance of oral health

Brushing, flossing, healthy eating and regular dental visits are explained as key to a healthy smile

According to a recent Oral Health America (OHA) survey, two Americas are emerging when it comes to oral health care. Those with a household income of under $50,000, including many who live in urban areas and young adults (including students), are more likely to skip or delay a dental visit, with 74 percent of those surveyed delaying care for financial reasons or due to lack of insurance coverage.

That’s why OHA’s Fall for Smiles campaign is so important this year. Every September and October, the campaign teaches Americans about the importance of maintaining a healthy smile by brushing and flossing daily, regu-
Pho-phy paste is 1.23 percent fluoride ion and promises splatter-free application

Keystone’s Gelato comes in six flavors

By Keystone Industries Staff

Dental professionals can spend copious amounts of time searching for a prophy paste that does it all. A paste considered to be ideal would be one that works well for the dentist, does its job in patients’ mouths and enables patients to leave the office with a good taste. With Gelato prophy paste by Keystone Industries, the possibilities have no limits.

The paste, which provides a smooth, splatter-free application, is 1.23 percent fluoride ion and will leave a patient’s teeth with excellent polish — and stains removed. Minimal enamel loss is met with each use.

Review: “Top Prophy Paste”

One of the biggest bragging rights Gelato prophy paste has earned is from The Dental Advisor. For two consecutive years (2013 and 2014), Keystone’s paste won Top Prophy Paste. In the review, based on more than 2,500 uses with 35 consultants, it earned a 4.5 grade out of 5 with a 91 percent clinical rating. Consultants, it earned a 4.5 grade out of 5 based on more than 2,500 uses with 35

The ranking would appear to confirm how the paste gets the clinical job done and also provides patients with the flavor options to leave their mouth feeling fresh and clean.

Coming in four different grits (fine, medium, coarse and x-coarse), Gelato has a wide range of uses for removing stains. Dental hygienists normally use the fine grit for routine work, and work their way up the grit scale for heavier stain removals. Whether it is an easy or tough job, dental professionals can always count on the quality of Gelato to get the job done.

A flavor for every taste

Keystone’s Gelato comes in six flavors: bubble gum, cherry, mint, pina colada, orange sherbert and raspberry. The paste is available in 6- and 12-ounce jars, and also boxes of 200 individual cups. Available in four different grits (fine, medium, coarse and x-course), Gelato Prophy Paste has a wide range of uses for removing stains. Dental hygienists normally use the fine grit for routine work and work their way up the grit scale for heavier stain removals. Photo/Provided by Keystone Industries

For those looking to engage and educate children, the campaign website features an activity booklet, coloring page, brushing chart and tip sheet to make caring for your teeth fun. Those who want to spread the message of the importance of oral health in their communities can use a press release template, letter to the editor template, social media guide, website button and customizable poster.

OHA also hosted an event on Capitol Hill on Sept. 10 with Oral Health Care Can’t Wait, an initiative of the Dental Trade Alliance, to address the oral health needs of communities throughout the country and meet with members of Congress to encourage members to support policies that impact overall health through improved oral health.

To learn more about Fall for Smiles, you can visit the campaign’s website at www.oralhealthamerica.org/fallforsmiles. With help from dental professionals, OHA plans to reach millions of Americans with the message that oral health affects overall health.

(Sources: Oral Health America)
INDUSTRY NEWS

FDI World Dental Federation has launched a “data hub for global oral health,” an evolving online database of oral health statistics and indicators.

The site went live in early September with limited information but will expand and deepen in coming months. Data is being gathered from global sources, including the World Health Organization, Niigata University, Malmö University, World Bank and Globocan. Guided by the FDI Oral Health Atlas Task Team, the site www.fdiworldental.org/data-hub is charged with making country-by-country global oral health data easily accessible to health professionals, policy makers, the media, industry and the general public worldwide.

(Source: FDI World Dental Federation)

New ergonomic hygiene handpiece designed for optimum comfort

Young Dental’s design includes contra-angled connector

Designed to fit the contours of the hygienist’s hand, the new Young Hygiene Handpiece delivers the ergonomic comfort and control clinicians need during polishing.

The first hygiene handpiece ever made by Young Dental is designed with a unique contra-angled connector, which attaches the handpiece to air tubing at a 45-degree angle. This angled connection is designed to help reduce cord drag aggravation and to make the handpiece feel lighter.

Unlike straight-bodied handpieces, the Young Hygiene Handpiece is constructed with a Reverse Radius™ silhouette that’s curved to fit comfortably in the dental hygienist’s hand for a smooth, ergonomic performance. The handpiece’s engraved matte grip rotates 360 degrees to help reduce the need to shift the wrist so often during polishing.

“I loved your handpiece for its comfort. The reverse radius nestled in my hand, but most of all, the curved hose attachment and swivel made my wrist feel so much better. What a great design,” said Denise Crowell, RDH, who tested the new handpiece. “[Some other handpieces don’t] have the curved hose attachment – only the swivel, which causes fatigue. The grip was also superior and I didn’t need to use as much tension.”

The handpiece is designed for optimal performance when used with Young Dental disposable prophy angles, so clinicians can get the most out of their polishing routines. Each handpiece comes with samples of the company’s newest and most compact disposable prophy angle, Vera by Young.

When it comes to care and maintenance, the Young Hygiene Handpiece nosecone and motor easily detach into two parts for fast preparation and thorough sterilization. The handpiece is made in the United States and is backed by a two-year warranty with quality guaranteed.

You can visit www.youngdental.com for more information about the new Young Hygiene Handpiece.

About Young Dental
Young Dental is dedicated to providing the dental community with innovative, high-value products that reflect the professionalism of the industry. Based in Earth City, Mo., the company is a designer, manufacturer and marketer of consumable supplies, instruments and other products used by dental professionals primarily in preventive dentistry, restorative procedures and instrument sterilization. Young Dental is committed to continuous improvement and the creation of high-quality products.

(Source: Young Dental)

‘Data Hub’ for global health

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(Source: FDI World Dental Federation)
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1 Based on findings from an independent research study of Springstone customers conducted by M. Lucier Consulting, July 2013.
2 The APR ranges from 3.99% to 17.99%. For example, a loan for $10,000 with an 8.99% APR for 72 months will have a monthly payment of $181. The APR will be determined based on the applicant’s credit at time of application. All loans made by NBT Bank, N.A., Member FDIC, Equal Housing Lender.
3 Publicly available data for dental loans as of July 2014.