Seaweed colloids in your toothpaste?

An interview with dentist and toothpaste collector Dr. Val Kolpakov

Dentist Val Kolpakov has an unusual hobby: he collects toothpaste. His collection is currently recognized as the largest in the world by the World Records Academy. Born in Russia, Kolpakov moved to the United States in 1993 to work as a researcher at the University of Michigan.

For the past nine years, he has been in practice at his own dental offices in Saginaw, Mich., and Alpharetta, Ga. Kolpakov spoke to Dental Tribune International Editor Yvonne Bachmann about his collecting passion, radioactive collectibles and seaweed in our toothpaste.

When did you get the idea to start collecting toothpaste?
It was 2002 and I was browsing the Internet. This was when I found some information on Carsten Gutzeit, a man from Germany who collected toothpaste. His collection stood at roughly 500 tubes.

This was when I realized what a wonderful hobby collecting toothpaste would be for a dental professional. Imagine the opportunities it offers to learn about other variations of your profession. With this in mind, I decided to start my own collection of toothpaste.

How did you get your collection?
I have friends living all over the world, so I asked them to mail me some of the toothpaste sold in their countries. In addition, I bought old toothpaste on eBay while acquiring contemporary ones in stores.

After putting up the Toothpaste World website, people began finding me on the Internet. There were several people who donated their small collections to me. Companies also donated their old and recent products.

Do you usually buy two samples, one to try and one to keep?
No, I normally just get one sample. I already spend a lot of money on my toothpaste collection and...
doubling the amount would be too much. Often, it is not even possible in the case of old tubes — which are rare finds to begin with.

If I am tempted to try a toothpaste that I have in my collection, I just open the only sample I have. All my old toothpastes are so dried up that I don’t think anybody would be willing to try them in their mouth.

**How many items do you have in your collection?**

The most difficult part of collecting toothpaste is keeping track of all the samples I get. I estimate that I have 2,000 samples. However, I cannot tell you the exact number at this time. I have more than 1,700 tubes counted and entered into my database, but there are several big boxes with more samples waiting for their turn.

**Where do you keep your toothpastes?**

Some of them are displayed in the waiting room of my dental office in Saginaw. However, most of them are stored in boxes. We are currently remodeling our office and planning to build a huge custom-made display for my collection, pretty much making a toothpaste museum of some sort. Anybody can come to my office and look at the samples displayed. I can also show other samples stored in boxes to interested people.

**Do you know any other people who collect toothpaste or dental equipment?**

I keep in touch with Carsten Gutzeit from Germany, whose collection inspired me. We have exchanged some toothpaste tubes. Since I started my collection, I have been contacted by several people who have small collections of toothpaste. Some of them have donated their entire collections to me.

There is also a good collection of toothpowder tins at my alma mater, the University of Michigan dental school. They also have a very good collection of various vintage dental items.

**Which are the most interesting items in your collection?**

I would consider one item to be the oldest, most rare and most expensive: a silver, English antique Georgian toothpowder box from 1801. This was a time when toothpaste had not yet been invented and toothpowders were used instead. I paid over $1,500 for it. The oldest toothpaste I have is dated 1906 and was made by Colgate.

My favorite kinds of toothpaste are alcohol flavored. These range from whiskey, like scotch, rye and bourbon to red wine, amaretto, champagne and many more.

Another passion of mine is chocolate-flavored toothpaste. I have a set of pure chocolate cream packaged in a toothpaste tube with a toothbrush for chocolate lovers. This is more of a gag gift, considering that it is not intended for brushing teeth regularly.

However, there are several real tubes of toothpaste with chocolate flavoring as well. Speaking of unusual flavors, the Breath Palette Company tops them all. They came up with 31 flavors, including some of the oddest kinds such as Green Tea, Pumpkin Pudding and Indian Curry.

My most unusual collectible is Doramad toothpaste, which was dug out of World War II trenches and has an active radioactive compound. At that time, some people believed that radiation could revive dead tissues and that radioactive toothpaste could revive gums.

**What do you estimate the value of your collection to be?**

I have spent close to $20,000 on all my samples. Considering all the work and time I have spent on my collection over the last nine years, I would estimate it at $30,000. But at that time, I have no interest in selling it. It is my hobby, my passion, the way for me to attract people’s attention to my dental practice and spread information about this wonderful topic.

**Are toothpastes generally the same? Is toothpaste bought in Japan any different from toothpaste bought in Italy?**

The main ingredients of all toothpastes are basically the same. However, there are local differences in flavor and some ingredients. Oriental toothpastes often contain ingredients like bamboo salt or ginseng. Japan is well known for its high-tech toothpastes that rebuild enamel, remineralize teeth and halt the development of caries.

**Is there something people may not know about toothpaste?**

You may not recognize the scientific names listed on toothpaste packaging, and thus may be surprised to know that ingredients such as seaweed can be found in many fluoridated toothpastes. In fact, according to the American Dental Association, thickening materials include seaweed colloids, mineral colloids and natural gums.

**Do you collect any other unusual items?**

I have a small collection of denture containers — holders of different shapes in which edentulous people place their dentures for the night. I also have a collection of dental movie props, including some fake teeth that actors put over their own teeth to look like vampires or homeless people with rotten teeth.

**Do you hold a Guinness World Record?**

I’ve considered applying to the Guinness World Records for a long time, but just can’t seem to find the time. Recently, I was contacted by an English journalist who interviewed me and wrote a story about my collection for an English newspaper. Somebody at the Guinness

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**Tell us what you think!**

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Miracle Corners of the World (MCW), a U.S.-based non-profit organization, recently sent a team from the United States to Dar es Salaam, Tanzania, to inspect and oversee the installation of state-of-the-art dental laboratory equipment. The initiative was part of a second Memorandum of Understanding (MOU), signed in October 2010 between MCW and the Muhimbili University of Health and Allied Sciences (MUHAS).

The project builds on an earlier MOU, signed in September 2008, devoted to bringing the MUHAS School of Dentistry and MCW together to collaborate on an oral health-care initiative supported by in-kind donations by private sector companies.

Tanzanian President H.E. Jakaya Mrisho Kikwete and leadership from the Ministry of Health have supported the project from the beginning.

Dr. Paulo Sarita, former head of restorative dentistry, made a compelling argument to Dr. Marion Bergman, MCW’s director of health-care projects. In a proposal submitted to MCW by the dental school...
April was Oral Cancer Awareness Month, and thanks to the efforts of the American Dental Association (ADA), the Oral Cancer Foundation (OCF) and hundreds of ordinary dentists throughout the country, patients everywhere were able to get screened for the life-threatening disease. In all, more than 1,250 practices across the nation registered their screening events with the OCF.

Although many dentists perform oral cancer screenings as a routine part of examinations, the ADA encouraged dentists to perform community outreach during the week of April 11-15 to provide free oral cancer screenings to people who might not regularly visit a dentist, according to ADA spokespeople.

“Early detection is critical in increasing survival rates for patients who have developed an oral cancer, and recognizing and managing precancerous lesions is extremely important in prevention,” Silverman said.

One practice, the Gentle Dental Group, with offices throughout Florida, uses the VELscope Oral Cancer Screening System as a tool in detection of the disease. The U.S. Food and Drug Administration and Health Canada recently cleared the VELscope System for assisting dentists and hygienists in discovering cancerous and precancerous growths that may not be apparent to the naked eye.

With the VELscope System, a dental professional can screen for oral cancer in one to two minutes during a conventional examination or during a common procedure such as teeth whitening.

Dr. Neal Ziegler, chief dental officer of the Gentle Dental Group, says his practice has always conducted annual comprehensive oral cancer screening as part of the routine dental exam. He said that oral cancer is typically discovered in the late stages of development, when the five-year survival rate is only 22 percent.

“By detecting potential problems earlier, we’ll be providing our patients with the best defense against oral cancer currently available,” Ziegler said. “Gentle Dental Group is deeply committed to providing the best dental care available for its patients, including the latest technology and techniques.”

Brian Hill, the executive director of OCF and an oral cancer survivor, also stressed the importance of early detection and the important role that dentists play.

“Early detection is important because it reduces treatment-related morbidity and improves survival rates,” Hill said.

In 2010, the National Cancer Institute estimated that approximately 36,540 people were diagnosed with oral cancer and approximately 7,880 people died of oral cancer. The National Institute of Dental and Craniofacial Research (NIDCR) estimates that the five-year survival rate for people diagnosed early, when the disease has not spread beyond the original location, is approximately 85 percent compared to a 20 percent survival rate for those who were diagnosed when the cancer has spread to other organs.

This year, approximately 37,000 Americans will be newly diagnosed with oral cancer, and one person will die every hour of every day from this disease, according to the OCF. HPV16, one of about 130 versions of the virus, is now the leading cause of oral cancer, and is found in about 60 percent of newly diagnosed patients, the OCF reports.

In 2010, The Journal of the American Dental Association published “Evidence-based Clinical Recommendations Regarding Screening for Oral Squamous Cell Carcinomas,” which was developed by an expert panel convened by the ADA Council on Scientific Affairs. The panel’s report concluded that clinicians should remain alert for signs of potentially cancerous lesions while performing routine visual and tactile examinations in all patients during dental appointments.

Risk factors for mouth and throat cancers include tobacco use, heavy consumption of alcohol, particularly when they are used together, as well as infection with the human papillomavirus, which is better known as HPV.

“In a painless, three-to-five minute oral cancer screening, most of the signs and symptoms of oral cancer can be seen with the naked eye, felt with the fingers or elucidated during the patient’s oral history interview,” said Dr. Ross Kerr, an oral medicine specialist at New York University College of Dentistry.

More information is available online at www.oralcancer.org.
The Dental Trade Alliance has been honored with an award for its significant contributions to Donated Dental Services (DDS), a program of Dental Lifeline Network. The award was accepted by Gary Price as DDS celebrated its 25th anniversary during the recent 2011 National Association of Dental Laboratories Vision 21 Meeting in Las Vegas.

Presenting the award was Dental Lifeline Network President Fred Leviton. Formerly known as the National Foundation of Dentistry for the Handicapped, Dental Lifeline Network is a charitable affiliate of the American Dental Association. Through DDS and other programs, the organization provides comprehensive dental care to people with disabilities or who are elderly or medically at-risk and has a nationwide volunteer network of 15,000 dentists and 5,200 laboratories that contribute more than $22 million worth of needed services annually, including nearly $2 million in fabrications.

“Without the outstanding support of the DTA, DDS could never have reached today’s milestone of providing dental therapies valued at $187 million to 101,000 people in 50 states,” Leviton noted. “The DTA has been instrumental in linking us with the dental trade industry, providing incalculable value in our ability to serve the needs of vulnerable people nationwide. We are profoundly grateful to the alliance, its foundation and to our colleagues in the industry.”

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Non-compete & trade secret agreements

By Stuart J. Oberman, Esq.

Dentists are often concerned about how to best protect their patient base when an associate dentist leaves the practice. The owner of a dental practice must make sure that associates cannot take the practices’ patient base or employees with them when they leave.

There are two methods of preventing this type of devastation to a dental practice, which are non-compete agreements and trade secret agreements. Both of these types of agreements should be incorporated into an associate’s employment agreement. In order to ensure an employment agreement is properly drafted, you should consult with legal counsel who is familiar with dental employment agreements.

Non-compete agreements

Dentists may have been exposed to a wide variety of terms when contemplating the issue of protecting their patient base, such as non-compete agreements, non-competition clauses, covenants not to compete and restrictive covenants. These are all different terms used to essentially describe a non-compete agreement.

A non-compete agreement is typically a section of an employment agreement, however, a non-compete agreement may also be a separate document that an associate may be required to sign as part of his or her employment. A non-compete agreement allows the owner of a dental practice to limit a former associate from starting his or her own dental practice that competes with his or her former employer, and a non-compete agreement may also prohibit an associate from working for a competitor. Generally, non-compete agreements are enforceable; however, state laws may vary.

The owner of a dental practice should always consult with his or her attorney before entering into any type of non-compete agreement.

In order to ensure that a non-compete agreement is enforceable, there are some general requirements that must be complied with. First, the non-compete agreement must be reasonable in that it protects the legitimate interests of a dental practice.

The dentist’s interest in protecting the time he or she has put into training a new associate must be balanced by the associate’s freedom to work where he or she chooses, and the public’s interest in obtaining the services of a particular dentist.

The second requirement for an enforceable non-compete agreement is that it must have a specific time limit. The shorter the period of time, the more likely the agreement will be enforced. Typically, a non-compete agreement with a duration less than three years will be enforceable.

The third requirement for an enforceable non-compete agreement is that it must contain a reasonable geographic limitation. If a former associate moves to a dental practice within a 10-mile radius of a previous employer, the former associate has a 10-mile non-compete agreement (depending on state law), the court would likely uphold the agreement as valid and issue an injunction against the former employee.

However, if a non-compete agreement attempts to restrict an associate from practicing within a 50-mile radius of the associates’ former practice, it may be considered too broad as to the geographic restriction and, as a result, the agreement may be considered unenforceable.

If a court determines that certain provisions of a non-compete agreement violate state law, the court may utilize the Blue Pencil Rule. This rule allows a judge to modify the terms of the non-compete agreement that may be too burdensome on one party and yet enforce the remainder of the agreement to make the agreement more reasonable.

For example, if the non-compete agreement reasonably protects the employer’s legitimate interests and has a reasonable geographic limitation but the agreement states that the non-compete is to be enforced for a period of five years, the court may strike the five-year time period and replace it with a two-year time period, and enforce the remainder of the contract.

However, some particular states prohibit the use of the Blue Pencil Rule, and as a result, the agreement will be either upheld or invalidated in its entirety. For this reason, it is extremely important that a non-compete agreement comply with state law.

Non-compete agreements are widely used in the purchase of a dental practice. If a dentist purchases a dental practice, the purchase price by way of special allocation typically includes the personal and corporate goodwill of the seller and patient accounts. However, without an effective non-compete, the seller of a dental practice may open another dental practice across the street.

A non-compete agreement would prevent the seller from competing with the buyer in a specified geographic location for a specified period of time once he/she sells the practice, which would in turn permit the purchaser of a practice to establish his or her new practice.

Additionally, when hiring a new employee, a dentist should always ensure that the new employee is not subject to a non-compete agreement with his or her previous employer. In some states, a new employer may be held liable for hiring an employee who violates a non-compete agreement with a former employer.

Trade secrets

Trade secret provisions in an employment contract will also help protect the patient base of a practice. A trade secret provision should provide that all patients and their confidential information are trade secrets of the practice and note that sanctions will be enforced against any associate or employee who attempts to use this confidential information for his or her own personal gain.

Generally, trade secrets laws have three components, which are: any information that is not generally known to the public, that confers some type of economic benefit on the holder of the confidential information from not being publicly known and to which the beholder has taken reasonable efforts to maintain its secrecy.

In dental practices, patient lists are clearly not public knowledge and such patient information definitely confers economic benefit on the owner of a dental practice. As long as an owner of a dental practice takes reasonable steps to maintain the privacy of his or her patients, patient information is a deemed trade secret and shall be protected accordingly.

In a dental office, patient lists are probably the most important asset of a dental practice. In determining whether a patient list constitutes a trade secret, courts will generally look at whether the information on the patients — such as the status of their health, the dental procedures the patients have completed and those procedures still needed, the type of insurance the patients carry and amount of insurance the patients have — is not easily ascertained by a competitor.

Although information readily accessible through public records cannot be considered a trade secret, generally patient lists in a dental practice constitute trade secrets and may not be used by a former associate to solicit patients.

While it is true that patient names, telephone numbers and addresses may be a matter of public record, the health records of the patients, the dental treatments they require or the patients’ general health insurance information is not accessible to the public. This information would therefore con-
All associates should be required to sign a non-compete and a trade secret agreement at the beginning of their employment.

(Photo/www.dreamstime.com)

stitute a confidential trade secret and should be protected through an employment agreement.

The owners of a dental practice should be able to prevent an associate from taking valuable assets when he or she leaves the practice. Detailed patient lists are protectable.

Dentists should be familiar with non-compete and trade secret agreements, and they should have these agreements incorporated into their employment agreements.

All associates should be required to sign a non-compete and a trade secret agreement at the beginning of their employment. Without these agreements in place, patient lists are not protected and the dentist is exposed to the risk of an associate leaving the practice and taking patients with them.

Prevent fraud in dental offices

Stuart J. Oberman, Esq., who has extensive legal experience in representing dentists, has been invited to lecture at Boston University Henry M. Goldman School of Dental Medicine. Oberman will be one of the featured speakers at a continuing education course, titled “How to Prevent Fraud in the Dental Office,” on June 27.

He has lectured extensively on the legal issues facing the dentistry profession, and is also a regular contributor to Dental Tribune.

Oberman has also written articles for dental publications such as Doctor of Dentistry, Woman Dentist Journal and Georgia Dental Practice Solutions. He is on the board of directors for the DDD Foundation, an organization that provides dentistry for the developmentally disabled.

For more information on Stuart J. Oberman, please visit www.gadentalattorney.com, or go to the corporate website at www.obermanlaw.com.
Six steps to financial solvency

By Sally McKenzie, CEO

Remember the good ol’ days? You know, the ones in which your schedule was booked for months, the patients were flowing like champagne from a fountain and you were rolling in the green — or at least you thought you were. Then came the recession; it put a cork in the bubbly, made Swiss cheese of the schedule and as for cash flow, accounts receivables went from sto-so-to “uh-oh!”

The truth is you probably have little or no idea what your receivables were before the economy hit the skids because you were virtually racing through your days too quickly to give nary a glance at the figure. And after all, enough patients were paying up front and in full. Ah yes, the good ol’ days.

By the time 2008 rolled around, practices had come a long way in educating patients about payment expectations. Gone were the days of patient-d dictated payment plans, “I would like to pay $50 a month on my $1,200 bill, that way I’ll have it paid off in just two years. No problem, right?” Practices put their collective feet down and said goodbye to the banking business. These plans were not only adopted, they were actually implemented. Business staff became more confident at explaining financial policies to patients and patients were more willing to accept them. Then economic circumstances changed and dental teams panicked.

Three years later, it’s time to hit the pause button on practice panic and pay attention to what I’m about to tell you. We all know that the economy has ushered in a series of changes and challenges over the last several years. That being said, the expectation remains: practice collections should yield 98 percent for treatment currently being performed.

Should you be sensitive to your local economy? Absolutely, but not at the expense of the practice’s financial solvency. It’s time to issue a “collections correction” and get your accounts receivable back on track. But before you dig in, you have to dig in — into key practice reports that is. These are your guides to cash in the bank.

Accounts receivable aging report
All credit balances and all debit balances should be included in this report. It is vital to understand how many dollars are outstanding at 30, 60 and more than 90 days. Because practice costs for tracking and collecting old balances can far exceed the actual value of the account itself, this report should be printed monthly.

Outstanding insurance claims report
This identifies how many dollars in outstanding claims there are in each category: current, 30, 60 and more than 90 days. This report is crucial because the longer dollars remain outstanding in claims, the more costly it is to the practice. Print this report monthly. Many of today’s software systems allow you to track daily.

Accountant earnings report
This details exactly how many dollars are being written off in each category: accounting adjustments, insurance plan adjustments, professional cour tesies, pre-payment courtesies, etc. This report should be monitored daily and monthly.

Production by provider report
This one allows you to track individual provider production for each dentist and hygienist. It is important to track individual production numbers to determine productivity. Typically, hygiene production should produce approximately 50 percent of the total production in an office. However, if exam rates are not included, the number tends to be lower.

Production by code report
This report gives you an opportunity to track how many times a specific procedure is done. This can be used to determine productivity, treatment acceptance rates and much more.

Also, if the practice is utilizing special techniques, tracking the production by code will help to determine effectiveness, i.e., tooth whitening, periodontal surgery, crowns, bridges and implants.

Treatment plan report
This identifies how many dollars are being presented to patients. Using this report effectively can identify your success rate in treatment acceptance. The formula for this is: dollars recommended divided by dollars accepted equals case acceptance rate. Your case acceptance percentage should be at least 85 percent.

Once you’ve carefully reviewed these key practice financial reports, you’ll have a much better understanding of where your practice’s financials stand, and you are ready to follow the “Six Steps to Solvency.”

Step No. 1: Revisit the financial policy
A plan that is too rigid will not be effective in any economy. However, that doesn’t mean that you return to the days of patient-d dictated financial plans.

Pay attention to what patients are telling you, and if necessary, make adjustments. Consider incorporating the following:
• Establish a relationship with a treatment financing company, such as CareCredit.
• Allow patients to build a balance on their account before beginning treatment.
• Allow patients to pay for larger cases in two or three installments over a specific period of time.
• Offer a 5 percent discount if the case is over $500, paid in full and will not be submitted to insurance.
• Make arrangements to bill the patient’s credit card on a recurring basis until the treatment has been paid in full. Orthodontic practices do this routinely.

Step No. 2: Maximize over-the-counter collecting
Before their visit, patients should be made aware of what is to be done and what fees they will be charged so they’ll be prepared to pay.

Your financial coordinator/business administrator should be professional, matter-of-fact, positive and friendly, and should follow a well-rehearsed script in explaining the services, the charges and the payment options.

Additionally, a printout of services provided — along with anticipated insurance payment as well as amount of patient payment — should be given to patients at every visit.

If a patient does not pay, give him or her a return envelope and say, “This will make it easy for you to mail us your check when you get home.”

Step No. 3: Send bills daily rather than monthly
Every statement should include a due date that is two weeks after the statement date. Make sure that there is a space for the responsible party to write in a credit card number and expiration date as a means of payment. A self-addressed payment envelope should also be provided.

Step No. 4: Track insurance
More specifically, track available bene fits as well as uninsured procedures to calculate the anticipated insurance payment. Collect the patient portion at time of dismissal. After your software performs a validation process on each claim, claims should be sent electronically on the day of service.

Each week generate a delinquent insurance claim report grouped by carrier so that one call can be made per carrier to check on all claims that are 30 days delinquent.

Cash flow can be enhanced by tracking and processing secondary insurance; keeping signatures on file so that after EOB (explanation of benefits) is received, the patient portion may be calculated and a credit card automatically processed; auditing submitted claims and automatically aging them until they are either paid off or written off.

Step No. 5: Follow up on delinquent accounts
Delinquent account calls should begin one day past the due date on the first statement. The manner and tone used will greatly influence the effectiveness of the call. Therefore, set the tone as “working together to resolve this situation.” The caller’s key question should be, “When can we expect payment?”

Enter highlights of the conversation into the computer to keep a record of collection attempts. On the same day, follow up the phone conversation with written confirmation. Finally, address the most critical col-
No. 1: Revisit the financial policy.
No. 2: Maximize over-the-counter collecting.
No. 3: Send bills daily rather than monthly.
No. 4: Track insurance.
No. 5: Follow up on delinquent accounts.
No. 6: Train your team.

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 at www.mckenziemgmt.com. In addition, the company offers a vast array of business operations programs and team training.

McKenzie is also the editor of the e-Management newsletter and The Dentist’s Network newsletter, sent complimentary to practices nationwide. To subscribe visit www.mckenziemgmt.com and www.thedentistsnetwork.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 sallymck@mckenzie_mgmt.com.
Why shouldn’t you ‘look a gift horse in the mouth’?

An interview with veterinarian Richard B. Tanner at the Rood & Riddle Equine Hospital in Lexington, Ky.

By Robin Goodman, Group Editor

Have you ever wondered where the expression “don’t look a gift horse in the mouth” came from? Well, if you know a little about horses you probably know the answer. If you don’t: it’s because a horses’ teeth show the horse’s age. Thus, out of politeness, if you are going to look at the horse in the mouth, you should wait until the one who gave you the horse is not around.

During an October 2010 visit to the World Equestrian Games (WEG) in Lexington, Ky., to watch the jumping event, I realized that although I rode horses competitively in my childhood for eight years and am now back in the saddle fairly regularly riding a friend’s horse, I still know very little about the growth and care of equine teeth.

As a result, I visited the Rood & Riddle Equine Hospital booth, a sponsor of the WEG, and asked if one of their veterinarians was available for an interview. A few days later, I was treated to a tour of the hospital and was able to meet with Richard B. Tanner, DVM, to get the full story on equine dentistry.

Dr. Tanner, how long have you been a veterinarian?

I graduated and began an internship with Rood and Riddle Equine Hospital in 2005. I have remained with the hospital since graduating and have made equine dentistry a focus area of my practice.

What are the basics in terms of horses’ teeth?

Horses’ teeth are constantly erupting, which of course is very different than you or I. By the time we’re 18 or 20 years of age, all of our teeth have erupted as far as they are going to, and vertical crowns are as exposed as they’re ever going to be. However, this is not the case with horses. Their teeth continue to erupt up until their 20s. As they get older, the teeth wear out, but they’re constantly erupting.

If you took a radiograph of a young horse, you’d see that the tooth roots are extremely long. As they erupt, the teeth get longer and longer, and the upper arcades grind against the lower arcades. The premolars and molars are the ones we watch very closely, and the reason for this concern is that in a horse’s head, the maxilla is quite a bit wider than the mandible.

If you look at the skull we have here on the table, you’ll see very clearly that the maxillary teeth do not come into perfect contact with the mandibular teeth. A horse’s normal chewing motion is side to side and slightly forward. If you’ll note on this horse skull, you can see all the sharp points on the buccal sides of his teeth. These points are of course enamel, but it’s also cementum, a bonelike compound. If the horse doesn’t have a constant grind and good occlusal surface contact with the mandibular arcade, the buccal side of the tooth continues to erupt. Indeed, the entire tooth is erupting, you just don’t see it because they wear part of it away with normal chewing.

As a result, an adult horse needs an annual visit from the vet to grind that buccal surface down to get rid of the sharp points, which is called “floating teeth.” Younger horses will need two visits per year though.

What will happen if you don’t do this are ulcerations along the
cheeks, and they'll be so sore the horse won't want to eat. Or, when you put a bit in the horse's mouth and ask him to carry his head differently, he'll start acting up and someone may want to discipline him, but it's really because there is more pressure being put on his teeth and it's hurting him.

The converse is true of the mandibular arcade. Because it's more narrow, the lingual aspect of the teeth do not have good contact, so there is nothing to grind them down. Thus, we need to grind down the lingual aspect of the mandibular arcade’s pre-molars and molars. That's where the power tools come in handy because we are going through enamel and cementum.

In years past, we didn’t have power tools, we were using hand tools, and as we would manually grind the horse would get upset with what we were doing. You have about a 15- to 20-minute window to work before the horse would get tired of this and you’d have to stop. Of course, we would tranquilize him to calm him a bit, but he can feel what’s going on in his mouth.

A horse’s head is full of huge sinus cavities, and as you grind, the sound is echoing through those sinuses, getting louder and louder as you're working. So because this can sometimes really freak the horse out, having a horse under a bit of sedation makes all the difference in the world.

And, of course, horses don’t just open wide like a human patient would. We use an item called a mouth speculum. Using a very bright LED light source we’re able to take a good look around. We use dental mirrors and dental picks to evaluate the occlusal surface, the mandibular and maxillary pre-molars and molars, and then we look for diastemas, fractures, chipped teeth and cavities, which are not in abundance.

It’s really about balancing the mouth, and this is of particular importance for performance horses, who must be pain-free. Some of the horses at this [WEG] competition have a bit in their mouth, there is someone sitting on their back who is asking them to carry their head in an unnatural position, and then maybe jump five and a half feet in the air, then land and let’s go do it again real quick.

Their head carriage already puts more pressure on their TMJ, so if one tooth is sticking up further, it will put more pressure on the tooth above or below it. When that happens, it is exponentially more painful as they flex their head.

The anatomical portion of an equine dental chart.

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What about the incisors? They are also constantly erupting, and they will start off almost vertical to one another. If you look in the mouth of a young horse, the teeth will be nice and vertical, but as they age, they grow out, which is part of normal aging. Typically, if we see problems with the incisors, it’s the result of something back in the molars and premolars. It could be that the horse is chewing on one side of the mouth more than other. Thus, when you look at the incisors on the side that the horse is not chewing on, you'll notice that he’s not wearing a particular incisor as much as the others. In a case such as this, we actually cut off the end of that incisor. Incisors can become damaged and fractured from chewing on fence or stalls, which is a common vice of stabled horses, and is called cribbing.

I've heard that horses have what are called “wolf teeth.” Can you tell me about these? The wolf teeth on a horse are actually the first premolars, which unlike the other premolars have a single tooth root. Wolf teeth are commonly removed before the horse starts being trained at around the age of 1 or 2 years. People still debate it, but the common belief in the United States is that it interferes with the bit and could be a source of pain and discomfort in the future. In other countries, such as Great Britain, they typically leave the wolf teeth alone. It’s a simple procedure where we sedate and elevate around that tooth, right through the periodontal ligament. Often, if a horse is 2 years old and the wolf teeth are already present, and there is no inflammation, we may not need the anesthetic because the horse doesn’t react at all to what I’m doing in his mouth. Surprising, right?

Do you see many instances where a tooth problem has caused a sinus cavity problem? Yes, it’s actually very common. We’ll find an apical tooth root abscess, say on the fourth cheek tooth for example, and a lot of times you’ll be able to discern a foul order coming from the horse’s nose, and a nasal discharge as a result of the sinus infection.

We cannot make this diagnosis without radiographs of course, so you can look for a fluid line to verify sinus infection. Often times you will
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not see external swelling because a horse has a hard facial crest. Rather, the horse will go off his feed or he'll become a very slow eater. However, on the mandibular teeth you will see swelling. It's common in young horses where you'll see these little eruption bumps from the new tooth coming in.

Mandibular teeth have very long roots and one has to be very careful during extraction because you can fracture the mandible in a diseased bone situation.

What are the basics a horse owner needs to be aware of in terms of taking care of the animal's teeth? All young horses, that is, those 5 years of age and younger, should have their teeth examined twice a year. Up until 1 year of age, you're just evaluating the occlusion of the arcades. If they have an overbite or underbite, you would address that.

Typically you wouldn't start balancing a horse's mouth, which is called “floating teeth” in layman’s terms, without the horse being at least a year old. Once they are that age, it's best to do an examination twice a year.

At 5 years of age, all the teeth have erupted. At that point, the teeth are worn down a little more naturally and you can drop down to once a year evaluations. Some horses will have abnormalities that, if addressed early, those situations never become problems. Equine dentistry is an area where an ounce of prevention is better than a pound of cure. Some horses do fine and don't have their teeth floated for many years, but those are the minority. Thus, most horses need to be evaluated and have their teeth floated regularly.

A horse with bad teeth can lose weight and get colicky, which is our term for abdominal pain. A horse's intestinal track is very long and nothing is spot-welded down, so if it becomes filled with gas and it floats up and rotates, this can be fatal for the horse.

Is there a semester or a few weeks on equine dentistry during veterinary school? Can people actually specialize in equine dentistry?

Although there is a board certification process for veterinary dental medicine, there currently is no specific “equine only” tract for this specialty. Should a veterinarian wish to become board certified in dentistry, he or she would be required to learn and study all species, including equine, as they pertain to dentistry. This field is increasing in popularity as there is growing interest from owners and trainers to have quality dental procedures performed in a safe and painless manner. There are very few equine dental residency programs available in this country.

There are several schools that will educate a layman or a veterinarian and provide a certificate in equine dentistry, and this is with or without a medical license. Of course, this is not the same as being a board-certified dentist.

In veterinary school, all first year students take anatomy and learn the dentition of many animal species—dog, cat, horse, etc. So it’s taught, and as you go through your fourth year of veterinary school, which is a clinical year, you have opportunities to work on horses to get firsthand experience. Yet, today there is no such thing as an equine dentistry residency to get additional training.

There are some very capable practitioners who are available, who do wet labs and continuing education in order to teach other, younger veterinarians things they have learned through the years. There are also a couple of journals that publish dental articles.

The American Veterinary Medical Association is one such journal. Another is the Journal of Equine Dentistry, which has an editorial board, and both veterinarians and certified equine dentists submit cases.

Equine dentistry is indeed a growing field. For years it was just float teeth, meaning the goal was to get rid of the sharp points. Yet, we've learned and evolved and now we're starting to find things like open pulp chambers, and the area of restorative dentistry is becoming less of a black hole.

There are some people using perio units where they are using high-speed drills and subsequently filling cavities and using impression materials.

So, it's evolving, just not at a fast pace. We're getting there, but we're very far behind our dentist counterparts who work on humans. There are some veterinarians who have dedicated their lives to equine dentistry, and those folks are extremely knowledgeable.

Richard B. Tanner, DVM
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Abstract
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Foreign bodies discovered during routine dental treatment

By Devon M. Almog, DMD; Samuel Melcer, DMD; Rachel Berley, DMD & Kenneth Cheng, DDS

While the public and some scientists continue to claim that dental amalgam causes health problems, other scientists and the FDA concluded that clinical studies did not establish a causal link between dental amalgam and health problems. This case report will discuss the entrapment of amalgam particles.

Case report

Recently, a 50-year-old Caucasian male presented to the VA New Jersey Health Care System Dental Service at East Orange seeking dental care. The patient came to our facility exploring, among other things, the viability of a dental implant in the region of tooth #30. Nevertheless, considering the patient’s dental history. Approximately three years ago, his right mandibular third molar (#32) was scheduled for an amalgam-alloy core buildup following root canal therapy. A crown lengthening procedure using reflected, full-thickness buccal and lingual flaps was performed.

While the flaps were reflected, an amalgam core buildup was performed. The foreign bodies visible in the radiographic images are most likely amalgam alloy particles that either became trapped in the apical portion of the flap or in the interstitial tissue.

Comprehensive oral and maxillofacial examination included an intraoral and extraoral exam, full-mouth periapical X-rays and a panoramic radiograph. Among other clinical findings, the panoramic radiographs revealed incidental foreign bodies, most likely amalgam, embedded in the soft and/or hard tissue of the oral cavity due to iatrogenic treatment (Fig. 1).

The patient consented to explore the feasibility of a dental implant in the region of tooth #30 and, at the same time, explore the region of #32 in order to determine the orientation and proximity of the foreign bodies to critical anatomical landmarks.

For that study, a cone-beam CT (CBCT) 3-D scan of his lower jaw was obtained utilizing an i-CAT™ CBCT (Imaging Sciences International, Hatfield, PA). A panoramic slice/image provided the exact locations of the foreign bodies and their relationship to the adjacent anatomy.

Using CBCT to explore the amalgam pieces in the region of #52 revealed scattered pieces entrapped under the oral mucosa outside the alveolar crest plates, both lingual and buccal to tooth #52. It was also noted that the crown-to-root ratio of tooth #32 was much compromised and the tooth should be considered for extraction.

By using the i-CAT 3-D CBCT, precise 3-D software was employed to visualize the bone in three dimensions from different viewing angles (Fig. 2). It was revealed that some of the amalgam foreign body fragments were resting on the buccal side of the jaw bone on the right side, while other foreign fragments rested on the lingual side of the jaw bone under the lingual undercut (Figs. 5a–c).

As no soft-tissue inflammation and/or bone remodeling has occurred, following a professional dialogue between the restoring dentist and the oral surgeon, the amalgam foreign body fragments incidentally observed in this case were left intact, posing no medical risk and or interference in our proposed dental treatment plan for a dental implant in the region of tooth #30. Nevertheless, continuous follow-up was strongly recommended.

Conclusions

Fortunately, following careful assessment, our patient did not experience symptoms associated with the amalgam remnants embedded under the oral mucosa, as has been reported in some cases in the literature.1 This case also demonstrates that restorative procedures and simultaneous full-thickness flap elevation, especially those involving amalgam restorations, ought to be reconsidered.

When the patient was seen by the oral surgeon for extraction of the adjacent tooth #31, the surrounding areas were evaluated as well. The patient wished to leave #32 alone, despite recommendations for extraction, so no further actions were taken at the time with regard to exploration of amalgam foreign bodies because they were asymptomatic.

This report also attempted to provide justification for the use of CBCT scans in order to visualize abnormalities from a 3-D perspective, ultimately facilitating case management.

While outcome assessments in this area of dentistry are difficult, the authors believe that it is justified from a diagnostic perspective, and what’s more, with renewed interest in mercury toxicity from amalgam fillings, the use of a CBCT scan to visualize amalgam foreign bodies and possible bone remodeling may offer invaluable information regarding treatment protocols.

References

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It’s all in Anaheim in May

Once a year, sunny Anaheim, Calif., opens its arms to tens of thousands of dental professionals from around the world for CDA Presents the Art and Science of Dentistry. This year’s meeting will take place May 12 to 14 (Thursday through Saturday) at the Anaheim Convention Center.

Attendees will have the opportunity to learn about the industry’s latest clinical and technological advancements, take advantage of an extensive exhibit hall, where nearly 600 companies will showcase today’s latest products and services at exclusive show-special pricing. In addition, the meeting will offer plenty of opportunities for networking and fun (more on that below). In all, meeting organizers expect 26,000 dental professionals to attend.

The CDA Presents Board of Managers plans meetings 18 months in advance by selecting speakers they have scouted at other national meetings. Their mission is to provide a wide range of continuing education programs to the entire dental team.

Here are some of the highlights of the meeting.

Lasers in dentistry workshop
Among the many educational highlights of the meeting will be a workshop, “The Wonderful World of Lasers in Dentistry,” to be held on Thursday from 8:30 to 11 a.m., and repeating from 11:30 a.m. to 2 p.m. and again from 2:30 to 5 p.m.

Moderated by Dr. Donald J. Coluzzi, this course will use lecture and clinical simulation demonstration methods. Coluzzi will guide participants through basic laser physics, dental laser device description, operating modes, delivery systems and clinical uses for dental lasers.

Participants will then perform a variety of dental laser applications on pig jaws. The course will include clinical simulation of the most-used dental

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About the authors
Dov M. Almog, DMD
Chief Dental Service, VA NJ Health Care System (VANJHCS)

Rachel Berley, DMD
GPR Resident, VANJHCS

Samuel Melcer, DMD
Asst. Chief Dental Service, VANJHCS

Kenneth Cheng, DDS
Oral Surgeon, VANJHCS

For inquiries about this article, please contact:
Dov M. Almog, DMD
VANJHCS
585 Tremont Ave.
East Orange, N.J. 07018
Tel.: (973) 676-1000, ext.1254
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Get out and see Anaheim

Disney's California Adventure Park in Anaheim. (Photo/ www.sxc.hu)

Show your CDA Presents badge
to receive discounts
at a myriad of shops and restaurants.

Want to have some fun in Orange County when you aren’t at the meeting? Check out the ideas below.

GardenWalk

There’s no need to worry about transportation to GardenWalk — no matter where your hotel is, if you’re close to the convention center, it’s a few footsteps away. It’s also the perfect place to delight with a stroll under sunny Southern California skies or starry nights.

GardenWalk is an open-air district (more than 400,000 square feet), featuring 100 stores, including The Foundry, Chico’s, Harley Davidson, White and one IMAX screen. Some of the plex with luxury seating and dining features a 14-screen movie complex with luxury seating and dining and off-site entertainment options, including AMF 300, an interactive VIP coupon book ($5 value). Show your badge and save an additional 15 percent off your purchase.

“GardenWalk gives Anaheim’s visitors and locals alike a place to dine, shop and explore like no other in Orange County,” said Bill Stone, principal of Excel Realty Holdings, LLC.

Tasty treats

• Balboa Bar: On Balboa Island in Newport Beach, enjoy the famous Balboa Bar, a square vanilla ice cream treat on a stick, dipped in chocolate and rolled in your choice of candies or nuts.

• Knott’s Berry Farm; 5309 Beach Blvd, Buena Park, (714) 220-5300; adults get tickets for the discounted rate of $35.99. Children ages 3-11 and senior citizens older than 62 get 25 percent off regular priced admission.

• Medieval Times Dinner and Tournament; 7602 Beach Blvd., Buena Park, (888) 953-8878; get 50 percent off general admission price.

• Queen Mary; 1126 Queen’s Highway, Long Beach, (562) 490-1701; receive one free general admission ticket with one paid admission.

• Wild Rivers Waterpark; 8770 Irvine Center Drive, Irvine, (949) 788-0808, ext. 215; receive $7 off general admission and $3 off junior admission (shorter than 48 inches). Park opens May 24.

Sports and recreation

• Black Gold Golf Club; 1 Black Gold Drive, Yorba Linda, (714) 961-0060; 20 percent discount on non-resident green fee; 50 percent discount on all club rentals. Reserva-
tions may be made only three days in advance for this offer.

• Discovery Science Center; 2500 N. Main St., Santa Ana, (714) 542-2825, ext. 5156; get a free “Dino Quest Interactive” attraction transmitter ($5 value).

• Flightdeck Air Combat Center; 1601 S. Sunkist, Suite A, Anaheim, (714) 957-1511; show your badge and receive two tickets for the price of one on any open party (public), two-hour whale-watching or ocean adventure trip. Not valid on Tuesdays.

Retail

• The Block at Orange; 20 City Blvd., Suite C3, Orange, (714) 789-4001; show your convention badge at guest services to receive a coupon book.

• Citadel Outlets; 100 Citadel Drive, Commerce, (325) 888-1724; get a free preferred customer savings and offers card.

• Desert Hills Premium Outlets; 48400 Seminole Drive, Cabazon, (951) 848-5018; receive a complimentary VIP coupon book ($5 value) with discount offers at many of the 150 designer and name-brand stores. Mention the “Show Your Anaheim Badge” at the management office (West Wing, Suite 601).

• House of Blues Anaheim Retail Store; 1550 S. Disneyland Drive, Anaheim, (714) 520-2575; show your badge and save 10 percent off retail items.

Restaurant

• Anaheim White House Restau-

rant; 887 S. Anaheim Blvd., An-

heim, (714) 772-1381; complimenta-

ry transportation services for parties of eight to 50 people from Anaheim hotels with advance reservations, based on availability. Twenty percent discount off food items for lunch (before 2 p.m.).

• Dine & Dasher’s; 20 City Blvd., Orange, (714) 768-1515; get a free $10 game with the purchase of a $10 game play.

• House of Blues, Anaheim; 1550 S. Disneyland Drive, Anaheim, (714) 520-2575; receive 20 percent off food with convention badge.

• Newport Diner; 1500 Orange Avenue, Costa Mesa, (714) 776-6200; get 10 percent off food.

• O’Neil’s Bar & Grill at Arroyo Trabuco Golf Club; 26772 Avery Pkwy., Mission Viejo, (949) 503-5115; play a round of golf and receive 15 percent off lunch and/or dinner.

• Tortilla Jo’s; 1515 Disneyland Drive, Anaheim, (714) 535-9000; get 10 percent off food.

(Source: Anaheim/Orange County Visitor’s & Convention Bureau)
laser procedures.

Participating companies will be available to answer questions.

Digital technology workshop

Another highlighted course is “Digital Dentistry: Systems and Clinical Applications,” to be offered Thursday from 8:30 to 11:30 a.m., and repeating from 1:30 to 4:30 p.m.

Led by Dr. Dennis J. Fasbinder, the course will challenge current concepts of restorative dental treatment by providing an introduction to alternative digital technology and its clinical application. Digital technology, in the form of chairside CAD/CAM systems, is available to provide ceramic restorations in a single appointment.

Innovative digital systems are also available to replace traditional impression materials for transferring tooth preparation geometry and occlusal relationships electronically to the laboratory for the fabrication of high-strength ceramic crowns and fixed partial dentures.

The course will offer an extensive opportunity for hands-on experience to explore the clinical workflow of a number of digital systems.

New dental board regulations

The Dental Board of California has recently adopted new continuing education (C.E.) regulations. The regulations no longer specify courses as Category I and Category II. The regulations, however, are specific regarding the content type and limit the number of credits for specific content areas.

To facilitate California licensed dental professionals in complying with the new regulations, the CDA will identify each course’s content as either a “core” or a “20 percent” course. This is very similar to the previous Category I and II and divides continuing education courses into two categories that are defined as follows:

• Core courses must make up a minimum of 80 percent of the credits in a renewal cycle. These courses include courses that directly enhance the licensee’s knowledge, skill and competence in the provision of service to patients or the community.

• Twenty percent courses can make up only 20 percent of the credits in a renewal cycle. These courses include courses considered to be primarily of benefit to the licensee.

Exhibit hall

CDA Presents will feature more than 550 exhibiting companies showcasing the latest in dental technology, products and services. Stay ahead of the curve by exploring the innovative new products being launched in the exhibit hall.

The exhibit hall will be open Thursday, Friday and Saturday.

The grand opening of the exhibits will take place Thursday at 9:30 a.m. Exhibit hall hours are Thursday from 9:30 a.m. to 5:30 p.m.; Friday from 9:30 a.m. to 6 p.m.; and Saturday from 9:30 a.m. to 4:30 p.m. Family hours are daily from 9:30 a.m. to noon.

The Spot

Back again this year by popular demand, The Spot is the meeting place to learn, engage and recharge. Located in the exhibit hall near registration, this oasis offers an educational theater providing C.E. credits, cool and new products, an Internet Café and WiFi lounge and convenient C.E. stations.

CDA Beach Party

Get ready to have a ball at the CDA Presents beach party! Attendees will enjoy tasty fish tacos, sliders, hot dogs, appetizers and other refreshments while grooving to the lively beach tunes of the Beach Toys Band. This entertaining group will have you singing, dancing and reminiscing to the songs of the Beatles and Beach Boys.

Create a team with your colleagues and friends and enjoy a friendly match on the volleyball court, relax in a cabana, or if you prefer, visit one of our surf-side boardwalk games for some amusement.

The party will take place Friday from 7 to 10 p.m. at the Arena Plaza at the Convention Center. The cost is $65 per person.

Disney tickets

No trip to Anaheim would be complete without a visit to a Disney park, and significantly discounted Disneyland Resort theme park tickets are available to attendees during CDA Presents.

These tickets will only be available for purchase online. These tickets are created just for you, and not all are available at the front gates of theme parks. To purchase these tickets, visit www.cdapresents.com.

Please note that purchase of theme park tickets is separate from CDA Presents registration. Ticket store closes at 9 p.m. PST on Saturday, May 7. All tickets are valid May 8 to 21, 2011.

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The third annual Dental Tribune Study Club (DTSC) Symposia at the Greater New York Dental Meeting (GNYDM) 2010 was a great success, attracting more than 2,000 registrants. As the official online education partner of the GNYDM, an event that draws many from the international dental community, DTSC hosts a focused lecture program on the exhibition floor.

In case you were not able to attend last year’s program, you may view all of the presentations online. Each lecture was recorded and archived at www.dtstudyclub.com as a C.E.-accredited webinar. The list of lectures available includes:

- Dr. Howard Glazer: Beautifil: Go with the FLOW
- Dr. John Flucke: Light-cured Adhesive Dentistry: Science and Substance
- Dr. Martin Goldstein: A Simplified Approach to Multi-layer Direct Composite Bonding
- Dr. Richard Rosenblatt: Digital Impressions: Are they for me?
- Dr. Louis Malmenacher: Total Facial Esthetics for Every Dental Practice
- Dr. Dirk Gieselmann: How aMMP-8 Testing Can Change A Dental Office and the General Health Economy
- Mrs. Noel Brandon-Kelsch: Eco-friendly Infection Control
- Dr. Gregori Kurtzman: Understanding Adhesives and How to Incorporate New Advances in Dental Materials and Techniques into Your Restorative Practice
- Dr. Marc Gottlieb: Exciting New Tools for Superb Impressions
- Dr. Marc Gottlieb: A Game-changing Approach to Difficult Class II Composite
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- Dr. Dirk Gieselmann: How aMMP-8 Testing Can Change A Dental Office and the General Health Economy
- Mrs. Noel Brandon-Kelsch: Eco-friendly Infection Control

Furthermore, the recorded lectures from GNYDM’s Live Dentistry Arena can also be found at www.dtstudyclub.com/gnydm.

For the fourth year in a row, the DTSC team is preparing the symposia at the GNYDM, which will include four days of focused lectures in various areas of dentistry. Each day, from Nov. 27-30, will feature a variety of presentations on topics that will be led by experts in that field.

Participants attending for three out of four days will receive 21 hours of continuing education credits. Participants attending for all four days will receive 28 hours of continuing education credits.

Keep updated on DT Study Club happenings by joining the DTSC Facebook group. Search for DTSC on Facebook by using www.dtstudyclub.com.

Membership is free and grants one access to live and interactive online courses, archived C.E. webinars, expert video blogs, product reviews, discussion areas and more.
Solving one of dentistry’s challenges: fear of injections

Of all the procedures performed on a routine basis, the one procedure that is universally perceived by patients as the most fear- and anxiety-provoking is the dental injection. In spite of the significant advances made during the past 100 years, our profession has yet to conquer one of the greatest challenges of dentistry—or has it?

Milestone Scientific after spending a decade responsibly and methodically studying this problem, now believes that with the introduction of its new product, the Wand/STA System instrument, it has finally conquered this age-old problem. The Wand/STA System instrument represents the world’s first and only technology that uses the patented Dynamic Pressure Sensing (DPS) technology that accurately and safely performs a pressure-regulated intra-ligimentary dental injection.1

The new Wand/STA System can also perform all traditional dental injection techniques, i.e., inferior alveolar block, supra-periosteal infiltration, etc. All techniques are performed more efficiently, more effectively and virtually painless.2,3

Milestone’s new technology incorporates visual and audible real-time feedback, giving clinicians tactile control. The experience for both patient and dentist is one that is significantly less stressful.3

Milestone Scientific created and defined a new category of dental instruments called C-CLAD (Computer-controlled Local Anesthetic Delivery) systems.2

These are the only dental injection instruments that have the published scientific data that substantiate the claim of eliminating or reducing pain perception when performing a dental injection.4,5

This technology has undergone the rigorous of clinical testing that has been conducted in numerous universities and research centers throughout the world for more than a decade.

According to the company, these studies are published in some of the most highly respected dental journals in the profession. No other instrument, technology or device developed specifically to reduce pain and anxiety while performing a dental injection can currently make that statement.

With the introduction of C-CLAD technology, several newly defined injections were also introduced to dentistry.6 The Wand/STA System has been optimized to perform these new dental injections.

The first of these techniques, the anterior middle superior alveolar (AMSA) nerve block, published in 1997 by Friedman and Hochman, is a contemporary technique to achieve maxillary pulpal anesthesia of multiple maxillary teeth from a single palatal injection without producing the undesired collateral anesthesia to the lip and face.7

Subsequently, Friedman and Hochman introduced a second injection, named the palatal-approach anterior superior alveolar (P-ASA) nerve block, in8 which pulpal and soft-tissue anesthesia of the central and lateral incisors are achieved by a single palatal injection.

The general reduction in pain perception for all injections has led to innovative ways to producing more efficient and effective dental anesthesia.

In addition to the new dental injection discussed above, the Wand/STA System instrument improves the success rate of traditional injections such as the inferior alveolar nerve block.9

Holding the Wand handpiece, with a pen-like grasp allows the clinician to easily rotate while simultaneously moving the needle forward, increasing accuracy by decreasing needle deflection.10,11

Added to the ability to use the new multi-cartridge injection feature, the Wand/STA System instrument provides numerous advantages when performing traditional injection techniques.

The introduction of the Wand/STA System instrument represents a material improvement over previous versions of this technology.

Numerous innovative new features are available in the Wand/STA System. They include automatic purging of anesthetic solution that primes the handpiece prior to use, automatic plunger retraction after completion of use, a multi-cartridge feature allowing multi-cartridge injections and reduction of cartridge waste.

Milestone Scientific has developed a novel training feature in the Wand/STA System instrument, providing clinicians with spoken instructional guidance on the use of the instrument, thereby substantially reducing the initial learning curve.

The Wand/STA System instrument is today’s most advanced C-CLAD technology and represents the next generation of computer-controlled drug delivery instruments for dentistry.12

References

The ‘Denture Comfort’ procedure

We’re all well aware of the difficulties that traditional dentures present to both you and your patients. There are more than 39 million Americans suffering every day with difficulties related to eating, speaking and painful sore spots.

Today, with a great focus on the relationship between dentistry and systemic health, we must take into consideration that edentulism has a direct impact on patients’ overall health with problems ranging from psychological to nutritional and digestive concerns.

According to Dr. Carl Misch, study shows that due to bone loss is associated with illness; 17 percent of edentulous people take medicine for gastrointestinal disorders.

In a transformative document called the McGill Consensus, which was published in 2002, it was determined that all mandibular dentures should be retained with a minimum of two implants. This would greatly prevent any further bone resorption and provide for a more stable, more retentive denture. The ADEA endorsed this form of treatment in 2004.

It begs the question: why have so few dentists followed these recommendations? The answer is simple: the population we hoped to serve more often than not did not have the time, bone or money to afford conventional two-stage dental implants.

Here are just a few of the staggering statistics:

- 88 percent of people in the United States who could benefit from implants never receive treatment due to lack of time, bone or money
- Of the U.S. population who are aged 65 and older and have lost all of their natural teeth, 55.5 percent has an annual income of less than $15,000; 25.3 percent has an annual income between $15,000 and $24,999
- Only 22 percent of older persons are covered by private dental insurance.

So it begs the question: why have so few dentists followed these recommendations? The answer is simple: the population we hoped to serve more often than not did not have the time, bone or money to afford conventional two-stage dental implants.

TheEMS promise: painless ultrasonic therapy

Switzerland’s Electro Medical Systems (EMS) wants to demonstrate how treatment with an ultrasonic scaler can be enhanced even more with the brand new Piezon Master 700. EMS points to the special refinements of integrated i.Piezon technology. It is designed to assure smooth interaction between the original Piezon handpieces and the EMS Swiss instruments made of bio-compatible surgical steel to ensure the best in patient comfort.

The company says that the i.Piezon module assures that instrument movements are perfectly aligned with the tooth surface, and vibrates 32,000 times per second to make it extremely effective.

The intelligent feedback control minimizes damage to the tooth surface. The result is a uniquely smooth tooth surface and maximum soft-tissue protection. As EMS explains, this is the formula for incomparable precision and therapy that is practically painless thanks to optimum instrument movements.

The balanced Piezon handpieces show how substantially improved illumination of the oral cavity can be achieved with the six LEDs arranged around the tip of the handpiece.

In the words of the manufacturer, which describes itself as the leading maker of dental hygiene systems, this advance enables dentists to handle ultrasonic instruments with even greater precision.

This means even greater precision for periodontal and root canal treatments, calculus removal, cavity preparation and other conservative treatments.

The seamless housing of the Piezoelectric Master 700 has an aesthet- ic, ergonomic and hygienic design, which promises a high degree of operator comfort.

The touch panel can be rapidly and precisely operated by simply touching the self-exploratory operating elements or tapping on the desired action. This enables the system to meet all the requirements in respect to ease of use, and especially hygiene.

The two replacement bottles with a capacity of 550 ml or 500 ml for holding various antisepsis solutions are resistant to UV radiation and can be replaced easily and quickly thanks to their snap-shut caps.

Dentatus' goal is to make available a new ultrasonic scaler that integrates just as conventional diameter, machined-surfaced implants. In 2007, a five-year study performed by NYU reported a 94 percent survival rate and 100 percent patient satisfaction.

Isn’t it time you looked into this treatment option to restore quality of life for your denture patients? Dentatus makes it easy for you to get started with their half-day hands-on workshops.

All the materials for your first case are included in the registration fee, and the course will pay for itself once you perform your first case. For more information check out www.dentatus.com, call (800) 525-5156 or visit Dentatus at CDA booth No. 584.
XTend ceramic kits and turbines for high-speed handpieces

With the XTend™ ceramic line of turbines and kits, ProScore offers dentists the best quality do-it-yourself products for high-speed handpieces in the market. Not only are XTend ceramic products backed by the best warranties in the business—one year for turbines and six months for rebuild kits—XTend products outperform steel bearings, last longer and produce less noise and vibration.

The Ceramic Bearing Technology incorporated in XTend ceramic products provides many handpiece performance benefits:

• Reduced wear: ceramic balls are twice as hard as steel balls.
• Increased durability: ceramic balls are 40 percent lighter than steel balls, which reduces the internal forces and loads caused by high-speed rotation.
• Longer life: ceramic bearings perform better than steel under marginal lubrication.
• Quieter and smoother operation: noise and vibration are reduced as a result of lower loads.

ProScore’s other EZ Solutions offer dentists various do-it-yourself repair and maintenance options.

EZ Press III™ and EZ Rebuild™ Kits
The EZ Press III Repair System is the answer to the high costs and downtime associated with sending high-speed handpieces out to be repaired. Allowing the dentist to easily change those parts that have worn out, the EZ Press III utilizes simple procedures, requires no guesswork and ensures precision placement of the bearings on the spindle.

EZ Install™ Turbines
For an instant repair, dentists can replace cartridges chairside with EZ Install Turbines, which are manufactured with the highest quality parts and quality assurance procedures in the market, including dynamic balancing. The result is a high-performance, long-lasting turbine that outlasts others in the market.

Smart Cleaner
Smart Cleaner is a one-of-a-kind, all-in-one base, liner and final restorative. Approved for all indications (Class I–V) based on physical properties that rival leading hybrids on the market. ‘Stay-put’ handling and superior adaptation that offers distinct benefits compared to traditional hybrid packing techniques.

BEAUTIFIL Flow Plus
Shofu presents BEAUTIFIL Flow Plus, an all-in-one flowable base, liner and final restorative. Approved for all indications (Class I–V) based on physical properties that rival leading hybrids on the market. ‘Stay-put’ handling and superior adaptation that offers distinct benefits compared to traditional hybrid packing techniques.
The device gently holds the patient’s mouth open, keeps the tongue out of the working field, illuminates the oral cavity and guards the patient’s airway—all while continuously evacuating saliva and excess moisture.

Additionally, the company announced that Isodry, a non-illuminated dental isolation system, was named by www.drbicuspid.com as “Best New Instrument” in its 2011 Dental Excellence Awards. Isodry was introduced in February 2010 and was also named by Dentistry Today magazine as one of its “Reader’s Choice Top 50 Technology Products” for 2010.

Both Isolite and Isodry dental isolation systems use the patented Isolite Isoflex mouthpiece. The super soft mouthpiece used with the device makes for a more comfortable experience for the patient, and allows dental professionals to work more efficiently with greater control over the oral environment.

Mouthpieces are available in six

Isolite Systems’ dental isolation technology continues to receive praise from its users and recognition from the dental industry for its dental isolation technology.

The Isolite™ dental isolation system was named one of the “50 Greatest Game Changers in Dentistry” by Dentaltown magazine. Recognition of the product’s contribution to the advancement of dentistry is a major milestone for the device.

Isolite’s inclusion in the list placed it among some of the dental profession’s biggest advancements, including fluoride, local anesthesia, dental handpieces and digital radiography.

Isolite is a dental isolation system that combines the functions of light, suction and retraction into a single device that solves many of the frustrations that dental professionals deal with on a daily basis.
Schick’s CDR Elite digital radiography system combines truly outstanding image quality, an easy-to-use design and a robust, hard-wearing construction to provide an intraoral radiography experience that is truly “elite.”

CDR Elite was developed with guidance from a panel of leading dental radiologists and validated by an extensive range of dental practitioners from all fields.

It is quick, providing instant X-rays.
It reduces radiation; provides high-quality images for enhanced diagnosis; enhances patient communication and increases case acceptance; is easy to use for both the clinician and staff; eliminates the repetitive costs of film, chemicals and disposal of those chemicals; and eliminates time wasted while waiting for film to be developed.

CDR Elite images provide bold bone trabeculation, crisp lamina dura and a clear, clean DEJ to meet the diagnostic needs of every clinician.

Schick’s CDR Elite system is designed to focus on ease of use, diagnostic image quality and durability.

Simple and easier sensor placement, even for vertical bitewings, comes from an optimally located sensor-cable interface and a new color scheme that provides high visibility in the oral cavity.

Embracing the success of Schick’s unique removable cable technology (introduced with the CDR Plus-Wire), CDR Elite incorporates this technology on all three sensor sizes, ensuring that every clinician and every dental practice can enjoy the simplicity and convenience of a one-step cable-replacement process.

CDR Elite integrates fully with Schick’s intuitive and easy-to-use CDR DICOM imaging software, as well as Eaglesoft and Patterson Imaging, which all feature multiple tools for enhanced diagnostic capabilities and patient communication.

The dentist can add other Schick products such as iPan, CDR PanX and USBCam2 for a complete digital solution.
Introducing ProMax 3D Mid
2-D and 3-D fusion in one unit

The new PLANMECA ProMax® 3D Mid is a CBVT unit including 5-D imaging, panoramic, extra-oral bite-wing and cephalometric all in one machine that can accommodate all of your clinical needs.

The PLANMECA ProMax® 3D Mid:
• provides an extended selection of 3-D volume sizes combined with traditional 2-D panoramic and cephalometric imaging;
• and has the unique ability to meet all of your diagnostic needs, including implantology, endodontics, periodontics, orthodontics, as well as dental and maxillofacial surgery and TMJ analysis.

The volume sizes range from ø3.4 x 4.2 cm to ø16 x 16 cm. This wide selection of volume sizes allows for optimizing the imaging area according to specific diagnostic task — always complying with the best practices of dentistry including the ALARA (as low as reasonably achievable) principle to minimize radiation.

Versatility
• Adjustable KV and MA.
• Pediatric Mode automatically reduces volume according to child’s anatomy.
• Works natively in MAC OS environment.

• Provides volume sizes for every clinical application.
• Cephalometric upgrade available.

Ease of use
• Simple, effortless patient positioning.
• The intuitive graphical user interface offers preprogrammed target sites and exposure values for different image types and targets.
• Fully integrable with third-party software.
• Comes with a complete software system for diagnosis.

SmartPan, unique panoramic imaging
• A unique SmartPan imaging system also uses the same 5-D sensor for panoramic imaging, eliminating the need to change sensors.
• The SmartPan system automatically calculates nine different panoramic curves in a 1 mm shift.
• The user can browse between the panoramic images and select the most suitable for diagnosis after the exposure.

For an in-office consultation or more information call (650) 529-2500 or visit www.planmecausa.com.

Products to fit your entire practice

Keystone Industries is proud to announce the addition of the Gelato line of oral health care products and the Prehma line of disposable and surgical products to its overall offering.

Keystone has long been a major supply source for the dental laboratory industry and, in recent years, has made strategic acquisitions that have expanded the product offerings into the dental operatory arena.

With the addition of the Gelato and Prehma lines, Keystone now has the ability to offer products in almost every item class, including anesthetics, articulating, cements, cosmetic dentistry, disposables, endodontic products, small equipment, evacuation products, finishing and polishing, impression materials, infection control, lab products, matrix materials, preventives, surgical products, waxes and office products.

Here are a few of Keystone’s products, all of which are made in the United States.

Gelato APF Fluoride Gel
This is an economical and 60-second acidulated phosphate fluoride gel that contains 1.25 percent fluoride ion. The smooth and creamy thixotropic formula will not run, preventing patient gagging. It is available in cherry, mint, orange vanilla, piña colada, bubble gum, strawberry, grape, cotton candy, mango smoothie and marshmallow. The formula is gluten-free.

Gelato Home Care Rinse & Gel
This 0.65 percent stannous fluoride perio rinse 10 oz (284 g) bottle with pump comes in two natural flavors: mint and raspberry. It is antimicrobial and alcohol-free and relieves tooth sensitivity, reduces gingival inflammation, helps inhibit plaque build-up, prevents remineralization and promotes re-mineralization. The formula is gluten-free.

The 0.40 percent stannous fluoride brush-on gel 4.5 oz (120 g) tube also comes in two natural flavors: mint and red berry. The product reduces sensitivity and plaque biofilm, while inhibiting the microbial process. The formula is gluten-free.

Gelato 0.12% Rinse Chlorhexidine Gluconate
This “alcohol-free” formula is a broad-spectrum, anti-microbial oral rinse that has been proven safe and effective for treating gingivitis. The time-released formula continues to work after rinsing, reducing redness and swelling of gums.

Gelato Foam Fluoride
The 1.23 percent acidulated phosphate fluoride formula provides comfort and consistent and efficacious coverage. The foam remains in the fluoride tray under bite pressure to eliminate patient gagging. It is available in these flavors: cherry, bubble gum, grape, mint, strawberry and cotton candy.

High-volume evacuator (HVE) tips
This gel has no bitter aftertaste and is fast-acting with no systemic absorption. It is available in seven flavors: cherry, piña colada, bubble gum, mint, mango, strawberry and raspberry.

It contains 20 percent benzocaine for effective temporary pain relief during procedures such as local anesthetic injections, periodontal curettage, impression taking, scaling, intra-oral radiographs, root planning and prophylaxis.
CareCredit®, the nation’s leading patient payment program, continued its support as founding donor of the American Dental Association Foundation Give Kids A Smile® Fund with its fifth consecutive $100,000 donation.

The donation was made at the Give Kids A Smile National Advisory Board meeting, Feb. 23, in Chicago.

The funding will help the American Dental Association Foundation continue to make grants that support the Give Kids A Smile Program.

The American Dental Association’s Give Kids A Smile program has several objectives:

- to raise awareness of the high level of oral disease suffered by children primarily from low income families;

Funds put toward goal of ‘cavity-free kids by 2020’

CareCredit, founding donor of the ADA Foundation Give Kids A Smile Fund, presents a $100,000 donation during the GKAS National Advisory Board meeting Feb. 23 in Chicago. On hand for the presentation are, from left, Dr. William R. Calnon, ADA president-elect; Jeff Beutler, ADA Foundation interim CEO; Cindy Hearn, CareCredit senior vice president; Steve Kess, Henry Schein vice president, Global Professional Relations; and Dr. Raymond F. Gist, ADA president. (Photo/Provided by ADA News)
• to demonstrate dentistry's commitment to addressing access to care;
• to enable volunteer dental teams across the country to provide free dental care, screening, and education to children in need; and
• to urge policymakers to increase funding for children's oral health.

In 2010, with the help of CareCredit's contribution, the ADA Foundation awarded grants to the Hispanic Dental Association (HDA), the National Dental Association (NDA) and Oral Health America.

The HDA is using its grant to fund local dental-student-led oral health programs in Los Angeles, San Antonio and Boston, to expand their mobile dental van program and participation in local health clinics.

The NDA is enhancing the Deamonte Driver Dental Project, a memorial to a young boy who died from an infection in his brain that was caused by untreated dental decay, to reach more elementary schools and expand mobile dental van services.

Oral Health America's grant funds have been distributed to Smiles Across America sites in California, Minnesota and Nevada, which has enabled thousands of children to receive education, preventive care and restorative services.

"Dental disease among children is a serious issue in the United States. When a child has disease and pain, it makes it difficult for him or her to eat, sleep and learn. CareCredit became the founding donor of the American Dental Association Foundation Give Kids A Smile Fund to help increase children's access to treatment throughout the year."

"Each year we are so impressed with how the grant recipients use the funds to reach out in their community," stated Cindy Hearn, board member and senior vice president of marketing at CareCredit.

"The ADA Foundation and its Give Kids A Smile Fund greatly appreciate CareCredit's continuing support. CareCredit's generosity will play a key role in helping Give Kids A Smile achieve its goal of cavity-free kids by 2020," stated Dr. David A. Whiston, president of the ADA Foundation.

Today, CareCredit is offered in more than 86,000 enrolled dental practices. CareCredit is exclusively selected for their members by most state and national dental associations, and is also recommended by leading practice management consultants.

For more information on CareCredit, call (800) 500-5046 ext. 4519 or visit www.carecredit.com/dental.

Information on Give Kids A Smile can be found at www.givekidsasmile.ada.org.

Nikon D7000 clinical camera package

The Nikon D7000 fits into the Nikon lineup between the D90 and the D300s in regard to price and size, but beats both of them when it comes to features. The D7000 takes the resolution up to 16.2 megapixels (compared to the 12.3 mp resolution of the other two cameras) and adds full 1080p HD video capture (the D90 and D300s have 720p HD video).

Nikon has also introduced User Modes (U1 and U2) on the D7000. This has been a popular feature on the Canon 40D, 50D and 60D. For clinical use, one can use the User Modes to pre-program the camera and simplify switching between portrait and closeup views.

The User Modes are also nice in case someone changes settings on the camera. To get back to the proper settings, you simply turn the dial to another mode and then back to the User Mode and then all of the pre-programmed settings are restored.

The D7000 has two SD memory card slots, and you can program the camera to use the slots in Backup Mode (each image is written to both cards), Overflow Mode (when the first card is full, the camera switches to the second card) or RAW Slot 1-JPG Slot 2 Mode (RAW files are written to the first card and JPGs to the second card).

The camera system features Nikon's 85mm macro lens and a Metz wireless macro flash.

For more information, please visit www.photomed.net or call PhotoMed at (800) 998-7765.

Nikon's 85mm macro lens and a Metz wireless macro flash.
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<table>
<thead>
<tr>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDA South</td>
<td>Florida Dental Assoc</td>
<td>National Dental Assoc</td>
<td>CDA North</td>
<td>ADA</td>
<td>Madow Brothers and GNYDM Greater New York</td>
</tr>
<tr>
<td>The Texas Meeting</td>
<td>Garden State Dental Conference</td>
<td>AGD</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Booth 1651</td>
<td>Booth 287</td>
<td>Booth 309</td>
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800.862.1125 www.milestonescientific.com
Take a cosmetic practice to the next level with facial injectables

By Zev Schulhof, DMD, MD

Minimally invasive cosmetic facial procedures are quickly becoming the most exciting and controversial topic in cosmetic dentistry. In my mind, there is no better clinician with the capabilities and qualifications to provide these procedures than the dental professional.

Over the last three to four years, we have trained hundreds of practitioners in the art of facial injectables. In doing so, we have found that dentists have the greatest inherent skills and artistic ability when compared to any other professional.

Dentists often ask me why I think that they are qualified to do these procedures. In response, I ask them some simple questions:

• Which medical professional injects the most patients on a daily basis?
• Who knows the ins and outs of giving as painless of an injection as possible?
• Who knows how to anesthetize the tissues of the face via intraoral techniques?
• Who is in tune, on a daily basis, to facial and peri-oral anatomy and symmetry?
• Who knows the dental and skeletal relationships on the soft tissue of the face?
• Who knows the anatomy of a proper lip line?
• Whom do patients trust (every six months) to continuously inject them?

The answer, of course, is you do! Using facial injectables is a natural progression for the cosmetic dentist. For example, we all understand that enhancing a patient’s smile is more than just placing some laminates. In our courses, we tell clinicians to imagine the teeth as a picture and the

Fig. 1: 62-year-old female with a chief complaint of ‘thin and misshapen’ lips. (Photo/Provided by Dr. Zev Schulhof)

Fig. 2: One week after augmentation with 1 cc of Restylane.

AACD general session speakers focus on involvement, opportunity

Attendees of the annual scientific sessions of the American Academy of Cosmetic Dentistry’s (AACD) have come to expect memorable and unique general session speakers. This year’s session, slated for May 18–21 in Boston, is no exception.

The AACD solicited feedback from attendees to learn the three things they want in their keynote speakers: education, motivation and entertainment. This year’s lineup will deliver on those three and more.

The AACD will kick off the conference with Peter Sheahan, author of “Flip.” Sheahan, CEO of the Centre for Skills Development, has spent a decade teaching businesses how to flip their thinking. Real money is made in the cracks, according to Sheahan, and the opportunity for mind-blowing success is all around.

The problem is that humans are conditioned by their experience, blinded by business models and conned by popular media to believe that success is a product of economic conditions.

Sheahan’s clients include NewsCorp, Google, Hilton Hotels, GlaxoSmithKline, Harley Davidson, Cisco and Goldman Sachs, many of which engage him on an ongoing basis to provoke their leaders to rethink their assumptions and challenge them to find innovative ways of doing business.

Photographer Joel Meyerowitz, creator of The World Trade Center Archive, will continue Sheahan’s momentum with his presentation, which will inspire attendees to get more involved. Meyerowitz is internationally renowned for his pioneering work in color photography and his view-camera artistry.

A Guggenheim Fellow and an NEA and NEH award winner, Meyerowitz was the only photographer to gain unlimited access to Ground Zero after 9/11. In his presentations, he conveys his intense belief in the transformational power of art. He reaches beyond photography
lips as their frame. When you look at a middle-aged woman with beautiful veneers and a thin, colorless upper lip with many smoker’s lines, it tends to dampen the cosmetic effect.

As a matter of fact, when you start planning those veneers, you should be taking into account the effect the veneers will have on lip support, as well as incisal show, both in relaxed and animated positions. Then, when you enhance her lip, you have to take into account the proper lip outline and volume, as well as incisal show. In other words, the two procedures go hand in hand. Which medical professional could possibly understand this better than a dentist?

The first thing the practitioner needs to realize is the difference between Botulinum toxin (Botox® and Dysport®) and facial fillers (Restylene®, Perlane®, Juvederm® and Radiesse® among many others).

Botulinum toxin is a clear fluid medication that comes in a lyophilized (freeze-dried) form. It is then mixed with saline and injected subcutaneously or intramuscularly with the intention of weakening the target muscle. Contrary to popular belief, it does not “fill” lines, nor does it “smooth” wrinkles.

In order for a muscle to contract, a signal is sent down the motor nerve terminal and at its nerve ending, acetylcholine is sent across the gap to the motor nerve terminal to the muscle. Contrary to popular belief, the intention of weakening the target cutaneously or intramuscularly with Botulinum toxin (Botox®, Dysport®) and facial fillers (Restylene®, Perlane®, Juvederm® and Radiesse® among many others).

Because it is not a protein, the risk of allergic reaction is extremely low. There is another filler material, Radiesse, that is made up of calcium hydroxylapatite (CaHA) microspheres suspended in a water-based gel carrier. This is similar to the hydroxyapatite found in our teeth and bones.

Another important learning aspect is which areas require Botulinum toxin and which areas require filler material. Many times, a combination of both materials is required for the most esthetic effect.

When looking at the aging face, it is important to understand the difference between static wrinkles and dynamic wrinkles. If you tell a patient to relax her facial muscles and not make any movements, and you see a wrinkle or groove at rest, this would be a static wrinkle (see nasolabial fold). By definition, botulinum toxin would do very little for these wrinkles or grooves because the toxin would “relax” the underlying muscles. However, in this patient we know that even if the muscles are relaxed, they still have this wrinkle at rest. Therefore, filler (or combination therapy) would be better.

A dynamic wrinkle is one that is caused by animation or muscle function (see forehead). In this instance, botulinum toxin would do very well. It would weaken the underlying muscle and cause a chemical denervation. In turn, this would stop the overlying skin from wrinkling.

For the beginning injector, we generally recommend starting with three areas of the face that generally receive botulinum toxin and three areas that generally receive filler material. In the botulinum toxin area, the toxin needs to be injected at a specific incidence to cause denervation.
course we teach both Botox and Dysport and focus on the glabella complex (the frown lines between the eyes), the forehead and “crow’s feet” (smile lines around the eye).

In the filler course, we focus on the nasolabial folds (lines from the ala of the nose to the corners of the mouth), the “marionette lines” (lines from the corners of the mouth to the inferior border of the mandible) and the lips. We can accomplish this by placing the fillers via an intra-oral route, without any bruising or swelling, allowing patients to go right back to work.

Once the practitioner gains experience and confidence, there are many other exciting procedures that can be done. Instead of doing a genioplasty, you can augment the chin with filler material. You can do a liquid rhinoplasty (nose job), cheek lift or brow lift, just to name a few. How about combining botulinum toxin and filler material in multiple areas of the face?

Another application of botulinum toxin in the dental arena is in the treatment of temporomandibular disorders (TMD). Temporomandibular disorders can span a wide variety of etiologies, including muscular, ligamental, intra-articular or bony sources. A diagnosis relies on an extensive history, physical exam, radiologic studies and diagnostic procedures.

Botulinum toxin is just one treatment modality included in an extensive algorithm used in treating TMD. Recent studies show that botulinum toxin contains both a muscle relaxing and an analgesic effect. In my opinion, the reason this has become such a controversial topic throughout the medical community is because of the encroaching competition that the other specialties are feeling in this multi-billion dollar industry.

Over the last five years, non-invasive cosmetic procedures have experienced significant growth due to their increasing popularity and virtually painless, highly profitable, office-based administration, and their ability to make patients’ faces look younger and fuller for longer periods of time. Many specialties, such as gynecologists, family practitioners and ER physicians, are offering these procedures without any backlash.

Surely, the dentist is better prepared, better trained and has more experience in the peri-oral and facial arena than these other specialties.

The ADA definition of dentistry is defined as “the evaluation, diagnosis, prevention and/or treatment (non-surgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body.”

Whether you are interested in providing these procedures or not, it is important to defend the skills and talents that the dentist inherently holds. It is time to show the medical community and the rest of the world that we are truly physicians of the oral cavity and its associated structures.

About the author

Dr. Zev Schulhof is a board-certified oral and maxillofacial surgeon as well as a physician. He is currently the president of the American Academy of Facial Cosmetics. Schulhof lectures nationally on a variety of topics, including non-invasive facial cosmetic procedures. To date, Schulhof has trained hundreds of dentists and physicians in the art of neurotoxins and facial fillers. You may contact him at zev.schulhof@gmail.com.
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Myofunctional therapy

A structured, individualized treatment for retraining and restoring normal oral function

By Stephanie Wall, RDH, MSDH, MEd

Orofacial myology, or myofunctional therapy, is the treatment of an orofacial muscle imbalance, incorrect swallowing pattern, TMJ muscle dysfunction and/or the elimination of certain habits. The main muscles of concern to the orofacial myologist include the temporalis, masseter, internal and external pterygoid, buccinator, orbicularis oris and the mentalis.

Orofacial myofunctional therapy is a form of oral facial physical therapy. It involves exercises and stimulation designed to inhibit inappropriate oral behaviors and/or strengthen appropriate muscle functioning.

Resting postures of the tongue, jaw and lips are very important. When the tongue rests against the posterior teeth, they may not erupt, but rather remain in an open position. When the tongue rests against the maxillary anterior teeth, especially if the upper lip is short or weak, the teeth may begin to protrude too far forward. When the lips are not in a closed rest position, growth and development of the mouth can be adversely affected.

Excessive non-nutritive or non-speech oral behaviors, such as clenching, bruxing, thumb or digit sucking and nail biting, can also affect the condition of the teeth and health and functioning of the mouth, especially the jaw. When any oral habit is excessive in intensity, duration and frequency, the pressures or collision forces can have a serious impact on normal facial appearance and orofacial health and functioning.

Orofacial myologist may treat individuals with the following:

- high arched hard palate
- weak lip structure
- facial grimace when swallowing
- anterior open bite
- protrusion of the tongue when in repose
- over developed mentalis muscle
- sleep apnea.

Upper airway infections and obstructions are frequently identified as causes of orofacial myofunctional disorders, especially when these problems cause the mouth to rest in an open position. Reduced oral muscle tone or poor orofacial muscle posture appears to negatively impact the growing mouth and facial structures.

Long-term non-nutritive sucking habits can also malform the oral structure. Sometimes poor speech articulation patterns may indicate neurological or physical deficits. It is often difficult to determine why an orofacial myofunctional disorder exists because the behaviors can be the result of stimuli no longer fully obvious.

Regardless of cause, once inappropriate oral behavioral patterns are established, they tend to continue until some external stimulus or...
Back to school?

The bachelor’s of science in dental hygiene degree is becoming more difficult to obtain due to the closing of many traditional four-year programs. This leaves many hygienists with an associate’s degree in hygiene. While an associate’s degree allows a graduate to practice dental hygiene, a four-year degree is preferable for many positions associated with dental hygiene. If one has aspirations of being employed in dental hygiene education, corporate positions, sales, etc., a bachelor’s degree is sometimes necessary.

Degree completion programs are available to obtain a bachelor’s degree in dental hygiene and there are hygienists who wish to pursue that degree. For those interested in a career in dental hygiene education, this is usually the mandatory path. In many programs, full-time teaching positions may even require a master’s degree in dental hygiene education.

For the other positions, the course of study is just as important. Bachelor’s degrees in other courses of study mix nicely with the profession of dental hygiene. Hygienists can often be heard saying they feel like counselors. Understanding the way human beings learn, think and are motivated help hygienists relate to patients. For these reasons, clinical dental hygiene is well complemented by a parallel degree in psychology.

For those interested in a sales position, a degree in business may prove to be a good parallel degree. A hygienist who likes to write might want to consider a degree in journalism. Those who have a patient base that speaks languages other than English may benefit from a degree in a foreign language. Clinicians interested in research might want to consider majoring in a field they would like to research, such as biology. A four-year degree in something other than dental hygiene may open doors to other career opportunities if one decides to leave the dental hygiene profession.

These degrees can be obtained in a variety of ways. There are the traditional avenues, such as attending courses on a campus. However, this may not be the most convenient for working adults. With the inception of non-traditional learning, the working adult population can continue to work and complete a four-year degree.

There are universities that offer evening classes in an accelerated format that meet in person and/or online. A quick inquiry of local colleges and universities can provide information about one’s options.

Paying for an education up front might pose a hurdle for some students. Adults can apply for financial aid. This is a relatively easy process and filing an application will let a potential student know what assistance is available. If one is not eligible for grants or scholarships, student loans are another option. These loans often have low interest over a long period for repayment. Acquiring a bachelor’s degree is doable and well worth the time and effort. If you have been thinking about going back to school, there is no time like the present to do some investigating. There are universities that offer evening classes in an accelerated format that meet in person and/or online. A quick inquiry of local colleges and universities can provide information about one’s options.

In an editorial published in the California Dental Hygienists’ Association’s (CDHA) newsletter, the organization continues to voice the importance of raising awareness about dental health.

California children continue to face oral health epidemic

Despite being one of the most preventable of all diseases, tooth decay continues to rank as the most widespread public health issue for California children, according to the California Dental Hygienists’ Association (CDHA). The warning comes on the heels of a report identifying California as being “off track” when it comes to addressing the dental needs of children.

“Poor oral care contributes to speech impediments, low self-esteem and a wide range of health problems involving infections,” said Ellen Standley, CDHA president. “It is unfortunate that one in four children have never even been to a dentist and that tooth decay is five times more prevalent than asthma.”

The Pew Center, a not-for-profit organization dedicated to improving public policy, which issued the report, issued a “C” grade to California, where it says more than 750,000 elementary school children had untreated tooth decay in 2006; conventional wisdom suggests that number is now closer to 1 million, according to the CDHA. According to the Pew Report, California falls short in these key oral health-care policy benchmarks:

- Only 27 percent of California drinking water supplies are fluoridated — far less than the national average of 75 percent.
- Nationwide, the percentage of dentists’ fees reimbursed by Medicaid is 80 percent, while California lagged behind with 54 percent.

The CDHA continues to voice related concerns. For instance, many dentists are not comfortable treating infants or very young children, and instead they refer them to a pediatrician. CDHA officials say this demonstrates why the role of a dental hygienist is so vital.

“The dental hygienist can provide mothers of infants and young children with simple nutritional counseling to help prevent dental decay,” said Standley. “We are a trusted and reliable source of information about everything from proper brushing to the safe use of hot bottles and sippy cups.”

Additionally, disparities exist across race, ethnicity and type of insurance when it comes to the length of time between dental care visits. Most dental practices don’t accept Medicaid-enrolled children of any age, said Standley, and children are seen on an average of 10 times in a medical office before the first dental exam is ever scheduled.

“While the CDHA continues to raise awareness of pediatric oral health among policy makers, parents and the public health community,” said Standley, “the good news is that with knowledge and public education, we can make headway in reducing tooth decay in our children.”

The CDHA is the authoritative voice of the state’s dental hygiene profession. The organization was established 25 years ago when two regional associations merged to form a unified professional group. The CDHA represents thousands of dental hygienists.

(Source: PRWEB)
treatment alters enough of the patterns so that new behaviors can be learned. Sometimes the changes of the oral environment by an orthodontist may bring improved oral functioning.

However, orofacial myofunctional therapy may be necessary when there are indications that dental treatment or orthodontic intervention alone may not bring about the desired changes in oral behaviors. Adverse oral behaviors can often interfere with dental or orthodontic treatment and the stability and condition of the mouth.

Orofacial myofunctional therapy is a structured, individualized treatment for retraining and restoring normal oral function and speech articulation. Therapy may include any or all of the following:

- elimination of damaging oral habits,
- reduction of unnecessary tension and pressure in the muscles of the face and mouth,
- strengthening of muscles that do not adequately support normal functioning,
- development of normal resting postures of the tongue, lips, jaw and facial muscles,
- establishment of normal biting, chewing and swallowing patterns.

The length and timing of therapy depends on the severity and nature of the disorder. In most cases, therapy is a short-term process with the active stage of treatment lasting about three to six months. Follow-up visits may be required with decreasing frequency over a period of six to 12 months.

Orofacial myofunctional therapists have received specialized training to evaluate and treat a variety of orofacial disorders. Many clinicians have additional professional training in the areas of speech language pathology, dental hygiene, dentistry or another health-related field. Most are members of the International Association of Orofacial Myology (IAOM).

The IAOM regulates how orofacial myology is practiced, how the course material is constructed and delivered, and monitors the certification process that assigns the credential of Certified Ororfacial Myologist (COM). Certification is not required in order to practice, however, it is highly recommended.

To learn more about the IAOM and the profession of orofacial myology, please visit www.iaom.com.

About the author

Stephanie Wall has been a dental hygienist for more than 25 years. She owns her own business, Cranial Health Solution, where she practices orofacial myology and craniosacral therapy. In her spare time, she is a writer for www.dentaltubules.com and other dental and dental hygiene publications. Wall is also a four-time attendee of CareerFusion, manages the organization’s newsletter and blog site and is available for speaking engagements.

You may contact her at walls879@aol.com.
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