Dentists can identify undiagnosed diabetes

In a recent study, “Identification of unrecognized diabetes and pre-diabetes in a dental setting,” in the Journal of Dental Research, researchers at Columbia University College of Dental Medicine found that dental visits represented a chance to intervene in the diabetes epidemic by identifying individuals with diabetes or pre-diabetes who are unaware of their condition. The study sought to develop and evaluate an identification protocol for high blood sugar levels in dental patients and was supported by a research grant from Colgate-Palmolive. The authors report no potential financial or other conflicts.

“Periodontal disease is an early complication of diabetes, and about 70 percent of U.S. adults see a dentist at least once a year,” said Dr. Ira Lamster, dean of the College of Dental Medicine, and senior author on the paper. “Prior research focused on identification strategies relevant to medical settings. Oral health-care settings have not been evaluated before, nor have the contributions of oral findings ever been tested prospectively.”

For this study, researchers recruited approximately 600 individuals visiting a dental clinic in Northern Manhattan who were 40 years old or older (if Hispanic or non-Hispanic white), and had never been told they have diabetes or pre-diabetes. Approximately 250 patients with at least one additional self-reported diabetes risk factor (family history of diabetes, high cholesterol, hypertension or overweight/obesity) received a periodontal examination and a finger stick, point-of-care hemoglobin A1c test. In order for the investigators to assess and compare the performance of several potential identification protocols, patients returned for a fasting plasma glucose test, which indicates whether an individual has diabetes or pre-diabetes.

Researchers found that in this at-risk dental population, a simple algorithm composed of only two dental parameters (number of missing teeth and percentage of deep periodontal pockets) was effective in identifying patients with unrecognized pre-diabetes or diabetes. The addition of the point-of-care A1c test was of significant value, further improving the performance of this algorithm.

“Early recognition of diabetes has been the focus of efforts from medical and public health colleagues for years, as early treatment of affected individuals can limit the development of many serious complications,” said Dr. Evanthia Lalla, an associate professor at the College of Dental Medicine, and the lead author on the paper. “Relatively simple lifestyle changes in pre-diabetic individuals can prevent progression to frank diabetes, so identifying this group of individuals is also important. Our study sought to develop and evaluate an identification protocol for high blood sugar levels in dental patients and was supported by a research grant from Colgate-Palmolive. The authors report no potential financial or other conflicts.”

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Domestic violence survivors

According to the American Psychological Association, nearly one in three adult women experience at least one domestic assault by a partner during adulthood, which translates into approximately 4 million American women who experience domestic violence during a 12-month period.

As a dentist in Kalamazoo, Mich., Brett Magnuson, DDS, performs a spectrum of procedures designed to give his patients a fresh start in life. In cooperation with the American Academy of Cosmetic Dentistry (AACD), Magnuson dedicates his time and cosmetic dentistry expertise to the Give Back a Smile (GBAS) program, which provides free consultations and dental treatments for survivors of domestic violence.

The need is great for those affected by domestic violence. "The Give Back a Smile program, AACD members like me assist those in need by treating any dental injuries sustained from domestic violence," he says. "The AACD and I remain dedicated to helping these patients reclaim their smiles, their self-esteem, and ultimately, their lives."

Victims of domestic violence who have suffered dental injuries can contact GRAS toll-free at (800) 775-GRAS (4227), or visit www.givebackasmile.com for more information. Survivors of domestic violence must make an appointment with a counselor, domestic violence advocate, social worker, or therapist to complete the application section of the GBAS application.

GBAS then reviews the application and turns it over to the dentists. If eligible, the AACD connects the survivor with a local GRAS volunteer who provides treatment at no charge to the recipient.
The American Dental Implant Association is an organization that encourages collaboration and communication among dental implant professionals. It supports education and research to improve implant techniques and products as well as increase public awareness concerning the benefits of implant dentistry. This symposium will allow you the opportunity to hear from numerous experienced lecturers on the advancements and cutting edge techniques in implant dentistry of today and the chance to network, exchange information and socialize with colleagues and friends from around the country and the world.

SEPTEMBER 9–10, 2011
HYATT REGENCY MIAMI

This event fills up fast, so be sure to reserve your spot soon!
AGD members visit with lawmakers to advocate for general dentistry

Academy of General Dentistry (AGD) member dentists attended the AGD’s annual Government Relations Conference recently in Washington, D.C. The members and guests went to the nation’s capital to discuss advocacy and lobbying issues that affect their practices and patients.

More than 60 AGD members from across the country and representatives from the National Dental Association and American Orthodontic Society attended the event. During the two-day conference, attendees met with legislators from both political parties to discuss topics including alternative dental health care providers, the lack of practicing dentists on Institute of Medicine (IOM) panels, and the Dental Coverage Value & Transparency Act’s Employee Retirement Income Security Act (ERISA) provisions, among others.

A total of 145 appointments were made with various representatives in Washington, D.C. The meetings took place April 12 and 13.

“It is events like the Government Relations Conference that demonstrate AGD members’ ability to come together and change the face of dentistry in the eyes of our elected leaders,” said AGD President Fares Elias, DDS, JD, FAGD. “It is imperative that we maximize every opportunity to communicate member needs and educate our elected officials about how their actions affect our practices and our patients.”

Conference attendees had the opportunity to hear presentations from Morton Kondracke, a local journalist for more than 30 years, executive editor of Roll Call, and a regular contributor to public affairs programming; and JP Paluskiewicz, deputy chief of staff and health policy advisor to Rep. Michael Burgess, MD (R-Texas). Paluskiewicz oversees the congressman’s legislative agenda and acts as chief advisor in all public policy issues.

Rep. Paul Gosar, DDS (R-Ariz.) — a special guest due to his dual role as politician and dentist — spoke about encouraging dialogue within the profession and with elected officials, the success of the 1099 repeal, and many other opportunities for change. Rep. Gosar sponsored the Competitive Health Insurance Reform Act (H.R. 1150) in an effort to repeal the McCarran-Ferguson Act, a federal law that exempts the insurance business from most federal regulation.

“Rep. Gosar’s attendance at the conference was extremely valuable and provided a fresh perspective on the issues we all face as dentists,” said Myron Bromberg, DDS, chair of the AGD’s Legislative & Governmental Affairs Council. “His insight and guidance surely will help advance our efforts to advocate for general dentists across the country.”

Additionally, in recognition of his outstanding legislative achievements throughout the past year, Sen. Patrick Leahy (D-Vt.) received the Legislator of the Year Award. Sen. Leahy also has been a strong leader in a cause that is very important to the AGD: The repeal of the McCarran-Ferguson Act.

“Being a part of this event not only furthered my interest in advocacy issues, but it helped the AGD get its messages to key stakeholders,” said Bettina Laidley, DMD, FAGD, president of the Vermont AGD, who attended for the presentation of Sen. Leahy’s award. “I’m glad that Sen. Leahy’s efforts were recognized in this way, as he has made significant contributions for our state.”

(Source Academy of General Dentistry)
Desert Friends of the Developmentally Disabled opened a dental clinic in mid-July to provide free dental services to developmentally disabled children and adults.

“We already have a waiting list of nearly 100 people from throughout Riverside and San Bernardino counties who are in desperate need of dental care,” said Marianne Benson, co-founder of the Rancho Mirage-based non-profit group.

The clinic is located behind the Rancho Las Palmas Shopping Center in an office building at 42-900 Bob Hope Drive, Suite 111. Desert Friends of the Developmentally Disabled signed a three-year lease on the 1,200-square-foot office, which was renovated right in preparation for its mid-July opening.

“We’ll start off with two dental chairs, but we will eventually expand to four,” Benson said.

California has 240,000 disabled children and adults, 24,000 of whom reside in Riverside and San Bernardino counties. About 1,500 of them live in the Coachella Valley.

“Adults over 21 have lost most of their medical and dental healthcare benefits as a result of state budget cuts during the past three years,” Benson said. “We’re trying to help them by providing dental care, though we hope to eventually provide other healthcare services as we recruit more volunteers.”

While disabled children still have their medical and dental benefits, it is very difficult to find dentists willing to work on them, Benson said, adding that Desert Friends of the Developmentally Disabled has initially focused on providing free dental services, since state statistics indicate that 88 percent of disabled children and adults have unmet dental needs.

State lawmakers have eliminated numerous medical and dental services for developmentally disabled adults, including all dental services, speech therapy services, podiatric services, audiology services, chiropractic services, acupuncture services, optometric and optician services, psychological services as well as incontinence creams and washes.

Lawmakers have also proposed cutting additional services for developmentally disabled adults this year in an effort to reduce the state budget deficit.

“All of this is happening,” Benson said, “because this is a population that cannot speak up for themselves. So their services are among the first to be cut.”

(Source: Desert Friends of the Developmentally Disabled)
It’s interesting how people tend to evolve into certain positions in the dental practice. One in particular is that of office manager. In our survey, we see a lot of loyal employees, such as a hygienist or a dental assistant, who have “graduated” to this role.

As is often the case, they are bright and energetic, good with patients and the dentist perceives that those skills are all that is needed to be an effective office manager. Unfortunately, it’s at this point that things start to go wrong. The employee may exhibit too little initiative or too much control. Others on the team may resent their former colleague being promoted to a managerial position. Often, the “office manager” role is not a true role from the clinician. If there is a job description, it’s typically vague at best. Finally, the dentist begins to wonder if she (or he) has made a terrible mistake.

In most cases, office managers are dropped into the position with no training. The dentist assumes that if the individual has been with the practice for a while, she knows what it takes to do the job. Additionally, dentists often look at the designation of “office manager” as a reward for the employee’s hard work and dedication to the practice. Sadly, their good intentions often do not pan out as expected.

The case of “Dr. Smith” is a prime example. He felt very strongly that awarding one of his staff standouts a new moniker was a good idea. After all, everyone appreciates the prestige that goes along with an important title, or so he thought. Additionally, Smith was searching for a way to curb staff turnover that had been disrupting his office for several months.

Julie was a good employee. Smith saw her as a rising star. She was bright, energetic and enthusiastic. She had excellent rapport with the patients, and the staff, and she was certainly the kind of employee the practice wanted to keep around. The problem was that Smith hadn’t thought he could pay her much more. Therefore, he reasoned that a new title and new challenges would be the opportunity that would “keep Julie off the payroll.”

When Smith brought Julie in to his office to tell her that he would like to appoint her as office manager, she was thrilled that Smith felt she was up for the challenge. Julie’s primary responsibilities are scheduling and confirming appointments, greeting patients, managing financial arrangements, etc. However, when she inquired as to how her duties might change, the good dentist didn’t have a good answer. He simply told her he’d like to see what she could do and they would go from there.

When she asked if the new position meant an increase in her salary, Smith was non-committal. Julie was puzzled. “What is the point of being named office manager if there is no salary increase?” Julie later confided to a coworker.

Not surprisingly, things went downhill from there. Smith assumed that because Julie was bright and confident, she could design her role as office manager. Yet, with no direction from the dentist, she was making up her duties as she went along. Julie suggested that she be involved in staff evaluations, but Smith told her that would not be appropriate.

She asked him if he would like her to provide assistance evaluating the financial reports, “No, I can handle that,” was his response. She suggested that the team work together to develop some scheduling objectives. Smith thought that might be a good idea, but continually put Julie off each time she raised the issue.

Julie had the title of office manager, but not the responsibility or any decision-making authority. Julie eventually checked out emotionally from the position and then physically from the practice. It was a waste of the potential talent that the dentist recognized in Julie, but he could not bring himself to relinquish control of certain areas or involve a subordinate in a partnership role. It’s a concept that some dentists find just too threatening to pursue.

Every employee must have a job description that clearly defines the job, spells out specific skills needed for the position and outlines precisely the duties and responsibilities. A job title is not a job description. That being said, I readily acknowledge that writing a job description for an office manager is no small challenge.

Job descriptions for multiple positions in the practice — including scheduling coordinator, treatment coordinator, financial coordinator, patient coordinator, etc. are readily accessible on practice management websites, including McKenzie Management’s site, with the exception of office manager. Why? As Smith’s case illustrates, different dentists interpret the office manager position quite differently, and many interpret the position incorrectly.

The majority of dental practice office managers answer phones, make appointments, do financial arrangements, etc. However, these are the responsibilities of a front office employee or a business coordinator. Certainly, an office manager will take on these duties when necessary, but the role stretches well beyond these tasks.

If your practice is to make the most of an office manager, the appointed person will need a set of skills that goes beyond being a loyal employee. She (or he) must be well suited to work with staff and patients. This person should be a natural leader. She (or he) has to be comfortable taking the reins on an issue and addressing it.

Being a good problem solver by nature is essential because the office manager, not the dentist, should be the first point of contact for the patients and the staff when issues arise. In addition, the office manager needs to have the right personality traits for the position. She should be both personable and efficient. In other words, she needs to have a good balance between thinking and feeling in temperament type.

Additionally, if a practice hopes to get the most out of appointing an office manager, the employee should be comfortable working with numbers and be able to access, as well as fully understand, practice reports. Moreover, the office manager must be able to work well under pressure because she will be pulled in multiple directions.

Yet, that is just the beginning. A true office manager is responsible for overseeing practice overhead and her most critical duty is effectively managing the office’s human resources.

The office manager is in charge of recruitment, hiring and firing all employees, performance reviews, schedules, grievances, raises, salary reviews, employee policies and team meetings. The position requires leadership skills and includes overseeing and managing all of the business measurements, analyzing fees and reviewing the profit and loss reports.

The dentist is the chief executive officer (CEO) while the office manager is like the chief operating officer of the corporation that is your dental practice. The office manager is responsible for overseeing the practice, including all of the business measurements, analyzing fees and reviewing the profit and loss reports. However, the chief executive officer should be the first point of contact for the patients and the staff when issues arise. In addition, the office manager needs to have the right personality traits for the position. She should be both personable and efficient. In other words, she needs to have a good balance between thinking and feeling in temperament type.

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Does a dental practice need an employee handbook?

By Stuart J. Oberman, Esq.

For a practicing dentist who aims to always deliver high-quality patient care, staff retention is an important value. Staff retention aids the dental practice in providing stability and continuity and eliminates the high costs associated with employee turnover.

Obviously, staff members are more likely to continue working when they feel they are treated fairly and consistently. In this respect, an employee handbook is important to a dental practice as it documents the practice’s policies and procedures, sets expectations and provides for a framework for uniformity.

An employee handbook can be a valuable communication and employee relations tool because it demands consistency among managers and clearly dictates employee policies. The employee handbook allows an employer to lay out what he or she expects from employees and what employees can expect from the employer.

Clear office policies lend support to disciplinary procedures and reduce any likelihood of discrimination charges. In addition, handbooks often help new employees get acquainted with their new position and let them know what is expected of them.

For an employee handbook to be most effective, it should be written in a simple, clear, organized and concise manner to avoid confusion among employees. The employee handbook should be easy to use so that employees may refer back to it as often as they wish. The employee handbook should be distributed to every employee in the dental office.

When you distribute your employee handbook, allow all members of your dental practice an opportunity to read it. Each employee should then sign and date an acknowledgment form that states they understand and agree to be bound by the policies outlined in the employee handbook.

An electronic copy of the employee handbook should be stored on a computer that all employees can access, and a bound copy should be kept in the office for general reference. The handbook should also be updated as office policies change and each employee should sign an acknowledgment for each change.

It would be prudent to include job descriptions in the employee handbook so each employee knows what is expected of him or her.

While employee handbooks will vary among dental offices, there are guidelines for dentists to follow in creating their employee handbook. There are numerous laws that govern the relationship between employer and employee. Many of these laws apply to even the smallest dental practices.

Therefore, it is important for the employee handbook to reflect these laws. In addition, many provisions should be included in the employee handbook to promote uniformity, thus helping employees present a united front to patients and to reduce the risk of an employee initiating a lawsuit for unfair treatment.

Every employee handbook should begin with an introduction, which should welcome new employees and introduce your practice’s goals, mission statement and history. There should also be a disclaimer stating that the employee handbook is not an employment contract and does not affect the employment-at-will doctrine. After this introduction, the employee handbook should briefly describe several subjects.

It would be prudent to include job descriptions in the employee handbook, so each employee knows what is expected of him or her. Performance reviews and grievance procedures should be discussed and work schedules and dress code should be outlined. The handbook should identify the days and hours of the workweek as well as schedules for lunch and breaks.

Full-time employees’ work schedules should be defined and differentiated from those of part-time employees. Compensation and benefits should be detailed and should inform employees of the payroll schedule, holidays, vacation, sick leave, bereavement, jury duty, military leave, leave of absence and health insurance.

If your dental office has 50 or more employees, you must comply with the Family and Medical Leave Act, and this should be included in the employee handbook. Personal use of the telephone and Internet, procedures for safety and hygiene of dental employees as well as policies on smoking and substance abuse should be included as well.

The employee handbook should contain an anti-harassment policy as well as an Equal Opportunity Employment provision stating that your dental practice will not discriminate in offering employment. These provisions are extremely important, as they make it clear that you will not tolerate harassment or illegal discrimination, describes the steps that can be taken to report violations of these policies, outlines the steps that the dentist will take in responding to these allegations and confirms that the dentist is an equal-opportunity employer.

About the author

Sally McKenzie is a nationally known lecturer and author. She is CEO of McKenzie Management, which provides highly successful and proven management services to dentistry and has since 1980. McKenzie Management offers a full line of educational and management products, which are available on its website, www.mckenzie mgmt.com. In addition, the company offers a vast array of Business Operations Programs and team training. McKenzie is the editor of the e-Management newsletter and The Dentist’s Network newsletter sent complimentary to practices nationwide. To subscribe visit www.mckenzie mgmt.com and www.thedentistsinetwork.net. She is also the Publisher of the New Dentist® magazine, www.thenewdentist.net. McKenzie welcomes specific practice questions and can be reached toll free at (877) 777-6151 or at sally@mckenzie mgmt.com.
opportunity employer.

In addition, HIPAA privacy laws should be outlined in the employee handbook to ensure that each employee is informed about the law and understands how the dental office intends to comply with the law.

As noted above, it is important to preserve the “at will” employee relationship. Some courts have found that statements made in employee handbooks create a contract that limits the “at will” relationship. For this reason, a disclaimer should be included in the handbook that clearly states that nothing in the employee handbook shall be construed as a promise or a contract.

At-will employment means that either party may terminate the relationship with or without notice, for any reason or no reason. However, obvious reasons, such as age, race and gender, remain illegal grounds upon which to fire an employee.

Including these provisions in an employee handbook provides the dental employer an extra level of protection in the event an employee commences a lawsuit for harassment, discrimination or wrongful termination.

It is much simpler for the dentist to prove that a policy was in place when he can produce a signed acknowledgment from the employee.

While dentists should be sure to avoid creating an implied employment contract in drafting the employee handbook, without these written policies your daily conduct in managing the office will become “policy,” and will lead to more liability exposure when employees claim unfair or inconsistent treatment.

By developing and enforcing a comprehensive employee handbook, your employees will be more knowledgeable about applicable laws, know what to expect when commencing employment, and will be more likely to feel that they are treated fairly, which reduces the practice’s legal exposure, allowing you to do what you do best: practice dentistry.

Stuart J. Oberman, Esq., has extensive experience in representing dentists during dental partnership agreements, partnership buy-ins, dental MSOs, commercial leasing, entity formation (professional corporations, limited liability companies), real estate transactions, employment law, dental board defense, estate planning, and other business transactions that a dentist will face during his or her career.

For questions or comments regarding this article, visit www.galdentalattorney.com.

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AGD to hold its annual meeting in San Diego

The Academy of General Dentistry (AGD) will hold its 59th Annual Meeting & Exhibits in San Diego July 27-31, Wednesday through Sunday, at the San Diego Convention Center. The exhibit hall will be open Thursday, Friday and Saturday.

“This meeting is your destination for top-notch continuing education,” says AGD President Dr. Fares M. Elias. “With first-rate speakers, extensive lecture and participation courses the all-new Shamu show, AGD 2011 Annual Meeting and Exhibits in San Diego will offer you the excellent education and distinctive experiences you have come to expect.”

For the first time in AGD history, dentist registrants will receive access to up to 80 hours of recorded continuing education free with their AGD Annual Meeting & Exhibits registration.

Meeting highlights

Dr. J. Craig Venter, the pioneer scientific researcher who uncovered the sequence of the human genome

Dr. J. Craig Venter, the pioneer scientist who uncovered the sequence of the human genome. The AGD honors the incredible accomplishments of the 2011 class of Fellows, Masters and Lifelong Learning and Service Recognition (LLSR) recipients at the AGD Convocation Ceremony. The ceremony will be held at the San Diego Convention Center.

Saturday Night Celebration

Everyone is invited to share in the camaraderie as the AGD honors the incredible accomplishments of the 2011 class of Fellows, Masters, and Lifelong Learning and Service Recognition (LLSR) recipients at the AGD Convocation Ceremony. The ceremony will be held at the San Diego Convention Center.

Welcome Reception

You’re invited to enjoy foods and entertainment that reflect the San Diego culture during an event that offers attendees, friends and family a first look at the breaking new technologies and products available to general dentists today. The Welcome Reception will feature cash bars, hors d’oeuvres and entertainment alongside the best products in the profession from dental manufacturers, suppliers, labs and service providers.

Educational Program

The AGD meeting will offer a comprehensive educational program, offering attendees the opportunity to learn and grow. Featured courses include the following:

- **Thursday and Friday: Academy of Laser Dentistry – Lasers in Dentistry: A Two-Day Standard Efficiency Course**, presented by Baher A. Convissar, DDS, FAGD
- **Omar Zaffarani, DDS, MAGD**
- **Mark I. Malterud, DDS, MAGD**
- **Lifelong Learning and Service Recognition (LLSR) recipients at the AGD Annual Meeting and Exhibits in San Diego**
- **Friday: Maximizing Material Performance for Direct Composite Placement**, presented by Mark Latta, DMD, MS.
- **Friday: Creating Solutions With Nano Hybrid Composite Crowns in Less Than an Hour**, Presented by Mark L. Malterud, DDS, MAGD
- **Saturday: A Hands-on Approach to Diagnosis and Treatment Planning of the Geriatric or “Special” Needs Patient**, presented by Eric Shapiro, DDS, MAGD, MA, MHA.

Exhibit Hall

The exhibit hall will offer meeting attendees the opportunity to view the latest in products and technology. Hourse for the exhibit hall are as follows:

- **Thursday:** 4:30 to 7:30 p.m. (All Attendee Welcome Reception from 5 to 7 p.m.)
- **Friday:** 10 a.m. to 6 p.m. (dedicated hours from noon to 2 p.m.)
- **Saturday:** 10 a.m. to 3 p.m. (dedicated hours from noon to 2 p.m.)

“From sandy beaches to exciting nightlife, family-friendly attractions to exquisite dining, the AGD Annual Meeting and Exhibits in San Diego is one meeting you and your family will want to go to,” Elias says. “Let’s go to a place where the temperature always hovers around 70 degrees, where the sun is always shining, and where we can take advantage of all AGD Annual Meeting and Exhibits has to offer.”

**Things to do in San Diego**

San Diego is packed with world-famous fun activities and exciting attractions for kids, adults—the whole family. Here are some of the biggest attractions:

**SeaWorld San Diego**

**seaanimalpark.com/seaworld-sandiego**

Come celebrate the wonders of the sea at SeaWorld San Diego. Experience the all-new Shamu show, One Ocean, and thrilling rides like Journey To Atlantis. Get up-close to beluga whales, polar bears, sharks and penguins. And experience the amazing world of the sea turtle in the brand-new Turtle Reef.

**San Diego Zoo**

**www.sandiegozoo.org**

The San Diego Zoo is more than a zoo: it is a sanctuary for thousands of animals, a landscape of rare plants from all climates and a living classroom that entertains as well as educates. Learn about animals that lived in Southern California 12,000 years ago and meet their living counterparts at The Harry and Grace Steele Elephant Odyssey.

The new 7.5-acre multispecies habitat features elephants, California condors, jaguars and more and offers guests insight about the Zoo’s conservation efforts to protect wildlife from becoming extinct like the mammoth and saber-toothed cat.

**LEGOLAND California**

**www.legoland.com**

LEGOLAND California Resort is growing, and there’s a lot to experience. The World’s First LEGOLAND Water Park has seven slides, a 45-foot LEGO tower and the unique Build-A-Raft river. LEGOLAND California is home to more than 60 rides, shows and attractions. And right next to LEGOLAND, SEA LIFE Aquarium is the perfect way to introduce children to the wonders of the aquatic world.

**San Diego beaches**

**www.sandiego.org/article_set/Visitors/5**

The beach is more than a boundary dividing land from sea, more than a place to swim or sunbathe. In San Diego, the beach is a way of life, a source of pride and joy, a defining influence in people’s lives.

For some, the mere memory of a mid-summer sunset melting into the Pacific is reward enough. Others have a more intimate relationship with the sea: surfing and sailing, biking and running, swimming and diving along San Diego’s many coastal beaches and bays.

(Source: San Diego Convention & Visitors Bureau)
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After years of having nowhere to turn, finally, you have a friendly alternative in the banking world. At Live Oak Bank, we’re not afraid to do the mega-deals most banks would find mouth-numbing. Not only will we provide unique, big business loans to entrepreneurial dentists like yourself, we can also help you expand, remodel, refinance or acquire an existing dental practice. Finally, a bank that doesn’t act like a bank.

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Office Managers (AADOM) will introduce. I’m excited to be a part of AADOM’s new initiative.”

“Office managers be prepared for most situations that a team leader will run of Teresa Duncan, MS, FAADOM. Duncan said, “Our goal is to help dental here to shorten the learning curve.”

“Management by trial and error is not the ideal way to run a practice. We’re common situations that new managers face. Colicchio also emphasized that and insurance management. The team-taught course will also discuss the emphasis will be placed on financial systems such as accounts receivable team, essential office systems and leadership as a dental office manager. AADOM President Heath-

“...and rock-solid. Now more than ever, Somnomed is collaborating with the GNYDM to offer the first Somnomed Academy Sleep and Appliance Exposition.”

With an expert team of clinicians and staff from Somnomed, attend-

ees will have the chance to explore popular topics, including obstructive sleep apnea fundamentals, advanced oral appliances and therapy as well as how to implement dental sleep therapies into your practice over a four day period.

In addition, the GNYDM will again partner with Align Technology to present its four-day Invisalign Expo-

this. This diverse array of educa-
tional courses is taught by a seasoned team of Invisalign specialists. Dental professionals learn the logistics of tooth alignment, including treatment for crowding cases and other ortho-
dodontic abnormalities.

With no pre-registration fee for admission, the GNYDM continues to be the largest health care and dental event in the United States, attract-

ining more than 300 full- and half-day seminars, essays and hands-on work-

shops. The enormous exhibit floor includes more than 1,500 booths rep-

resenting more than 500 exhibiting companies showcasing the newest products and technology available in dentistry.

As the largest global dental event in the United States, the GNYDM offers free multi-language courses in Portuguese, French and Spanish on a broad range of topics. New programs are always an addition and never a replacement as plans to expand the course offering are already in the works, such as with a free Italian and Russian program.

When the workday is done, attend-
ees always have a world of excite-
ment at their fingertips. During the holiday season, New York is indeed a magical place to be with the city dressed up in all its holiday finery, the festive spirit is evident citywide. Meeting attendees enjoy world-class museums, Broadway theaters, res-
taurants, historical sites and stores lavishly decorated for the season.

The “Introduction to Dental Office Management” course will be held on the first day of the conference. Registration information and course specifics can be found online at www.dentalmanagers.com/conference-2011.

The largest association of its kind, its mission is to provide our members with networking opportunities, resources and education to help them achieve the highest level of professional development.

For more information, please call (752) 842-9977 or write info@ dentalmanagers.com.
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Sirona CEREC® users who send digital files save $20 per unit when prescribing restorations without model work.

Wear Compatibility

![Graph showing wear compatibility between Natural Enamel, Glazed BruxZir®, Glazed IPS e.max, and Polished Ceramco®3.]

In a recent study¹ to measure the volumetric loss of enamel, glazed BruxZir was found to wear compatible with enamel and virtually identical to glazed IPS e.max.


Antagonist Wear

![Graph showing antagonist wear between Polished BruxZir®, Polished Ceramco®3, and 110±48.]

The antagonistic (Staintite balls) wear shows BruxZir only with 72±21 micron, which is significantly lower than Ceramco®3 (110±48 micron). The University of Tübeningen study was run using an eight chamber Willytec Chewing Simulator at 1.2 million cycles.

*Price does not include shipping.

CEREC is a registered trademark of Sirona Dental Systems. IPS e.max is a registered trademark of Ivoclar Vivadent. Ceramco is a registered trademark of DENTSPLY Ceramco.

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GLIDEWELL LABORATORIES
Premium Products—Outstanding Value
IACA San Diego meeting: ‘The best dental meeting in the best city’

By Dan Jenkins DDS, LVIF, FACP, CIDE-
AADC

The International Associa-
tion of Comprehensive Aesthet-
ics, (IACA), will hold it’s seventh
annual meeting at the Grand Hyatt
on the Bay Hotel from July 28–30.
The presentations will be like no
other meeting. The energy will be
like no other meeting either.

The enthusiasm for learning is
evoked by the fact that each
year during the lectures, the hall-
ways and the exhibits are empty!
(Do you know of any other con-
vention that can say that?) San
Diego has a reputation for being
the “best city” and it is fitting that
the IACA returns to where it held
its inaugural meeting.

This meeting has grown each
year and continues to excite those
in attendance. The subject mat-
ter is always changing, with courses
involving dental sleep medicine, reconstructive
restorative dentistry, TMJ disor-
der treatment, cosmetic dentis-
try, endodontics, laser dentis-
try, orthodontics and many pro-
grams for the dental team on prac-
tice management, dental hygiene
and laboratory technician tech-
niques.

Are you having difficulties with insurance companies? Then
come hear Dr. Amy Norman speak
on how she handled it in her
practice. The presentations will be
like no other meeting.”

Dr. Omer Reed’s presentation,
“It’s Not Doin’ it … it’s Gettin’ it
To Do!” will help you get the cases
you want to do.

Dr. Kit Weathers will present on the “magic” of endo.

As if that isn’t enough, Dr. Ron
Jackson will present the latest
information on bonding tech-
niques and materials. Jackson’s
lectures are always overflowing
into the hallway so get to his room
early!

Combining the medical com-
ponent with dentistry to address
snoring and sleep apnea, the IACA
will host a panel of medical spe-
cialists, including Dr. Brian All-
man, a diplomate in dental sleep
medicine; Dr. Ronald Mathiasen,
an otolaryngologist; Dr. Samir
Damani, a cardiologist; and
Dr. Michael Lucia, a pulmonolo-
gist.

This panel will present a unique
model for working with various
medical specialists in the treat-
ment of sleep disorders as demon-
strated in their own community.

Images from previous IACA meetings. (Photos/Provided by the IACA)

This will give you the infor-
mation to make your own decision
as to whether a product is ready
for you or not. How many new
products have you purchased over
the years that you brought home
and never used?

A real treat this year will be to
have a Saturday evening celebra-
tion on the aircraft carrier, the
USS Midway (included in the reg-
istration for the meeting). Each
day will start out with a stimulat-
ing presentation to inspire you in
your aspiration to accomplish all
you wish for your dental practice.
You may need this type of per-
sonal experience because reading
a book or just listening to some
recordings is not the same and
a magazine article is not enough.

Buffet meals are provided
each day of the meeting and are
includex in the registration fee
(Just don’t invite the guy from the
off-ramp!). Each year the meals
have been outstanding and not
what you might expect as “meet-
ing meals.”

Please visit www.theiaca.com
and check it the information found
therein then register. Finally,
you’ll come to San Diego July
28–30, and hopefully, have the
best experience you have ever had
at a dental meeting.
In 2007, when the American Heart Association changed the recommenda-
tions for antibiotic prophylaxis for routine dental care in patients with
valvular heart disease, some dentists scoffed, others rejoiced. The policy
change was the first of its kind since the organization began recommend-
ing prophylaxis for routine dental procedures 50 years earlier.

Considering the fact that an estimated 2 percent of the U.S. popula-
tion carries the diagnosis of mitral valve prolapse, a relatively benign
heart-valve disorder that had, until 2007, required administration of an-
tibiotics in advance of any dental procedure (including routine clean-
ing), this was indeed a noteworthy change.

The use of antibiotics for the intended prevention of endocarditis
in individuals at higher risk (those with valvular pathology) had far
reaching effects on antibiotic resis-
tance rates, the cost of medical and
dental care, the number of emer-
gency visits for allergic reactions to
medications, even overall compli-
anse with routine teeth cleaning
visits.

Some dentists chose to ignore the revised recommendations, respond-
ing that the risks of bacterial endo-
carditis were outweighed by the
benefits of antimicrobial admin-
istration, regardless of population
effects. Other dentists were not
aware that the recommendations
had even been changed. Most have
complied with the current recom-
mendations and do not insist on
antibiotic prophylaxis unless so indi-
cated by evidence-based research.

Health policy has, in many ways,
changed the way that dentists and
dental implant practitioners prac-
tice. The influences of various
medical societies will continue to
have an impact for dental implant
practitioners in the years to come
given the expanding use of elec-
tronic health records, the institu-
tion of government-driven health
reform programs and the paradigm
shift from practitioner instinct to
evidence-based decision making.

These policy changes are intend-
ed for the betterment of societal
health care as a whole, however,
they do not always reflect a con-
sensus among medical and dental
societies nor are they always readily
applicable to the patient directly in
front of us.

A hotly contested topic between
orthopedic surgeons, dentists and
infectious disease experts involves
the extent to which antibiotic pro-
phylaxis prior to specific dental
procedures is required to prevent
bacterial seeding of the joint in
patients who have received total
joint replacements.

Previously, the three groups
aligned and supported antibiotic
prophylaxis for individuals who
had had joints replaced within two
years and those at higher risk, due
to medical conditions, however, a
more recent publication from the
American Association of Orthopae-
dic Surgeons (AAOS), put forth in
February 2009 and revised in June
2010, states that all patients with
total joint replacements should be
given antibiotic prophylaxis for spe-
cific medical and dental procedures
for the rest of their lives.

The impetus, consequences and
controversy of this change are still
being widely debated. In response to
the AAOS statement, the American
Academy of Oral Medicine issued
a pointed rebuttal debunking the
reasoning behind the AAOS state-
ment paper and reminded practi-
tioners to make their own clini-
ical decisions.

From health policy makers at
the American Dental Association
through the American Academy
of Oral Medicine, the American
Academy of Orthopedic Surgeons,
and the American Heart Associa-
tion, there is a clear realization
that we are starting to treat our
dental patients as patients, rather
than as a collection of components
that we must work around to
achieve our goals.

By Arun Garg, DMD

Health policy and the
dental implant practitioner
New universal self-etch bonding agent without the need for a separate activator

Oxford Scientific Dental Products introduces Oxford Bond SE, a simple-to-use, self-etching bonding agent. Oxford Bond SE is designed for use in both direct and indirect techniques. The agent provides strong, reliable bonding of composites, compomers and resin-reinforced glass ionomer materials to dentin and enamel.

Unlike most self-etching bonding systems, Oxford Bond SE can be used for indirect procedures without adding a separate adhesive or dual-cure activator. This simplifies the procedure and makes it more reliable by eliminating any variability introduced by various staff members, ensuring a tenacious bond with every procedure.

Proven to be superior
Oxford Bond SE provides all the benefits of a cutting-edge self-etch adhesive: less patient sensitivity, ease of use and fewer application steps. It exhibits superior bond strengths to both dentin and enamel. In a laboratory study (data available upon request), Oxford Bond SE showed bond strengths superior to six of the leading self-etch adhesives on the market.

Oxford Bond SE received a +++ rating from The Dental Advisor. More than 50 percent of the evaluators stated they would switch from their current self-etch bonding agent to Oxford Bond SE. Oxford Bond SE is very simple to use. Application requires only three steps with a total time of 45 to 50 seconds. Light curing is achieved in 20 seconds and self-curing is achieved in 5 minutes.

Oxford Bond is supplied in 5 ml bottles (or 0.15 ml single doses). The single-dose delivery system is highly reliable. Gravity feeds the fluid in the upper chamber into the lower chamber, insuring a complete and homogenous mixing of the components.

Each single-dose container has enough volume to bond to at least three units. This single-dose system provides enough material for a standard procedure without wasting and inordinate amount of bonding agent in the mixing well. It also promotes good infection control.

Oxford Bond SE is competitively priced and represents a very good value for your supply dollar. To order Oxford Bond SE or to obtain additional information, call Finessan Enterprises at (888) 686-1950 or go to www.oxfordscientificdental.com.

About Oxford Scientific Dental Products
Although the Oxford Scientific brand name may be new to North American dental professionals, the company has been manufacturing dental consumables for a number of U.S. companies for nearly 20 years. Oxford Scientific Dental Products are manufactured to the highest standards. The facility is FDA registered and the products are CE certified.

The company’s mission is to provide the dental consumer with the finest quality materials based upon state-of-the-art manufacturing and the pride of a dedicated workforce. The company’s portfolio currently contains: a core build-up material, Oxford Zircore Nano, a dual-cure, nano zirconia filler reinforced resin core build-up material that was rated “Excellent-Good” by an “independent, non-profit dental education and product testing institute” in its January 2011 newsletter; a complete line of temporary crown and bridge materials, such as Oxford Temp, a temporary C&B material, Oxford Temp Cem, a temporary cement and Oxford Correct, a flowable composite repair material for the temporary C&B material.

Oxford Correct was selected by the “independent, non-profit dental education and product testing institute” for its 2010 Buying Guide, published in its December 2010 newsletter.

The Oxford Scientific Dental Product portfolio will constantly expand to fulfill the needs of every practice for high-quality restorative materials at a competitive price, while maintaining a commitment to satisfaction.


Yet will that seemingly harmless decision undermine antimicrobial compliance improvement efforts elsewhere?

Hospitals and other large health-care facilities are initiating programs known as “antibiotic stewardship programs” to facilitate responsible and appropriate antimicrobial use in a particular health care institution. And while these programs are most often undertaken in larger health-care settings, the reality is that application of certain principles at the micro level will enhance antibiotic effectiveness in the general population provided all practitioners (and patients) use antimicrobial agents appropriately.

The relevance of antimicrobial stewardship at the hospital level does trickle down to the individual provider in the dental implant practice. Every antibiotic prescribed conveys a risk of allergic reaction, drug-drug interaction, antibiotic-associated diarrheal illness, decreased population effectiveness and increased cost to the health-care system.

Nonetheless, when indicated, a single dose of preoperative antibiotics or a course administered for a wound infection is absolutely essential.

Limiting antibiotic use to those cases supported by evidence-based practice (and espoused by consensus statements from multiple organizations) will help reduce the amount of antibiotic resistance within the population. Individual practitioners will ultimately be the ones responsible for effecting change at the population level.

(Photos/Provided by Oxford Scientific)

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(Photos/Provided by the ADIA)
Oxford Bond SE

A better bond... at a better price.

Oxford Bond SE gives you everything you’d expect from a 7th generation bonding agent and more... all at a price that’s less than the leading competitors’. Oxford Bond SE is a unique, simple-to-use, self-etching adhesive designed for use in both direct and indirect procedures without requiring additional steps or use of a separate activator.

THE DENTAL ADVISOR™ consultants liked both Oxford Bond SE’s dual-cure feature as well as the single unit-dose packaging. In fact, 54% of consultants reported they would switch to Oxford Bond SE and 79% would recommend it.*

Oxford Bond SE features:
- High bond strengths to both dentin and enamel
- Dual-cure versatility without the need for a separate activator
- Reduced postoperative sensitivity for maximum patient comfort
- Multiple or single-use dispensing for greater convenience

To order the bonding agent that gives you much more for much less, visit www.oxfordscientificdental.com or call 1-888-686-1950.

BruxZir® Solid Zirconia crowns and bridges were originally designed by Glidewell Laboratories as an esthetic alternative to posterior cast gold or metal occlusals. As dentists began placing BruxZir restorations and were satisfied with the results, they started to prescribe BruxZir for bicuspids. The lab realized it needed to increase the translucency of the material if dentists wanted to prescribe BruxZir in the anterior.

When Glidewell R&D was ready to test the material, I gave them an esthetic challenge we all face: the single-unit central incisor crown adjacent to a natural tooth. This article highlights the clinical steps for placing an anterior BruxZir restoration. For a crown that is 100 percent zirconia with no ceramic facing, I think the lab pretty much nailed it.

Figure 1
Tooth #8 is going to be prepoped for a BruxZir crown. I chose this case because tooth #8 is a natural tooth, tooth #7 is an all-ceramic crown and teeth #10 and #11 are a PFM cantilever bridge. It will be a good test of how this light interacts with the BruxZir crown versus the natural tooth and two restorations.

After anesthetizing the patient with the STA System, I break the proximal contacts just enough to place the first of two retraction cords into the sulcus (Ultrapak Cord #00). Then I use the 801-021 bur to trace around the gingival margin before making my depth cuts: 2 mm at the incisal edge, 1.5 mm at the junction of the incisal and middle thirds and a 1 mm half-circle reduction at the gingival margin. Depth cuts ensure that we get enough facial reduction to have an esthetically pleasing crown that is the same size as the adjacent natural tooth. This is difficult to achieve.

Figure 2
My depth cuts are now finished, which allows me to fly through the rest of the prep because the gingival is essentially done. The incisal edge takes about 15 seconds, and the facial reduction is marked with a depth cut. I turn my handpiece speed to 5,000 RPM and shut the water off to dial in and smooth the margins.

Figure 3
At this point, the prep is essentially done. After I place the top cord (Ultrapak #2E), I have a final opportunity to get a great look at the prep. Typically, I spend about 45 seconds polishing the prep, especially the gingival margin. Once again, I turn the handpiece down to 5,000 RPM and the water off, using a red-striped fine grit 850-025 bur to give the prep a mirror-like finish.

Figure 4
I place on the prep a ROEKO Comprecap ana
tomic, which helps keep the retraction cord in place. Slightly wetting the inside before placing it keeps the tooth moist. I ask the patient to bite down for 8-10 minutes. The result is a sulcus that cannot be missed with an intraoral tip. (When your assistant pulls the top cord, look down from the incisal with a mirror to see what I mean.) The impression material flows into the sulcus. This level of detail enables the dental technician to build a proper emergence profile into the restoration.

Figure 5
I try in the BruxZir crown and find the fit to be acceptable. I decide to cement the restoration rather than bond it into place because I have sufficient prep length and it is not over-tapered. I use RellyX Luting Plus Cement because of its natural bond to dentin and simple cleanup. The inside of the crown is coated with Z-Prime Plus from Bisco to enhance the bond of the cement to the zirconia crown. A pinewood stick provides pressure while the cement sets.

Figure 6
This is the final BruxZir Solid Zirconia crown (tooth #9) on the day of cementation. It probably won’t be mistaken for a natural tooth, but it blends well with the adjacent natural tooth (tooth #8). When I compare it to the existing crowns in the anterior segment, I think the BruxZir crown looks better.

While I don’t recommend that you jump into prescribing BruxZir for single-unit central incisors, this clinical anterior BruxZir Solid Zirconia crown cases demonstrates that this material is one step closer to being as well-suited for anterior restorations as it is for posterior restorations.

Fight oral cancer!

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerselfexam.com. This website was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations.

Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

Conducting your own inspection of patients’ oral cavities provides the perfect opportunity to mention that this is something they can easily do themselves as well.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?
Why is now a great time to build your practice?

If you’ve been thinking about building your own dental practice, now’s a great time to jump in. Market conditions continue to support favorable mortgage rates and construction costs, while the U.S. government has reached out to small businesses with even greater tax deductions for equipment purchases in 2011.

In addition, owning your commercial property still appears to be a reliable and potentially profitable investment for your future.

 Favorable commercial property values
Commercial property values are at their lowest level in decades, providing purchasers an opportunity to obtain far more for their investment than they could have just a few years ago. Plus, property values are likely to increase over time as the economy recovers, making commercial real estate a relatively secure long-term investment.

Commercial property can also become a potentially valuable source of retirement revenue — either through outright sale of your practice and the underlying property or through sale of your practice and lease of the property, creating a lifetime revenue stream.

 Historically low mortgage rates
As with residential properties, commercial real estate mortgages continue to be at historically low levels. Today it is possible to secure long-term commercial mortgage payments that rival the rental payments for a comparable leased space.

In addition, down payments for financing can be as low as 10 percent of the total loan amount if financing is obtained through an SBA program.

 Stable construction costs
Costs for construction materials such as plywood, copper and diesel fuel have climbed during the “great recession,” jumping 5.4 percent during 2010.* Nevertheless, construction companies are still holding the line on bid prices due to intense competition and weak demand for their services.

As demand for commercial building construction increases with a recovering economy, expect construction costs to increase as well. Now is an excellent time to build your own practice while the costs of building remain relatively stable.

 Section 179 tax deduction
Higher allowable IRS Section 179 tax deductions for 2011 mean your investment in building your practice actually costs less. The 2011 deduction limit is $500,000, up from $250,000 previously, and can be used to write off the costs of purchasing new or used equipment, including new software.

The 2011 limit on equipment purchases that qualify for the deduction is $2 million, up from $800,000 last year. In addition, the government offers a 100 percent “bonus” depreciation on new equipment, taken after the $500,000 deduction limit is reached.

In addition, you can purchase equipment for your new practice any time during the year, and as long as the equipment is placed in service during the 2011 tax year, you can write it off for 2011 — even if you do not start making payments on your purchase until 2012.

So if you’re considering building your own practice, don’t wait. Current market conditions have created an unprecedented opportunity to build your own dental practice.
GC America Inc. is very pleased to announce a series of promotions that will help the victims of the recent earthquake and tsunami in Japan. The RESTORE JAPAN promotion features GC America’s restorative line of products. Depending on the promotional offer utilized, up to 10% of the sales will go directly to help the devastated areas through coordination by JDA (Japan Dental Association - www.jda.or.jp/en/index.html). You will also receive a GC America RESTORE JAPAN gift in appreciation for your donation.

Promotions begin June 1st, 2011.

For more information contact your authorized GC America dealer, visit www.gcamerica.com or scan the QR code below with your smart phone.

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The ultimate online presence

Part 1 of an interview with Dr. Sean Fahimi, president of Solution21, a website design and marketing company.

We hear millions of visitors search online for dentists every month. How important is it for a dentist to have an online presence?

An online presence is not a luxury anymore. It used to be that all people expected to see about you online was your phone number or directions to your office. Now having a website is as important as having a business card.

Why is the look of a website so important?

When a patient is searching the Internet for a dentist, the only piece of information he or she has is the website. Fair or not, that is how your practice is judged. So it is very important that your website reflects a professional image.

How can a website stand out?

These days, in each area there are several websites that compete for patient’s attention. There are many similarities between dental websites, so you want to find something that makes you stand out. For example, you don’t want to use a template based system that generates designs that are exactly the same. You want to make sure your design is exclusive to your area. Also, you want to offer features that are unique, such as patient education videos, spokespersons or a video introduction.

Is it possible to appear on search engines quickly?

Yes, the most reliable form of marketing online is pay-per-click advertisement. There are thousands of SEO companies out there, but you want to work with one that rates designs that are exactly the same. You want to make sure your design is exclusive to your area. Also, you want to offer features that are unique, such as patient education videos, spokespersons or a video introduction.

PhotoMed launches VALO Cordless

Ultradent recently announced the launch of VALO Cordless, another expertly engineered development in LED curing light technology.

VALO Cordless maintains the powerfully efficient broadband technology offered by the multiple award winning VALO and adds a battery-operated, cordless wand for mobility.

VALO Cordless features custom, multi-wavelength light emitting diodes (LEDs) to produce high intensity light at 595-480 nm — capable of polymerizing all light-cured dental materials. This intensity can penetrate porcelain and is capable of curing underlying resin cements similar to a quality halogen light.

VALO Cordless comes with VALO rechargeable batteries and a battery charger suitable for power outlets from 100 to 240 volts. The standard lithium-iron-phosphate rechargeable batteries are safe, inexpensive and optimized for power and longevity.

The new handpiece is designed to rest in a standard dental unit bracket, or can be custom mounted using the bracket included in the kit. It offers consistent curing intensity and output in a durable, aerospace aluminum body with a Teflon coating and a sleek, ergonomic design.

For more information, please contact Ultradent’s customer service at (800) 552-5212 or visit us at www.valo-led.com.
For more information about Ultradent, call (800) 552-5512 or visit www.ultradent.com.

**What is local listing?**
All major search engines offer an interactive map. As part of this service, they offer a business listing that connects businesses to their locations on the map. They also allow business such as dental offices to claim these listings and optimize them for their potential patients. This is a tool that should be used by every dentist.

For more information, please contact Solution21 at (877) 423-8125.

Part II of this interview will be published in the next edition of Dental Tribune.


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**Dental Tribune | July 2011**

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**877.423.8125 Solution21inc.com**

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For more information about Ultradent, call (800) 552-5512 or visit www.ultradent.com.

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Biomimetic principles applied to cosmetic dentistry

By Susan M. McMahon, DMD and Emily Byron

Biomimetic dentistry is based on the philosophy that the intact tooth in its ideal hues and shades and, more importantly, its intracoronel anatomy, mechanics and location in the arc, is the guide to reconstruction and the determinant of success. This approach is conservative and biologically sound and in sharp contrast to the porcelain-fused-to-metal technique in which the metal casting with its high elastic modulus makes the underlying dentin hypofunctional.

The goal of biomimetics in restorative dentistry is to return all of the prepared dental tissues to full function by the creation of a hard-tissue bond that allows functional stresses to pass through the tooth, drawing the entire crown into the final functional biologic and esthetic result. According to Douglas A. Terry, DDS, in dentistry there is no one biomaterial that has the same physical, mechanical and optical properties as tooth structure (i.e., dentin, enamel, cementum) and possesses the physiological characteristics of intact teeth in function. By utilizing biomimetic-therapeutic approaches, dentists can improve and become closer to natural biological structures and their function.

There are two major perspectives to which the term “biomimetic” is applied: a purist perspective that focuses on recreating biological tissues and a descriptive perspective that focuses on using materials that result in a mimicked biological effect. Although different, both share a common goal of mimicking biology in restoration. This has been an increasingly common goal for dentists and patients alike in achieving esthetic and functional dentistry.

Biomimetic dentistry techniques provide the patient with minimally invasive options that conserve sound tooth structure as a clinical imperative. Biomimetics is essentially described as a mimicking of natural life, which can be accomplished using contemporary composite resins and adhesive dental procedures. Conservation and biological mimicry make up the foundation of a biomimetic philosophy and together produce the effect that today’s patients expect.

From an esthetic/restorative perspective, biomimetics or biomimicry is the application of methods and systems to artificially replace biologic elements in order to recreate optimal oral health. Practicing interdisciplinary esthetic restorative dentistry enables dentists to achieve biomimetic results with cosmetic dentistry. These techniques and materials are crucial to modern dentistry in that they combine a focus on dental health and appearance. A biomimetic material should match the part of the tooth that it’s replacing in several important ways, including the modulus of elastic property and function of the respective areas (e.g., pulp, dentin, enamel, dentoenamel junction).

The production of bone-, dentine- and enamel-like biomaterials for the engineering of mineralized (hard) tissues is a high priority in regenerative medicine and dentistry. The ability to manufacture such materials has allowed dental restorations to attain significantly more nature-like results that inevitably perform at a higher level than less life-like materials of the past.

The physiological performance of an intact tooth requires a balance between biological, mechanical, functional and esthetic parameters in order to achieve biomimetic qualities. This necessitates the development of “anatomical morphological thinking” when developing a restoration so that it replicates the natural tooth in form, function and esthetics. Such biological thinking will enable dentistry to focus on future health as well as the lasting appearance of the patients’ smiles, both of which are necessary for patient satisfaction.

According to Wynn Okuda, DMD, “modifications to existing cavity design should be based on preservation of natural dentition. The goals and objectives of biomimetic replacement should be to mimic the structure being replaced, thus allowing minimal removal of non-affected adjacent tooth structure.” Incorporating biomimetic principles stems from somewhat of a philosophical approach to practicing dentistry, Okuda says. Dentists must take time to research methods of minimally invasive approaches to solving dental problems.

Over billions of years, nature has created a formula for highly functioning materials that have withstood evolution. To create structures that will continue to function at such a level, dentistry must copy and integrate nature’s complex methods. Terry states that “we need to develop treatment modalities that allow us to reproduce the biomechanical behaviors of the intact tooth. As research scientists, clinicians and technicians work together in understanding the complex orientation of this composite material called tooth...

Fig. 1: Preoperative smile.
Fig. 2: Note the significant spacing between the upper and lower anterior teeth.
Fig. 3: Note staining and discolored spots.
that provides excellent esthetics and preservation of tooth structure given that the preparation is limited to only areas of affected unsupported enamel.21

Patients today want their dentistry more aesthetic but less invasive and composite resin accomplishes both.22 Evidence suggests that composites can provide optimal esthetics with minimal or no tooth intervention, immediately improving esthetics while leaving options for future orthodontic and restorative care.23 Furthermore, as a person ages, so do their restorations.

Eventually, teeth that have been restored will break down and need to have those restorations replaced.4 Fortunately, if an initial restoration was created using minimally invasive procedures, there should be more tooth structure to work with at the time when a second restoration may be needed.2

In this way, the biomimetic approach takes into account both the present and future dental health of the patient.

Nowadays, there are many modern composite resins developed for highly aesthetic procedures that, when properly used, can result in restorations that are indistinguishable from natural dentition.24 This article extrapolates the minimally invasive biomimetic principles of restoration and applies them to procedures for introducing missing tissue and creating cosmetic improvements, which ultimately benefit the patient’s overall oral health and appearance.

The process of mimicking tissue that was not initially present uses biomimetic methodology similar to that used in restorative dentistry that conserves tooth structure. Two cases will be presented that demonstrate the diversity of options biomimetic techniques provide for the field of cosmetic dentistry.

Case No. 1
A 34-year-old, healthy male presented for treatment of the spacing between his upper and lower anterior teeth as well as whitening. He desired a more aesthetic appearance overall. After an examination, the patient was presented with two options. Both porcelain veneers and biomimetic composite bonding would eliminate spacing and create a whiter smile, though the composite bonding technique demonstrated several advantages that made it the right choice for the patient.

The biomimetic effect of composite bonding ensures that the patient will attain a natural and highly functional result. Today’s composites have much improved physical and esthetic properties, enabling minimally invasive treatment modalities to be performed with immediate results that are able to satisfy the most cosmetically discerning patients.16–19

Porcelain veneers, on the other hand, require greater and irreversible tooth intervention. In addition, they would require at least two appointments and somewhat considerable tooth preparation.20 The composite bonding chosen for this patient involves minimal intra- enamel preparation from sandblasting or cleaning the enamel surface with pumice and no local anesthetic.21

With this type of treatment, fewer teeth (or just parts of teeth) can be treated and, because there is no laboratory fee, there is less cost for the patient.22 Composite bonding can be considered as a viable minimal or non-invasive treatment alternative.20,21

Treatment
An initial in-office whitening procedure was accomplished one week before the composite fill restoration. Treatment for general upper and lower diastemas was then carried out and consisted of the following: the maxillary anterior teeth and mandibular anterior teeth were pumiced with Pumice structure, improvements will continue.24 The same philosophy of using nature as a guide for restoration and regeneration can be extended to a functional solution creating missing structures in cosmetically focused patients.

Minimally invasive treatments are procedures that restore form, function and esthetics with minimal removal of sound tooth structure. This is accomplished by removing only dental tissues that cannot be adhesively bonded.8 This conservational approach leaves patients with as much of their natural tooth structure as possible while restoring or creating tissue that will enhance utility and appearance.

While indirect porcelain veneers can require a great amount of preparation and removal of tooth structure, direct composite bonding follows the conservative approach. Direct resin composite restorations offer an alternative treatment

Fig. 4: Postoperative smile. Note the natural appearance.

Fig. 5: Postoperative.

Fig. 6: Postoperative.
Prepries (Whip Mix Corp.), rinsed and dried. The teeth were then treated with Ultra Etch 55 percent phosphoric acid (Ultradent Products) for 15 seconds, rinsed and left moist. Bonding agent Prime & Bond NT (Dentsply Corp.) was applied to the teeth, air thinned and then light cured for 20 seconds.

The diastemas were restored with Esthet-X HD Micro Matrix Restorative (Dentsply Corp.). A layer of A2 was applied to block light transmission through the diastema, simulating the dentin layer. Characterization was accomplished by adding Pink Tint Venus applied with a No. 10 endodontic file into the surface of the A2.

Case No. 2
A 25-year-old healthy male presented with one peg-lateral incisor that he wished to improve esthetically. A peg-shaped lateral incisor can be defined as a tooth with markedly in the incisal direction. A peg-shaped lateral incisor. No prepping of enamel was performed; the Esthetix-X HD an excellent option for this application. The restoration was then finished and polished with Sof-lex discs (3M ESPE).

Summary
Biomimetic principles can be applied to cosmetic dental cases to minimize the reduction of existing healthy tooth structure in the pursuit of improved esthetics. The results can accomplish the esthetic enhancement, the cost to the patient can be reduced and the underlying tooth structure can be preserved for the present and future dental health of the patient.

References
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Snoring and sleep apnea: Are they a nuisance or disease continuum?

The hygienist and dental team play a huge role in screening and identifying patients at risk

By Ashley Truitt, RDA, BBA

Two-thirds of partnered adults say their other half snores, while six out of 10 of all adults (59 percent) say they snore. Sleep apnea may be present in 20 to 40 percent of the adult population that experience snoring.

According to the U.S. Department of Health and Human Services, more than 45 million Americans suffer from sleep apnea, a disorder that causes a person to briefly, and repeatedly, stop breathing during sleep.

Obstructive sleep apnea (OSA) is a life-threatening and often life-threatening sleep disorder and an estimated 800,000 patients are being diagnosed with OSA per year in the United States while approximately only 10 percent are being treated.

Primary care practices are not actively screening patients for OSA, which leaves a large void in the number of patients being identified with this killer disease. OSA has directly been linked through numerous research papers to co-morbidities such as stroke, heart disease, hypertension, impotence and diabetes.

For those patients who have been diagnosed and have had continuous positive airway pressure (CPAP) recommended, some may be intolerant of the therapy and are currently going untreated. There are millions of patients who need treatment, including those who cannot tolerate their CPAP machines and are looking for alternatives.

The dental practice is a prime portal to not only screen and identify patients at risk, but also to offer clinically proven therapy with oral appliances.

How to implement oral appliance therapy

It starts with education for the dentist and the dental team. Currently there are many continuing education courses available on the topic of dental sleep medicine and oral appliance therapy, and these are usually two- to three-day courses with subsequent workshops and follow up that is essential. I must emphasize, in order to be successful with implementation, the entire team needs to be involved — dentist, hygienist, assistants and front desk staff.

Following the education, the implementation process begins, which involves asking questions, observing, communicating, initiating.
Flying with Hilda

Flying can be a wonderful or stressful situation, and more often than not I find it brings stress. On a recent trip, I found myself on the edge. The first leg of my flight was delayed due to issues with the plane, which then cut into my layover time, which was only 45 minutes to begin with. When my first flight landed, there was no one available to drive the jet bridge next to the plane, so another 15 minutes ticked off my connection time. Once I deplaned, I had exactly 10 minutes to get to another terminal and, of course, the gate was the last gate in the corridor.

I walked as fast as I could, pulling my wheeled bag behind me. I was not about to run (what a sight that would be). Images of O.J. Simpson running through the airport for a commercial some 35 years ago sped through my head. I knew I would never be able to pull off what O.J. had. As I got to the gate and the attendant scanned my boarding pass she said, “Run, we are closing the door.” This comment struck what might have been my last nerve, and I was upset.

I reached my seat with a second to spare.

Of course, I always want the window seat so I can sleep by propping my head against the wall of the plane, so I disrupted the two women who were all buckled in and ready to go. “Ugh,” I thought to myself as I climbed in, “this is going to prompt a conversation.” I like to use my air travel as down time, but it was soon obvious that was not going to be the case this time.

The woman next to me said hello, I responded, and before I knew it, I was telling her my travel woes of the day. The conversation continued and I enjoyed every minute of it. As we talked freely, I realized this woman was amazing. She was talking about traveling, buying her tickets on line, printing off boarding passes, e-mailing with her friend using her cell phone and many other technically savvy pursuits.

She also shared some of her life story which was no less amazing to me than her technical abilities. I couldn’t help it, I wanted to know her age. I thought she was probably in her late 60s and to hear her speak of all the modern technological she used in her daily life was astounding. Finally, I mustered up the courage to ask her age and proudly announced, “I am 84 years old.” I could not believe it.

I have given lectures to dental hygienists who do not have a cell phone. I have been in dental offices that still do not have a computer. And here I was sitting next to a woman that has embraced progress to the fullest extent at age 84.

When we landed, I thanked Hilda for the conversation we had. I also told her she had inspired me to keep educating people about progress in technology. As dental professionals, we are being asked and we are asking others to take advantage of technological progress every day. Even though we may be resistant to change, we can do it. If a woman who is 84 years old can do it, so can we. We have no excuse. We need to get with the program or we will be left behind wondering where everyone else went.

I guess there was a reason my flights were delayed after all.

Best Regards,

Angie Stone, RDH, BS

When a patient is finally able to get a good night’s sleep, oral appliance therapy can be truly life changing.

Have you ever had a sleep study?

- Have you been told you snore?
- Are you excessively tired during the day?
- Have you ever had a sleep study?

following the screening process, a dentist cannot diagnose OSA. The gold standard in care is to refer your patient to a sleep laboratory for a diagnostic sleep study known as a polysomnogram (PSG). This is where you will start to build a mutual referral relationship with your local laboratory and reporting sleep physician.

The multidisciplinary referral pathway should be that you refer your patients for a diagnosis and — providing the results fall within the American Academy of Sleep Medicine (AASM) guidelines for oral appliance therapy, mild to moderate apnea with no co-morbidity — the patient should be referred back to you with a prescription for an oral appliance. This is important for reimbursement too. Oral appliances are also recommended for severe OSA patients if they cannot tolerate their CPAP, although they should always try CPAP first.

Home sleep testing (HST) is becoming more popular and there are companies that offer an interpretation service for patients who will not or cannot to go to a sleep laboratory. There are a wide range of HST devices available to the dental market that can be used for screening, diagnosis (providing they have a certified physician interpret the report and sign off

[Image of Angie Stone, RDH, BS]

Have you been diagnosed with sleep apnea?

Do you wear a CPAP?

When we landed, I thanked Hilda for her technological progress every day.
on the treatment recommendation) and the main function in the dental office where it is used to check the effectiveness of the oral appliance therapy and ongoing efficacy.

Once you have a diagnosed patient who is dentally appropriate for oral appliance therapy, you are ready to do a full patient examination, evaluation and work up, including impressions and a bite registration incorporating pro-trusive and vertical dimension. It would be at this stage that you check their medical insurance and benefits to see if they are covered for this type of treatment.

There are numerous custom fit oral appliances available on the market, all with varying degrees of efficacy, patient comfort and cost. Consider fabricating and dispensing only FDA-cleared devices when treating OSA in order to secure insurance reimbursement because oral appliance therapy is covered by medical insurance not dental insurance.

Medical billing is becoming a more common necessity in the dental practice for a variety of treatments and procedures. The learning curve and process of medical billing and cross coding can be somewhat consuming, however, there are software solutions available and also companies that will handle the entire process for you which is very helpful, especially for those just getting started.

Once a patient is fitted with an oral appliance, a follow-up protocol is essential in order to ensure that the appliance is adjusted to the optimum position whereby snoring is eliminated and the apnea is reduced significantly. Initially this is done with an HST device and ultimately, when efficacy has been achieved, refer the patient back to the sleep laboratory for a sleep study (PSG).

The HST and PSG results should correlate well, which gives the sleep physician confidence that oral appliances are proving effective, and in some cases a good alternative, to CPAP.

Oral appliance therapy can be truly life changing for these patients and being able to change the quality of someone’s life is extremely powerful and rewarding. I have seen many tears and hugs from grateful patients who didn’t even realize how bad they felt until they started to feel the benefits of their treatment.

In summary, a large part of this treatment can be performed by the hygienist working closely with the dentist and incorporating a multidisciplinary approach. Dental sleep medicine is a substantially rewarding practice and our country is in desperate need of more awareness and treatment options.

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