Humanitarian group provides care in Nicaragua

IMAHelps assembled a team of more than 80 doctors, surgeons, nurses, dentists and support personnel for a 10-day medical mission to Estelí, Nicaragua, in August.

“This will be our largest medical mission since we started organizing humanitarian missions 11 years ago,” said Ines Allen, president and co-founder of Rancho Mirage-based IMAHelps.

A small team of volunteers departed the Coachella Valley for Estelí in late July to prepare for the medical mission, which took place Aug. 4 to 14.

This year’s team of volunteers included plastic, maxillofacial, orthopedic and general surgeons as well as cardiologists, obstetricians, general physicians, pediatricians, gynecologists and support personnel, including four pharmacists. A prosthetist who can fit patients with donated artificial limbs, a dermatologist, dentists and a specialist in endodontics were also on the mission.

IMAHelps organizes medical missions each year. Founded in 2000, the group started with medical missions to South America, but has since broadened its efforts to include medical missions to Central America and Asia. The group is also organizing a medical mission to China in September.

During their 10-day medical mission to Somoto, Nicaragua, in August, IMAHelps volunteers provided medical services to 8,446 people, including dental care.

One-third of Americans have cut back on dental visits

A recent public opinion survey commissioned by Oral Health America found that in the past year, more than one-third (35 percent) of those who regularly visit the dentist have cut back. Though this finding tracks with the fears and realities of our current economy, routine dental visits play a vital role in preventing oral and systemic disease and keeping future health-care costs down.

This finding was one of the many reasons why on Sept. 1, Oral Health America launched its second annual Fall for Smiles campaign, aiming to remind policymakers and the public about the importance of dental self-care, regular dental visits, healthy food choices and avoiding tobacco products.
California Dental Association honors school districts for commitment to oral health

The California Dental Association (CDA) has recognized the top California school districts for their ongoing efforts in support of the state’s Children’s Oral Health Assessment law (AB 1455) to encourage children’s oral health needs are being met. Sixty-four California school districts have collected and submitted data each year since the dental check-up program began in 2006.

The top-performing districts include Sierra Plumas Unified, San Francisco Unified and Plumas Unified. These districts consistently make oral health a priority by obtaining and reporting the dental checkup data required by law every year.

CDA recognizes the districts’ leadership in ensuring their school children are healthy and ready to learn.

“It is important to understand the relationship between children’s oral health and their readiness to learn in school,” said CDA President Andrew Soderstrom, DDS, a pediatric dentist. “We appreciate the efforts made by these school districts to ensure their students maintain good oral health; it provides them with the opportunity to learn and perform at their full potential.”

Dental disease is a hidden epidemic among school-age children. Tooth decay is the most common chronic childhood disease, more common than asthma and obesity, affecting nearly two-thirds of California’s children by the time they reach third grade.

Although tooth decay is easily preventable, it is a progressive infection that does not heal without treatment. Left untreated, children’s dental disease can have debilitating effects, including chronic pain, difficulty learning and inability to eat properly, smile and feel good about themselves.

California children miss an estimated 874,000 school days each year due to dental problems, costing local school districts approximately $28.8 million. The CDA continues to work with its partners in education and health to support AB 1455, which requires children to have a dental checkup by May 31 of their first year of enrollment in a public school (kindergarten or first grade).

The intent of the law is to determine unmet dental needs, support children’s school readiness and encourage regular dental care. Further, it carries an essential message to parents about the important relationship between a child’s oral health and overall health and provides simple tips for keeping children healthy.

A list of the top performing school districts and counties supporting the Children’s Oral Health Assessment law is available at cda.org/1455.

(Source: California Dental Association)

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Fall for Smiles runs through the end of October. Dental offices, health educators, school dental program officials, parents and others can find a variety of tools to promote healthy mouths, including a social media guide, coloring sheets and campaign materials online at www.oralhealthamerica.org/fallforsmiles.

“Fall for Smiles reminds families to prioritize the health of their mouths in back-to-school routines,” said Beth Truett, president and CEO of Oral Health America. “The commitment to dental health starts at home, and continues with regular visits to a dental care provider. We have a societal responsibility to educate Americans about why oral health is important, and to ensure that all Americans, particularly those most vulnerable to disease, are able to obtain the care they need.”

Additional findings in the public opinion survey found that a greater number — nearly one-half (47 percent) — of larger households and those with younger children have cut back on their visits to the dentist in the past year. Those who have younger children cut back more frequently than those households that have slightly older children.

This further emphasizes the impact the economic downturn is having on young families who are struggling to get established and the need for policies and programs that support dental care and educational resources for them.

“The findings from the public opinion survey reinforce why Oral Healthcare Can’t Wait is involved with Fall for Smiles,” said Gary Price, president of the Dental Trade Alliance. “The messages that Fall for Smiles promotes are vital when Americans are making choices about how to allocate resources and stay healthy.”

Oral Health America is a national, non-profit organization dedicated to changing lives by connecting communities with resources to increase access to dental care, education and advocacy. The Fall for Smiles Survey is sponsored by Oral Healthcare Can’t Wait and Plackers, a brand of consumer oral care products, and conducted by Harris Interactive. The survey was conducted online within the United States by Harris Interactive on behalf of Oral Health America in June 2011.

Fall for Smiles is supported by Aspen Dental, DentaQuest, Ivoclar Vivadent, Midmark, OralDNA Labs, Patterson Dental, Plackers and Young Dental.

(Source: PRWEB)
A fluid developed by researchers at the University of Leeds has shown promising results in initial testing. A team of researchers led by Dr. Amalia Aggeli, at the university’s School of Chemistry, created the peptide-based liquid, which can be painted on teeth and appears to reverse the initial stages of dental decay.

“This may sound too good to be true, but we are essentially helping acid-damaged teeth to regenerate themselves. It is a totally natural nonsurgical repair process and is entirely pain-free too,” said Professor Jennifer Kirkham, from the University of Leeds Dental Institute, who has led development of the new technique.

Professor Paul Brunton is overseeing the testing on patients at the University of Leeds Dental Institute. “If these results can be repeated on a larger patient group, then I have no doubt whatsoever that in two to three years time this technique will be available for dentists to use in their daily practice,” Brunton said.

(Source: University of Leeds)
Go ahead, tell ’em what you really think

By Sally McKenzie, CEO McKenzie Management

“It all comes down to communication.” Those immortal words have been used to describe success or failure in business, on the playing field and the battlefield, in the classroom, the treatment room and virtually every other environment in which information must be effectively conveyed from one person to another to ensure a desired outcome.

In the dental practice, your communication with staff and patients has a profound and powerful impact on whether you struggle or sail through your days.

Consider the case of “Dr. Roberson.” He is a truly gifted clinician. His patients are tremendously fortunate yet, I suspect few have any real understanding of the talent this practitioner brings to the profession of dentistry. His employees, tragically, do not understand Dr. Roberson. Few have lasted more than a year.

He doesn’t have a “team” because the non-stop turnover in the office never allows a team to take shape. Thus, Dr. Roberson has employees, mostly temporary ones. He does not understand how other practitioners can keep staff, sometimes for years, and he is on a seemingly perpetual quest to secure just one good worker who will not “find a better opportunity” within months.

In Dr. Roberson’s mind, perfection is a “must.” He learned long ago that it is important to give feedback to employees the moment he sees them doing something incorrectly. Thus, as soon as he witnesses an employee performing a task that is not the way he would perform it, he gives immediate feedback. The scenario typically unfolds something like this:

Nicole is setting up instruments when Dr. Roberson walks in.

“What are you doing?” Dr. Roberson says. He doesn’t realize that his query has put Nicole on the defensive. She can sense that Dr. Roberson is upset.

“I’m preparing instrument set ups, doctor. Is there something else you would like me to do?”

“Why are you doing it like that? They should be set up this way.” Then he briskly shows her how to do it, and whisks out of the room without another word.

Unfortunately, Dr. Roberson has no regard for the impact of his communication. His intention is to set the employee straight on how he thinks the task, no matter how trivial, should be done.

He believes that because his intentions are pure — he must ensure that things are done “just right” in his practice — it’s not important how the message is communicated. Instead, he has totally disregarded one of the most critical facts for effective communication:

How you say it has far more weight than the actual words you use.

In fact, words alone are only 7 percent of the message you convey. Tone, attitude, body language and facial expression have a far greater impact on whether the recipient of your message actually receives it or shuts it out because your delivery of that message made him or her angry, upset or uncomfortable.

Dr. Roberson is not only impatient, he is also very direct. He has patients to see and doesn’t have time to beat around the bush. As a result, what he believes is edifying feedback comes across as agitated criticism, which in truth is neither helpful nor constructive.

Sadly, because Dr. Roberson is a boss whom his employees fear, no one is giving him feedback regarding his communication style. Thus, until he seeks to understand why his practice appears to have a revolving door, his productivity will continue to struggle or sail through his days.

How do you respond to suggestions and comments from those around you? Are you defensive? (Photo/Scott Rothstein, www.dreamstime.com)
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to fall well below its full potential.

Conversely, Dr. Berenson’s practice is lined with mediocre performers, most of who are convinced they are the “American Idol Superstars” of the dental team. Dr. Berenson has made these “superstars” herself.

If there are issues or concerns with an employee, Dr. Berenson gives a little hint here and there that maybe a few things could quite possibly be ever so slightly improved. All the while, she is extra careful not to be too specific about anything so as not to offend the staff member who just might get mad and — heaven forbid — walk out.

The employees all go along assuming everything is fine and believing they are effective and contributing members of the team. Meanwhile, Dr. Berenson is convinced that if she keeps dropping hints, the staff will figure it out and take steps to improve their performance.

Nothing ever changes, except the percentage of lost revenues, which only increases. In reality, hints and subtle clues are not feedback any employee is likely to act upon.

Turn feedback into profits

It is the interesting irony of many dental practices that employees do not give each other feedback because they fear they will cause conflict. They don’t communicate frustrations or irritations because they want to go along to get along. This is the double-edged sword of politeness.

Employees who are overly polite to the point where they will not address issues that need to be dealt with are, in actuality, being dishonest. They are engaging in destructive passive-aggressive behaviors that create conflict.

A system of effective feedback is much like a system of proper oral health care. Specific steps must be taken daily to ensure the health and vitality of the group. For example, verbal feedback can be given at any time, but it is most effective at the moment the employee is engaging in the behavior that you either want to praise or correct.

If “Abby” at the front desk managed to expertly convince the difficult “Mr. Denney” to keep the crown appointment that he wanted to cancel at the last minute, tell her; and do so publicly. Similarly, if her handling of a situation is not consistent with practice goals and objectives, explain to her constructively how you would like for her to address similar situations in the future, but do so privately. Positive feedback and pats on the back should be given publicly. Constructive criticism should be given privately.

Choosing to avoid opportunities to give employees feedback is like choosing to help them to fail. That being said, this street runs both ways and employees must be willing to accept feedback and take action on it. In reality, if employees are open to it, feedback is all around them from colleagues and patients. The key is to take the feedback and turn it into positive action.

Consider how you respond to suggestions and comments from those around you. Are you defensive? Do you take it as a personal affront? Are your feelings hurt or do you become angry when someone recommends doing something a different way? Do you dismiss feedback because you don’t like the person giving it? Instead, separate yourself from the action and look at feedback as an objective view of a particular task or procedure and, most importantly, as one of the most essential tools you can use to excel.

The best way to become comfortable in receiving and acting on feedback is to ask for it. We are incapable of seeing ourselves as others see us, which is why being open to feedback is essential in achieving our greatest potential. When receiving feedback, make a conscious decision to listen carefully to what the person is saying and control your desire to respond.

In other words, resist the urge to kill the messenger. Ask questions to better understand the specifics of the person’s feedback. If the individual giving the feedback is angry, ask him or her if you can discuss the problem when you are both calmer and can avoid responding emotionally.
Thank the person for trying to help you improve, even if you didn’t particularly care for what he or she told you. Resist the urge to blow off those comments you considered to be negative. Over the next 48 hours, think about the information you have been given and devise three to five steps you can take to change your approach.

For example, Dental Assistant Laura is very frustrated because she feels that Business Employee Betsy is unnecessarily interrupting the clinical team when they are with patients. Betsy feels that Laura is trivializing her need for clear information.

Instead of lashing out, Betsy decides to ask for examples and listens to Laura’s perception of the interruptions. She thanks Laura for calling her attention to the issue and decides to focus on addressing the matter constructively rather than reacting negatively to what she could choose to interpret as unjust criticism.

Betsy develops a plan to raise the issue at the next staff meeting. She is prepared to share with the team situations in which she has felt the matter necessitated an interruption and would like guidance on how to handle similar situations in the future.

Don’t sit back and wait for feedback, actively solicit it and use it! Recognize that feedback is one of the most critical tools you have in achieving your full professional potential.

Constructive feedback – not criticism – should be given and received daily to help all members of the dental team continuously fine tune and improve the manner in which everyone carries out their responsibilities.

The best way to become comfortable in receiving and acting on feedback is to ask for it.

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About the author

Sally McKenzie is CEO of McKenzie Management, which provides success-proven management solutions to dental practitioners nationwide. She is also editor of The Dentist’s Network Newsletter at www.thedentistsnetwork.net; the e-Management Newsletter from www.mckenzie mgmt.com; and The New Dentist” magazine, www.thenewdentist.net. She can be reached at (877) 777-6151 or sallymck@mckenziegmt.com.
Two cases

The first case will deal with the anterior segment of soft-tissue asymmetry caused by trauma. The ERA implant is used primarily to provide support for dentures in areas where the remaining bone will not support conventional implants without significant bone grafting and other invasive procedures.

It accomplishes this by reducing the size but not the material composition of the conventional implants while adding an aggressive thread design that provides a self-tapping feature to the implant.

The second case deals with a patient with a Type III lip, significant bone loss before implant placement and presents with an aesthetic challenge. When doing a diagnostic work-up, if we line up each challenge that is an obstacle in our quest to provide both a functional and an aesthetic end result, each solution we find brings us much closer to a predictable overall result.

This article will address the challenge of soft-tissue asymmetry in the cosmetic zone with a new approach to a very challenging problem that, until recently, had few predictable solutions.

The area extends from molar to molar in the maxillae in patients with Type II and III lips. These are patients that show some soft tissue when smiling (Type II lip) to those that show significant soft tissue (Type III lip).

Case No. 1

The first patient presented with a bridge that had been placed after trauma to the anterior maxillae. Although one hard-tissue and two soft-tissue grafts had been performed and the new bridge constructed, the defect was still unacceptable to the patient. The hard- and soft-tissue defect was 6 mm inferior and 4 mm palatal to where it was necessary to create ideal tissue symmetry (Fig. 1).

Fig. 1: Case No. 1 — The patient already had one block bone graft and two soft-tissue grafts that produced this result. (Photos/Prodived by Dr. Joe Carrick)

Fig. 2: We made a resin bridge from the upper left cuspid to the upper right central incisor, replacing the left lateral and central incisor.

Case No. 2

When doing a diagnostic work-up, we line up each challenge that is an obstacle in our quest to provide both a functional and an aesthetic end result, each solution we find brings us much closer to a predictable overall result.

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Fig. 1: Case No. 1 — The patient already had one block bone graft and two soft-tissue grafts that produced this result. (Photos/Provided by Dr. Joe Carrick)
After a complete work up, the patient also needed his occlusal plane leveled for ideal function. While it would be relatively predictable to do an onlay graft to correct the facial defect, the vertical defect utilizing conventional grafting techniques was not predictable, as the patient had already experienced.

We presented the patient with a treatment option that included orthodontics to correct the functional challenges, and offered him a treatment option that would incorporate a variation of distraction osteogenesis in combination with surgical vertical displacement of the previously onlay graft utilizing the small diameter ERA implants.

With their aggressive thread design and subsequent fine tuning with three-dimensional displacement of the bone, the ERA implant allows for conservative surgery to maintain blood supply while separating the cortical bone plates and allowing controlled movement of the bone in the healing surgical site. We divided the treatment into three phases.

**Treatment phase No. 1**

We made a resin bridge from the upper left cuspid to the upper right central incisor, replacing the left lateral and central incisor (Fig. 2). We then placed a 2.2 x 10 mm ERA implant in the area of the upper left central and one in the upper left lateral incisor, making sure that we engaged the previous graft site extending well into the residual bone that was grafted (Figs. 3, 4).

The resin bridge was cemented but out of contact with the implants that were placed without an incision with the abutment supragingival (Fig. 5). The orthodontic treatment was initiated during the four months while bone integration took place around the implants.

**Treatment phase No. 2**

The pontics were removed and altered by measuring the clinical crown of the upper right central and lateral incisor (measured from the gingival crest to the incisal edge) then connected to the implants. This then created a step in the incisal edges in this area corresponding to the hard- and soft-tissue defects (Fig. 6).

After connecting the new resin crowns that correspond in size to the adjacent central and lateral, a conservative vertical incision was placed mesial to the upper left central and distal to the left lateral. The soft tissue was raised via tunneling to bone on the facial, but not on the lingual, in an attempt to preserve the blood supply to the bone around the implant, and was also the reason no horizontal incision was placed.

The cortical plate was cut such that the implants and the bone between them was freed to allow us to pull the implants via altered resin crowns incisally to have the “in edges” as close to being level without blanching the tissue (Fig. 7). The area was grafted with mineralized and demineralized cancellous bone, collagen membrane was placed and the vertical incisions were closed with 4-0 sutures.

The surgical site was stabilized using the wire that was secured to the adjacent teeth and orthodontic brackets (Fig. 8).

**Treatment phase No. 3**

After the soft tissue healed and the sutures were removed, the...
Fig. 6: The altered crowns over the implants were made to the same size as the adjacent teeth and this created a step on the incisal aspect, which was the amount of movement necessary to move bone.

Fig. 7: The arrows mark areas of vertical incision.

Fig. 8: Implants and bone secured using the orthodontic brackets.

Fig. 9: Four months after ERA implant placement and prior to primary implant placement.

Fig. 10: Arrows show osteotomy sites utilizing 2.4 mm triphine bur to remove ERA implants. Narrow ridge regained height but not width.

Fig. 11: a) Donor site; b) size and shape graft and c) block graft.

Fig. 12

Fig. 13: Six-months post-implant placement. Two-weeks post second-stage abutment and temporization.

Fig. 14: After shows post ERA implant distraction post. Primary implant placement integration and final temporization before final prosthesis.
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active controlled orthodontic was reinstated.

**Treatment phase No. 3**

After four months of orthodontic intervention to create an ideal functional occlusal scheme and osteogenesis in the anterior region (Fig. 9), we removed our ERA implants using a 2.4 trephine bur that was ideal for placing our 3.5 mm implant in the lateral area and 3.75 mm implant in the central incisor area.

We gained the necessary vertical height in bone via our combined surgery and small amount of orthodontic osseous distraction, but were still deficient facially, which we achieved by expanding the ridge with the implant in the undersized osteotomy along with bone augmentation utilizing an autogenous block graft harvested from the mandible (Figs. 10–12).

It took another five months to finalize the orthodontic treatment, at which time the abutments were placed and the ideal soft-tissue symmetry and emergence profile was refined with the anatomically shaped resin transitional crowns (Figs. 13, 14).

In conclusion, while the total treatment was 15 months, utilizing orthodontics to correct not only occlusal disharmony but also help create hard-tissue support for the implants, soft-tissue symmetry was actually the conservative treatment option.

I believe that orthodontics will play a much larger role in providing new bone for cases requiring implant support.

**Case No. 2**

In the second case, the patient presented with no complaints, having recently completed the restorative phase of her full-mouth rehabilitation. It was noted that she had an extremely short upper lip that revealed a very toothy smile. The maxillary incisors were supported with four individual implants and her final restorative result was functionally sound.

The esthetic result was compromised by extremely long incisors due to the loss of soft tissue (Fig. 15). Even if that had not been the case, she would have been compromised because of the amount of soft tissue visible. The patient stated that she had been presented with options such as soft-tissue grafts post implant placement; repositioning the muscle attachments to minimize lip movement, thus exposing less soft tissue when smiling; and even an orthognathic procedure that would truly be the only way to predictably solve her esthetic dilemma.

The only procedure (Laforte) that would provide our patient with an ideal solution was very expensive, invasive and had its own potential set of postoperative problems. As a result, the patient was content to do nothing because the only predictable option was financially out of reach: the functional restorative plan was itself a financial burden, not to mention the thought of yet another lengthy phase on top of what she had already been through.

Sometimes the “K.I.S.S. Theory” (keep it simple, stupid) is the best. If we could find a non-surgical, inexpensive and reversible procedure that could at least improve on some of her esthetic challenges, she would be receptive.

We took impressions and sent them to the lab to produce an insert (bumper) that has the ability to blend in with the underlying soft tissue and make the junction invisible (Fig. 16). After placing the insert and adding some texture, the margins disappeared (Fig. 17). Although the lip still shows too much soft tissue, the teeth are now symmetrical (Fig. 18).

**Summary**

The use of the 2.2 mm ERA implant and orthodontics as tools to aid in bone augmentation — even though they are not thought of as conventional tools for this — proved to be very effective.

I believe we will see more situations where they will be thought of as a treatment of choice to produce more predictable results.

**References**


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Clinical


Fig. 17: A simple solution for a complex problem.

Before

After

Fig. 18

About the author

Joe L. Carrick, DDS, graduated dental school in 1977 from the University of Texas at San Antonio; he then served 4 years in the Navy where he did much of his postgraduate work. In 1980, he started his practice in San Diego. Over the last 15 years Carrick has lectured and taught implant surgical and prosthetic courses internationally and domestically. In 2008 he started Simply Secure Dentures, which is dedicated to not only teaching clinicians to place and restore patients with the ERA implant, but also set up a network of offices through the United States that achieves predictable results. Presently he has a private practice in Conroe, Texas, that allows him to pursue his passion for teaching.

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Here’s some content from past editions of Dental Tribune that you can find online ...

Implantology

Intro to CBCT as it pertains to prevention of failures in oral implantology, by Dr. Dov M. Almog
www.dental-tribune.com/articles/content/scope/specialities/section/implantology/id/4564

Management of two implants in the esthetic zone, by Dr. Saghi Parham
www.dental-tribune.com/articles/content/scope/specialities/section/implantology/id/4567
Here’s just one of countless scheduling decisions facing you at the upcoming 2011 American Dental Association (ADA) Annual Session: See if Chumlee, one of the “Pawn Stars” from Gold & Silver Pawn Shop, will make you an offer on a treasure you’re willing to part with — or push your office finances into higher gear by attending Lois Banta’s course, “Build Your Practice with Paid-for Dentistry.”

Just be sure to keep this in mind as you’re deciding between the two Tuesday-afternoon offerings: Banta’s “Paid-For Dentistry” session has no fee, is worth 2.5 C.E. credits, and with one insight could easily pay for your entire trip to Vegas. And Chumlee’s offer on your 19th-century ivory-handled tooth key? Well, more on Chumlee and the Pawn Stars Gold & Silver Roadshow later. First, a few more-critical details about the event.

The 152nd ADA Annual Session and World Marketplace Exhibition, Monday through Thursday, Oct. 10–13, in Las Vegas, Nev., offers: 260-plus continuing education courses spread across four days; 500-plus dental supply and service companies in the World Marketplace Exhibition; former U.S. Secretary of State Condoleezza Rice at the opening general session; the return of the popular ADA Health Screening Program after its 2010 hiatus; and countless other education and networking opportunities — all under one roof in the Mandalay Bay Convention Center.

Nonstop education

More than half of the 260 C.E. courses are free (no extra fee beyond your annual session registration). Course topics cover all aspects of running a successful dental practice and keeping pace with the latest advancements in patient care and treatment. Among the possible education tracks: esthetic dentistry, ethics, federal dental services, geriatric dentistry, preventative dentistry, new dentist, and team building.

Additionally, the American Dental Association features six separate dental procedures performed live with actual patients. (Photo/ American Dental Association)
The Dental Assistants’ Association, whose 2011 annual meeting runs concurrently with the ADA Annual Session, worked with the ADA to develop a dental assistant track featuring 18 courses. There also are courses and events focused on all other positions within a typical practice, including hygienists, who can use course attendance toward license-renewal requirements.

**World Marketplace Exhibition**
The World Marketplace Exhibition hosts more than 500 of the industry’s leading suppliers of dental products and services. But there’s far more than just shopping going on. The Annual Session’s education theme is heavily represented in the marketplace, too, confirmed by The LOC (Learn, Optimize, Connect) and its 50,000 square feet devoted to exploring the latest tech trends in dentistry. Highlights include:
- **The Laser Pavilion** gives you the opportunity within a single workshop to touch and compare virtually every laser on the market while you learn basic laser physics and other fundamentals.
- **Pride Institute Technology Expo** features best-of-class high-tech products identified by Pride Institute’s “Tech Expert Leadership Council.”
- **The 3-D Imaging Center**, presented in cooperation with The American Academy of Oral and Maxillofacial Radiology, offers hands-on firing of various CBCT machines, with a comprehensive overview of CBCT principles and practices.
- **The CAD/CAM Stage** features 45-minute company presentations and full demonstrations of the making of a crown from prep to delivery on a typodont.
- **Open Clinical and Science Forums**, hosted by the ADA Council on Scientific Affairs and the Journal of the American Dental Association, give scientists and opinion leaders a platform to present sometimes controversial and always thought-provoking concepts in a lively discuss-and-debate format.
- **And back after its successful 2010 debut, the New and Emerging Speaker Stage** gives on-the-rise educators a one-hour lecture platform to present courses on some of the industry’s most important topics.

**Education in the Round**
Sponsored by Philips Sonicare and developed in cooperation with the American Dental Education Association, these diagnosis-to-treatment scenarios put you in a real-time, live learning environment. Six live-patient procedures are performed in a fully functional operatory, enhanced with the display of close-up, high-definition images of the procedures, step-by-step. The courses are:
- **Live Surgical Demonstration of an Extraction/Ridge Preservation Procedure**
- **Active Clinical Treatment: The Art and Science (new-dentist track)**
- **Live Patient, Seeing is Believing: From Evaluation and Treatment Plan to Completed Prosthesis**
- **Live Surgical Demonstration of Root Coverage Grafting of Multiple Teeth in the Maxillary Arch**
- **Minimally Invasive Dentistry: Solving Anterior Esthetic Problems with Composite Resin**
- **Live Patient Biomimetic Dentistry — A New Generation**

And plenty of fun
But this is Las Vegas. So you’ll need to break up your education focus with a few opportunities for fun. Among the many lighter-side activities sponsored by the ADA is the Pawn Stars Gold & Silver Roadshow, which brings us back to Chumlee (Austin Russell). From 2–4 p.m. Tuesday on the LOC Main Stage in the World Marketplace Exhibition, you’ll get to see the stars of the wildly popular HISTORY Channel show. Rich Harrison, Richard Harrison (Old Man), Corey Harrison and his pal Chumlee will appraise hand-held items brought to the stage by a limited number of $49-ticket holders. That could lead to an actual sale transaction at the Gold & Silver Pawn Shop in Las Vegas, site of the breakout reality show. It’s another opportunity to pay for your entire four days in Vegas.

Never heard of “Pawn Stars” and have no interest in changing that? No problem. There are countless other opportunities vying for your attention at that same time. All you have to do is pick one.
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see it. hear it. believe it.
DTSC Symposium at the Greater N.Y. Dental Meeting

People from around the world flock to the annual Greater New York Dental Meeting (GNYDM) — held this year Nov. 27–30 — for reasons that go well beyond the fact that there is no registration fee. New York city is a delight at this time of year, offering lots of options outside the convention center.

Dental Tribune, the official media partner of the GNYDM, has joined forces with GNYDM organizers to offer four days of Dental Tribune Study Club (DTSC) Symposium in various areas of dentistry. Participants not only earn C.E. credits, but also have the opportunity to learn diverse aspects of dentistry and how to integrate a variety of treatment options into their practice.

For exact program details, please check the schedule at www.dtstudyclub.com/gnydm. Be sure to preregister as a GNYDM visitor for free at www.gnydm.com.

DTSC at the GNYDM

Sunday, Nov. 27
• 10–11 a.m., Dr. Howard Glazer, GHOMERS: New Giants of MI Dentistry
• 11:15 a.m.–12:15 p.m., Dr. Shamshudin Kherani, Comprehensive Dentistry Using Digital Impression Technology
• 12:15–1:15 p.m., Dr. Ron Kaminer, Minimally Invasive Dentistry: Tips and Tricks to Maximize Success
• 2–3 p.m., Dr. Louis Malcmeacher, The Hottest Topics In Dentistry
• 3:15–4:15 p.m., Technology To Improve Your Caries Management (speaker to be announced)
• 4:30–5:30 p.m., Dr. George Freedman, Evolving Conservative Restorations

Monday, Nov. 28
• 10–11 a.m., Dr. Fay Goldstep, What Patients Want ... What Dentists Want: Easy, Healthy Dentistry!
• 11:15 a.m.–12:15 p.m., Dr. Damien Mulvany, Why View Your 3-D Patients With 2-D Images? A Common Sense Approach To 3-D Imaging
• 12:15–1:15 p.m., Dr. Larry Emmott, Remember When “e” Was Just A Letter? Use e-Services to Improve Patient Care and Increase Profitability
• 2–3 p.m., Dr. Fay Goldstep and Dr. George Freedman, Diode Lasers and Restorative Dentistry
• 3:15–4:15 p.m., Dr. Shamshudin Kherani, Laser Dentistry Overview with an Update on Closed Flap Osseous
• 4:30–5:30 p.m., Dr. Marty Jablokow, Understanding the Advances in Self-Adhesive Technology and How To Incorporate Them Into Your Restorative Practice

Tuesday, Nov. 29
• 10–11 a.m., Dr. Gregori Kurtzman, Topic to be announced
• 11:15 a.m.–12:15 p.m., Dr. Stanley Malamed, Remember When “e” Was Just A Letter? Use e-Services to Improve Patient Care and Increase Profitability
• 12:15–1:15 p.m., Dr. Amna ZhumadiLOva, director of the Department of Dental Therapy and Oral Surgery at Astana Medical University, Kazakhstan, received her AAPI membership certificate and medallion.

AAIAP and ADIS meet in Jamaica

The American Academy of Implant Prosthodontics (AAIP) joined with its affiliates, Atlantic Dental Implant Seminars (ADIS) and the Linkow Implant Institute, to present a five-day comprehensive implant training program in Montego Bay, Jamaica, for 10 dentists from Kazakhstan. The course, held August 4–8, included two days of lectures and three days of clinical patient treatment. Taught at Cornwall Regional Hospital, the course was the fourth cooperative effort of the Jamaican Ministry of Health and the American Academy of Implant Prosthodontics.

Under the direction of Dr. Mike Shulman, the students placed 57 implants and performed 10 sinus lifts. Prosthodontic treatment of the patients will be performed at subsequent implant courses in Jamaica sponsored by the AAIP and ADIS.

American Academy of Implant Prosthodontics membership certificates were presented to the course participants. Dr. Anara ZhumadiLOva, director of the Department of Dental Therapy and Oral Surgery at Astana Medical University, Kazakhstan, received her AAIP mastership certificate and medallion.

Dr. Mike Shulman is course coordinator, Dr. Leonard I. Linkow is course director and Dr. Sheldon Winkler is course advisor for AAIP/ADIS-sponsored programs in Montego Bay and Kingston, Jamaica.
Additions to the NiTi rotary file market
What to bring in and what to leave out

By L. Stephen Buchanan, DDS, FICD, FACD

Nickel-titanium rotary shaping files fundamentally changed everything in endodontics; conceptually, procedurally and economically. The efficiencies gained offset the costs, and dental companies were loved for making files that cost four times more than SS hand files but delivered a tenfold improvement.

Those seeds of success have grown into today’s endo market where we have come to expect another new file on the market every six months. Granted, it’s a quality problem, but while some of these new instruments have significant improvements in tip and blade geometry or were made with improved metallurgical and forming processes, some have offered little advancement over existing technology.

Their introductions were just business moves proposed to benefit a dental company instead of dentists and their patients.

So how do we sort through the list of new instruments and decide whether any of them truly offer clinical advantages commensurate with the high cost of purchasing new instrument inventories, new handpieces and the retraining needed to become competent in their use?

To my mind, there are only a few reasons to change to a new rotary file system:
1) Improved safety and consistency of result.
2) Improved efficiency if the safety and outcomes imperatives have been met or exceeded.
3) Improved procedural simplicity and/or cost of providing endodontic services to patients.

In that order! Any new instrument delivering improved efficiency at the cost of safety and predictability of outcome is a fool’s choice. So if we are choosing for excellence of outcome, we usually look at our failures and consider how we could eliminate those painful and expensive experiences from practice.

However, deconstructing endodontic failures can be nearly impossible, so it is imperative for dentists to choose for the right reasons.

One of the greatest challenges to dentists making these decisions wisely is the difficulty of deconstructing endodontic failures — the prime example being failures due to apical damage caused by aggressive tip and flute geometries.

Dentists who use rotary files have all suffered instrument separation when difficult anatomy is encountered and rotary files are allowed to rotate for too long. This is why dentists interpret a new rotary file that cuts effortlessly to length in such positive light, despite the reality that serious laceration will almost always result when aggressive tip and blade geometry intersects difficult apical anatomy.

The only evidence of the disastrous shaping outcome is the inevitable overfill that follows — a result of the absence of a consistent and predictable shaping process.

Additions to the NiTi rotary file market
What to bring in and what to leave out

DENTAL TRIBUNE | SEPTEMBER 2011

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BEAUTIFIL Flow Plus

- Indicated in classes I, II, III, IV & V
- Physical properties rival hybrids
- Stackable & sculptable; stays put
- Self-polishing “leveling-effect”
- High radiopacity, beyond enamel

BEAUTIFIL Flow Plus is the next step in the evolution of restorative materials, combining the delivery of a flowable and the strength, durability, and aesthetics equal to or better than leading hybrid composites.

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TRIAL OFFER $99.95 A $160.00 VALUE!
Shofu Dental is holding product demonstrations at ADA booth No. 658, featuring its new injectable hybrid restorative, BEAUTIFIL Flow Plus. This restorative combines hybrid-like strength and functionality, unique handling and stackability and a flowable delivery. Additionally, the material has 15 percent more radiopacity than enamel and offers the benefit of fluoride release and rechargability. Those interested in seeing the material can attend a hands-on demonstration to come see what all the excitement is about at the Shofu booth.

According to Shofu, BEAUTIFIL Flow Plus is lauded as the next step in the evolution of restorative materials based on its convenient flowable delivery system, physical properties and functionality that rivals leading hybrid composites. Brian Melonakos, president of Shofu Dental, said he has been very pleased with the success of the product. “We’ve always known that we have an amazing product on our hands … but none of us imagined how quickly it would catch on,” he said. Unlike other flowables, BEAUTIFIL Flow Plus has stay-put handling and physical properties that allow use on the occlusal surface and marginal ridge, eliminating the need to pack a hybrid composite on top.

A flowable base, liner and final restorative material, BEAUTIFIL Flow Plus is approved for all indications (Class I–V). With a smooth, self-leveling consistency, the material leaves a tight margin seal on the bottom and a smooth ready-to-polish surface on top. Moreover, Shofu’s proprietary S-PRG (surface pre-reacted glass) technology provides sustained fluoride release and recharge that can’t be found in any other composite material.

BEAUTIFIL Flow Plus is available in two distinct viscosities. F00 (zero flow) offers precision stacking, and F05 (low flow) is an ideal base/liner. For a limited time only, BEAUTIFIL Flow Plus is available in two introductory kits. The standard kit (PN 2000S) offers two 2.2-gram syringes of both viscosities in shades A2 and A3, and the pedo kit (PN 2000F) offers two 2.2-gram syringes in both viscosities in shades A1 and bleach white.

Both kits also contain samples of Shofu’s top-selling products, including the seventh-generation bonding agent BeautiBond, One Gloss, Super Snap and Shofu’s hybrid material, BEAUTIFIL II. The kits retail for $99.95 (a $160 value).

About the author

L. Stephen Buchanan, DDS, FICD, FACD is a diplomate of the American Board of Endodontics and an assistant clinical professor at the post-graduate endodontic programs at USC and UCLA.

He maintains a private practice limited to endodontics and implant surgery in Santa Barbara, Calif., and is the founder of Dental Education Laboratories, a hands-on training center serving general dentists and endodontist upgrading their skills in new endodontic and implant technology. Buchanan can be reached through his business, Dental Education Laboratories, at www.endobuchanan.com or info@endo-buchanan.com.
CAESY Cloud from Patterson Dental

CAESY Cloud is Patterson Dental’s latest edition to the CAESY Patient Education Systems family of products. CAESY Cloud is online and guarantees dental professionals immediate access to more than 280 multimedia patient education presentations, including the most up-to-date materials featuring 3-D animation, full-motion video, narration and colorful images.

CAESY Cloud features include:
- Easy startup with no installation required and only a low monthly subscription fee so you can start using CAESY Cloud in your practice immediately.
- Compatibility/accessibility with both PC and Mac services, Smartphones and the iPad, iPhone and iPod — no additional software purchases are necessary.
- No network connections are necessary between participating computers, allowing presentations to be accessed from multiple locations within the practice with no additional charge.
- Presentations are updated frequently and with the ease of a standard Internet connection, users will immediately be able to use the latest videos in all patient appointments.

With the addition of CAESY Cloud, dental professionals now have more tools and more options than ever before to present their patient educational materials with three chairsides formats to choose from — CAESY Cloud, CAESY DVD or CAESY Enterprise, and entertaining and informative front-office programming, Smile Channel. Countless dental professionals have seen how CAESY optimizes staff time, eliminates the fatigue of repeating explanations and increases case acceptance rates in the practice.

Dr. Marty Jablow, a beta-tester and new user of CAESY Cloud said: “I have found that the convenience of a cloud-based system delivers many benefits in comparison to the alternatives. Using a cloud-based system eliminates the need for time-consuming and frustrating installations. It’s as simple as opening up a web browser and logging in to a website.”

“With some other patient education systems, there is a need to update software or install the latest version. However, with CAESY Cloud, practices have instant access to all updates and all new presentations automatically. There is no hassle updating software, IT headaches, and more importantly, IT costs are eliminated by using the cloud.”

Jablow concluded that, “I find that using CAESY Cloud along with other educational tools such as CAESY Smile Channel from Patterson Dental in the reception area are an effective way to educate patients and create new business. I would definitely recommend it for small and large practices alike that want to increase case acceptance rates and put their practice at the forefront of technology.”

CAESY Education Systems has been dentistry’s premier developer of leading-edge patient education technology and content since 1995. Patterson Dental Supply Inc. acquired CAESY in May 2004. The award-winning multimedia information on preventive, restorative and esthetic treatment options helps dental practices worldwide educate their patients and grow their practices.

The CAESY content is distributed via video and computer networks, DVD players and now through the Cloud throughout the clinical and reception areas of the dental practice. The entire family of products includes CAESY Cloud, CAESY DVD, Smile Channel, DVD and CAESY Enterprise, which includes CAESY, Smile Channel and ShowCase. For more information, please visit www.caesy.com or call (800) 284-5504.

New Piezon Master 700

Get a feel for perfection with the new Piezon Master 700: versatile, simple and hygienic

The formula for no pain

The new Piezon Master 700 is a symbiosis of intelligent technology and unequalled precision. A perfect match between the Original Piezon LED handpieces and the Piezon No Pain module for instrument movements perfectly aligned with the tooth. An incomparable fit when used with EMS Swiss Instruments made of ultrafine biocompatible surgical steel.

The result is a treatment, which irritates neither teeth nor gingiva — and which delivers extra smooth tooth surfaces without abrading the oral epithelium.

This development from Swiss-based E.M.S. Electro Medical Systems comes close to perfection. Still more features result in an easier and quicker handling for more efficiency without affecting patient comfort. Everyone benefits, all feel good — patient, practitioner, the whole practice.

Features

Versatile

Two integrated bottles, two handpieces, two magnetic handpiece holders and a multifunctional foot control allow for a versatile use of the Piezon Master 700. Customers choose and easily switch between different anaesthetic solutions, a variety of handpieces and tips, between endo and standard mode.

By simply switching on or off ultrasound, irrigation or power boost, they personalize the PM700 for each treatment and application. Versatility means personalization.

Simple

With the Touch N’ Go front panel, the customer benefits from a hygienic and user-friendly interface. All settings (power, treatment mode) are operated by touch on a highly sensitive panel, which reacts even through surgical gloves.

Blue LEDs clearly display the current setting. Moreover, a modern flat design without joints or gaps is easily wiped and cleaned, and does not leave any space where debris, residue or bacteria may hide.

Hygienic

Benefit from the unit’s intuitive and automatic cleaning mode and follow the exact progress of the cleaning process. Of course, the Piezon handpiece LED, EMS Swiss Instruments and accessories are...
Adjustment-free appointments are actually possible and can be routine. Delivering veneers, inlays, onlays, crowns, bridges and partial dentures with very little or no proximal and occlusal adjustment can be common when a laboratory adheres to a strict protocol of the handling and die spacing, and has a firm understanding of how to properly equilibrate correctly mounted stone models and understand solid models verification.

Basic cusp to fossa occlusion occurs when cusp inclines on posterior teeth do not touch other posterior inclines. Crowns must hit static stops in central fossa.

In laboratory model equilibration there is nothing more than the removal of all incline interferences and allowing cusp tips to occlude at 90-degree angles to opposing marginal ridges and central fossa. Anterior guidance should allow complete freedom from maximum intercuspation, immediately with lateral guidance on the canines. This will not activate the elevator muscles, therefore decreasing any chances of TMD.

Equilibrating mounted casts is crucial to achieving adjustment-free delivery appointments. Less than 1 percent of technicians understand why we need to, much less, how to perform this task. Because of this, the following are common techniques used to try to achieve adjustment-free cementation appointments:

- Placing metal foil under the working die to create a space. If too much foil is used, the crown may be shy of occlusal contact. When that tooth does erupt into occlusion, it may work into an incline interference, creating an avoidance pattern for the mandible.
- Pushing die up so crown appears out of contact. With too much die removal, cusp tips show through.
- Placing metal foil under the working die to create a space. If too much foil is used, the crown may be shy of occlusal contact. When that tooth does erupt into occlusion, it may work into an incline interference, creating an avoidance pattern for the mandible.
- Placing metal foil under the working die to create a space. If too much foil is used, the crown may be shy of occlusal contact. When that tooth does erupt into occlusion, it may work into an incline interference, creating an avoidance pattern for the mandible.

An example of model equilibration for a #30

1) Opposing model and working models are both poured in liquid/powder ratio measured die stone. (Crucial)
2) At mounting accurately, verify the mounting. Bite should not be taken with base plate wax but with a polyvinyl bit block material which can be trimmed to allow only cusp tip show through. Use double-sided, Exacta-film red/black of 19-micron thickness, use black for centric, tap models together. Notice not all teeth are in contact.
3) Initial incline contacts should be removed. Do not ever remove cusp tips. Remove only inclines, as would be done for intraoral equilibration.
4) With the red side of Exacta-film, move models laterally and remove all red marks except those on canines, without removing black holding contacts on posterior teeth. The goal is to have black dots on all posterior teeth and red marks on the anterior teeth.
5) A black dot stable holding contact should be found in the fossa of adjacent teeth; #51 and #29 in this example.
6) There should be no contacts found on inclines, only on cusp tips and fossa. These holding contacts are found on all teeth. You can now proceed to the anterior guidance equilibration process.

Lateral equilibration

1) There should be no change in vertical dimension of the equilibrated models in centric because this replicates a “power clinic” of all teeth. (Periodontal ligaments are fully depressed.)
2) At Williams Dental Laboratory, we go one step further to absolutely ensure no posterior interferences. We know all healthy teeth intrude into their periodontal ligament and move laterally. In this example, imagine the canine will move laterally 56 to 75 microns in a clinching lateral force.
3) We safely remove approximately 5 degrees off of canine discision to further “shallow” the guidance to ensure no posterior interferences. Posterior interferences must then be rechecked. Remember: the key is that lateral equilibration will not change the vertical dimension, only shallow the discision, further ensuring no posterior interferences.

By Bob Clark, CDT, LVIM

About the author

Bob Clark, CDT, LVIM, is the first and only lab technician in the world to receive mastership status with LVI. He is co-owner of Williams Dental Laboratory, a small family-operated, full-service lab located in Gilroy, Calif. His team has been working and training with LVI dentists for many years. Clark may be reached at (800) 715-5390 or bob@williamsdentallab.com.
Thank You

for bringing the global community together...
the journey never ends.

Dr. David Babin: Victoria, British Columbia, Canada
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Dr. Arturo Garcia: Sugarland, Texas, USA
Dr. Jerry Lim, Singapore
Dr. Craig Newman, Merimbula, NSW Australia

"I have never felt so reassured in my lab partner even though you are halfway around the world. You have been very calm in handling the unexpected."

-Jerry Lim, B.D.S., FRACDS
Replacing congenitally missing lateral incisors

By Robert M. D’Orazio, DDS, FAGD, MIIF, ABOM/ID and Mark A. Iacobelli, DDS, FAGD, FICD, MIIF

It is estimated that 6 percent of the American population — 18 million people — are congenitally missing a maxillary lateral incisor. To address this need, DMX Implant Corp., the dental implant division of Dentatus Ltd. (www.Dentatus.com, (800) 523-5156) has created a unique narrow-body implant called the ANEW Implant System. ANEW is the only narrow diameter implant that accepts a screw-retained abutment. This advantage affords prosthetic options unlike other narrow diameter implants.

The high success rate of narrow-body implants has expanded treatment options for both dentist and patient. Primarily, narrow-body implants can be placed into anatomically challenging areas that would be contraindicated for standard diameter implants without site modification procedures, such as bone grafting and orthodontics.

These procedures increase treatment time, cost to the patient and morbidity. This can deter the patient from dental implant therapy, thereby subjecting the patient to limiting their treatment plan to less definitive options such as “flipper” appliances, removable partial dentures and “bonded” and conventional bridges.

In 2001, in conjunction with the NYU Department of Dentistry, DMX established a specific prosthetic protocol. In 2004, the FDA approved ANEW Implants for “long-term use or any length of time as determined by the healthcare provider.” The low profile 3 mm head accommodates divergent angles, offering natural looking esthetics.

The non-hygroscopic screw-cap abutment facilitates fabrication of a fixed transitional restoration at the time of implant placement, thereby providing the patient with an immediate, predictable and cosmetic result. During the healing period, the restoration contours can be easily modified to the contours of the tissue architecture, thereby eliminating a final “black triangle” result.

ANEW narrow-diameter implants are minimally invasive and designed to fit into narrow spaces with implant diameters of 1.8, 2.2 and 2.4 mm respectively. The ANEW tapered, one-piece implant design eliminates minimization related crestal bone loss, facilitates one-stage surgery, provides immediate restoration and is more conducive to flapless implant placement.

Additionally, utilizing a minimally invasive flapless procedure with an immediate restoration eliminates many postoperative challenges as well as reduces total treatment time.

ANEW narrow diameter implants have been tested with university-based research from the around the world. In 2007, Dr. Stuart Froum and his colleagues from the New York University Department of Implant Dentistry published a study in the International Journal of Perio and Restorative Dentistry stating, “40 ANEW Implants in patients for 1 to 5 years postloading. No implant failures were reported, yielding a 100% survival rating.”

In 2005, the Journal of Oral and Maxillofacial Implants published Dr. Michael Rohrer’s histology study on Dentatus implants. Dr. Rohrer determined that the percentage of bone in contact with the body of Dentatus implants in “the same range and sometimes higher than what is usually seen with conventional implants.”

These results support well-known literature about implant design and materials in the following ways: ANEW narrow-body dental implants are composed of Grade V titanium alloy; the threaded portion of the implant is mechanically roughened to increase surface area and maximize the bone-implant interface; and the tapered design better facilitates implant placement, promotes initial implant stability and better distributes occlusal loads along the body of the implant. Predictably, ANEW implants have been placed in various places within the mouth with high success.

Case study

A 15-year-old girl and her father came to the office for diagnosis and treatment planning as her orthodontic treatment was coming to an end. She presented with congenitally missing lateral incisors. Her orthodontic treatment had provided appropriate root separation of the cuspsids and centrals as well as good esthetics during treatment. This was accomplished by having a prosthetic tooth, #7, suspended from the archwire and retention of the upper left deciduous lateral incisor throughout the entire treatment course (Figs. 1–5). The treatment plan accepted was to proceed with the completion of the orthodontic treatment and debracketing (Fig. 4) that same day, extract the upper left deciduous lateral incisor and then place ANEW implants in the lateral incisor positions of #7 and #10.

Once the ANEW implants were placed, an immediate fixed provisional crown would be fabricated on each implant. They would then be held in static occlusion as part of the orthodontic retention as well as to help provide initial stability for the ANEW implants during osseointegration (Figs. 5, 6).

It was clearly understood that as the still growing patient would continue to mature, the provisional crowns would need to be removed and revised and/or remade in order to properly form the papillae and modify the incisal length. This would easily be accomplished with the ANEW screw-retained abutment and provisional crown possibilities (Figs. 7–9). The final restorations supported by the ANEW Implants will be fabricated when the growth of the premaxilla is complete in 4 to 5 years at age 19 and 20.

About the authors

Robert M. D’Orazio, DDS, ABOIM/ID, is a graduate of the University of Detroit, School of Dentistry. He is a fellow at the Midwest Implant Institute and the American Academy of Implant Dentistry, as well as a Diplomate of the American Board of Implant Dentistry. D’Orazio currently maintains a referral-based implant dental practice located in Sterling Heights, Mich.

Mark A. Iacobelli, DDS, FAGD, FICD, MIIF, is a graduate of Case Western Reserve School of Dentistry. He has been in private practice since June 1982 and holds licenses and sedation permits in the states of Ohio and Florida. Iacobelli is a fellow of the Academy of General Dentistry, the Midwest Implant Institute and the International College of Dentists. He is also a past president and board member of the Midwest Implant Institute Fellowship, Iacobelli lectures for The Center for Osteo Studies, Camlog Corporation, the Midwest Implant Institute Fellows, Jamison Consulting of Florida, the Midwest Implant Institute and the DMX Implant Corporation.
At the end of the 19th century, when researchers developed the first X-ray machine, they knew it posed potential danger. Due to leakage from X-ray tubes, scientists developed protocols to protect operators from imminent X-ray exposure during procedures. These protocols included lead-lined walls, lead vests and/or the operator leaving the room. Such steps remained intact through the end of the 20th century.

Now things have changed.

When Aribex developed a handheld X-ray system in 2005, the company created a device that was inherently safe from the get-go. Clinicians can now safely hold a lightweight cordless X-ray unit, called the NOMAD®, in their hands while taking X-rays.

“Numerous studies have been done to ensure that the NOMAD is indeed safe,” says Dr. Larry Emmott, DDS, considered the leading authority on dental high-tech in the country. “In fact, one study actually showed Nomad users received less exposure than those who used a traditional system.”

This is made possible through Aribex’s patented shielding on the X-ray source and collimator cone, as well as the leaded acrylic backscatter shield that protects the operator from reflected radiation. More than 30 independent and third-party evaluations and scientific studies from universities, physicists, test houses, government and military groups have concluded the Aribex NOMAD Handheld X-ray System are both safe and effective.

With the handheld X-ray system, the operator can not only hold the unit and stay in the room; he or she can also keep the NOMAD in place while taking X-rays and reassure anxious patients, including children. The device can be operated anywhere, anywhere, at the point-of-care. “In fact, as the ultimate benefit of mobility, you can use the NOMAD at a nursing home, mobile clinic or on a humanitarian mission,” Emmott said.

Because it is so easily transportable, the NOMAD allows dentists to practice in remote areas where conventional X-ray devices could never go. In addition, because of the built-in shielding and backscatter shield, numerous independent tests have proven its safety for operator and patient alike.

“The NOMAD has forever changed the way that dental radiography is performed,” said Dr. D. Clark Turner, president and chief executive officer of Aribex. “It has become a staple in dental offices everywhere.”

For more information on Aribex and the safety, convenience and various studies for the NOMAD, please visit www.Aribex.com or see us at booth #1050 during the ADA.
Many adults have poorly aligned teeth and would like orthodontic treatment. Some may already have had braces previously and have seen their teeth crowd up again. The majority of adult patients do not want to wear braces. For more than 20 years, Myofunctional Research Co. (MRC) has developed orthodontic appliances to improve the dental and facial development of children using myofunctional orthodontic techniques. The new MYOBRACE for Adults™ appliance system has been developed to cater to the increasing demand from adults wanting this form of treatment. The system is designed to correct orthodontic problems by assisting the treatment of the myofunctional causes and to simultaneously align the teeth.

The MYOBRACE for Adults is a series of appliances that incorporates many of MRC’s proven appliance design principles, including features that correct poor oral habits, along with other newly adapted design characteristics specific to treating malocclusion in adults.

Although adult treatment is more limited in terms of the potential for growth, biological adaptability and the ability to change in comparison to treating children, the concept remains the same. Clinical tests have proven the system successful in correcting habits and improving dental alignment for adults.

The MYOBRACE for Adults is a three-phase appliance system that incorporates the myofunctional characteristics consistent in all MRC appliances. As with all MRC appliances, the Myobrace for Adults includes features that correct poor oral habits and encourage correct tongue posture and breathing.

Using the force of the tongue indirectly expands the maxillary arch form. The appliances are also made in the ideal arch form to assist in the correction of natural arch development by applying light forces to the anterior teeth.

The system is designed to be used in sequence, with treatment ideally starting with the lighter more flexible appliances combined with the Farrell Bent Wire System™ (BWS), and finishing with the harder final appliances used to achieve final alignment and retention. Using the BWS in combination with MYOBRACE for Adults appliances can improve treatment results and lessen treatment time.

By attending an MRC educational program, you can learn how to effectively incorporate these appliances into your practice, delivering the best results for your patient while maximizing your financial gain. The majority of dental practitioners can see the demand for a simple yet effective solution to treating malocclusion in adults. The demand for adult treatment is evident, and the MYOBRACE for Adults is the solution.
**R-SI-LINE METAL-BITE**

**Perfect bite registration**

For more than a decade, R-dental has offered METAL-BITE® the universal registration material. The dark grey A-silicone guarantees excellent universal registrations. According to the German opinion leader Prof. Dr. Gutowski, METAL-BITE is also usable for the biteplate of the face-bow registration system and for dynamic registrations (FGP-technique).

METAL-BITE shows perfect physical properties: It is extremely fast and hard, thixotropic and high standable. The snap-set guarantees the highest precision.

Once cured, METAL-BITE is inflexible and not crumbly, with a sufficiently long working time (25 seconds). A high Shore D-hardness (40) and high dimension stability are convincing advantages of this reliable registration material.

The universal registration material is available in cartridges of 50 ml in addition to accessories. For more information, please contact the manufacturer.

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**Tuttle named as president, CEO of D4D Technologies**

D4D Technologies, the developer and manufacturer of the E4D Sky™ Network of products including E4D Dentist™, E4D Labworks™ and E4D Studio® Systems announced the appointment of Donald “Don” L. Tuttle as the company’s new president and CEO, effective August 1.

“We are thrilled to welcome Don as the new president and chief executive officer of D4D Technologies LLC,” said Basil Haymann, D4D Technologies founder and board member. “With his in-depth expertise and long track record of success in the dental industry, Don will bring exceptional leadership and vision to our company.”

“With Don’s skilled leadership, we are confident that we will continue to further our innovative technology offering and continue to advance D4D as a leader in the CAD/CAM market,” said Mark Quadling, founder and co-chief technology officer for D4D.

Tuttle joins D4D Technologies with a wealth of dental industry experience, including nearly three decades of significant management, operations, sales and marketing experience.

“I am pleased to join the strong D4D Technologies team,” said Tuttle. “I look forward to the opportunity of guiding D4D Technologies to the position of world leader in dental CAD/CAM technology, increasing the productivity of our customer’s practices and enhancing the quality of care that dental professionals are able to provide to their patients.”
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Dr. Buchanan holds patents for some instruments used in these courses.
Is there new hope for periodontal patients?

By Jeanne R. Bosecker, BSN, RDH

As clinical dental hygienists, we want our patients to be as healthy as possible. This means having the skills and knowledge to treat them as effectively as possible. When a patient presents with periodontal disease, scaling and root planing with or without osseous surgery are the modalities for treating this condition.

However, what about the cases that do not respond well to these treatments? It is important for us to keep ourselves aware new treatment developments that may provide some more hope for these patients. This could involve looking outside the dental field. I learned about this new treatment for osteoporosis from a patient of mine who is an orthopedic physician.

We are all aware of the bisphosphonate drugs for treating osteoporosis and the potential for complications they bring. A new drug for osteoporosis has been shown to regenerate bone. Teriparatide, marketed under the name Forteo, is a parathyroid hormone injection taken once a day.

Forteo is used to treat osteoporosis in cases that do not respond to traditional treatments. It has just recently been introduced and is still very expensive for the patient, so bisphosphonates are still the first choice for the treatment of osteoporosis.

Forteo is the portion of human parathyroid hormone (PTH) amino acid sequence 1 through 34 of the complete 84 amino acid molecule. PTH is the primary regulator of calcium and phosphate metabolism in bone and the kidneys. PTH increases the serum calcium partially caused by bone resorption. Thus, chronically elevated levels of PTH can lead to depleted bone stores, however, intermittent exposure by a daily 20-microgram injection will activate osteoblasts more than osteoclasts.

Daily injections of teriparatide have a net effect of stimulating new bone growth. According to a new report series by iData Research, the leading global authority in dental market research, the U.S. dental hygiene and oral care market, which includes instruments and consumables used in the office setting, recovered from the economic recession in 2010 to reach over $1.6 billion.

By 2017, the market will reach over $2 billion driven by the rapidly growing digital caries/cavity detection, professional teeth whitening and fluoride varnish segments. In the United States, dental caries/cavity detects more than 95 percent of the adult population.

“Sales of specialized light-emitting diode (LED) and fluorescence laser-based digital caries detection devices, which enhance the ability to detect dental decay with greater accuracy and specificity, is driving dental hygiene market growth,” says Dr. Kamran Zamanian, CEO of iData Research. “In 2010, this market grew almost 50% led by Acteon, Air Techniques and Kavo.”

The report also states that the professional teeth whitening segment is expected to see strong growth through 2017, due to increased sales of professional take-home whitening systems, in which dentists fabricate custom trays for use at home. These products are considered more convenient and preferred by dentist and patients. In 2010, Discus Dental, Ultradent and SDI led this market.

“The professional fluoride market will be another area of strong sales growth, reaching double-digit rates by 2017,” says Dr. Zamanian. “This segment is being driven by sales of fluoride varnishes, which is growing in popularity among dentists and patients due to the products mild taste, easy application, reduced risk of over-ingestion, its ability to treat tooth hypersensitivity and a shorter treatment time. 3M ESPE dominates this market, however smaller competitors such as Varnish America have released lower-priced varnishes that have received positive reviews.”


About iData Research

iData Research is an international market research and consulting group focused on providing market intelligence for dental and medical device companies. iData covers research in: dental implants, equipment, BGS, prosthetics and more.

(Source: iData Research)
formation, leading to increased bone mineral density. Teriparathaid was approved by the FDA on November 26, 2002, for the treatment of osteoporosis in men and post-menopausal women who are at high risk for fractures. The drug is also approved to increase bone mass in men with primary or hypogonadal osteoporosis who are at higher risk for fractures. It is the first, and to date only, FDA-approved agent for the treatment of osteoporosis that stimulates new bone formation.2

When I heard about Forteo I was interested to see if any studies had been done on the regeneration of alveolar bone. Could you imagine: A drug that could regenerate bone in the jaw could potentially cure periodontal disease? How exciting for the future!

It turns out there is only one study, conducted at the University of Michigan, “Teriparatide and Osseous Regeneration in the Oral Cavity.” The study had 40 participants with severe, chronic periodontitis who had undergone periodontal surgery and received daily injections of teriparatide or placebo, with oral calcium and vitamin D supplementation for six weeks. The patients were followed for one year.

Primary outcome was radiographic linear measurement of alveolar bone level. The mean linear gain in bone at one year in the teriparatide patients was 29 percent versus 3 percent in the placebo patients. Reduction of periodontal probing depth was 55 percent versus 20 percent and a gain in clinical attachment level of 22 percent versus 7 percent. Teriparatide, as compared with placebo, was associated with improved clinical outcomes, greater resolution of alveolar bone defects and accelerated osseous wound healing in the oral cavity.

No adverse reactions were experienced in this study, but the sample population was very small. Teriparatide was shown in animal studies to increase the risk of osteosarcoma. This is the biggest risk of taking Forteo, and it is a pretty serious one. Patients with a history of Paget’s Disease of bone or unexplained elevation of serum alkaline phosphatase, open epiphysis or prior radiation therapy involving the skeleton should not take Forteo. Patients taking Forteo should not smoke or drink alcohol, and the most commonly reported side effects are nausea, leg cramps and dizziness.

Forteo is definitely a promising method for treating periodontal disease, but the risk of bone cancer is definitely something patients and practitioners need to consider. We must remember as clinicians that our traditional methods have had success and should be utilized first, and Forteo can be used in the cases that do not respond to scaling and root planing or periodontal surgery. Forteo certainly will change how we view periodontal cases, but at this time it is a risky treatment and has not been studied enough with periodontal patients to say for sure that it will eradicate periodontal disease.

The introduction of this drug and the potential for new modalities of treatment do offer some promise for our patients, but we need more information.

More studies need to be done and more information gathered before we can decide if Forteo is an appropriate treatment for resistant periodontal cases. Hopefully, we will be hearing more about this drug and how it relates to dentistry in the future.

In the meantime, we will continue to provide our oral surgical patients the best care we can using our traditional methods. The future is bright for dentistry.

References
4. Forteo: teriparatide (rDNA origin) injection.

About the author
Jeannie R. Bosecker, BSN, RDH, is a private-practice dental hygienist living in the Chicago suburbs. After graduating from nursing school, she found her true passion in dentistry after working as a dental assistant for several years. Since graduating with her dental hygiene degree, she has worked for three small general dentistry practices. You may contact her at jeanneb@comcast.net.
Are you technologically and ergonomically balanced?

By Renee Graham RDH, MEd

Ergonomic and/or lightweight handpieces may help to reduce the risk of certain musculoskeletal disorders (MSDs) such as carpal tunnel syndrome (Dong 2006). Advances in technology have provided improvements in ergonomics; thereby, helping to extend the longevity and careers of dental professionals. Improved technology along with normal and neutral positioning of the body, spine and hands will work together for positive health.

Over the years, poor posture can affect the musculoskeletal system, which can lead to other complicating health factors. Although, poor posture habits have been created throughout life, it is not too late to learn ergonomic principles that can contribute to a long-lasting, pain-free way to practice with less fatigue. Learning and practicing good posture while working should be one of the primary goals for increasing and continuing work efforts.

Another effort on the behalf of the clinician is to engage and embrace new technology and allow that technology to work for you. Many clinicians are intimidated by technology and hesitate to make changes, although these changes are for the best.

Repetitive stress injuries (RSI) are defined as cumulative trauma disorders resulting from prolonged repetitive, forceful or awkward movements. These movements result in damage to the muscles, tendons and nerves (Nainzadeh 1999).

Because clinicians are at risk for developing wrist injuries, ergonomic considerations are very important. The correct grasp on instruments, power scalers or dental equipment will help prevent RSI. The use of powered scaling devices is one of the prevailing recommendations for reducing these injuries. Ergonomically designed ultrasonic equipment includes scaling units with rotating cables and inserts with balanced handpieces. Power scalers must have a light modified pen grasp.

The advantages of the light grasp are tactile sensitivity, patient comfort and reduced fatigue. In addition, the clinician has the advantage of rolling the handpiece between the fingers to have continuous access to the tooth surface, line angles and interproximal and subgingival areas. In other words, the equipment is doing the work; the clinician is guiding it.

Another area of concern is the management of the cords coming off handpieces, equipment and units. Equipment that must have a power cord revisits the fact that improper management and poor design of the cords can increase drag on hand, wrist and arm. This in turn increases the risk of repetitive injuries, as your fingers must continually counter the force of the cord drag.

The new Midwest® RDH Freedom handpiece, above, is cordless, balanced, lightweight and easy to maneuver. The hygienist can take any position around the patient’s head to maintain proper ergonomic angles in the arm and wrist. (Photos/Provided by DENTSPLY Professional)

The Midwest RDH Freedom handpiece is cordless, balanced, lightweight and easy to maneuver. The clinician is guiding it.

Another area of concern is the management of the cords coming off handpieces, equipment and units. Equipment that must have a power cord revisits the fact that improper management and poor design of the cords can increase drag on hand, wrist and arm. This in turn increases the risk of repetitive injuries, as your fingers must continually counter the force of the cord drag.

The new Midwest® RDH Freedom® handpiece is cordless, balanced, lightweight and easy to maneuver. Because of the diameter of the handpiece and lack of a cord, it takes less of a pinch grip and no drag to set up ergonomic advantages. This allows the hygienist to take any position around the patient’s head to maintain proper ergonomic angles in the arm and wrist. Combine these features with the cordless foot pedal and it predicts less fatigue and better ergonomics.

In a survey with hygienists, 100 percent of the hygienists approved of the weight of the cordless handpiece with the attached disposable prophy angle. In addition, 90.9 percent found that the Midwest RDH Freedom handpiece was easier to maneuver than a corded device. 93.9 percent of hygienists rated their fatigue light to none at the end of the day using the Midwest RDH Freedom handpiece versus only 33 percent indicating light to no fatigue when using their current polishing handpiece. A remarkable difference!

Modern technology supports ergonomics, and therefore, aids in promoting the longevity of the clinician and comfort for the patient when supported with proper posture and technique. Many times technology is not maximized to the fullest, therefore, limiting the benefits. Take advantage of modern advancements in engineering and design and allow your equipment to work for you.

References
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For more information, call 1-800-983-6829 or visit www.midwest-rdh.com

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