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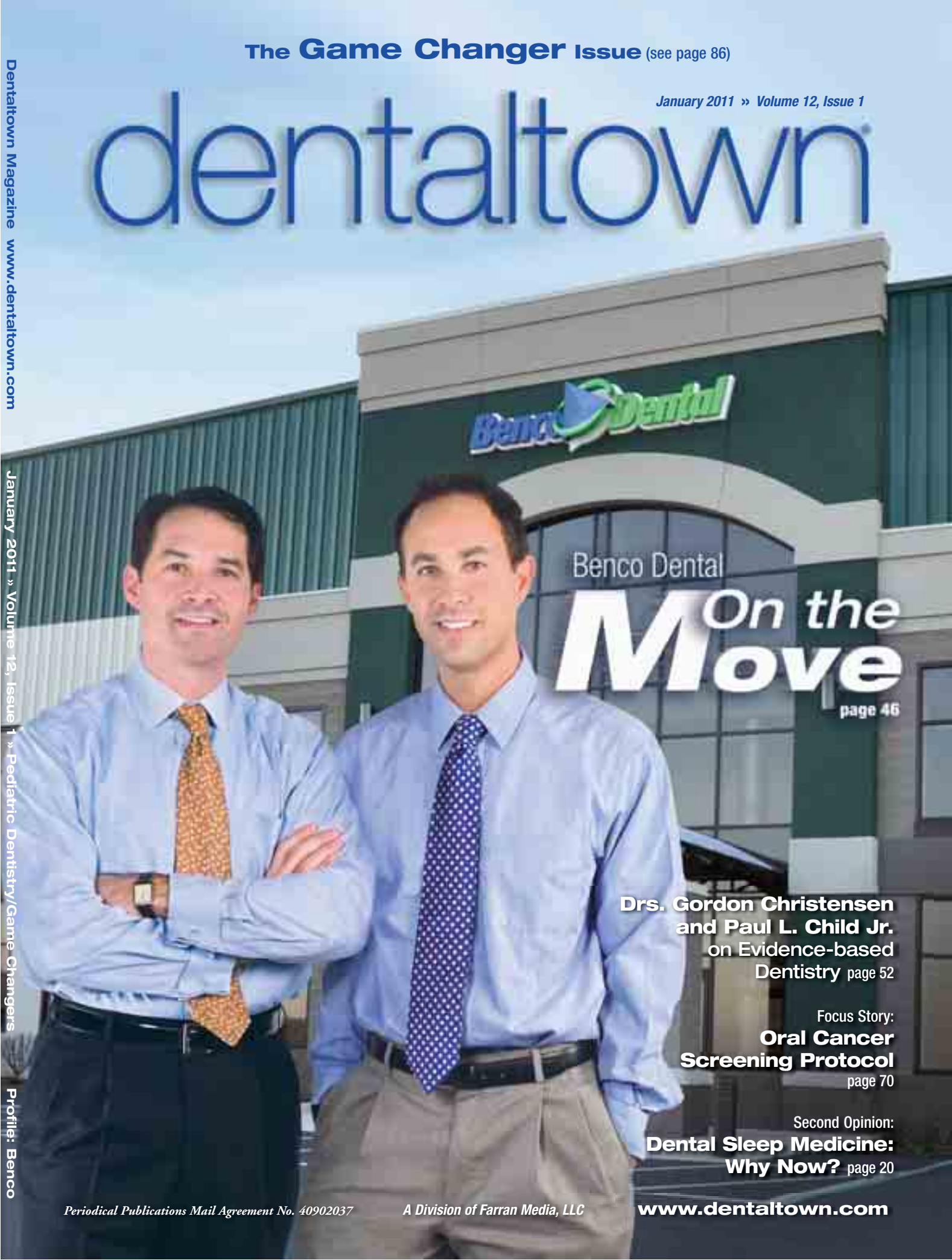

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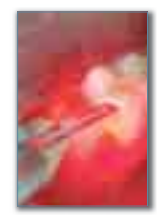

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A. Hard tissue
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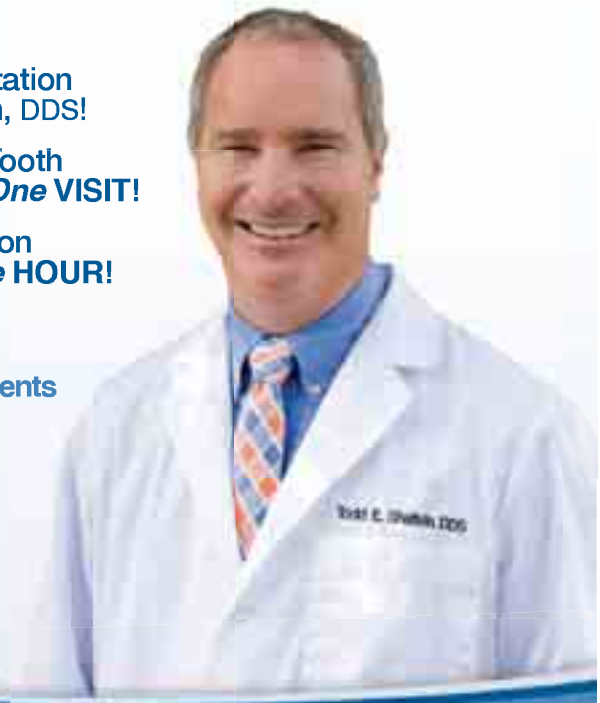

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Getting to the Heart of Mom

by Howard Farran, DDS, MAGD, MBA, Publisher, *Dentaltown Magazine*

Quick, before you start reading this column, put the magazine down and ask your front desk, "Who schedules most of the appointments with us? Is it Mom or Dad?" Go ahead and ask; I'll be here when you get back...

...Welcome back! So, what'd she say? If she said, "Dad," she's lying to you. Ever since I started lecturing in 1990, I've asked dentists and receptionists from New York City to Sydney, Australia, "Who makes the most appointments?" and the answer is always, "Mom."

I know people don't like talking about the difference between men and women for fear they'll be labeled "sexist." But the fact remains, men and women are different. I am not an anthropologist. I don't make any claims to be an evolutionary biologist. I don't know why men like to push lawn mowers, hammer nails and fix things, or why women want careers in health care and education, but the bottom line is men and women are just different.

In the 1960s, zoologist Desmond Morris wrote *The Naked Ape,* and showcased the differences between male and female apes. Morris found that for every intersocial contact a male ape has, a female has five. Humans are closely related to apes, and the same ratio can be inferred. You don't even have to do the research or read Morris' book to know this to be true; just look at how your patients interact in your own practice.

When I do a hygiene exam on Mom, I spend twice as much time with her than with Dad because we talk about her teeth, and her daughter's teeth, and her son's teeth, and when Jr. is going to need braces, and why her husband needs to get his two cavities filled because if they become root canals it will cost them $4,000 instead of $400. Women are much more social than men, and she makes all of the medical decisions in the household! I firmly believe that we are not a paternal society order animal. I think humans have much in common with whales. If you study whales, the female, who is half the size of the male, swims out in front and calls out orders for the males to follow as they migrate from Hawaii to Alaska and back. In the whale world, Mom is the boss. In economics – especially in health care and education – we live in a female-dominated society. And because Mom makes almost 90 percent of the dental appointments, shouldn't you focus your practice on her?

Building Rapport

One of my biggest pet peeves is when the dentist numbs up Mom, and then goes back to his private office for 10 minutes to read the paper and drink coffee. *Why aren't you in that operatory building a relationship with Mom?!* You might have graduated *summa cum laude* from the most prestigious dental school on the planet. You might be the best dentist in the world. But that's not going to keep Mom in the chair. That's not going to entice Mom to refer you to all her friends. You know what will? Getting to know her. Staying with her. Answering any and all of her questions. Explaining to her what she's going to experience. Earning her trust. Credentials are necessary, but even more necessary for the life of your practice is building that rapport with Mom!

First Impressions

And what about your Web site? How well are you coming across to Mom who is checking you and your practice out for the first time? Take a good look at your Web site. Does it promote your training at the Pankey Institute? Does it say you attended LVI or the Scottsdale Center for Advanced Dentistry? Is there a mention on there about your Fellowship from the Academy of General Dentistry? There is? That's all well and good, but why is that information on your Web site? Who does it serve? These days, your Web site is likely the first thing Mom checks out when she wants to learn about you. All of those credentials are outstanding, don't get me wrong, but does Mom really care about all that stuff? Do you even think she knows what LVI or Pankey is? Look, Mom knows you're a dentist. She already assumes you know how to do crowns and fillings and root canals. She wants to know if you're a good person. She wants to be assured that she can trust you. She wants to know what other patients have to say about you *(on a related note, if you want to read more about online practice reviews, check out Dr. Thomas Giacobbi's Professional Courtesy column this month, "The False Feedback Loop").* Mom wants to know if you're married, if you have kids, and where you were born and raised. Are there pictures of you and your family on your site? Why not? Most dental practice Web sites I see are written by dentists for *other dentists* – not Mom. You have to show your patients your human side.

continued on page 14

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Mastering Google

The Yellow Pages are dead and buried. They have been for almost a decade. I don't understand why some of you feel the need to get out the shovels every year and dig it back up! Ask every patient what he or she uses to look something up and I bet you'll hear "Google" almost every time. Google is the most powerful Web site on the planet! It's the first thing Mom thinks of every time she wants to search for something on the Internet.

Google searches are just mind blowing to me. When someone types in "dentist" and your hometown, the first name that comes up in the search gets something like three times as many clicks as the second option down, which gets maybe four times as many clicks as the third click and the third click gets like five times as many clicks as the fourth click. It is like an upside-down pyramid. All the action is on the first or second person that comes up.

Did you know you can buy those first clicks? Visit the Google homepage and you'll find a little word under the search bar that reads "Advertising." When you buy first clicks those are the little green listings at the very top above the search-optimized blue listings. At a recent lecture, I asked woman after woman after woman which listing they clicked and they always say, "The first one." I clarified and asked whether they clicked on the blue listing or the green listing at the very top. Each one told me "the green one at the very top."

Facebook

At one of my recent lectures, I asked all of the women in the audience to raise their hands. Then I asked all of the women to keep their hands raised if they use Facebook. Not a single hand went down. So I walked around the room and asked, "How often do you check Facebook?" And everyone I asked would cover their faces or start giggling, but the average answer was somewhere around five times a day. Then I asked the men how many of them use Facebook. I'd say maybe 10 percent of the guys in the crowd raised their hands. Some of them registered for Facebook but haven't signed back on since. Women are communicators – that's how they're wired. So it's no surprise to me to know that women dig Facebook, which is an outstanding avenue to mass communicate!

So if Mom is on Facebook, why aren't you? Seriously, get your practice on Facebook. When Mom's in the office, ask her to "like" you on Facebook. Put up a placard on the front desk or a sign on your front window that reads "Find us on Facebook" and include your direct URL link where your practice can be found. This will keep you in constant communication with your patients. Today's Dental has a Facebook account (http://www.facebook.com/todaysdental). We've put up videos promoting oral health and comments we've received from patients. Say you just returned from a sleep medicine seminar and you're planning on implementing sleep studies into your practice. Put a note up on Facebook about what you just did, like, "Dr. Smith just returned from a two-day course on snoring. Do you snore? Make an appointment today and we'll get you on your way to silent sleep"… or something like that. Or maybe you want to offer a deal of the week, like $50 off bleaching – you can inform your Facebook followers of that. And how much did that cost you? Nothing. Don't know where or how to get started? Check out Dr. Jason Lipscomb's updated book *Social Media for Dentists 2.0* (www.socialmediadentist.com) – it's a great resource to get you started.

Building your relationship with Mom is key these days. Mom is your word-of-mouth generator. Mom is the head of the household. Mom gets the kids and Dad in for their appointments. You need to be where Mom is – on the Internet, on Google and on Facebook.

And hey doc, quit being so proud. When Mom is checking out, why don't you reach behind the counter, grab five of your business cards and give them to her. Why don't you tell her, "These are for your five best friends. I promise I'll take as good of care with them as I do with you." What does it hurt to ask for referrals when your patients love, trust and respect you? ■

Howard Live

Howard Farran, DDS, MBA, MAGD, is an international speaker who has written dozens of published articles. To schedule Howard to speak to your next national, state or local dental meeting, e-mail colleen@farranmedia.com.

Dr. Farran's next speaking engagement is **January 22, 2010, at the Vegas Implant Symposium in Las Vegas, Nevada.** For more information, please call Colleen at 480-445-9712.

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The False Feedback Loop

by Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

In a world where some kids play soccer and don't keep score, it can be difficult to get honest feedback. I first noticed this disturbing trend when I purchased a new car four years ago and the agent for the dealership was very clear that they wanted a perfect score on the evaluation that would come from the auto manufacturer. If they did not earn a perfect score, they wanted to know so they could correct the matter so I could tell their parent company they were perfect. Is this really a method for honest feedback? I'm sure you could name other instances where you were put on the spot to provide a perfect rating or someone would be personally affected.

We live in a world where the ability to rate and provide feedback on every product and service we experience is possible. There are entire Web sites dedicated to the process and your online reputation has become a difficult tiger to tame. So much importance has been placed on having reviews of your business online that it has launched a cottage industry of businesses that will assist you with managing your online reputation. A recent article in *The New York Times* described how an online merchant climbed to the top of many Google search results by garnering as many negative reviews as possible. Yes, negative reviews; he claims in the article that he discovered an increase in business the more he was reviewed online.[1] While I would not advocate this approach, it is an indication that online reviews are not yet a perfect science.

> *"We live in a world where the ability to rate and provide feedback on every product and service we experience is possible."*

The anonymity of reviews is the most obvious hole in the current system. They allow malicious individuals or competitors to post things that are not true. Many of the major review aggregators have processes to remove these fraudulent posts, but it can be a difficult process. By the same token, people have been accused of posting reviews of their own business to improve their rating. Most reputation firms subscribe to the old adage: the best defense is a good offense. In other words, ask people to post the truth about how great your business really is and the negative reviews become insignificant. Others might choose to ignore this trend completely, but that is a short-term strategy in my opinion. Just ask any dentist who said having a Web site was a waste of time.

While you do not need to become obsessed with your online reputation, you should be monitoring the major sites that list dentists. I provided a very comprehensive list in my December 2009 column, which is archived on Dentaltown.com. Encourage your patients to visit these sites and share feedback about your practice. If you prefer a more formal approach, many of the appointment reminder companies can automatically send an electronic feedback form to your practice after their appointment. In this case, the results are for your internal use and benefit. However, if you already have a smoothly running practice, the feedback link could point your patient directly to one of the online review sites.

One final thought on this process: don't be afraid of some less-than-positive feedback. Some review-generating partners will allow you to view a review before it is public, and I'm told that some users will fall into the trap that they only allow the five-star reviews to come through. When I read reviews online, if there isn't a bit of criticism about the product or service, I'm immediately suspicious of the entire batch of reviews.

Do you have a personal experience to share with the online review process? Share it on Dentaltown.com. Your comments and suggestions for future topics are always welcome: tom@dentaltown.com. ■

1. *http://www.nytimes.com/2010/11/28/business/28borker.html?pagewanted=all*

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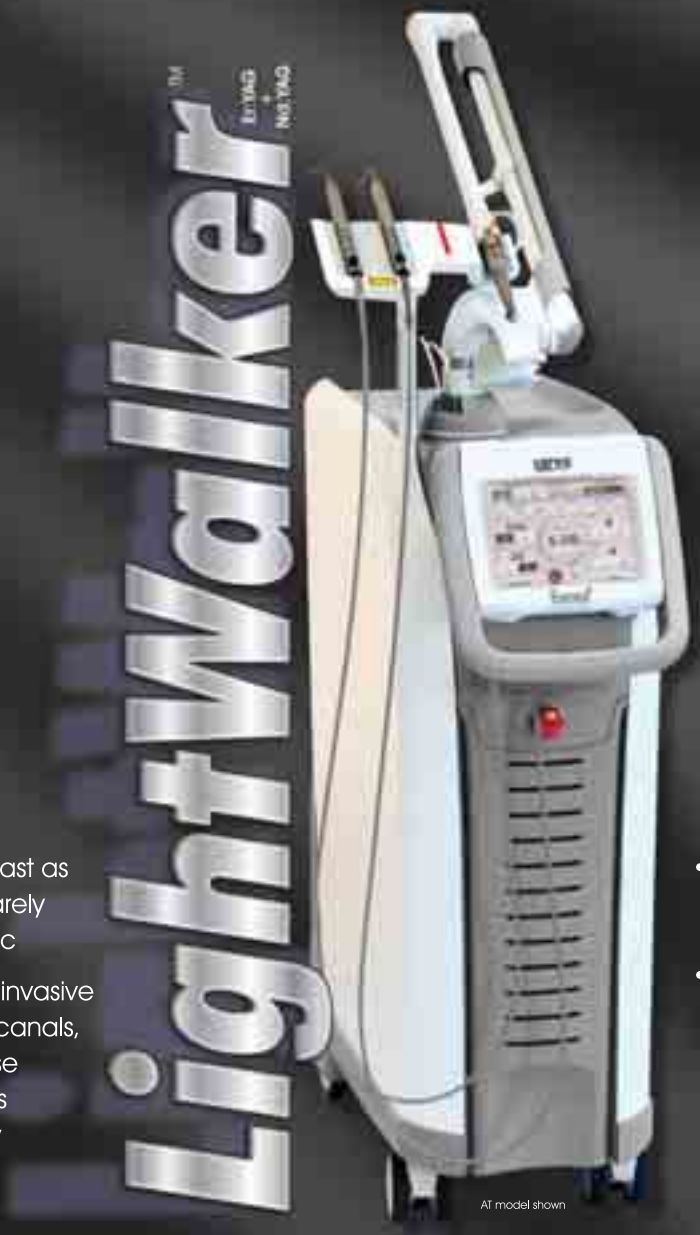

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1. *Journal of Applied Microbiology*, 2009; 107: 682-690.

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Dental Sleep Medicine – The Time Is Now

by Gy Yatros, DMD

Second opinions are common in health care; whether a doctor is sorting out a difficult case or a patient is not sure what to do next. In the context of our magazine, the first opinion will always belong to the reader. This feature will allow fellow dental professionals to share their opinions on various topics, providing you with a "Second Opinion." Perhaps some of these observations will change your mind; while others will solidify your position. In the end, our goal is to create discussion and debate to enrich our profession. — Thomas Giacobbi, DDS, FAGD, Editorial Director, *Dentaltown Magazine*

My timing can be remarkably bad. I bought tech stocks, and then watched the dot-com bubble burst. I purchased "investment properties" just before the mortgage meltdown. But the one thing I know I've done right is getting my dental practice involved in the treatment of snoring and sleep apnea. I've lowered my stress level, grown my practice income steadily throughout the recession (while other dentists in my area are down 30-50 percent) and, most importantly, I've been saving lives.

I have been a dentist for more than 20 years, but treating patients with snoring and obstructive sleep apnea (OSA) throughout the last 10 years has been the most gratifying time in my career. I'll never forget when my grumpiest, sleep apnea-suffering patient came into my office with tears in his eyes. I thought he was going to punch me – but instead he hugged me and, overcome with emotion, thanked me for how I had changed his life.

Dental sleep medicine is the fastest growing area in dentistry, and for good reason. Dentists are not just tooth doctors anymore. Research continues to elucidate the connection between poor oral health and poor general health. Sleep is among the hottest topics in both dentistry and medicine. You can't pick up a trade journal or grocery store magazine these days without seeing an article on some sleep-related topic. Dentists are the perfect health-care providers to recognize, screen for, lead patients toward testing and treat this progressive disease. The opportunities for personal satisfaction and financial growth in this field are tremendous.

Pathophysiology of Obstructive Sleep Apnea (OSA)

A partial or complete closure of the upper airway during sleep, from a few seconds to more than a minute, depletes the blood of oxygen and disrupts sleep. Normal airway patency is restored after activation of the sympathetic nervous system and increased respiratory effort. Apneas (no air moving at all) and hypopneas (labored, decreased air movement) are added together and indexed per hour of sleep, resulting in an Apnea Hypopnea Index (AHI). Mild (AHI 5-15), Moderate (AHI 15-30) and Severe (AHI > 30) OSA is diagnosed by physicians who read the raw data from a full sleep study (polysomnogram) or a home sleep test (HST). Signs and symptoms of sleep apnea include snoring, excessive daytime sleepiness (EDS), gastro esophageal reflux disease (GERD), mood swings, impotence, morning headaches, insulin resistance, decreased mentation, glucose intolerance, increased risk of auto accidents and an overall decreased quality of life.[1] Cardiovascular consequences include hypertension, congestive heart failure, myocardial ischemia and infarction and stroke.[2]

The Problem – Many Have It, But Few Know About It

Medical students get, on average, about an hour of lecture about sleep medicine. Fewer than half of all dental schools offer a one-hour "elective" course on the subject to their dental students. If doctors and dentists don't know about sleep apnea, how can we expect our patients to know? If you work in a dental office, you now have a unique opportunity to save lives through the recognition and treatment of sleep apnea in your patients.

Studies have estimated that as many as one in five adults has moderate OSA,[3] and that more than 90 percent of people with OSA might not know they have it.[4] This means there might be more than *30 million patients* in the United States who don't know they have OSA. If you have 2,000 adult patients in your practice, then you might have close to 350 patients who have sleep apnea *and don't even know it.* And *you* can help them feel better and live longer. Talk about being in the right place at the right time!

continued on page 22

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continued from page 20

Treatment Options for OSA

Continuous positive airway pressure, or CPAP, pneumatically "splints" the upper airway open during sleep. Although CPAP is the current preferred treatment among our physician colleagues,[5] it is a real inconvenience to wear – the mask, hoses, leaks and noise often result in poor compliance.[6] Poor compliance is considered to be the major drawback of CPAP; the more side effects a patient incurs with CPAP use, the less likely he or she is to utilize it.[7]

Surgical options for the treatment of OSA include operating on any part of the upper airway, basically from the nose and mouth down to about the Adam's apple. Surgical interventions are normally reserved for patients on which conservative measures have failed (gross anatomic abnormalities being the exception). Surgeries aimed solely at soft tissue reduction (UPPP, tonsillectomy), although only moderately successful, remain popular in many circles today. Relapse occurs in a significant proportion of initially successfully treated patients.[8] More encouraging results have been realized with surgeries that reposition soft tissue by means of skeletal modifications, including genioglossal advancement, hyoidthyroidpexia or maxillomandibular advancement surgery,[9] but all of these surgeries carry substantial risk.

Oral appliance therapy continues to gain popularity as an alternative to CPAP and surgery.[10] Oral appliance therapy (also called dental device therapy) aims to reposition the mandible, tongue and pharyngeal structures, thereby preventing collapsibility of the upper airway during sleep. Patients tend to prefer oral appliances to CPAP in most randomized trials.[11,12] In fact, a literature review in February 2006 of *Sleep* states: "Oral appliances (OAs) are indicated for use in patients with mild to moderate OSA who prefer them to CPAP therapy, or who do not respond to, are not appropriate candidates for or who fail treatment attempts with CPAP."[13] As the primary providers of oral appliances for OSA, dentists are in a unique position to offer these less invasive, nonsurgical treatment options to their patients.

Functional Classification of Oral Appliances

There are three basic functional classifications of oral appliances. They are mandibular advancement devices (MADs), tongue retaining devices (TRDs) and combination CPAP/dental device therapy.

Mandibular advancement devices (MADs) comprise the majority of devices used by dentists. There are approximately 30 dental devices that have FDA approval for the treatment of snoring and sleep apnea. They vary in materials, method of retention and advancement mechanism. Research comparing one appliance to another is severely inadequate in our field.

Fig. 1: CPAP device used in the treatment of OSA.

Fig. 2: Oral Appliance (left) versus CPAP (right). Which do you think your patients will prefer?

Fig. 3: SomnoMed dorsal design oral appliance made by SomnoDent.

Fig. 4: TAP 3 appliance made by Airway Management, Inc.

Fig. 5: SUAD appliance made by Strong Dental.

Fig. 6: Patient wearing his SUAD mandibular advancement device.

Fig. 7: Aveo tongue retaining device made by Glidewell Laboratories.

Fig. 8: This is one of the easiest things to get your patients to say "yes" to in your practice.

continued on page 24

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continued from page 22

However, custom-made, adjustable dental devices have been shown to be as or more effective than CPAP at treating non-severe OSA.[14]

What works best in your hands and comfort for the patient are of paramount importance. That being said, some of my most used dental devices include the dorsal design (SomnoDent and Respire Medical), the EMA, the TAP3 and the SUAD.

Tongue retaining devices (TRDs) directly manipulate the tongue to dilate the airway. They are much more difficult to accommodate and are therefore used less frequently. They can be utilized when patients have inadequate dentition, severe TMJ problems or as a temporary appliance during restorative dental work.

Combination CPAP/dental devices (hybrid therapy) is reserved for severe OSA, patients who have had problems with CPAP or patients who were not treated successfully with a dental device alone. Hybrid therapy is a great opportunity to work with medical professionals in your area. Hybrid therapy results in lower CPAP pressures, fewer mask leaks and the ability to use masks without straps.

How to Become Involved

If you want to start treating snoring and OSA in your practice, I highly recommend you first become educated on the subject. There are many resources at your fingertips.

For formalized training, the American Academy of Dental Sleep Medicine (AADSM) is a good place to start (www.aadsm.org). The AADSM is the fastest growing sleep organization in the country; membership comes with many perks, and they offer educational courses about three times a year. I also encourage you to work toward becoming a diplomate of the American Board of Dental Sleep Medicine (ABDSM).

What Are You Waiting For?

There has never been a better time to become involved in the treatment of snoring and sleep apnea, and never before have dentists been able to serve as a first line of treatment for patients diagnosed with sleep apnea. This is truly one of the easiest services to get patients to say "yes" to in your practice. Most people would prefer a dental device over any other viable treatment option for OSA. We just need more dentists who are properly trained to help deliver this service and become leaders in the field.

Not only is treating snoring and OSA rewarding to you and your patients, but you can also create higher profit margins with an easier workload in your practice. To sum up my experience: becoming involved in dental sleep medicine is financially rewarding, physically non-demanding and provides the best opportunity for patient gratification (more than anything else in dentistry) So what's stopping you? Whether you just screen patients and help them get diagnosed, or you decide to dedicate your practice solely to dental sleep medicine, please just do it! We need to educate ourselves and the public, and I promise you (and your patients) won't regret it. ■

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Author's Bio

Dr. Gy Yatros has been in private practice on Anna Maria Island, Florida, since 1992 and also has offices in Sarasota and Tampa where he practices sleep dentistry exclusively. He is an international lecturer on the subject of dental sleep medicine and speaks throughout the country for Sleep Group Solutions. Dr. Yatros is a diplomate of the ABDSM, past president of the Manatee Dental Society, and is an affiliate assistant professor of the Department of Internal Medicine with the University of South Florida, College of Medicine. He is co-founder, along with Dr. Richard Drake, of Dental Sleep Solutions, Franchising LLC. For more information, or to contact Dr. Yatros, please visit www.dentalsleepsolutions.com.

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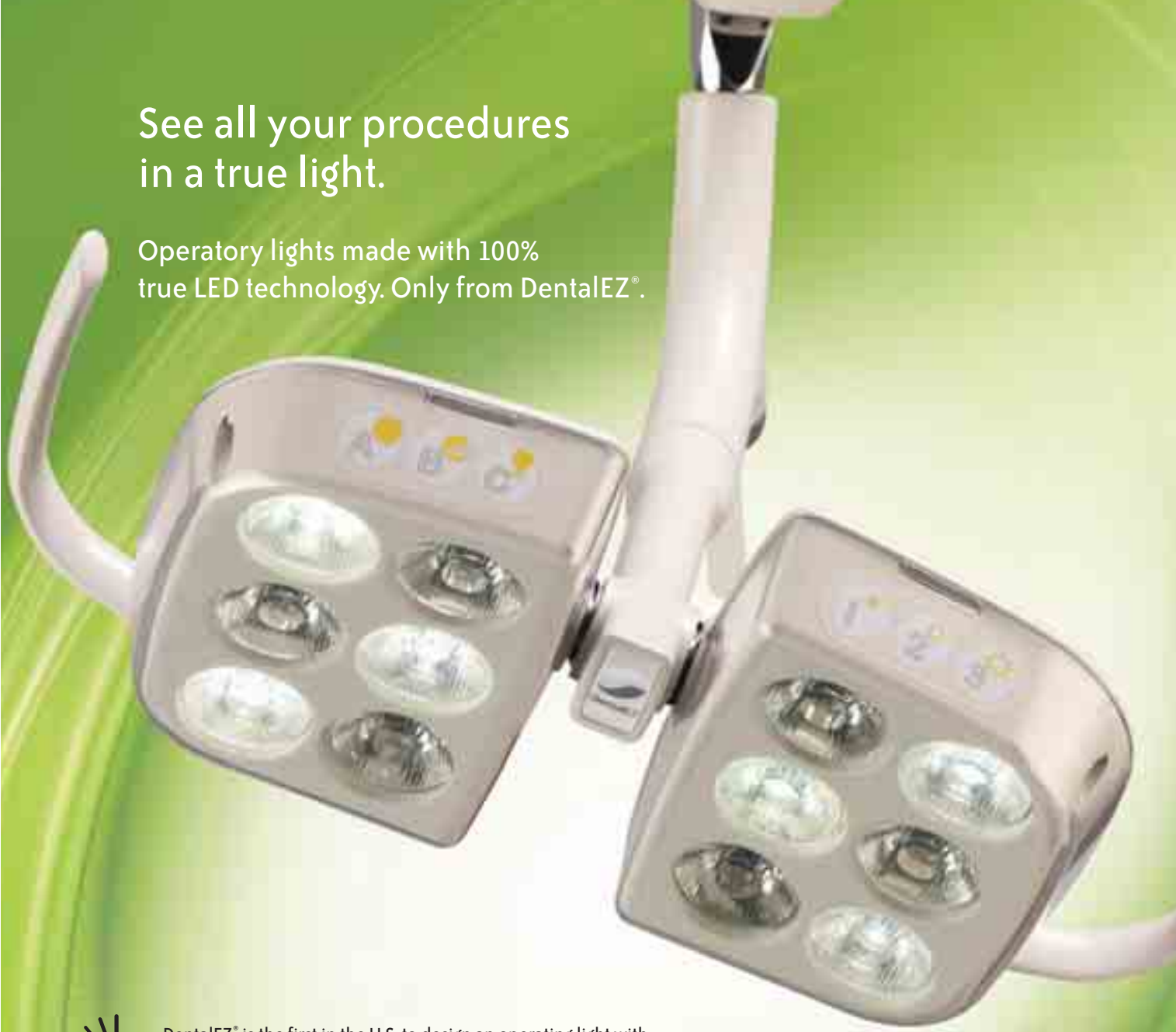

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Dental News in Brief

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GC America, Inc., Expands Manufacturing Facility

GC America, Inc., (GCA) recently held a grand opening ceremony for its expansion and renovation project in Alsip, Illinois. A 40-year resident in Alsip's industrial community, GCA expanded its manufacturing facility by 25 percent to 100,000 square feet. The new facility includes a state-of-the-art manufacturing plant. GC Corporation has transplanted its dental stone manufacturing plant from Japan to Alsip. This move increased production in the United States, and expanded employment opportunities directly and indirectly, making GCA a leading global manufacturer. Visit www.gcamerica.com for more information.

Oral Health America's Gala Returns to Field Museum

Reservations are now being accepted for the 21st Annual Oral Health America (OHA) Gala & Benefit Dinner, to be held Wednesday, February 23, 2011. The event is returning to the spectacular Field Museum with a new theme, "Celebrating *You* and *Your* Commitment to Oral Health." The black-tie optional evening features a cocktail reception, four-course dinner and dancing with live music. If purchased by January 15, tickets are $300 each or a table for 10 can be purchased for $2,750. To purchase tickets or sponsorships, or for additional information contact Joe Donohue at OHA by calling 312-836-9900 or joe@oralhealthamerica.org. Find out more at www.oralhealthamerica.org.

Osteogenics Biomedical Announces the 2011 Global Bone Grafting Symposium

Unique for its focus on dental bone grafting and treatment planning, the 2011 Global Bone Grafting Symposium will be held March 31 through April 2, 2011, at the Westin Kierland Resort and Spa in Scottsdale, Arizona. The symposium will feature a guided bone regeneration surgery live broadcast by Dr. Paul Fugazzotto, optional hands-on workshops, and presentations by world-renowned speakers. Symposium speakers include Dr. Suzanne Caudry, Dr. Barry Bartee, Dr. Tom Wilson, Dr. Paulo Coelho, Dr. Sascha Jovanovic, Dr. Istvan Urban, Dr. Dan Cullum and Dr. Craig Misch. For more information on Osteogenics' 2011 Global Bone Grafting Symposium visit www.osteogenics.com/courses, or call 888-796-1923.

DentalEZ Group Presents DEZiree, Star Hygienist

DentalEZ Group introduces DEZiree the Dental Hygienist. DEZiree is the star of a new video blog recently created by the DentalEZ Group called "The DEZiree Show." DEZiree will star in a weekly video blog which interested hygienists and dental professionals can opt-in to view through weekly e-mails. The blog provides weekly updates of 30- to 90-second video segments with useful information and news regarding topics solely geared toward the dental hygiene profession. To sign up for "The DEZiree Show" weekly newsletter, or for more information visit www.thedezireeshow.com.

New Patients Are Your Future

Case Study #44
James Segulyev, DDS
Burbank, CA

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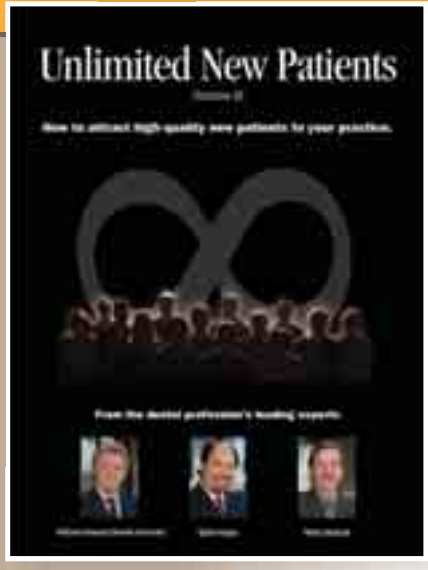

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Tips on Extractions

Extractions for kids are different. What tips or tricks do you use to make the experience better?

Workinghard
Posted: 11/10/2010
Post: 1 of 24

Thanks for all the tips on my previous thread on pulps/ssc and child management. The fingernail and shaking of the cheek has helped out tremendously.

I do find that extractions are still really difficult in my hands. Child will start crying and not cooperate. For example, today, started taking out #I. Broke off. Crying before and after. I go in to take the roots out. Mesial root out, kid screams. Decide to leave the distal one in there for now. Small amount budded up against permanent tooth. Thinking it will resorb or make its way out.

Used lido to numb, on buccal and palatal, around the gingiva. Did a pulp/ssc on other tooth prior to extraction. The restorative portion went really well.

How do you guys do extractions on kids? What wording? What technique? Fast versus slow?

We've started seeing more kids because the pedodontists in our area have stopped taking new Medicaid children.

Thanks. ■

jonlindblomdds
Posted: 11/10/2010
Post: 2 & 3 of 24

Profound anesthesia!

This is obvious, but I still feel that it's often overlooked when dealing with kids. By and large, children are not fussy with "pressure," but are fussy with pain. I can't really remember the last time a kiddo cried during an extraction (older than two). I always tell a short story about how teeth sometimes act like Rice Krispies. They can make snap, crackle, pop sounds and sometimes if they're lucky, we can hear all three! This way they understand that the sounds are normal, and actually the more sounds, the better! Prior to using forceps, I usually go around the tooth with a plastic instrument releasing gingival fibers – if they whine during this part, they are not numb! I do this only to check for profound anesthesia as primary teeth are pretty easy to remove without this step.

Also, if you're completing multiple quads of restorative work (or maybe you're just a little slower) the profound anesthesia that you initially had is wearing off. I usually perform extractions at the end of the appointment and if it's been a long appointment, they might need more local before the extraction. Good luck! ■

workinghard
Posted: 11/10/2010
Post: 4 of 24

I administered the extra anesthetic prior to extracting. I go around the tooth with a periosteal elevator to relieve the soft tissue. When you guys go to extract it, do you try to wiggle firmly or softly until it comes out?

Another dentist told me, once you have a hold, don't let go, because sometimes they won't let you back in. I do find that after trying and then going back in to try again, it is generally not successful. ■

mbullock79
Posted: 11/10/2010
Post: 5 of 24

Disclaimer: I am not a pedodontist

I tell the child that I am going to teach their tooth a new dance. It is called the wiggle, wiggle, shake, shake dance. While I am elevating I say wiggle wiggle. Then

continued on page 30

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continued from page 28

with the forceps I tell them I am shaking their tooth out. Sometimes I even sing a little song while I do it. "Shake, shake, shake… shake, shake, shake... shake your tooth, shake your tooth" (tune is the 90s song, "Shake Your Booty"). Most kids (and their parents) find this silly.

With that said, I always, always warn mom that some kids are just going to scream no matter how numb they are because they don't like the pressure. ■

ncj1978
Posted: 11/10/2010
Post: 6 of 24

I had one little whiny kid today for an extraction of S. I gave about 3/4 carp septo for block and buccal infiltration, and then right before I got started, blanched the tissue B and L with the rest just to make sure. I usually use a luxator as much as possible and then I tell them I need to use the old "wiggleometer" to see how loose it is. Yank that sucker out and make a show of how that was at least a 10 on the "wiggleometer." Works as well as anything I have done in the past. By the way my forcep is the wiggleometer if you can't figure that out. ■

NEDMD
Posted: 11/10/2010
Post: 7 of 24

I haven't had kids who cried during luxation in a long time. My secret is nitrous (almost always even for good kids) and profound anesthesia. I always elevate and I'm slow but firm with the forceps. Maybe one in 100 extractions results in a root tip breaking. Very seldom. ■

kiddent
Posted: 11/10/2010
Post: 9 of 24

Kids have a limit on how much they can take. If you did another op in the quadrant and then the extraction turned into something a bit more than a typical wiggle, there's a good chance they were just fed up and tired of being in the chair. Are you using nitrous? If not, and you continue to see kids, get it. You can charge out for it, and it will be the best decision you make.

To prevent breaking the tooth I don't reach for the forceps until it's rocking in place. I really elevate a lot, and I'll have the kids take a deep sniff while I elevate for a few seconds, then when they exhale I let go. We repeat this song and dance until I'm ready to get it out.

Remember the pedo roots are flared and it takes some finesse. Many times you need to roll it either buccally or lingually to get around the flared roots.

Profound anesthesia is the key. Experience will allow you to tell the difference between pain from elevation or pressure, and actual sharp pain. If their cry changes in intensity, chances are they are not numb enough. Remember that the palatal root can be large; make sure you get pretty far down on the palate. Also, if it is abscessed, it is acidic and the local won't work as well. ■

irish02
Posted: 11/10/2010
Post: 10 of 24

1. Profound anesthesia
2. I use a hollenback as my periosteal elevator.
3. Elevator
4. Adult forceps... if I cannot elevate the tooth out ■

workinghard
Posted: 11/11/2010
Post: 14 of 24

Thanks for the tip kiddent. I was not using nitrous. I'm going to start using it more often on children. I always tell mom, we'll try without, but I might be changing my tone. Your tip on the "fingernail" and shaking has done wonders for us! I just tell the kid, we're going to shake your cheek to sleep, and oops my fingernail hit you, let me move it. Works just about every time. ■

continued on page 32

FREE FACTS, circle 21 on card

continued from page 30

kiddent
Posted: 11/11/2010
Post: 22 of 24

If you like what you're reading, check out this related message board...

STA for Pediatric Patients
Search: ***STA for Pediatric***

Here's the key to pediatric dentistry. Really, in my opinion, this is one of the most critical lessons to learn: Once you lose a child it is extremely difficult to get them back. The key is in preventing them from losing it in the first place.

Meaning, if you wait until they need the nitrous (crying, negative behavior) you've already lost them and even the best pediatric dentist will have a tough time getting them back. What nitrous does is prevents that from happening in most cases. Sure, a lot of kids can do fine without it. And sure, you probably know which ones need more than nitrous. But it's very hard to predict the ones that might lose it mid-treatment. Who knows why it is… bad taste, loud sound, etc. Whatever it is, you just lost them and your day just got tougher. So use nitrous on all kids eight or seven and younger and then you rarely run into this problem.

I, too, let it run all day. I rarely do ops without it. Usually it's a parental concern, and with that 99 percent of the time it's a financial issue (if I think their kid needs it I will do it gratis). I'd rather burn some nitrous and make my life easier than withhold and wish I hadn't.

Regarding the elevation of teeth we are extracting, there was a good thread on it last year. I believe I was in the minority in regards to elevating before extracting. ■

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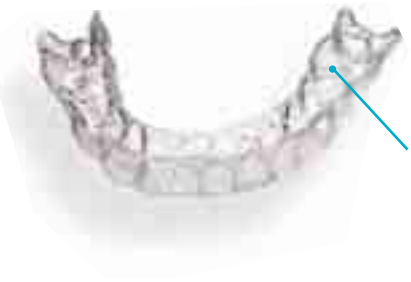

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Specialist Keeps Our Patients After Referral

When you send a child to the pediatric dentist for treatment, do you expect them to stay for all of their hygiene visits as well? How do you best communicate what is expected from the specialist?

sjaques
Posted: 11/3/2010
Post: 1 of 55

We see a lot of children in our rural practice and take care of most of them in house. The tough ones that need sedation are referred out. I began using a new specialist about 25 miles from us (closest one) and I went by the office to say hello and to stress that if we referred these children it would just be for restorative and we would keep them in our recall system. Just recently when trying to set two of them up for cleanings, we were informed it was being done at the specialist's office. When I wrote a letter reminding the specialist that I had specifically asked to have the patient returned and that I would look elsewhere for care, I got a note back saying that they couldn't ethically or legally refuse to see them. What do you think of this? What would you do? ■

gdersley
Posted: 11/3/2010
Post: 2 of 55

If I'm not able to treat a patient for whatever reason, it makes sense to me to have the dentist who can treat the patient be the one who maintains their health as well. ■

kiddent
Posted: 11/3/2010
Post: 3 of 55

I think you've made your point clear and have done so professionally. From his response, it certainly sounds like parents are choosing to stay at his office. That's a big difference versus him telling them to stay on board. We receive referrals, like your source, from many miles away since I am in a rural practice. Some choose to stay on with us and some choose to go back, but I always tell them they are welcome to and should follow up with the referring doctor. We can't force them to return. I wouldn't get too bent out of shape over it. ■

sjaques
Posted: 11/3/2010
Post: 4 of 55

I am upset because we already had a history of providing preventive care and now this patient is lost to our practice forever. In one instance the cleaning was done at the operative appointment and I am not getting the impression from the mom that she requested this. I thought when you referred to a specialist they provided the treatment requested and then returned the patient. Just like a dentist who sees a patient on an emergency basis. We always take care of the emergency and then tell them to go back to their dentist of record.

I am also upset because I asked upfront to have the patient returned and the specialist said that would not be a problem.

If I sent a patient for a graft to the periodontist, I would not expect them to be incorporated into their recall system. I don't see how this is different. Doesn't seem ethical to me. ■

continued on page 36

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kiddent32
Posted: 11/3/2010
Post: 5 of 55

This is a tough call, but while the specialist is absolutely correct (if the parent did in fact request), the issue is simply whether he/she has given you any reason to think that he/she made an overt effort to get the patient into recalls. I encounter the same issue (as a pediatric dentist). When GPs refer patients to me, I try to make an effort to determine if they are referring for a limited purpose or for comprehensive and continuing treatment. In those situations where the GP indicates that he/she would like to see the child again, I make a point of indicating to the parent that "Dr. Smith will be seeing Johnny in six months and I'm sure Dr. Smith will make sure to follow this or that." But then the tricky part starts. I hope this doesn't seem arrogant, but often (and certainly not always) the parent realizes that they were referred to me because frankly, I offer a service that the GP did not. And often, the parent simply says "I would really prefer that Johnny comes to see you, because I see that you can do this or that, and Johnny wouldn't even open his mouth for Dr. Smith." Or "Now that I've seen your gorgeous kid-themed office, I know Johnny would rather come here in the future." Even at this point, I will say "I am sure Dr. Smith can take care of Johnny from here-on" but usually by the time the parent tells me that she wants the child to be seen by me, my comments will fall on deaf ears. At that point, I will in fact see the patient six months later if they insist.

Don't get me wrong; although I am flattered by this, it doesn't always sit well. I am actually glad when patients go back to the referring doctor because then he/she realizes that the 60 percent of the time that they don't go back, it's not because I did anything overt to "take" the patient other than impressing the parent with the care. I am very cognizant of "burning" my referral sources. But realistically bear in mind that many parents will mention to the receptionist "why would I go back to Dr. Smith if he'll send me back here as soon as a problem shows up?" and as a parent, I can't really rebut that.

Even as a pediatric specialist, I, too, have had the same thing happen – a patient who asked that all operative work be done by a female dentist and then although she was very thankful for the referral to a female colleague, called to transfer records. I have to say that was a logical decision on her part and she actually referred other patients to me despite taking her kids elsewhere (they were twins; one needed operative and mom felt that her kids would only be calm for a female due to a fear of males). Or when I first opened and was not fully equipped, I referred an autistic patient for sedation in a colleague's office. Totally logical of them to stay there and I can't blame them.

Hopefully this gives some additional perspective. It does come down to trusting the referral source. If you have no reason not to believe him/her, I would err on the side of caution in judging what happened. Maybe have someone on your staff ask the parent "What happened? We'll miss you!" and judge from the response whether it's the parent more than the specialist who was responsible for the choice. The parent might be bashful about saying so, but it might very well have been her choice. ■

Read about what other Townies are saying about referring to specialists.

Jack of All Trades Lose Patients
Search: *Jack of All Trades*

Specialist Bad Mouthing the Referring Doc
Search: *Bad Mouthing*

canslip
Posted: 11/3/2010
Post: 6 of 55

This is not at all like a perio referral. You are referring for comprehensive care. The dentist who will be treating any future problems should be the one doing the checkups and diagnosing those problems. I think it is inconsiderate of you to insist that your patient return to you for cleanings, subjecting them to extra visits should work be needed. My kids would stay with the specialist once he/she did the work and that is what I recommend to my patients. ■

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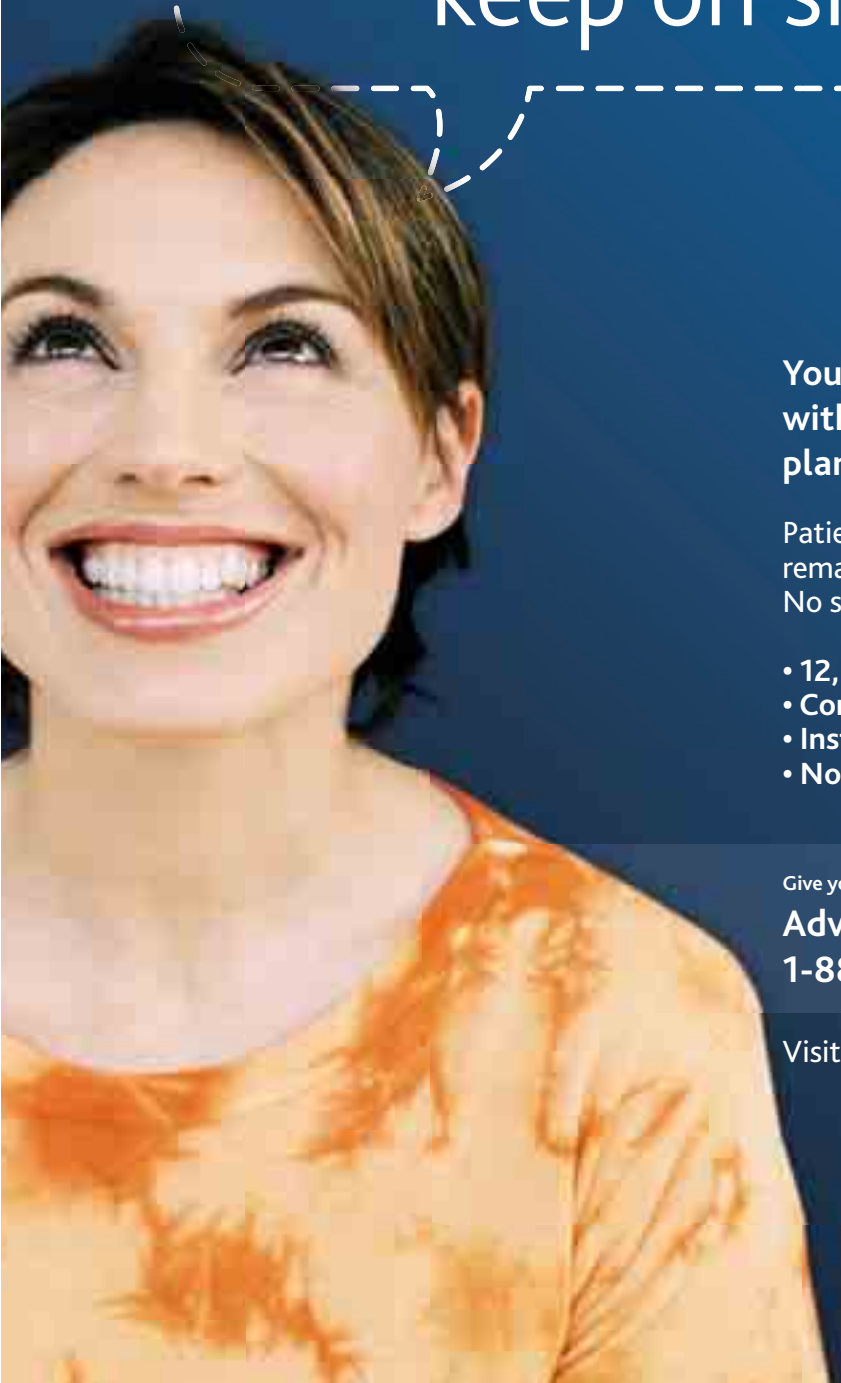

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sjaques
Posted: 11/3/2010
Post: 7 of 55

Thanks kiddent, you went to a lot of trouble to write all that and you are right about all of it. But what I did not go into were some details that make me pretty sure that it was not the mother's idea at all. The specialist made no apology whatsoever for what happened. These were Medicaid children and transportation is generally a big problem. Often mom is working, dad is not around and grandmom has to make arrangements. I actually have most parents begging me to try to treat the child. We are set up for kids – special waiting area, movies playing, booster seats, prizes, nitrous. We have gotten bitewings on some patients that the specialist has been unable to get. So we do provide good care in pleasant surroundings and I expect the specialist to support me by sending them back. All I heard back was a lot of excuses about why they were doing the cleanings. Most of these children will not need to be referred back to a specialist because within a year or two we can handle them in our office and it is not a bad experience for them. I am still shocked at the attitude I encountered. If I had been told at the beginning that they did not operate that way, I would never have sent them there.

To make another analogy, when I refer to the oral surgeon for third molars, he never jumps in and does other extractions. He follows my referral slip and returns the patient.

Thanks for your input and like I said, you are right about how it can play out. ■

DirtyHarry
Posted: 11/3/2010
Post: 9 of 55

You really think the pedodontist should refuse to allow patients to join his practice if that's what the parents want to do? Are you serious?

We invite parents to return to the referring dentist. Many do so. Many ask if we provide routine preventive care. The answer, of course, is yes. I'd have to be insane to tell them that they are not allowed to join our practice because their referring dentist.

It is the parents choice; not yours. If you want them to choose to come back to your practice, give them an experience that is superior to that of the pedodontist. It's called the free market. ■

jbdent
Posted: 11/4/2010
Post: 13 of 55

So you lose a few kiddie prophies, big deal. It's not going to matter that much to your bottom line and eventually these kids are going to work their way back into your office because of the convenience factor. Keep your eye on the ball and treat the parents well and everything will work out fine for you. ■

primaryteeth
Posted: 11/4/2010
Post: 15 of 55

Sounds to me like you have two options. Find a different pediatric dentist, or suck it up. If you are not capable or willing to comprehensively treat the child, then they should be going somewhere else. ■

DFish
Posted: 11/4/2010
Post: 17 of 55

I've said in the past that I'm sensitive to not being branded as one who steals patients. That being said, I still have kids and parents who prefer to stay with our office. When that situation comes up, we tell them we are glad to see them for restorative, but if they want to become patients of our practice they need to talk with the referring dentist and tell them why they want to switch and request a records transfer.

This has helped in minimizing issues with referring dentists. ■

sjaques
Posted: 11/4/2010
Post: 18 of 55

OK. Let me clear up a few things.

I called the mom 10 minutes ago. I said I wanted to follow up on the children's visit with the specialist. Mom said they are doing great. I then told her I was a

little surprised that they were going back there for their cleaning. Mom said, "Oh, they just went ahead and cleaned them and then made them an appointment in six months. And they told me my other son might as well come in with them too." We had not referred him. Then I told her that we would be happy to see them here if she would like. "Oh yes," she said, "you are only 10 minutes and they are 40 minutes." She said, "I thought they would send me back to you too." I asked if she was satisfied with our services and if her children had any problems with the office... no was the answer. So then I told her we would be happy to keep them in our system.

This is exactly what I suspected.

We treat the vast majority of kids who come in the door. I just finished a restoration on L on a three-year-old. Patient was fine! No crying and left happy. So I am very willing and very capable of treating my patients. I was upset because I made a point of asking for the children to be returned and I had the strong impression that this did not happen. If I am capable of diagnosing and referring in the first place, I can certainly re-refer if necessary. ■

operculum
Posted: 11/4/2010
Post: 37 of 55

From what I understand:

1. The GP referred to the pediatric dentist for sedation that the GP could not offer.
2. The GP had spoken with the specialist prior to any referrals. Why didn't the specialist at that time state that ethically she would not be returning the patient to the GP for comprehensive care that does not require sedation?

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3. Logistically, why would the mother/grandmother/caregiver drive 40 minutes to the specialist for care versus 10 minutes to the GP as they have been doing?
4. If the mother/grandmother/caregiver decided to stay at the specialist's office for comprehensive care, why didn't the specialist contact the GP and explain the situation?

I refer to specialists frequently. When it comes to pediatric patients, my pediatric specialist phones me if a patient's family has decided to have all care performed in his office. I am fine with that and I appreciate the professionalism of the specialist contacting me. While on-call for a friend, I saw a patient who stated she wanted to transfer to me simply because I'm female. I told her I was flattered, but that she was receiving excellent care from Dr. X. I phoned my male friend to inform him of all that happened. The patient came to me after all, but my friend was not upset. In fact, I think he was happy to get rid of her. I called him because it was the right thing to do and I knew he would do the same for me.

What this all boils down to is common courtesy. It isn't an issue of what patient "belongs" to whom. It's being there for each other and communicating especially between GPs and specialists. ■

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Patient Requests Write Off of All Co-payment

This is a valuable discussion which will clear up a common request from your patients, and serve to put others on notice for an all-too-common illegal policy.

johnson
Posted: 11/5/2010
Post: 1 of 44

Here is the scenario. One of our long-time loyal patients called us and indicated she had new insurance. However, her insurance does not cover posterior composite, but covers amalgam. She demanded that we give her the upgrade of posterior composite and not charge her a co-payment. The reason is she had talked to her co-worker, and her dentist wrote off all the co-payment including posterior composite. My staff tried to explain to her we cannot control what other doctors do or don't do, but we cannot write off all the co-payment and go into technical detail about why composite costs more (apparently she could care less). She got really upset and told us she had been coming to our office for seven long years, as are her son-in-law and grandkids because of her. Plus she is really short on cash, etc., etc., and on and on. We are in the Bay Area of California, unemployment rate is pretty high and she was laid off for almost a year and just got a job. I told my staff I have to think about this. What is the best approach to this? I know a lot of dentists in my area write off co-payments just to get patients in the door. ■

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Incorporating Insurance Myths on My Web site
Search: ***Insurance Myths***

jawbreaker
Posted: 11/5/2010
Post: 2 of 44

Well it's not a matter of being "nice" and "sympathetic" to her plight. Writing off a co-pay is illegal! Plain and simple… it's illegal! Tell her you simply can't write off the co-pay because your license to practice could be in jeopardy! ■

eeznogood
Posted: 11/5/2010
Post: 3 of 44

Tell her the best option you can offer her is a payment plan. Tell her you really appreciate her as a patient and wouldn't want to lose her. Explain to her she isn't getting ripped off with what you are doing, but what the others are dong is a desperate measure. A payment plan for her portion would help her out without shooting you in the leg. It's fair. ■

kkmcg
Posted: 11/5/2010
Post: 4 of 44

So if you write off the co-pay for her, she will tell all the rest of the people that she sent to you, and they will expect it too. Technically, this is insurance fraud. Is she worth breaking the law for and the dealing with the consequences for?

If you just do it a couple of times, then she has you. You will have committed insurance fraud and she has the evidence against you to threaten you with.

I say discuss it with her and tell her about the legal and ethical problems it would create. Then charge her the correct fee. If she doesn't want to stay, so be it.

If she stays you win, and if she goes – you still win. ■

konarocky
Posted: 11/5/2010 ▪ Post: 6 of 44

As everyone has said, it is illegal, so it's not a good idea. The primary reason insurance companies utilize co-pays and other cost sharing methods (e.g. 50 percent

for crowns) is to control costs. If you waive the co-pay you are also waiving the agreed upon cost control too. That's not fair to the insurance company. ■

johnson
Posted: 11/5/2010
Post: 7 of 44

Unfortunately, payment plan is not an issue. She just doesn't want to pay because her co-worker does not have to pay. I was almost going to tell her to go to her co-worker's dentist, but stopped and counted to 10. I think I'll try a very low monthly payment plan again and see what she decides on. I did not know a couple hundred dollars would cause such grief for this patient. ■

UTprosthodont
Posted: 11/5/2010
Post: 8 of 44

Are you kidding me? Why are we even allowing ourselves to cater to patients like this? Just trying to make a buck with your status at stake? Shoot, this kind of action not only puts you at risk, which by the way I would have no sympathy if you get caught, but also hurt surrounding dentists as a whole. You might not care about your colleagues, and I understand you have to look after number-one, but not like this.

If caught, I hope that dentist goes to prison! You are doing yourself and your colleagues a huge favor reporting that dentist. ■

eeznogood
Posted: 11/5/2010
Post: 9 of 44

Johnson, I have always been the kind of guy who advocates never accusing other dentists of anything, but if you are surrounded by dentists doing this and it's hurting you badly, blow the whistle anonymously. These guys enrage me and truly deserve it. ■

drfredc
Posted: 11/5/2010
Post: 10 of 44

Our front desk person is very clear about telling patients that they are asking us to commit insurance fraud and this something we don't do.

Fine print, our front desk staff gets paid as salary plus percent of collections. So when a patient asks the front desk to forgo a co-pay, they are asking her to take a pay cut, right out of her wallet. It takes the front desk staff less than a millisecond to say to themselves "like I'm going to sit here and let this clown steal from me!"

One thing you can do to prevent discounting issues on amalgam/composite pricing is to have the same price for amalgams as you do for composites. Since I don't do amalgams, it's kind of a no brainer anyways. ■

Jill Kring Carter
Posted: 11/6/2010
Post: 14 of 44

This is what you say to her, and you do not allow it to progress to discussion.

"I understand that you are under financial stress, and that you do not understand why there is a difference in cost for amalgam versus composite. Simply put, my fees reflect my costs. The issue here is insurance fraud, which writing off/not collecting co-payments falls under, without question. Other dentists and physicians have gone to prison for such practices, and I have no interest in joining them.

"All that said, while I might lose your business, and even that of your family due to my insistence on practicing dentistry and running my business within the law, I risk losing all my patients, my freedom and my future if I'm ever caught doing something that is illegal in my business. I'm sure you can understand this. I look forward to seeing you at your next appointment."

If she tries to engage in further discussion on this, cut her off and gently inform her that you "cannot discuss this any further and will be hanging up the phone now." Then do it. ■

continued on page 44

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cloud9
Posted: 11/7/2010
Post: 19 of 44

In general, it seems there are two issues discussed: breaking a contractual agreement and overbilling/fraud.

When you have signed a contractual agreement with an insurance company to be an in-network provider, usually the fine print says you cannot write off the co-pay. If you do, you are breaking a legally binding contract that you agreed to.

When you aren't bound to any insurance company agreement and you write off a co-pay, that can be considered overbilling/fraud. You are submitting an insurance claim stating you are charging the patient one amount, and you are actually intending to charge the patient a different amount.

Here's a clip from the ADA's Code of Ethics:

5.B.1. Waiver of Copayment. A dentist who accepts a third party payment under a copayment plan as payment in full without disclosing to the third party that the patient's payment portion will not be collected, is engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling dentist makes it appear to the third party1 that the charge to the patient for services rendered is higher than it actually is.

This article written by a dentist/attorney further muddies the water if you are in California: http://www.betterobin.com/oktowaive.html

The last paragraph, about insurance companies fighting this as a criminal rather than civil act, and using the RICO act is an eye-catcher. Especially if you've read the Dentaltown post about Roy Shelbourne! ■

Interested to read more about insurance topics?

Trade for Co-pay?
Search: ***Trade for Co-pay***

YourSmileCanOpenDoors
Posted: 11/7/2010
Post: 21 of 44

Cloud9, I know you posted this to show "ethical obligation" and I appreciate that. But don't get "ethical obligation" confused with "what is legal." The ADA is not a legal entity and cannot prosecute members or non-members.

There is a major difference between practicing "ethically" and "legally." It's sad, but laws don't reflect ethics oftentimes. My best recommendation would be to check out your state board regulations and your state insurance laws by contacting your state board of health and your state insurance commissioner respectively. ■

IAmSomebody
Posted: 11/7/2010
Post: 22 of 44

You made a good point, Mike. Ethics is different from legality. You can do unethical things and stay within the boundaries of laws. You might have to break the laws to maintain your ethical standpoint. Will you go to jail for that? Absolutely! ■

cloud9
Posted: 11/7/2010
Post: 23 of 44

Yep, very true. That's why I posted the second link by the dentist/attorney; it discusses the legal aspect, not the ethical aspect.

I wonder if the ADA addresses it from an ethical perspective because they don't have legal enforcement, or maybe because legality seems to be more of a state-by-state issue, not a national issue.

Maybe it's happened, but I've never heard of anyone, or seen any legal cases referenced, where writing off co-payments has actually been challenged by an insurance company, state dental board or by state attorney. Perhaps this is all a theoretical discussion, but in reality it is a non-issue. ■

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To think it all started with a man and a suitcase…

Benco founder Benjamin Cohen, center, circa 1930.

Benco Dental is on the Move

The full-service, family-owned dental distributor moves into its new home and expands its services nationwide.

by Benjamin Lund, Editor
Dentaltown Magazine

Stroll into the lobby of CenterPoint, Benco Dental's new home and hub of operations in Northeastern Pennsylvania, and you're hit with three impressions all at once: first, this company knows what it is; second, it knows where it's going; and third, it will never forget where it came from. If you stand at the entrance and look straight ahead, you'll view the headquarters' pristine and polished façade that might as well say, "Welcome to the future." Look to your right and soak in the dental distributor's immense and breathtakingly complete dental operatory showroom – the largest of its kind in the nation. For any dentist, it could trigger a salivary response. Look to your left and you find a larger-than-life, floor-to-ceiling image from the 1930s of Benjamin Cohen, the company's founder, aiding a dentist named Dr. Kniffen with a purchase at Benco's original Wilkes-Barre, Pennsylvania, location. The immensity of this 80-year-old image leaves no room for subtlety. Benco is proud of its heritage.

Rick (left) and Chuck Cohen, managing directors of Benco Dental.

Now led by the second and third generations of Cohens – Chief Customer Advocate Larry, and his sons, Managing Directors Chuck and Rick – Benco is unflinchingly focused on maintaining the values and competencies it has forged over eight decades, while embracing new standards and technologies necessary to keep moving forward.

A Little History

In 1930, weary from peddling dental supplies from his 100-pound suitcase for six years, Benjamin Cohen set up shop on the fifth floor of the Miners Bank Building in downtown Wilkes-Barre, Pennsylvania, to tend to the supply needs of area dentists. Back then, before the invention of the high-speed handpiece or UPS, dentistry was simpler, and dental distributors were small, over-the-counter storefronts. Ben's son, Larry, joined the family business as a sales rep in 1957, after completing graduate school.

The company stayed focused on the coal-mining towns of Eastern Pennsylvania until the 1970s. In 1972, Benco suffered two crushing blows. First, Hurricane Agnes ravaged the area, destroying most of downtown Wilkes-Barre and leaving Benco's brand-new headquarters under eight feet of water. The entire inventory was destroyed, and the company had no insurance to cover the losses. At the time, Benco had 25 associates, including Larry, and they faced a dire crisis: give up or press on. Thanks to a committed group of associates (three of whom still work at Benco) and a loan from the Small Business Administration, they shoveled out the mud and reopened – only to be shocked a second time with founder Ben's unexpected death later that year.

Despite these setbacks, Benco expanded throughout the 1970s and 80s, becoming one of the nation's first dental distributors to begin doing business over a wide geography, and introducing innovations like equipment specialists (sales representatives who specialize in selling equipment), fax ordering by customers (later replaced by Painless, the company's online ordering system), and the BluChip Buying Club, dentistry's original frequent buyer program.

When Chuck and Rick Cohen joined the family business in the 1990s, they began implementing several programs to keep the company focused on its mission of offering the widest variety of supplies and equipment possible, while developing meaningful partnerships with dentists and manufacturers to "deliver success smile after smile." Benco's own success was made tangible when, on January 4, 2010, the company consolidated three separate Northeastern Pennsylvania locations into its new CenterPoint headquarters – a 272,800-square-foot facility nestled in the rolling hills of Pennsylvania. For the first time in more than a decade, all of Benco's headquarters associates are stationed under the same roof. Benco's 1,100 associates now serve more than 30,000 customers in 40 states.

Captivating Culture

Benco has a unique corporate culture, similar to the work environment you might hear about at Google or Zappos. For seven of the last eight years, the company has earned a place on Pennsylvania's list of "Best Places to Work," ranking #43 in 2010. As the company expanded, culture remained extremely important to the Cohens and the Benco team. In order to promote a customer-focused culture in which every associate is involved in driving change, the company implemented a continuous improvement program called BCI (Benco Continuous Improvement) modeled on the principles of "lean manufacturing." A team of BCI associates leads events throughout the organization that eliminate waste and improve the customer experience – making Benco one of the first U.S. distributors in any industry to fully deploy the "lean" model.

Also incorporated into the Benco culture: support for charitable organizations and a relentless focus on the customer. The Cohens donate five percent of the company's profits annually to a family foundation that supports worthy causes like the United Way, National Foundation of Dentistry for the Handicapped and Head Start. And the Cohens insist that they, along with

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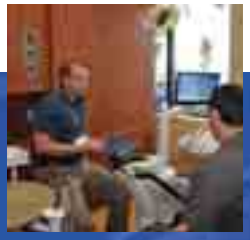

The CenterPoint Experience

Customer Testimonial on Dentaltown.com from Townie Chip Parrish, DDS
Parrish Family and Cosmetic Dentistry, Llano, Texas

"[Benco is a] great place to start if you are building or finishing out a new office. They have approximately 25 ops in one place with all kinds of delivery systems, cabinets, etc. The Benco advantage is that they have multiple brands of cabinetry, chairs, etc. Also, they have the different ops finished out with different paint, wall coverings, flooring etc., which can help to find the look you want for your office."

"We really didn't have time to explore the imaging, but they have a live imaging center where you can play with the latest and greatest pan/ceph/CT/tom machines. I imagine really useful if you are in the market. It's nice to actually see these things in person."

"Everyone we met with was very friendly and helpful. I never felt cornered. They made it clear they wanted our business, but they did not push anything."

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Larry Cohen cuts the ribbon at the CenterPoint grand opening ceremony in April 2010.

Associates gather in Kitty's Kitchen, Benco's on-site cafeteria.

Benco's senior management team, co-travel with the sales associates to meet with their dental customers personally. "Chuck and Rick co-travel a lot and they require it of our senior management and sales management teams," says Paul Jackson, vice president of marketing.

"It's all about face-to-face," says Chuck. "Our reps might be a little nervous about one of the owners of the company visiting dental practices with them, but they're excited to show off what they're doing. Everyone on our senior management team is required to go with a sales rep at least one day a quarter, and many of us get out at least one day a month. We all need to know what our clients want and don't want. In this business it is very easy to ignore the dentists. Here we make sure that never happens." It's all part of an ongoing effort to export the company's amazing culture throughout the organization – and co-traveling is one of the ways Benco ensures a close relationship between its sales reps, executive team and its dentist partners.

Building CenterPoint was literally a team effort, with a design process that solicited input from everyone at Benco. Because CenterPoint was going to be the home for every Benco associate, they all had a role in determining what amenities and features the facility should have, as well as what it shouldn't. Many BCI events were held to determine every single detail of CenterPoint, including building layout and flow, department placement and cubicle design. Decals of the company's core values are adhered to the floor of the warehouse. One of the features that came from BCI meetings was the addition of a health clinic, where Benco associates can go to get flu shots, donate blood and attend smoking cessation programs. Associates also asked for more than a cafeteria or break room at CenterPoint – so Benco added Kitty's Kitchen, named after founder Benjamin Cohen's wife, which offers an extensive and varied menu of hot and cold entrees each day. *(Author's Note: If you're visiting Benco and the "Jigsy Wrap" is on the menu, order it.)*

One of Benco's major goals was to build a headquarters with as little environmental impact as possible, with a focus on reducing waste, sewer and energy usage. As of this writing, Benco has applied for the U.S. Green Building Council's Leadership in Energy and Environmental Design (LEED) Silver Certification status for CenterPoint, which it expects to obtain in early 2011.

The Pearl of CenterPoint

When purchases can be made via catalog or the Internet, it might seem a little odd that Benco put so much effort into planning and developing its state-of-the-art equipment showroom. But it makes sense. "You wouldn't buy a car without test driving it first," says Rick Cohen. "When dentists are updating their offices or building a new one, they're buying gear that is going to cost tens of thousands of dollars. It makes sense to see whether the equipment you want to buy will work in your space. You're buying stuff you have to live with for 15 to 20 years. It's different than a car. At least you can get out of your car. You've got to be in your office eight or more hours every day."

CenterPoint Experience Specialist Sue Evans recalls a time when a dentist made the trip to CenterPoint with one goal in mind – to test out the fit of his own IV armrest on the operatory chair he was preparing to purchase. "The doctor had his heart set on a particular style of chair," says Evans. "He was close to purchasing a few of them for his office, but he wanted to make sure the IV armrest would fit on the new chairs, so he flew to CenterPoint to test the armrest on the chair in our showroom. It turned out the armrest didn't fit on the chair at all." Evans says the doctor tried the armrest on other chairs in the showroom before making his decision to purchase another make and model.

Since the showroom's opening, dentists who visit have been known to become weak at the knees from the overwhelming variety of equipment and operatory designs. "We believe in choices," says Rick Cohen. "If we meet with a manufacturer and they tell us they want us to be the sole distributor of their product, we tell them we don't want to do that. We don't want to carry just that one brand of a specific item. None of the lines we carry are exclusive to Benco, so it gives our dentist partners a greater choice. Dentists don't have to buy just one line of products from us; they can mix and match. Maybe they like the A-Dec chairs but want the Pelton & Crane lights. We can do that." Because Benco does not

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carry exclusive product lines, dentists who are renovating or building a new office have literally millions of design options from which to choose – from lights to chairs to even the color of their operatory walls. In fact, Benco has interior designers on staff to help dentists plan their operatories.

Distribution & Moving West

The CenterPoint warehouse is home to more than two miles of "smart conveyor" – which means when an order comes in, it is printed on a piece of paper with a corresponding barcode. The barcode is matched up with a tote that carries the same barcode on its side. As the tote travels through the warehouse, the barcode is scanned at multiple outposts to either make a stop to pick up an item on the order or move through to the end. Because the warehouse is largely automated, there are almost zero errors (current rate: fewer than three errors per 10,000 lines picked), but if there is ever a problem with an order, a dentist can call 800-GO-BENCO and will speak with a customer service rep. Most issues are resolved in one day (and any unresolved issues are handled by Larry Cohen personally).

For now, the CenterPoint distribution center is the only Benco warehouse that operates at such efficiency, but it hopes to retrofit its other distribution centers with the same technology. Of course CenterPoint is not Benco's only distribution center: it already has centers in Jacksonville, Florida; Fort Wayne, Indiana; and Dallas, Texas. And in a push to gain a foothold in all 50 states, Benco will open a new center in Reno, Nevada, in mid-2011 to service the entire West Coast. "With its fifth distribution center, Benco will be the first family-owned, full-service dental company with a national footprint," says Jackson.

After 80 years, why push to "go national" now? Jackson says it's because Benco Dental is a family business and worked slower to make the right investments. "We're privately held," says Jackson. "We would have loved to make a move to expand nationally 15 years ago – and if we wanted to go public we could have done that, but that would have meant making huge compromises. You can't please everyone, and when you're trying to please the stock market, it's hard to please dentists and have their interests at heart. So we chose to grow at a measured pace. As we generated profits, we reinvested them into expanding our offering and our footprint." CenterPoint is a prime example of how the family has reinvested in the business.

One of many equipment options on display at CenterPoint (left).

Another reason for Benco's national push revolves around its relationships with its manufacturers. "We deliver value not only to our dentist partners, but our manufacturer partners as well," says Jackson. "If a manufacturer wants to give us a product line, they want to know how their products will be covered nationwide. We're not going national for the sake of being bigger, we're going national to be better, especially for our vendor partners."

Asked if there's any fear that Benco could get too big, Chuck Cohen says Benco will continue to get bigger, but only as long as it is the right thing for the company and the customer. "It's about compromise," says Chuck. "In some ways you can argue that we're already too big because we're not as customer-intimate as we'd like to be. That's part of growing. But we're able to offer products and services that smaller companies can't offer, so it's a trade off. As we grow, our focus remains on giving every customer, no matter where they are, the same excellent experience."

The Benco Difference

There is definitely something different about Benco. Perhaps it is because the company remains family-owned, and can make uncompromised, long-term and well-researched strategic decisions aimed only to have a positive impact on its dental partners and its own associates. Perhaps it is the culture, meticulously cultivated via Benco's BCI program and upheld by every associate from the top down. Perhaps it is the non-exclusivity of its product lines that allow the distributor to carry a wide variety of products. Perhaps it's the personal touch and the no-pressure service it provides to ensure that its dental partners not only get what they want, but get what they need in order for both to succeed. …Or perhaps it's a combination of everything. n

Visitors can test drive various handpieces at CenterPoint.

Associates assemble for a Town Hall meeting with Rick.

Orders being filled on the smart conveyor.

You are invited to visit Dentaltown.com to ask questions or post comments about the following New Product Profiles. If you would like to submit a new product for consideration to appear in this section, please send your press releases to Assistant Editor Marie Leland at marie@farranmedia.com. All material is subject to editing and space availability.

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Is All "Evidence-based" Dentistry Trustworthy?

by Gordon J. Christensen, DDS, MSD, PhD and Paul L. Child Jr., DMD, CDT

To question the current widely used phrase, "evidence-based dentistry" is similar to questioning the Bible in a meeting with a devoutly religious group. However, in our candid opinion, we clinicians need to express our concern about the obvious respect for and overuse of this phrase and the unquestioning attitude of many dentists and authors toward it. More importantly, we need to open discussion about how evidence-based dentistry (EBD) influences our patients, third-party payers, dental education and ourselves. This school of thought is certain to spark some debate; our intention is to provoke serious thought and discussion on the following topic.

The purpose of this article is to help you to determine if, when and how "evidence-based" research projects can help your practice and your patients, and how to evaluate projects reported in publications.

What is Evidence-based Dentistry?

Throughout the past few years, clinical dental practitioners have heard and read the phrase "evidence-based dentistry" ad nauseum. Almost every article, dental faculty member, research paper, dental continuing education speaker and even lay publications have picked up and used this popular "buzz" phrase. If you were to observe the overall health science literature, you would find hundreds of articles (with which we will not bore you) proclaiming the advent and value of EBD and evidence-based medicine (EBM) in dental, medical, nursing and allied health science literature. However, there are a growing number of articles discussing the limitations of it, especially in medical literature. It is as if we have never had any evidence related to our practice procedures in the past; that we just bumbled on blindly. Because of the predominance and constant bombardment of the phrase "evidence-based dentistry" used by dental teachers, manufacturers and researchers, practitioners are wary of almost any dental paper that is published. All of us see research projects contradict each other in "evidence-based," "peer-reviewed" dental literature; some even in the same issue of a given journal. Additionally, it is not uncommon to see a so-called "evidence-based" publication offer results that are diametrically opposed to the long-time observations of experienced dental practitioners.

Is the phrase, "evidence-based dentistry" something new, a passing fad, an academic fetish or is it something to which we practitioners should pay strict attention to and use when making decisions regarding patient care? Are there limitations to evidence-based dentistry, and if so, what are they?

Evidence-based medicine is not new. In fact, David L. Sackett, MD, one of the leading physicians involved with analyzing and critiquing EBM in recent years says, "Evidence-based medicine, whose philosophical origins extend back to mid-19th century Paris and earlier, remains a hot topic for clinicians, public health practitioners, purchasers, planners and the public." He states further, "Criticism has ranged from evidence-based medicine being old hat to it being a dangerous innovation, perpetrated by the arrogant to serve cost cutters and suppress clinical freedom."[1]

How is EBD or EBM defined? Evidence-based practice (the term that is replacing the use of EBM/EBD) is "the integration of *clinical expertise,* patient values and the conscientious, explicit and judicious use of current *best evidence* in making decisions about the care of individual patients to improve clinical and functional treatment outcomes."[1, 2] In other words, we can conclude that it is not just scientific evidence. It includes clinical expertise. Often this aspect of evidence-based dentistry is overlooked in lectures and publications.

Many dentists are familiar with the "hierarchy of evidence" in research, which describes levels of evidence that are superior or more accurate than lower echelon levels. These evidence levels

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are commonly positioned or ranked based on the degree of bias or freedom of bias involved in the research methodology used. Most publications and organizations rank the levels of evidence from highest to lowest as follows:

- meta-analysis and systematic reviews
- randomized controlled clinical trials
- prospective cohort studies
- case control studies
- case series and reports
- observations, expert opinions and editorials
- unpublished clinical data and observations of which clinicians are all a part

What is the "best evidence"? The following definitions are self-explanatory.[3] The highest level of evidence is further explained by the following three categories.

Meta-analysis: A review in which the results of many randomized controlled trials are pooled and the overall results are analyzed. We routinely observe meta-analyses in our work. The significant problem with these compilations of data is that there are usually supporting papers both on the positive and negative side of any question, and you still have to come to your own conclusions. As an example, the Cochrane Collaboration is a widely used and quoted database of systematic reviews of randomized controlled clinical trials. In this system, outcomes of treatment are categorized as "likely to be beneficial," "likely to be harmful," or "evidence did not support either benefit or harm." This categorization is useful when a large amount of data exists and is *included* in the review. However, the actual number of randomized controlled clinical trials included is often small, and direction for the dentists in treating their patients is questionable. We often need more than just "likely to be beneficial" to come to our own conclusions. El Dib stated in a 2007 analysis of 1016 systematic reviews from the 50 Cochrane Collaboration Review Groups that 96 percent of the reviews recommend further research.[4] It has almost become a mandatory requirement to end any article with the phrase, "however, further research is required." What do practicing clinicians do in the interim until the "best evidence" can be provided? Do we ignore the other levels of evidence or our individual clinical expertise?

Randomized, double-blind controlled clinical trials: In a randomized, double-blind trial, neither the investigators nor the study participants know who is receiving whatever is being studied versus the control for the study.

Randomized, controlled clinical trials: Same as above, but not double-blind.

Our following critique is provided to guide you in making clinical decisions in treating your patients, and it is not intended to be overly critical of dental research.

What if only one randomized, properly designed controlled trial is reported in an article you are reading?

Can you trust the results? The results of one study could be purely a chance happening, in spite of a reported sophisticated statistical analysis on the data the investigators have obtained. Before making any decision about the value of a study, evaluate the following conditions:

- Do you know and trust the investigators/authors?
- Is the article featured in a trusted journal?
- What group, company, manufacturer, third-party payer or individual funded the study? There are often ulterior motive potentials for publications. Many negative research results are not published due to financial contracts with the manufacturers or manufacturer-funded "third-party" evaluation groups.
- Is the research truly blind?
- Does it appear that the funding parties for the research could be biased from a financial standpoint?
- Are the investigators actually practicing what they are studying? There are many authors who publish frequently, but rarely or never pick up a handpiece.
- Was the protocol aligned with real-world practice standards and conditions?

It is extremely difficult to analyze studies. We can name numerous studies in the literature that have had one or more of the preceding challenges, thus confounding the results. In fact, many of these studies have been published in some of the most respected peer-reviewed journals in the dental industry.

Determining whether the peer reviewers are competent and nonbiased can be another challenge. In our opinion, peer reviewers are only *sometimes* competent and nonbiased. We can cite numerous published studies in which the peer reviewers (who we were acquainted with) did not, in our opinion, have significant real-world clinical background in the subjects they were reviewing. Yet, the papers were published in well-known respected journals, misleading the readers and often providing significant income to the companies involved in the study.

What if a well-designed controlled clinical trial was not randomized?

It is obvious that if the group being studied does not represent the broad population, the results will be biased toward that group and only be representative of the characteristics of the group being studied. As examples, a study of dentures made by American Board Certified prosthodontic specialists does not represent the results to be expected from the total population of all dentists of various educational levels and experience. A study of dental caries in one state or country represents only that area and not a broader area. A Class II resin-based composite study accomplished by one excellent clinician does not represent the results to be expected from the broad population of dentists of all abilities. Almost every journal you pick up has studies in which whatever is being studied does not represent the true practice of dentistry. The studies are easily identified. Look for them, and accept them only for whatever specific population they studied.

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What if a study has been done in-vitro only, without a clinical component?

In our opinion, there are far too many studies in the literature of this nature. There must be a clinical component to an in-vitro study for any legitimate clinical conclusions to be made.

What about a single well-designed case-control or cohort study?

A cohort or longitudinal study is where subjects are prospectively followed over time without any intervention. A case-control study is where a group of patients and a group of control patients are identified and information about them is determined in retrospect.

We just finished looking at such studies relative to the longevity of amalgam and resin-based composite restorations over time. The results were so variable that only a few questionable conclusions could be made. On the other hand, such studies, which are considered to be of a lower level than the previous ones, are still useful if the groups represent real-world situations, and are accomplished carefully.

Can you trust evidence from literature reviews or single descriptive or qualitative studies?

Many authors review the literature to determine answers to clinical or basic science questions. The reviews might be minimal in scope or broad and detailed. The results could easily be based on chance findings or the biases and opinions of the author(s).

Single descriptive studies are interesting and often provide ideas and potentially useful information. Their results must be scrutinized to determine their value.

How about the reliability of "expert" opinions from authorities or expert committees?

In dentistry we constantly see these types of articles both in respected journals and in commercial magazines. Often, the people writing or speaking are true authorities who have broad knowledge of available research as well as clinical experience. Such trusted individuals have taken the time and made the effort to analyze the available information on a subject and make personal conclusions on the subject. The value of such opinions must be based on the reputation of the person providing the information, and past experiences relative to that person being able to make conclusions based on both research and his or her clinical experience.

Conversely, opinions of persons not based on the available information in the literature which express only personal opinions must be scrutinized to determine their value. Many "experts" or "key opinion leaders" have financial ties to the manufacturers of the products or techniques about which they publish or on which they speak. It is important to recognize those that are broad based in their expert opinions and equally assess all products, treatments and the research item being investigated.

Where are we? Can we trust anything?

Let's go back to Sackett's statements on the subject, which, in our opinion, are profound. He states "EBM is the conscientious, explicit and judicious use of *current best evidence* in making decisions about individual patients. The practice of EBM means integrating *individual clinical experience* with the best available *clinical evidence from systematic research."* This is right on. Evidence comes from many sources and it must contain two components: evidence from systematic research *and* evidence from individual clinical experience. Neither one by itself is enough!

Another definition of EBD that is in line with our own thinking is "Evidence-based dentistry is the practice of dentistry that integrates the best available evidence with clinical experience and patient preference in making clinical decisions."[5]

Another frustrating and growing use of "evidence-based dentistry"

Many insurance companies are moving toward "evidence-based reimbursement" in which they will not pay for treatment unless it can be proven by the highest levels of evidence. The medical industry has witnessed lawsuits against this practice, yet it still continues to be pursued. This growing trend is not only questionable, but limits new and improved treatments for patients. One technique exception is the growing number of insurance companies that are covering implant restorations in place of fixed partial dentures (bridges). Many more years will pass before the strongest level of evidence will be available on this subject.

Where can clinicians find the "best evidence"?

We know that practitioners have very little time to look up information and analyze multiple projects for their clinical value. However, from time to time you might want to look up a question which is bothering you. We have listed a few locations below for you to find answers. Use these locations to find scientific information:

- PubMed www.pubmed.com
- Embase www.embase.com
- MEDLINE www.medscape.com
- Cochrane Collaboration www.cochrane.org
- Google Scholar www.scholar.google.com
- Peer-reviewed journals
- Professional associations that publish guidelines when not all of the highest levels of research are available.
  - A recent example, The Academy of Osseointegration recognized that not all of the evidence is yet available, and they published useful guidelines for specialists and general dentists. Their 2010 Guidelines of the Academy of Osseointegration for the Provision of Dental Implants and Associated Patient Care states,

    . . . the Council (ADA) recognizes that evidence-based care requires the judicious use of current best evidence. It is nonetheless recognized that much of the current evidence base lacks consensus and, to this end, implant dentistry is often practiced on the basis of best anecdotal evidence,

which may or may not be supported by lower echelon studies and/or case reports. As such, there is a responsibility for individual clinicians to avail themselves of the parameters for patient care for the safe and effective provision of dental implants and to continue to avail themselves of ongoing documentation.

This statement gives clinicians guidance based upon many levels of research and advises the clinician to "follow" the literature for those improvements in treatment or higher levels of evidence.[6]

- Independent research groups.
  - Our own nonprofit group, *Clinicians Report (CR)* (Previously *CRA),* has for 35 years conducted controlled clinical trials, blended them with the trials of other groups, determined practitioner experiences and opinions on the subjects being studied, and made conclusions and suggestions for implementation into practice. All *CR* research and the subsequent publications have contributions from experts in their area, including all the specialties and representing both academic and practitioner orientation. *CR* implements a vigorous review process to ensure that the information is accurate, timely and representative of the majority of practicing dentists. The *CR* conclusions are based on the best scientific research available and the clinical information and opinions obtained from hundreds of experienced full-time practicing *Clinicians Report* Evaluators. The information is published monthly.

Conclusions on "Evidence-based Dentistry"

- It is fortunate that we now have the concept "evidence-based dentistry" re-identified. However, it is not new. It is only a logical system to assist us in identifying current truth for implementation into practice.
- The phrase evidence-based dentistry is greatly overused, misunderstood by many and perhaps too trusted by the profession.
- Projects that claim to be evidence-based can be and often are flawed, and the research needs your personal evaluation and comparison with your own clinical observations to determine the usefulness of the information.
- Basing your clinical decisions on just the "best scientific evidence" does not provide complete answers to questions. Clinical observations must be considered also.
- Often there are multiple "correct" treatments or solutions to our patients' needs that are equal in level of evidence. Infrequently is there only one treatment for a specific condition.
- Published articles must be scrutinized on many levels to determine their value for practicing dentists.
- There is "scientific evidence" on both the positive and the negative side of almost every clinical question.
- After observing the best scientific evidence available, clinicians should blend the scientific information with their own and their peers' clinical observations and experiences and finally make clinical conclusions.
- Whatever is considered truth (fact) today will probably be questioned or disproven tomorrow.
- Evidence-based dentistry concepts are only a guide. They are not inviolate and they must be observed with caution.
- Dentists are smart people. They can usually determine truth from hype on any clinical question. Such decisions come with careful analysis and time. n

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Author Bios

Dr. Gordon J. Christensen is founder and director of Practical Clinical Courses (PCC) in Utah. This group is an international continuing education organization providing courses and videos for all dental professionals. He is also co-founder of the nonprofit Gordon J. Christensen *Clinicians Report* (previously CRA), as well as an adjunct professor for Brigham Young University and University of Utah. He is a Diplomate with the American Board of Prosthodontics. Dr. Christensen has presented more than 45,000 hours of continuing education throughout the world and has published many articles and books. Further information is available at www.pccdental.com.

Dr. Paul Child is the CEO of CR Foundation, a non-profit educational and research institute (formerly CRA). He conducts extensive research in all areas of dentistry and directs the publication of the Gordon J. Christensen *Clinicians Report,* and their other publications. Dr. Child is a prosthodontist, a certified dental technician, and maintains a private practice at the CR Dental Health Clinic in Provo, Utah. Dr. Child lectures nationally and co-presents the "Dentistry Update" course with Drs. Gordon and Rella Christensen. He lectures on all areas of dentistry, with an emphasis on new and emerging technologies. He maintains membership in many professional associations and academies. Further information is available at www.cliniciansreport.org.

by Rhonda R. Savage, DDS

I met Dr. Frank Simmons on a snowy day in December 2007 in Minneapolis. He approached me after my presentation and groaned, "I came here to learn how to control my thermostat! You know," he said, scrunching up his face, "trying to keep 16 women happy all at once is like spitting into the wind!"

If you're like Dr. Simmons, there are employee-driven pet peeves and frustrations you deal with on a daily basis. If you've ever managed a team, you've likely had to deal with bad manners or behavioral issues. The problem is, while most of these pet peeves start off as small frustrations, they can turn into bigger problems for you and the practice in the long run. The question is, as a boss or office manager, what can you do to change these behaviors so they don't negatively affect the practice? Here a few of the pet peeves that dentists have about their staff and solutions to quell frustration.

1. We hate when they are only nice to us on special days.

"Why are they only nice to me on my birthday?" you ask yourself. You know this isn't really true, but it's how you feel sometimes. You feel unappreciated for all you do; some days it seems like it's never enough!

Dial up the praise and appreciation in your office by personally making a daily effort to recognize the good efforts of your team members. Chances are, your team feels the same way you do… like things are never good enough. Praise and appreciation, done well, is gen-

uine, specific and timely. The more you dial up the praise and appreciation, the morale of the practice will go up!

When morale goes up, production goes up. At your office meetings, let them know you're working on changing the office environment and ask if they've noticed a change. Ask for their help. The 90:10 rule applies: If your boss behavior is good 90 percent of the time, but 10 percent of the time you blow it by acting in silence or exploding in anger, they remember the 10 percent that is bad. Work on changing and ask if they've noticed!

2. We hate when we have to nag for things to get done.

"They brush their teeth in the hallway. I've asked them not to, but they still do it," you exclaim. Other pet peeves: a dirty break room, clutter and personal items lying around and employees not following through with directions or job responsibilities.

Asking for something over and over leads to frustration. Small things matter! You need to be careful not to micromanage, but if someone isn't doing what they need to do, respectfully correct them. Make certain they know what they need to do and ask them to write it down. Have your team members carry a small pad of paper with them and anytime you ask them to do something, ask them to write it down. Set a date for them to report back to you (a mutually agreed upon deadline) and then you won't have to wonder whether the task was accomplished. This eliminates the need to constantly nag them regarding a task.

Most leaders believe they over-communicate. Leaders actually under-communicate by a ratio of 1:10. Employees need detailed, specific instruction, coaching, feedback and appreciation or correction. If someone doesn't do what they need to do despite your efforts, the next step is to sit down with the employee, one to one, and resolve the issue.

One employee understood how annoying his habits were when the boss told him a personal story: Dr. Sam Johnson told the employee that his wife had been upset about the laundry. One day, she took him aside and said, "I've asked you a number of times to separate the whites from the darks. When you get lazy and don't do it, you're disrespecting me!" He changed his habits when he knew how much it bothered her.

At work, your team is like a big family. Everyone needs to pull their weight and respect others concerns, or you're disrespecting the other person or place of business.

3. We hate when they chew gum.

Chewing gum is unprofessional, especially in front of a patient. One manager recently complained to me: Nancy, her assistant, enjoyed chewing gum. She would forget and chew while she was working. Nancy would get "the look." Is there a "look" that you give your employees when you are annoyed? The look can be intimidating and especially worrisome if you don't spend the time coaching the person that very day. Employees need to know what they need to change. Be sure you have a chewing-gum policy and any other personnel policies in your office manual. Be clear about your expectations with your employees and hold them accountable, fairly and consistently, for their actions.

4. We hate when they don't check the floor after cleaning a room.

Cleanliness matters to most patients, especially your female patients. Explain to your team that women make many of the purchasing decisions in today's world. Women are very keen on attention to detail. A dirty floor means the entire facility is dirty. The team needs to know the reasons why they need to change their habits. Explain it to them in "black, white and *green!"* Our patients are spending their *paychecks* with us! We need to cater to our patients.

5. We hate when they don't introduce us to a new patient.

When we walk in for treatment and no one offers up an introduction, it's awkward. Introductions are common courtesy. Also, if we've already seen the patient for a quick

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appointment, emergency or consult, and now they're in the office for a thorough new patient exam/consultation, we might need to be reminded that we've *already* met the patient! Also, your staff should ease your way into getting to know the new patient by saying something like, "Dr. Savage, you and Kevin both played soccer in college!" Introductions don't have to be difficult and they are a great way to make patients feel comfortable.

6. We hate when they don't help us get to know the patients.

Every patient has a story and female patients usually aren't shy about sharing! Your staff has a better opportunity to get to know the patient better than you might be able to, due to time constraints. Their job is to get the story and summarize it for you. This connects the patient to the practice and makes the patient feel "heard." Listening skills are the number-one sales tool. Consider training your team to be better presenters, either with in-house training or training through a professional organization. ToastMasters International (www.toastmasters.org) is a very inexpensive way to train your team to be better presenters. ToastMasters will improve your staff's speaking skills, develop their listening skills and teach them to answer questions without getting flustered.

Ask your staff to let you in on the patient's story – what have they seen? How is the patient doing? Are there any concerns that exist? Train your team to speak for you. They need to feel confident that they're saying what you would want them to say, especially in a difficult situation. Scripting is a valuable training tool. Write down the common concerns and questions of your patients, and then write the answers for the employees. The goal is not to memorize the answer, but rather, internalize the message and make it their own. Verbal cue card training is available at DentalManagementU.com.

7. We hate when we have to do all the talking.

My staff connects wonderfully with the patients, but they don't educate the patients! An employee has an hour with them while you might only have five minutes. Social chitchat is normal in dental offices. We often see 75 percent of conversation with patients to be social in nature, while 25 percent of it is business. We need to flip those numbers. Talk about this at your staff meeting. Let your team know that they are not "just" employees. Provide training sessions with verbal skills. Ask the different departments to give mini training sessions on patient's concerns and your various services. There are certain oral health lessons that patients will only be informed about by their dental office. If the staff doesn't take the opportunity to teach, the lesson could go unlearned.

8. We hate the personal use of cell phones and Internet at the employee's desk.

Cell phone use, texting and personal Internet use are a form of time embezzlement. How many hours a day are you losing to personal cell phone and Internet time during business hours? Make sure you are held accountable to the same rules. Are you personally on your phone or on the Internet during business hours?

All team members need to be held accountable to the same standards. It's up to the owner or manager to limit use of these items. I recommend cell phones remain locked in personal lockers. Continued use of the Internet for personal reasons would require a corrective review. Many offices password control the use of computers to identify misuse. In addition, your IT person can limit access. Some offices have installed security cameras to monitor behavior.

Not only are these habits detrimental to the business and the patient, but resentment will build among your team members that are hard workers. When resentment builds, morale drops and when morale goes down, production goes down too.

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9. We hate when they cry.

To understand the emotional response that you might receive from an employee, I'd like to use an analogy. In the book: *Switch! How to Change When Change is Hard,* the authors Chip and Dan Heath use the analogy of an elephant with a rider on its back and the path that they're on to demonstrate how to get someone to change.

Consider this rider, elephant and path to be your employee. The rider is the employee's intelligence; the elephant is their emotional side; the path is the direction or the action the person is taking. To influence change, you have to touch the emotions, reason with the intellect and change the path that the person is on, making it easy for them to change.

If your employee is crying, the foundational question is *why?* With this analogy, picture the elephant as the emotions that rule our lives. When our brains get tired, it's much harder to control the emotional response. Ask the employee to take a break, to return when he or she is more collected and schedule a time to talk the next morning.

At times, tears might also be from frustration, anger or fear. Does your employee feel intimidated? Employers or managers who act out in anger by yelling or punish with silence will have more turnover and job dissatisfaction. Belittling or criticizing someone, especially in front of another person, anti-markets the business.

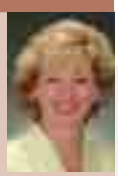
Tears can also be a form of control. You need to reason with this person and change the path by calmly talking about the (perhaps) inappropriate emotional response. I recommend you sit down and discuss why your employee feels the way she feels and how you might help resolve the issue or give tools to cope. The problem with a person who cries is that others will avoid approaching her for fear of her response. Sometimes, this is exactly what this person wants… making crying a form of control. As the leader, it's your job to facilitate the necessary change.

Summary

By following these guidelines, you can prevent innocent pet peeves from turning into big problems between you and your staff. Your staff will respect you for working with them to change these habits, rather than complaining about them to other employees. Helping employees understand their role in making the business successful keeps them involved and dedicated to doing their part. You'll be happier, you're staff will be engaged and the business will be successful! ■

Next month: Sorry doc, you're not getting off lightly here, as I'll present "Ten Things Your Staff Hates About You!"

Author's Bio



Dr. Rhonda Savage began her career in dentistry as a dental assistant in 1976. After four years of chairside assisting, she took over front office duties for the next two years. She loved working with patients and decided to become a dentist. Savage graduated with a B.S. in biology, cum laude, from Seattle University in 1985; she then attended the University of Washington School of Dentistry, graduating in 1989 with multiple honors. Savage went on active duty as a dental officer in the U.S. Navy during Desert Shield/Desert Storm and was awarded the Navy Achievement Medal, the National Defense Medal and an Expert Pistol Medal. While in private practice for 16 years, Savage authored many peer-reviewed articles and lectured internationally. She is active in organized dentistry and has represented the State of Washington as President of the Washington State Dental Association. Savage is the CEO for Linda L. Miles and Associates, known internationally for dental management and consulting services. She is a noted speaker who lectures on practice management, women's health issues, periodontal disease, communication and marketing and zoo dentistry. To speak with Dr. Savage about your practice concerns or to schedule her to speak at your dental society or study club, please e-mail rhonda@milesandassociates.net, or call 877-343-0909.

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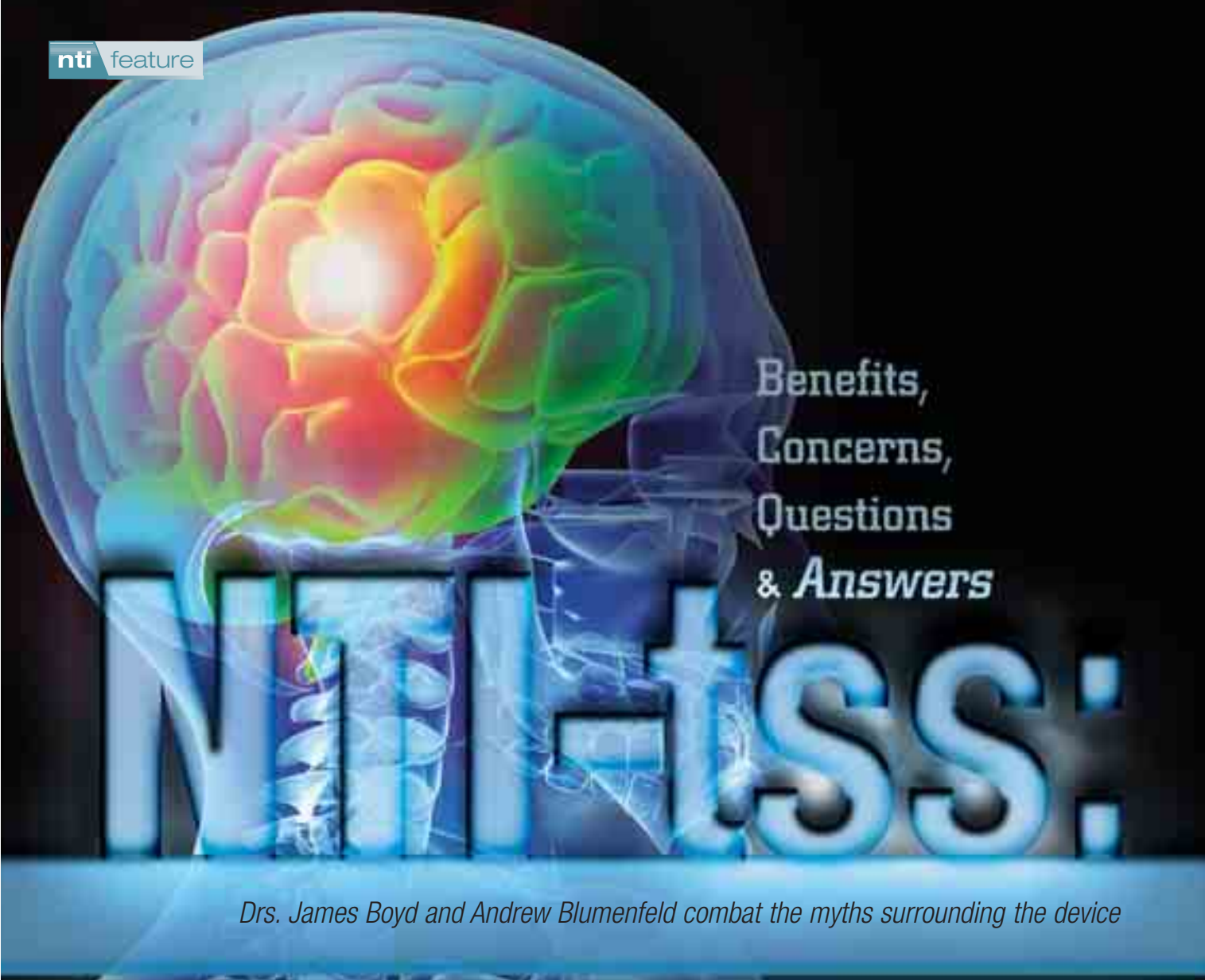

Benefits, Concerns, Questions & Answers

NTI-tss

Drs. James Boyd and Andrew Blumenfeld combat the myths surrounding the device

Ten years ago the FDA (U.S. Food and Drug Administration) approved the first nonpharmaceutical treatment for migraine headaches, the NTI-tss. Since then, more than 20,000 dentists worldwide have prescribed more than one million devices.

The developer of the NTI therapeutic protocol, James Boyd, DDS, recognized that patients in his general practice who suffered from frequent migraines had a common symptom – morning headaches. "Even though these patients would report of some days being relatively migraine-free, they reluctantly admitted to waking with some degree of discomfort every morning," says Boyd.

While some of Boyd's patients responded favorably to full arch occlusal splint therapy, those who reported chronic morning headaches seemed less predictable, with some even worsening with these splints. After reviewing the occlusion on these cases and looking for similarities, Boyd realized the occlusal scheme wasn't predictive of who would or would not respond to splint therapy. Instead of occlu*sion*, Boyd postulated that occlu*ding* was the problem. "As Henry Tanner used to say, 'it isn't what you have, it's *what you do with what you have* that causes and perpetuates the pain,'" says Boyd. He identified these chronic headache patients in his practice as *primary clenchers,* and his goal became finding a way to reduce and control the intensity of that parafunctional activity.

His development of a parafunctional control protocol, using an appliance design that was effective, durable, comfortable and cost effective for both the dentist and the patient, took nearly a decade, changing as Boyd's knowledge and insight of the medically diagnosed migraineur evolved. Boyd's patents are based on the provision of a prefabricated, enhanced discluding element, which provides immediate and continuous incisal guidance in

all mandibular movements by preventing posterior and canine contact on both the device and the opposing dentition.

After years of teaching the NTI therapeutic protocol to dentists, Boyd developed a new professional relationship that would have even wider repercussions for NTI use and credibility.

Andrew Blumenfeld, MD, a neurologist and recognized researcher in the field of headache and migraine, is director of The Headache Center of Southern California. "The more we discussed each other's field of expertise, the more we realized that we were talking about nearly the same thing, that both migraine and temporomandibular (TM) disorders were trigeminal nerve disorders: TMD resulting from trigeminal motor hyperactivity; and, migraines the result of trigeminal sensory dysmodulation. What intrigued us was the probability that either one may cause or influence the other."

Within the last three years Dr. Blumenfeld has presented research highlighting the NTI's migraine prevention efficacy in his practice at migraine research symposiums in Los Angeles, London, Philadelphia and Nice. Starting this fall, The Headache Center, in collaboration with Dr. Boyd, will initiate its most significant NTI research to date.

"No one in the migraine field disagrees that sleep has a considerable influence on headache frequency and intensity," says Blumenfeld. "What we don't fully understand is what exactly it is about sleep that is so influential. We will be doing a polysomnogram on 100 consecutive chronic migraineurs, complete with EMG recordings of temporalis activity. Following eight weeks of NTI use, we will repeat the sleep study (while the subject uses their NTI). Our hypothesis is that those who've reported the most relief will be those who've had the most significant reduction in temporalis activity."

Although future research promises even more details on how NTI achieves prophylactic and treatment success for migraine pain, both Drs. Boyd and Blumenfeld remain dedicated to combating current myths about NTI use.

Dentaltown Magazine had the opportunity to ask the doctors a few questions about NTI treatment. Below they address the benefits and concerns about the device to aid acceptance within the dental community.

Some practitioners warn against "long-term" NTI use, due to possible posterior supraeruption and incisor intrusion. Are you concerned as well?

Boyd: I asked my local orthodontist a hypothetical question. "If I needed you to extrude the most distal molar on one of my patients, but you were restricted from attaching any brackets to the molars, and could not use a removable device that touched the molars, and there would be no means of treatment throughout the day, could you do it?" The answer was no! That is, however, exactly what some dentists claim an NTI can do! As far as tooth movement in a general sense is concerned, there just isn't the means to forcefully extrude or intrude any teeth. However, that is not to say that the "one-in-1,000" case is not out there. With more than one million NTI devices in use, I have seen and heard of almost everything.

What about aspiration? It *that* a concern?

Boyd: I wonder how many acrylic temporary crowns are dislodged and swallowed or aspirated every night. I can't count how many times a patient has arrived for their permanent crown delivery, only to find their temporary crown missing, with the patient having no idea that it was gone. Proper NTI protocol adapts the NTI device onto unprepared teeth. Of course there is always a degree of risk inherent in all intraoral removable devices, but of more than a million NTI devices delivered, no more than three occurrences of aspiration have ever been claimed, and none verified radiographically or otherwise.

There are reports of anterior open bites "caused" by NTI use. Given the litigious nature of society, should a dentist even bother providing an NTI?

Blumenfeld: In the medical field, and especially in migraine prevention therapy, all of the medications we use have side effects, and some of those are particularly undesirable. With NTI therapy, we inform the patient that in a small minority of cases, a degree of change in their bite might occur and then a shared decision is made. In certain medical conditions the NTI becomes a first line choice.

Boyd: When I examine a potential candidate for NTI therapy, I note the degree of incisal overlap. If the overlap is minimal, or edge-to-edge, I advise the patient that an NTI can reveal orthopedic relationships that were previously not noticeable, meaning, the way their lower jaw fits up against their upper jaw could change.

Are there circumstances when the NTI is contraindicated?

Blumenfeld: There are no medical contraindications. There is no treatment that will help everyone. When it comes to migraine prevention, we like to prescribe an NTI to rule out nocturnal parafunction. Certainly not all migraines are affected

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by nocturnal parafunction like clenching intensity, but we find ruling out, or identifying and controlling nocturnal parafunction enhances our treatment efficacy.

Boyd: Because I see mostly refractory migraineurs now, a strict adherence to protocol is essential. For those with a compromised joint, the practitioner must confirm that the NTI does not complicate their condition further. That is not to say that an NTI is contraindicated for degenerative joint disease; in fact, quite the contrary. In the presence of nocturnal parafunction, the goal is to minimize muscle contraction intensity while minimizing joint strain and load, which a properly provided NTI allows for. However, simple oversights such as allowing for excessive vertical dimension in extreme protrusive can further complicate a patient's presentation. Just as a general practitioner is licensed to perform complex oral surgery, it would be considered "contraindicated" for the generalist to do so. The same exists with NTI therapy. As the demand for expertise increases, so do the risks of complications resulting from inexperience or lack of understanding about both the nature of the condition and the treatment modality. The NTI is easy to use but the therapeutic protocol must be followed to attain optimal treatment results. This means properly customizing the device to guarantee posterior and canine disclusion, adequate retention and proper vertical dimension.

Some claim that an NTI is simply an anterior deprogrammer and you're using some savvy marketing to rake in the dough. How do you respond?

Boyd: Use of a "deprogrammer" stipulates that lateral pterygoids are "programmed" to prevent certain occluding contacts from occurring during mastication. The practitioner employs the deprogrammer in a chairside setting, which is nothing like what happens during sleep. Comparing the NTI therapeutic protocol to traditional deprogrammers or full-arch occlusal guards doesn't make sense. By ensuring constant cuspid and posterior disclusion, the NTI, an *enhanced* deprogrammer, minimizes muscle intensity by as much as 70 percent and reduces joint load during nocturnal parafunction. Other anterior deprogrammers may allow posterior or canine occlusion and not only allow, but may increase muscle activity and intensity.

What research is available to prove the efficacy of the NTI as a migraine preventive treatment?

Blumenfeld: The standard used in medical practices in assessing the effect of migraine prevention drugs is that they should ideally reduce migraine frequency by at least 50 percent in at least 50 percent of the subjects. This usually involves comparing the active medication to a placebo and showing superior effects. Unlike drug trials, it is impossible to compare an intraoral device to a placebo intraoral device, as anything placed within the mouth elicits trigeminal sensory input. When compared to a "control" mouthpiece, the studies done to date show that the NTI reduced migraine events by 77 percent in 82 percent of the subjects.

If the NTI is effective, why hasn't the medical community embraced it?

Blumenfeld: Just as it is in dentistry, a physician will prescribe what he is familiar with. In addition, migraines remain underdiagnosed and undertreated in medical practices. The migraine specialist's goal for prevention is to eliminate or minimize as much noxious sensory input as possible, and a properly provided NTI does just that. However, most physicians are yet to understand it that way. We believe that our next study will help to expand the understanding of how the NTI affects migraines.

Aren't migraines caused by triggers like diet and weather changes?

Blumenfeld: Almost… the term "trigger" is correct, but "cause" is not. Trigeminal sensory dysmodulation is what *allows* something that would otherwise be "normal" input to activate a cascade of events that result in migraine pain. The less noxious bombardment the sensory nucleus is exposed to, the less likely the patient is to experience a migraine due to their "triggers."

To learn more about the NTI-tss therapeutic protocol, visit: (Chairside Direct) www.nti-tss.com or (Lab Fabricated NTI Plus) www.kellerlab.com. ■

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New Year's Resolution:

Talking to your patients about HPV, and the use of OraRisk HPV, which detects HPV strains connected to oral cancer

by Ronald C. McGlennen, MD
and Thomas W. Nabors, DDS, FACD

2010 was the year that the oral HPV/oral cancer connection made the headlines. It took a celebrity's oral cancer diagnosis to prompt several reporters to dig deeper and inform consumers that not all oral cancers are caused by tobacco and alcohol.

Physicians and dentists alike know that oral cancer can be disfiguring and deadly, particularly when presenting in its later stages. For generations, clinicians have been trained to look at alcohol and tobacco use as two of the main factors, other than family history, that put their patients in the high-risk category. And for generations, we've been evangelical about explaining these risk factors to our patients.

But now there's a new villain in the lineup; one that is running pace with smoking and drinking as a putative cause for oral cancer. This suspect is human papillomavirus, or HPV. In fact, of the 34,000 cases of oropharyngeal cancers diagnosed each year, HPV is now found in up to 50 percent of them.[1]

Whatever the cause, oral cancer at its earliest stages is difficult to discern from healthy tissue. By the time the lesion is visually apparent or symptomatic, it is likely to require surgical removal.

There are about 1,700 more people developing HPV-related oral cancers each year.[1] The risk profile for oral HPV includes anyone older than age 12 who is sexually active or who has had more than three sexual partners.[2] These statistics are now being cited in the mainstream media.

Like it or not, the fast-forward button has been pushed on the progress of oral medicine, which presents dentists with the two-edged sword of both great responsibility and opportunity. As the gatekeepers of oral health, don't dentists have a responsibility to their patients to look for cancers that originate and/or reside in the oral cavity at their earliest and most treatable stage?

There are several devices available to assist dental professionals in detecting possible cancerous lesions in the mouth.

Tissue fluorescence devices shine light of a specific wavelength onto the oral mucosa. The light interacts with dysplastic tissue differently than with normal tissue, and therefore fluoresces differently than normal tissue. Depending on the individual risk factors of the patient, the suspect lesion can be monitored over time for changes or symptoms, or a biopsy can be taken and tested for cancer.

Brush biopsy devices employ tiny wire brushes that scrape off the top layers of skin of suspect lesions, the cells of which are analyzed in a laboratory and described on a pathology report.

It must be noted that these two methods are used to screen for oral cancer, which might be attributed to the oral HPV virus. They do not directly screen for HPV as a potential precursor to oral cancer. Currently, the most convenient noninvasive way to definitively detect oral HPV is through a salivary diagnostic test.

OralDNA Labs recently introduced the OraRisk HPV test, a noninvasive, easy-to-use screening tool for identifying

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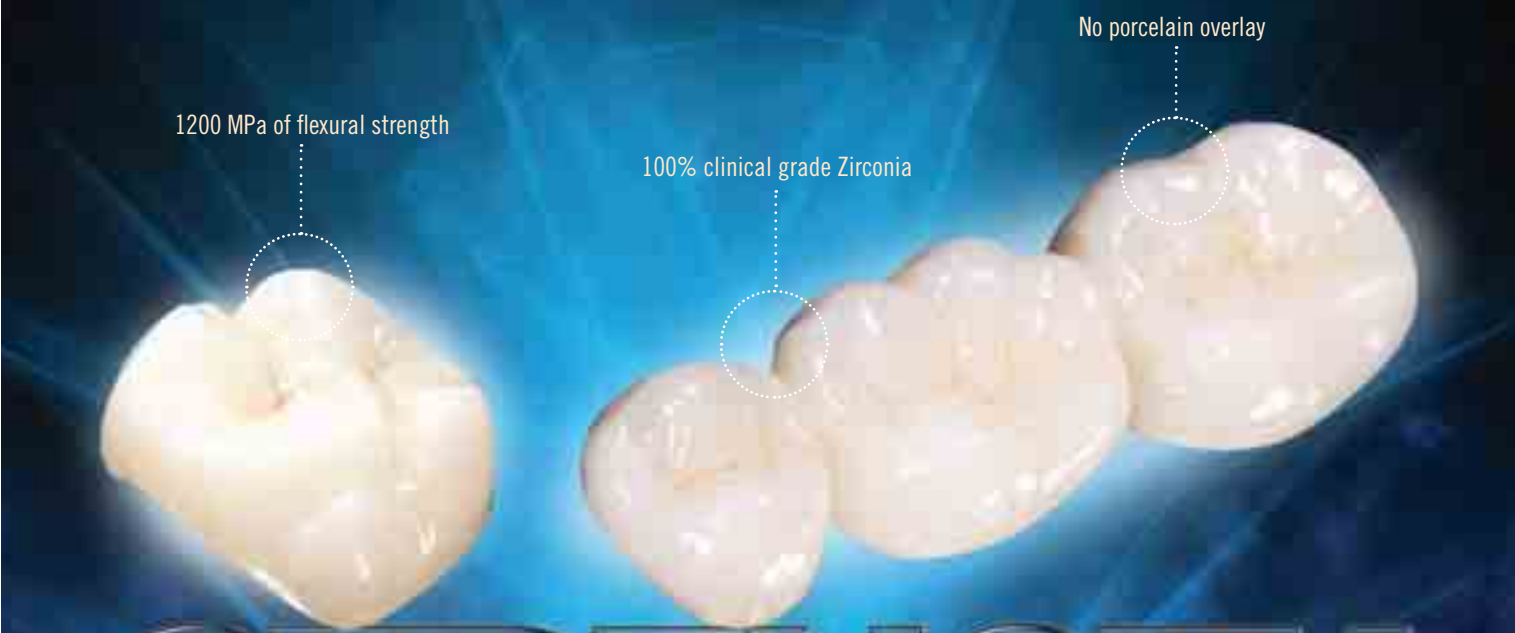

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the various types and levels of oral HPV infection, especially HPV-16 and HPV-18, which are the variants most commonly linked to oral cancer.[3,4]

Using salivary diagnostic testing, today's dental professional is in a unique position to not only save lives, but to play an important public health role in minimizing the spread of a sexually transmitted disease – the rationale being that once a patient knows he or she is oral HPV-positive, he or she might take the initiative to be more responsible and practice safe sex.

This opportunity to save lives and control the spread of sexually transmitted diseases is achieved through skillful patient communication, accurate diagnosis and prompt referral. There are four main questions that need to be answered before incorporating salivary diagnostic testing for oral HPV into your oral cancer screening protocol.

How to Discuss HPV

For most dentists and hygienists, the most probing question they ask their patients is, "Do you floss?" Now, in order to be a "mouth physician" testing for persistent HPV infection, much more personal questions need to be asked to patients who fit the following profile:

- Sexually active
- Family history of oral cancer
- Signs and symptoms of oral cancer
- Traditional risk factors for oral cancer
- Suspicious oral lesions

The oral HPV discussion is one that can be rehearsed and that over time will become more comfortable for dentists, hygienists and patients who will begin to accept the dental clinician's expanding role as a health care provider. The following is a sample script exerpt from the OralDNA patient education kit that can be used as a general guide on how to discuss oral HPV testing with your patients:

Doctor: *"As part of our regular oral cancer screening, we now incorporate an oral HPV test that helps us in several ways. It enables us to determine if HPV is present in your mouth and, if so, which types of HPV are present. This helps us determine if you are at increased risk for developing oral cancer and allows us to implement a plan for earlier detection and prevention of oral cancer."*

How to Test For HPV

As the patient education script explains, it's pretty easy:

The patient is instructed to swish a saline solution around the entire mouth, gargle deeply and expectorate into a specimen collection tube. This process takes 30 seconds.

The collection tube is then placed into its own plastic specimen transport bag and shipped from the dental office via prepaid FedEx envelope to OralDNA Labs in Brentwood, Tennessee for DNA analysis.

The OraRisk HPV lab report is then sent back to the ordering dentist via the secure Web site, so that he or she can share the information with the patient and develop a personalized treatment plan based on their test results.

How to Explain the Results of the HPV Test

OralDNA has created helpful patient education scripts for virtually every OraRisk HPV test result scenario:

Negative result:

Doctor: *Good news, your OraRisk HPV results came back negative, so there's nothing more to do at this time. On an ongoing basis, we would like to continue monitoring for new risks or changes in current risk factors. There are no current established guidelines for retesting, however; conventional wisdom or clinical judgment suggests one year is a reasonable time frame for repeat testing (similar to annual HPV testing of genital tract)."*

Positive result with no lesion:

Doctor: *Your OraRisk HPV results came back positive for HPV (HPV type 16, 18, etc.). You have no lesions or areas in your mouth of concern that we can see. However, to be safe, I recommend you have an examination of your complete throat area by an ENT, After that exam, we will discuss whether or not additional testing will be needed. By then, the virus may clear itself*

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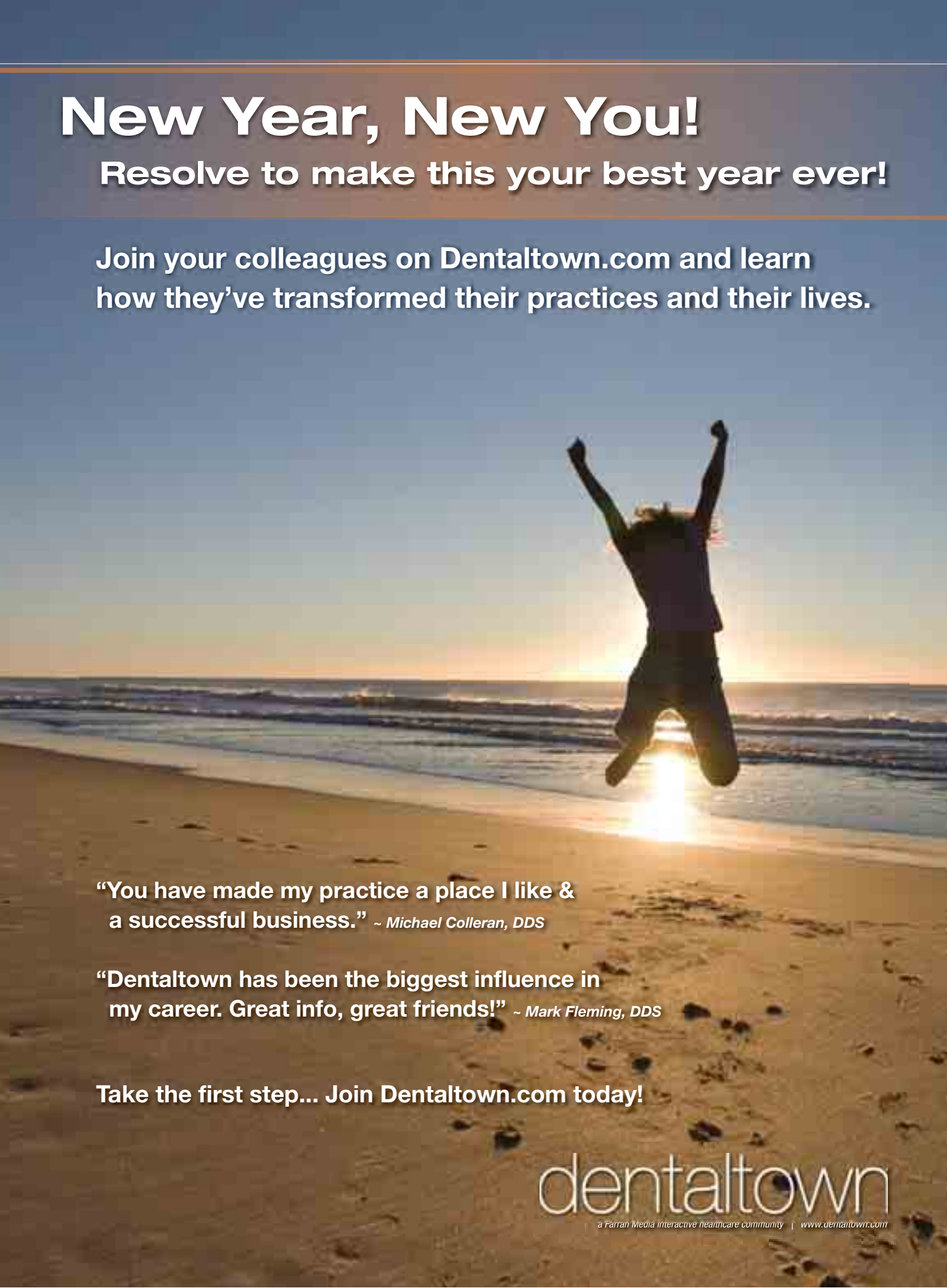

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from your body on its own, as is usually the case, and our test will provide certainty. Research has not determined the exact time frame for re-testing, but we suggest six to 12 months.'"

Positive with a lesion:

Doctor: *"Your OraRisk HPV results came back positive for HPV (HPV type 16, 18, etc.). Because you have a small lesion here (show patient the spot with an intraoral camera), I recommend you see a specialist who has experience in diagnosing these."*

Patient: *"What will s/he do?"*

Doctor: *"In many cases, they can tell just by looking if a biopsy is necessary. Biopsies these days are simple and painless. They will numb you in the area with an anesthetic, just like I do before a dental procedure. Then they may take a small brush and gently brush the area with it. This collects cells from the area that are sent to a lab for identification. Or, they may remove a very tiny part of the lesion and send it to a lab for identification."*

Patient: *"What if the biopsy is positive for cancer?"*

Doctor: *"Whenever we notice a lesion that does not get better on its own within 2 weeks, it's best to have it checked out by a specialist who will be able to provide the necessary treatment. The good thing is that we noticed it early. Treatment at the earliest stages is the most advantageous time to do something about it."*

What to Do Next

OralDNA Labs recommends that the treating clinician follow standardized follow-up protocols, and has created helpful workflow charts to map out the referral process for patients who test oral HPV-positive but present no visible lesions, and those who test oral HPV-positive and present visible suspicious lesions.

Conclusion

Armed with salivary diagnostic tests, dentists and hygienists are in a perfect position to diagnose oral HPV early, and not only have a positive impact on patient outcomes, but also on reducing the spread of oral HPV. As a New Year's Resolution, perhaps you can resolve 2011 to be the year you'll choose to update your oral cancer screening protocol. n

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Author Bios

Ronald C. McGlennen, MD, is the medical director of OralDNA Labs, Inc., a leading provider of salivary diagnostic tests to the dental profession, and a subsidiary of Quest Diagnostics, Incorporated. Dr. McGlennen is board certified in anatomic and clinical pathology, and also board certified by the American Board of Medical Genetics, with a specialty in clinical molecular genetics. He is internationally recognized as an expert in molecular biology and genetics.

Thomas W. Nabors, DDS, FACD, was a practicing dentist for more than 38 years. He treated periodontal patients using a variety of treatment philosophies: nonsurgical, surgical, laser therapy, as well as antimicrobial models. He has a rich background in the clinical application of current therapy philosophies and the application of clinical laboratory testing. He is a distinguished lecturer at the national and state levels on personalized periodontal disease treatment and the application of molecular testing methodologies within oral medicine. He has authored numerous articles on the subject. He co-founded OralDNA Labs in 2008 and serves as the company's chief dental officer.

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Oral HPV and the Dental Professional's Role in Public Health

by Margaret Scarlett, DMD: Captain, USPHS (ret.), Centers for Disease Control and Prevention CEO and President, Scarlett Consulting International

Much is known about the progression of human papillomavirus (HPV) in the genital tract. This includes the association of high-risk HPV with cervical cancer and its prevention by the newly available HPV vaccines. While long-term studies of the natural history of HPV within the oral cavity are not available, it is known that the acquisition of HPV occurs through open-mouthed kissing and oral sex.[1,2]

Oral HPV infection, and especially infection with HPV-16, has been acknowledged as a risk factor for developing oropharyngeal cancer, particularly oropharyngeal squamous cell carcinoma (OSCC) by the International Agency for Research Against Cancer. A recently published study in the *Journal of Emerging Infectious Diseases* suggests that there is a slow epidemic of HPV infection-induced oral cancers, notably OSCC.[3]

The incidence of these oral cancers, or number of new cases diagnosed, has increased significantly among persons between ages 20 and 39 in the U.S. Persons with prior HPV infections are 32 times more likely to develop oral cancers at the base of the tongue and tonsils than those who do not.[2,4] This is about 10 times greater than the risk associated with chronic alcohol or tobacco use.[2]

Throughout the last decade, the age at diagnosis, incidence, location of oral and pharyngeal cancers, and risk factors have changed dramatically. From 1998 to 2003, differences in the type of oropharyngeal cancers, the location and regional variations have been determined from epidemiologic data obtained from national cancer registries and behavioral data. At least one published review of data demonstrates that the incidence, or newly diagnosed cases of oral cancer at the tonsillar area and base of the tongue are increasing.[4] Several research studies, including at least one case control study, have suggested that these changes might be attributed to the acquisition/transmission of HPV.[1,2,3]

While the science is evolving, dentists should carefully consider their role in the prevention of oral cancers. This includes reviewing their oral cancer screening protocols periodically to include assessment of HPV infection in the oral cavity.[5] While there is limited data on oral practices, the highest-risk group is expected among young sexually active adults under the age of 25. Since many of these young people are otherwise healthy and do not regularly visit another primary care provider, dentists could play a significant role in the prevention of a growing subset of oral cancers.

Therefore, dentists should assess and expand their capacity to provide HPV screening, appropriate referral and counseling. They should be aware that open-mouthed kissing and oral sex carries some risk of HPV transmission. This is likely to be greater, especially when one partner is known to be infected with HPV, when either partner's HPV status is not known, and/or when one partner is not monogamous. Since at least one study shows that persons with more than six oral sex partners are nine times more likely to develop oral cancer than those who did not, dentists should evaluate their capacity to assess the patient's oral practices for risk of acquiring HPV infection.[2,5]

Oral care providers should also determine their ability to provide appropriate training, counseling or referral on oral sex practices, including the use of proper barrier protection and partner reduction to reduce risk of HPV-associated oral cancers.[5] n

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Two Concepts in Denture Occlusion

Lingualized Occlusion vs. Linear Occlusion – What's the Difference?

by William S. Jameson, BS, DDS, FACP, FICD

Denture wearers have three things they desire most from their prostheses: aesthetics (a natural look), comfort and function. Comfort and function are directly linked with the occlusal scheme incorporated into the prostheses. But what is the best scheme?

Occlusal schemes are divided into two classes – anatomic and non-anatomic. Depending on where an individual received his or her pre-doctoral training will play a significant role in the occlusal scheme a doctor selects. There is far too much material that needs to be taught and far too little didactic time available to permit an in-depth study of all aspects of denture occlusion in a pre-doctoral curriculum. Each school might by necessity emphasize one particular type of occlusal scheme depending on the philosophy and background of the school and department head. It is the responsibility of the dental school to prepare its students, first and foremost, to successfully pass their dental board examination. To that end, the student must be proficient in one occlusal concept, not all.

In these two categories, linear and lingualized occlusal forms (Condyloform and AutoCentric Posteriors, Candulor USA, Inc.) have a history of being the most functionally efficient. In the Glossary of Prosthodontic Terms both are defined.[1] For lingualized occlusion, "this form of occlusion articulates the maxillary lingual cusps with the mandibular occlusal surfaces in centric working and non-working position." More recently, the term has changed to "lingual contact occlusion" to dispel the misconception that the mandibular teeth have been moved lingually. The mandibular occlusal surface might be flat or poses a shallow central fossa into which the opposing lingual cusp articulates (Figs. 1a & 1b). For linear occlusion, "the occlusal arrangement of artificial teeth, as viewed in the horizontal plane, wherein the masticatory surfaces of the mandibular posterior artificial teeth have a straight, long, narrow occlusal form resembling that of a line, usually articulating with opposing monoplane teeth (Figs. 2a & 2b)." In the arrangement of both, the point of occlusal contact is over the crest of the residual ridge for mechanical stability. Lingualized occlusion has been likened to a mortar and pestle, whereas linear occlusion resembles a knife on a chopping block. From a personal perspective, a sharp knife on a chopping block is functionally more efficient than a grinding, crushing type of occlusion.

Stability of the mandibular prosthesis is directly associated with the lack of cusp/fossa interference in arriving at or exiting from centric occlusion position and the lack of interference in eccentric movements. This is much harder to attain with lingualized occlusion since there is a specific cusp to fossa intercuspation, whereas linear occlusion has no inclines with which the blade might contact when the patient closes into centric or eccentric articulation. With linear occlusion, articulating forces are in a vertical, stabilizing direction whereas tipping forces might occur in lingualized occlusion if there are any premature contacts prior to achieving centric articulation. Instability of the prosthesis leads to discomfort from tissue irritation and loss of residual ridge over time.

In addition to differences in occlusal form, there are differences in the principles of articulation. With linear


Fig. 1a


Fig. 1b


Fig. 2a


Fig. 2b

occlusion success is directly linked with noninterference between opposing tooth surfaces. That applies to the anterior component as well as the posterior component. To facilitate this, the mandibular anterior teeth are arranged in centric position a half millimeter below the occlusal plane, which is determined by the incisal edges of the maxillary central incisors in the anterior and halfway up the retromolar pad on either side in the posterior (Fig. 3). To prevent anterior contact in protrusive position, the mesial one-third of the maxillary first premolar is beveled at a 45-degree angle toward the distal contact area of the canine. This creates a straight edge against which the blade of the mandibular first premolar will make contact as the mandible moves forward and upward, preventing anterior contact. This creates a posterior, vertical force in the premolar area which seats rather than rotating the maxillary prosthesis on the anterior residual ridge (Fig. 4).

Fig. 3

Fig. 4

One reason for the popularity of lingualized occlusion can be attributed to the fact that its technical aspects are basically the same as conventional anatomic occlusion. That said, the inherent anterior vertical overlap is a given. Even if the anterior teeth are arranged out of contact in centric articulation, with occlusal wear (porcelain prosthetic teeth are rarely used) and posterior ridge resorption, the mandible will move forward and upward with resulting anterior tooth contact. When this occurs, a rocking or rotational movement of the prosthesis occurs with its associated anterior hyperfunction and in one of every four patients, loss of the premaxilla.[2, 3]

Arranging posterior lingualized teeth is much more difficult than linear prosthetic teeth due to the required cusp/fossa relation. If the maxillary anterior teeth are

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positioned for aesthetics and phonetics, followed by the mandibular anterior and posterior teeth, the articulation of the maxillary first premolar to the mandibular first premolar is usually problematic. If the maxillary posterior teeth are arranged followed by the mandibular posterior teeth, the mandibular anterior teeth might have problems filling the remaining space (Fig. 5). This problem does not exist with linear posterior teeth since the blade in one arch articulates anywhere on the flat surface in the opposing arch (Fig. 6).

Fig. 5

Fig. 6

The final difference to consider is occlusal adjustment or refinement. With lingualized occlusion, the first point of a premature contact will be hidden within the occlusal fossa. Because of this, one must rely entirely on marking the spot with articulating paper. In the mouth, if the first contact is on an inclined plane, the prostheses could shift as tissue is displaced under occlusal loading. The most accurate method would be an intraoral needle point tracing and lab remount. Some advocate using the intraoral tracing device with gradually closing the marking screw until contact is made, marked and relieved. This is repeated until bilateral uniform contact on all articulating surfaces is achieved. If the contacting force is too great, tissue displacement could still be a source of error.

As defined earlier, with linear occlusion, one arch contains a bladed occlusal form and articulates with flat monoplane teeth. The posterior linear occlusal teeth are manufactured in porcelain only. This allows the blades to be sharpened and resist wear. The arch with the flat occlusal surfaces is milled on a plate glass slab with 220-grit wet and dry sandpaper until all posterior teeth are in contact on the horizontal plane. Once this is achieved, these flat surfaces are never altered with a rotary instrument. Only the blades are adjusted vertically until bilateral, uniform contact is established.

To make an intraoral adjustment, the operator will first listen, then look and finally mark with articulating paper and reduce the offending blade vertically. After bilateral simultaneous contact is established, the blades are sharpened by grinding on the buccal and lingual of the blades. When rapidly tapping together in centric relation, a distinctive click or ringing sound is heard. If by chance the occlusion is off, a dull or double-click will be heard. The operator then parts the lips and has the patient close slowly into a retruded position. With no incline planes to obstruct the view, the first point of contact can be observed. Knowing this, the blades are marked and more accurately relieved. This is repeated until bilateral, simultaneous contact is achieved. With only vertical occluding forces, the possibility of lateral shifting of the prosthesis during refinement is eliminated. The patient is then instructed to bring the mandible forward into an end-to-end relationship and checked for contact. The bilateral fulcrum should prevent contact, but if present, either the maxillary or mandibular offenders are reduced until only light, kissing contact remains. The decision as to which teeth to reduce depends primarily on aesthetics.

Conclusion

The occlusal scheme chosen by the clinician will always be a personal decision based on knowledge and experience. This is basically the conclusion drawn by attendees at The International Prosthodontic Workshop on Complete Denture Occlusion[4] in 1972 when they stated, "At present, the choice of a posterior tooth form or arrangement for complete dentures is an empirical procedure. The available research fails to identify a superior tooth form or arrangement; therefore, it appears logical to use the least complicated approach that fulfills the requirements of the patient." Personally, I will always choose the one which will be functionally efficient and create the least amount of post-insertion problems, for me as well as for the patient. Over the years, I have found that linear occlusion satisfies that criteria for the majority of patients, both completely edentulous,[5] as well as combination cases.[6] To choose a scheme primarily because they merely look more like "teeth" is, in my opinion, a disservice to the patient. Granted, the desires of the patient must be taken into consideration, but we as the professional have an obligation to educate the patient about the need to preserve that which remains, not merely replace that which is missing. For the doctor wishing to use linear occlusion, two challenges must be

overcome, neither of which is insurmountable. The first is the need for training in the technique, which differs in many aspects from conventional procedures in denture fabrication. This can be accomplished by attending a hands-on course. There is no substitute for actually doing the procedures under supervision. The second challenge is the area of laboratory support. Shortcuts and modification of the required procedures will only lead to frustration and disillusionment with a return to the old ways. Over the years, this has proven to be the greatest hindrance in expanding the use of linear occlusion. Simply put, you need to find a laboratory trained in the technique in order to get the required support to achieve the desired successful outcome. ■

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Author's Bio

Dr. William Jameson graduated with honors from the University of Tennessee in 1954. He completed postgraduate training in prosthodontics at Tufts University in 1962 and was certified as a Diplomate for the American Board of Prosthodontics in 1967. He retired from the Air Force in 1976 to become a core faculty member at Oral Roberts University, School of Dentistry tasked with developing the removable prosthodontics curriculum. In 1980 he established a practice limited to prosthodontics in Tucson, Arizona. Since retirement in 1992, he has been a consultant and lecturer while maintaining a part-time practice limited to removable prosthodontics using linear non-interceptive occlusion. His presentations have covered complete dentures, removable partial dentures and implant reconstruction. He can be contacted at bbjameson@dakotacom.net.

Telephone Triage for Dental Emergencies

by Donald A. Crumb, DDS

The word "triage" is derived from the French word *trier,* meaning to separate, sort or select. Most of us are familiar with the triage process that takes place in hospital emergency rooms. It is a process of determining the priority of patients' treatments based on the severity of their condition. Put another way, triage is the initial assessment of a situation in order to determine the patient's need and the course of action to follow.

Whenever a patient presents to our dental offices with a dental emergency, the dentist or dental staff routinely perform triage to ascertain the extent and nature of the patient's problem and implement treatment to effectively diagnose and resolve the problem. Our objectives for an emergency appointment are to relieve our patient's pain or otherwise resolve their problem with efficient use of staff and doctor time. The extent of what we can accomplish in our treatment is often dictated by the amount of available doctor time – so time management is critical. Effective utilization of auxiliaries in the triage process provides more efficient use of available doctor time and therefore creates less stress and greater productivity. Triage is a team process.

Stress

When a patient is in pain, there is stress. When a front office team member answers the telephone and is confused by the patient's emergency problem or there doesn't seem to be any time available in the doctor's schedule, there is stress. When the clinical staff sees that an emergency patient has been squeezed into their busy schedule and no one seems to know what the patient is coming in for, there is stress. When the doctor examines the emergency patient and discovers that the patient's problem is not even close to what the front office had suggested and there is not adequate time to do what the patient needs, there is stress. Is there any wonder why in many dental offices emergency patients are considered inconveniences or worse?

The best-case scenario, in my opinion, for effective triage of an emergency dental patient would go something like this:

Front office: The initial conversation between the emergency patient and the front office staff person is the beginning of the triage process. This team member is responsible for a comprehensive assessment of the patient's problem that is provided in writing for the doctor's review. He or she is also responsible for scheduling the patient for an adequate amount of time for the clinical staff to either temporarily resolve the problem or make plans to do so by referral, etc. Inadequate or inaccurate information resulting from this dialogue will compromise the triage and treatment process.

Clinical staff: Upon the patient's arrival to the office, available clinical staff (either a clinical coordinator, hygienist or dental assistant) does a preliminary examination of the problem area and reviews and con-

firms the details of the initial triage report from the front office. He or she takes the necessary records including radiographs, intraoral photographs, etc.; prepares the treatment room for necessary clinical procedures and reports the clinical findings to the doctor.

Doctor: The doctor should have a detailed explanation of the patient's problem, including the results from radiographs and the preliminary exam before actually seeing the patient. The doctor determines the diagnosis and reviews treatment options with the patient. Clinical treatment will begin as time allows. Relief of any pain is accomplished by palliative treatment, prescribing medications or referral. If time allows, definitive restorations can be done. Otherwise, the patient is stabilized and appropriate follow-up appointments can be scheduled. Don't throw your whole day off trying to do more than is necessary!

The weak link in the triage process of most dental offices seems to be the information gathering from the initial emergency telephone call. Any miscommunication at this point can lead the team in the wrong direction and cause stress between the front office and the clinical staff. It is not uncommon for dental offices to "skip" the front office triage step because of a history of misinformation in handling past emergencies. If you have this problem, find out if it is due to lack of staff training or inadequate methods to record this important information or both.

If the dental office team is all on the same page, the emergency visit for the patient can be a very positive experience. It does take a coordinated effort by the entire staff to achieve the desired results… a win-win for the patient and the office. Successfully treated emergency patients are very appreciative and often become great referral sources.

Preferences in managing dental emergency patients vary considerably from office to office. There really is no one right way for all offices to handle such situations. However, if you want to lower the stress level in your office, pay attention to your triage process. It all starts when the telephone rings! n

Author's Bio

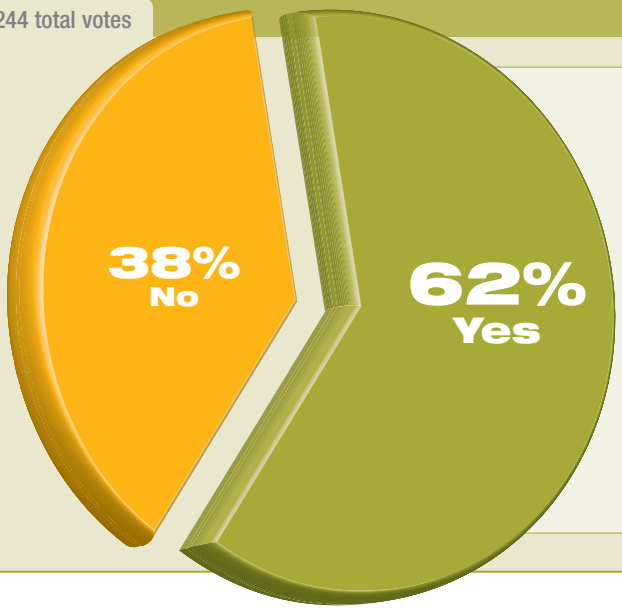
Dr. Don Crumb has practiced general dentistry in Syracuse, New York since 1976. Dr. Crumb is the founder of Crumb's Cranium, LLC, a company that recently introduced the only intuitive dental triage software on the market that enables front office staff with or without dental experience to effectively manage and schedule dental emergencies. For more information go to www.crumbscranium.com or contact Dr. Crumb at drcrumb@crumbscranium.com.

Dentaltown Research: **Cosmetic Dentistry**

Dentaltown is digging a little deeper. Based on the monthly poll on Dentaltown.com we're determining explanations for each poll result. Included with the poll statistics are the most popular write-in answers, as well as small fun facts and recaps of the Townie Choice Award's winning categories that coincide with our research topic. This is a work in progress, but remember to keep taking the poll on Dentaltown.com each month. The more opinions you can provide us, the better information we can supply to you. The following poll was conducted from November 5, 2010 to December 6, 2010 on Dentaltown.com.

Did you place any veneers in 2010?

1,244 total votes



- Out of 1,244 responses to this question, 478 Townies answered "no." The most common reasons why they said they did not place any veneers are represented by the following quotes:
  - "Didn't have a patient that wanted it."
  - "I prefer straightening and whitening. If really needed, then it's a crown, not a veneer."
  - "Patients can't afford them in this recession."

Do you recommend over-the-counter whitening products to your patients?

63% Yes
37% No

921 total votes

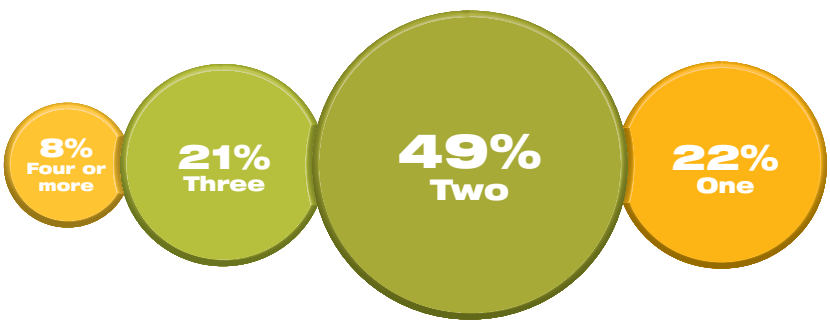
What percentage of the time do your anterior aesthetic cases have a periodontal surgery component?

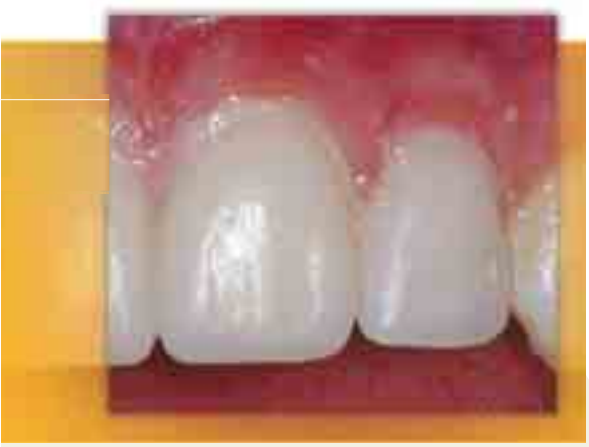
82% Rarely
16% Approximately 50 percent
2% More than 50 percent

913 total votes

How many shades of composite do you use for an anterior Class IV restoration?

919 total votes

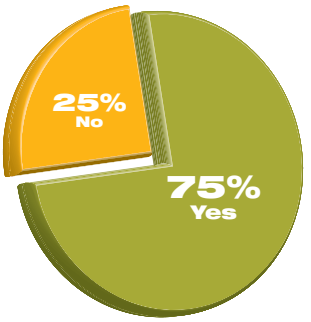




Do you routinely use flowable composite under posterior Class II composites?

923 total votes

- Twenty-five percent of poll responders answered no. The top two reasons given as to why:
  - "No real science shows that it is any better to do that extra step."
  - "I don't think the increase in shrinkage is worth the supposed better adaptation."



Townies' Thoughts on All Zirconia Crowns

- "I would not use them at this time until more evidence is available for their usefulness. Also I would never want to have to remove one by sectioning it."
- "Interesting product. Would like to see results of longer studies."
- "Sounds good, needs research and clinical follow up to see if they live up to the claims."
- "Unbeatable strength but slightly compromised aesthetics – perfect for posterior crowns."
- "I am concerned about wear on the opposing occlusion."

Fun Fact

The Inventor of Veneers: Dr. Charles L. Pincus In 1937, Dr. Pincus fabricated temporary veneers cemented with denture adhesive for the purpose of close up shots of movie stars with less than perfect teeth.

Source: Pincus, C. L.: Building Mouth Personality, J. South. Calif. Dent. Assoc., July-Aug., pp.125-129, 1938

Face Fact

A person's smile is the only facial characteristic people can detect from 300 feet away – the length of a football field.

The Zirconia Report

In a study presented in the March-April 2010 *International Journal of Oral & Maxillofacial Implants* the five-year success rate of zirconia implants was evaluated.

The result… after five years the overall implant success rate of the 831 implants placed in 378 patients was 95 percent.

Source: International Journal of Oral & Maxillofacial Implants, March-April 2010, Vol. 25:2, pp. 336-344

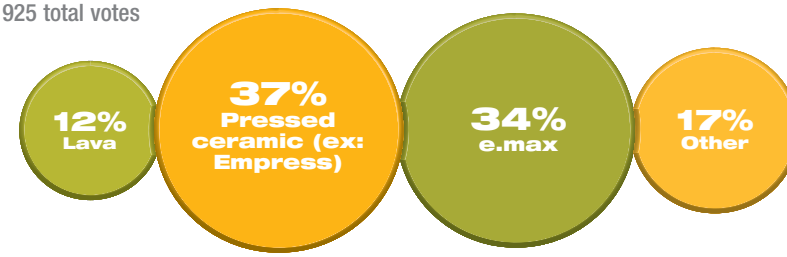
Did You Know…

The world's largest dental caps measure approximately 19 inches long, five inches in diameter and weigh 28 pounds each. They were fixed onto a pair of cracked tusks belonging to Spike, a resident Asian elephant at the Calgary Zoo in Alberta, Canada.

Source: Guinness World Records

What is your material of choice for an anterior crown?

925 total votes



When asked "What features are most important to you when choosing a material?" the number-one response from Townies was, "combination of aesthetics and strength."

Cosmetic Dentistry: 2010 Townie Choice Award Winners Recap

Cosmetic Bleaching – In-Office System:
Discus Dental, Inc. – Zoom!/Zoom2/Zoom! Advanced Power/Zoom! Advanced Power Plus

Cosmetic Bleaching – Over-the-Counter Products:
Procter & Gamble – Crest Whitestrips

Cosmetic Bleaching – Take-Home System:
Ultradent Products, Inc. – Opalescence/Opalescence Treswhite Supreme

Crown & Bridge – Veneers by RX:
Ivoclar Vivadent, Inc. – IPS Empress/IPS e.max

Crown & Bridge – All-Ceramic Crowns RX:
Ivoclar Vivadent, Inc. – IPS Empress/IPS e.max

Crown & Bridge – PFM Crowns by RX:
Captek-Precious Chemicals, Inc. – Captek Restorations

The FIFTY Greatest Game Changers in Dentistry

What has changed the way you practice dentistry? Is it the soft-tissue laser you love so much you even use it to cut the crust off your sandwich? Is it the eye-opening tutelage from a no-nonsense dental guru? Is it a harsh rule or regulation the government imposed upon the profession? Or maybe something you've used all along, but know you would be unable to perform high quality dentistry without it? Whatever the case, whether a dentist has been chairside for 50 years or five minutes – every single one of us has an answer for what's most impacted the way we practice dentistry.

Dentaltown was curious to find out what you thought the biggest game changers in dentistry were. So, before Townies opened their ballots for the 2010 Townie Choice Awards, we asked one simple optional question: ***In your opinion, what person, event, story, technology, product or service do you think has been the biggest "game changer" in all of dentistry?***

We thought we might get 100 answers, tops. But, man, were we wrong! More than 1,600 Townies answered the fill-in question. Some answers, we thought, were pretty spot on – others, like "my emergence into the dental field" and "my birth," well, some Townies are well known for their sense of humor...

As we tallied up the votes for the Townie Choice Awards, we compiled the "game changer" data and pared your responses down to the 50 most popular answers. Then we asked members of our Editorial Advisory Board, popular contributors to Dentaltown Magazine, and well-known dental industry professionals to weigh in on why they thought the following 50 items were considered game changers by the Townies. Herein we are proud to present the results and reasoning for the ***50 Greatest Game Changers in Dentistry,*** *in no particular order...*

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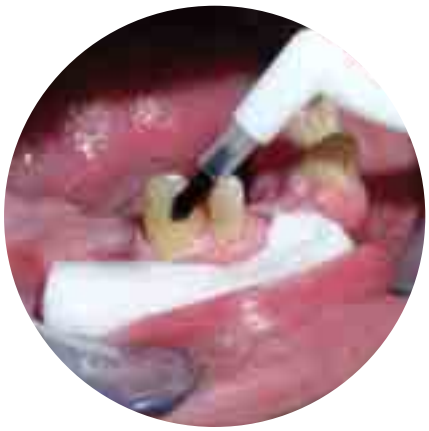
#1 CAD/CAM

Machines that take digital impressions, make virtual models and fabricate the restoration through porcelain/ceramic or composite milling have reformed the concept of practice for technologically open-minded dentists. CAD/CAM allows precise and aesthetic restorations to be completed in a single appointment. The need for traditional impressions, temporaries and additional appointments for seating and delivering the restoration are eliminated.

We all know that "stressful" feeling on the try-in appointment, the concern we have about adjusting those lab fabricated crowns that might not fit or have occlusal issues. CAD/CAM puts all the control in the hands of the dentist, greatly reducing the need for adjusting and refitting lab crowns. Done correctly, the marginal integrity, occlusion and aesthetics of CAD/CAM restorations is superb.

CAD/CAM restorative dentistry is *the* new paradigm in dental care. It is the future of restorative care.

Add up all the benefits that CAD/CAM provides to the practicing dentist and, as famous American songwriter and philosopher Bob Dylan once sang, "the times, they are a'changin." Restorative dentistry is "a'changin" and, yes, it's "a'changin" dentistry. – *GH*



#2 Bonding

Where would dentistry be without bonding? We'd have no need for curing lights, finishing discs and strips, mylar bands, Medieval-looking matrices, and a million little sticky bottles. Wouldn't life be great? Not!

We'd all have to remember what resistance and retention form are and do G.V. Black preps. We'd be back to heavy metal dentistry, dudes.

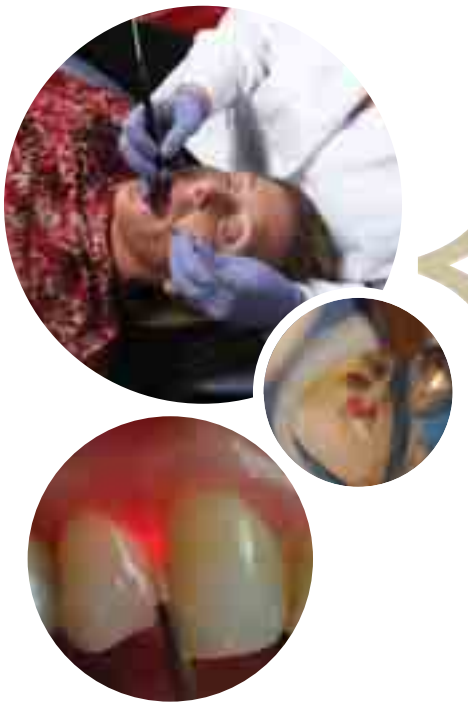
Bonding and the subsequent cosmetic dentistry revolution have put a new face on the dental profession. Instead of images of "shots," burning chicken feathers, whiny drills, and the red drool in the white sink, the public now see the dental office as a place of tiny injectors, aromatherapy, pajamas, 80s music and a chance for a better facial appearance. The potential of a better look and a better life puts the old, "nothing personal, but I hate dentists" line in the attic with grandma's dentures and my ABBA albums. Bonding has put a new smile on all of us. – *D. Carlsen*

#3 Composites

There is an obvious necessity to restore teeth in the smile zone and composite material provides miracles. Tooth-colored restorative material had an early start in dentistry as a single-color paste mix with limited application. The material had limited aesthetics and poor wear rates.

Generations later, we now have access to composite filling material of every color in the shade guide and reliable bonding agents to keep it in place for many years. Wear rates have improved so much that composite resin fillings are placed in all areas of the mouth. This aesthetic material threatens to completely replace amalgam as more patients demand tooth colored restorations. – *TG*

#4 Lasers



Lasers are accepted in the medical field, particularly in ophthalmology in the discipline of laser eye surgery. The acceptance that lasers can change our vision safely and painlessly has helped with patients' acceptance in the dental field. Dentists have been slower to pick up lasers for their practice primarily because of cost and education.

The price drop on soft-tissue lasers has brought many neophyte laser users into the field. This influx of dentists has driven up the demand for education – be it articles, lectures, hands-on training or Webinars. Many dentists are enthused at how these dependable, portable, lightweight diode soft-tissue lasers can be used for both soft-tissue surgery and the ablation of mild to moderate amounts of tissue in procedures like gingivectomies, crown troughing, frenectomies and fibromas. New procedures such as the treatment of oral lesions – aphthous ulcers, venous lake photocoagulation – have also been "hot" topics amongst dentists. In dental hygiene, we are seeing a growing interest to combine the laser with traditional methodologies to help decrease bacteria load in the gingival sulcus.

With the dramatic drop in price of soft-tissue lasers, combined with an increase in educational opportunities on this topic, more and more clinicians are "seeing the light." – *GV*

#5 Computerization/Practice Management Software

Computerization has been one of the best things to happen in dentistry. Dental practices are running more efficiently and they have easier access to their information than ever before.

The use of computer softwares like Dentrix, Eaglesoft and now Web-based Curve Dental, have made the dentist and dental teams more aware of every aspect of the practice and opened their eyes to the business side of dentistry. Dentists have more access to what is actually occurring in their business, and this has created a newfound interest in the administrative side of the practice. The technology allows access to the office computer from home or mobile device.

Dental teams are working together to provide better care. There is more focus on being productive and utilizing time wisely. Thanks to digital scheduling, practices have healthier recall systems and are more aware of patients putting off needed treatment. Computers in the practice have helped improve patient relations due to excellent communication capabilities.

Features like digital charting, digital scheduling and working paperless, save time and money. They also help decrease mistakes and increase security. Lastly, computer reports provide all the needed information for the dentist to have his/her finger on the pulse of the practice at all times. – *SP*

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#6 Digital Radiography

First and foremost, digital images have facilitated the paperless office concept *(Editor's note: see our feature on going paperless on page 100 of our December 2010 issue).* Additionally, this technology has eliminated costly and toxic chemicals from the office. The abilities to instantly view images as they are taken and digitally enhance the image are advances that we could only dream about when X-ray film dominated the profession. This technology continues to gain market share and will likely eliminate film-based X-rays in the same fashion that digital cameras have replaced film. – *TG*

#7 Implants

Dental implants have been around for thousands of years – and have even been found among Mayan ruins. Early 20th century implants were root-like metal baskets made of gold or iridium. In the latter half of the 20th century commercially available blade implants entered the market and competed with subperiosteal implants which are custom made by dental labs. These implant systems were successful but had high failure rates, were technically challenging and had limited clinical applications. These challenges left implants on the fringe of dentistry.

But developers of the modern implant like Drs. Per-Ingvar Branemark and Gerald Niznick didn't give up… since the introduction of osseointegration, implants have taken shape as a root-form titanium screw with a textured surface, proving both successful and predictable. This drove the rapid growth of large and small commercial manufacturers of implants and prosthetic components.

Advances continue in design, technique and materials, most recently with the use of zirconia in the place of titanium.

The importance of dental implants in dentistry is evident in the statistics. Sixty-nine percent of adults between 35 and 44 have lost a tooth due to trauma, decay, gum disease or a failed root canal according to the American Association of Oral and Maxillofacial Surgeons. And with a success rate of 95 to 97 percent over 20 years, it's no wonder consumers are excited about the emerging technology. – *WK*

#8 Dr. Gordon J. Christensen

Presenter of more than 45,000 hours of continuing education and co-founder of the *Clinicians Report* (formerly Clinical Research Associates), Dr. Gordon J. Christensen is one of the most well-known and well-respected dentists in the world. When Dr. Christensen speaks, dentists listen. "From the time I graduated in 1984, Gordon was the one who came around every year or so and gave a straight forward, honest and unbiased look at dentistry," says Townie "drjames." – *ML*

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townie choice awards 2010

Cosmetic Bleaching – In-Office System

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#9 Loupes and Magnification

Dentistry is so much easier if you can see what you are doing. Back in the "dark ages" of dental and surgical education, we were taught to do procedures using the naked eye with aid from the overhead dental light.

Operating microscopes were once seen only in the operating room. But, manufacturers saw the potential for dentistry and began producing scaled-down versions that made them affordable for dental practices. This technology became popular first among endodontists and restorative dentists, and then spread to other specialties. Now, operating microscopes are also seen in many dental practices, allowing precision in procedures that was not felt to be possible a generation ago.

Surgical telescopes (loupes) have become commonplace in dentistry in the last 15 years. No matter how minor the procedure, using magnification elevates your standard of care overnight. Being able to clearly see every detail of the operative field, even in the most distal areas of the mouth, makes dental procedures less stressful, faster, easier and more successful. The surgical telescopes of today have been significantly improved with lighter weight frames and lenses, making them more comfortable and less "nerdy-looking." Many of them can also be paired with integrated LED and fiberoptic headlight systems, enhancing visibility even further.

Seeing is believing. No matter what your specialty and what procedures you perform, adding magnification to our armamentarium with loupes or an operating microscope has enhanced our vision – both of the teeth and of dentistry as a progressive science. – *JR*

#10 The Oral-Systemic Connection

Just a tooth fixer? – not anymore. The modern dentist accepts the responsibility to identify, treat and manage the most common inflammatory process of the body – gum disease, and there is an insane amount of it running rampant, undetected and untreated. So as the prevention of periodontal disease continues to reveal more and more "whole body" benefits, patients will count on their dentist to help them live a longer, healthier and happier life.

Now physicians will be depending on dentists to manage the risk factors for serious disease that they have no control over. If a physician is responsible to manage the risk factors for serious diseases like cardiovascular disease, stroke, diabetes, cancer, and arthritis, in addition to preventing pregnancy complications, they must work with a dental team. One of the greatest paradigm shifts our profession has ever experienced is happening now – oral health affects body health. Get ready for the tsunami that will be oral systemic and the impact it will have not only on dentistry, but on the entire health-care community. – *CK*

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ENGINEERED TO DELIVER EVEN BETTER CLINICAL RESULTS

Invisalign's NEW SmartForce™ features are engineered to deliver the force systems to achieve **predictable tooth movements.**

POWER RIDGE™ FEATURES

Now for upper and lower incisors

OPTIMIZED ROTATION ATTACHMENTS

Now for cuspids and bicuspids

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Science in Every Smile

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#11 Digital Photography

Imagine trying to match single central incisors or document before-and-afters without digital photography. Imagine completing a smile design and not being able to capture an emotional after-picture of the patient. Imagine keeping your images in a storage room instead of a hard drive. Digital photography is as much a part of our practice as our handpieces and lasers, but without the precision and control that typical dental instrumentation requires for success.

Dentists are implementing more digital photography into their practices and finding themselves in an area that is dominated by subjectivity rather than exact depth cuts and correct wavelengths. This new role we play as dentists fosters positive relationships with our patients, as we gather more detailed information than ever before, to help dentistry achieve new levels of success. Digital photography allows us to have instant communication with our laboratories while our patients are still in the chair. Patients can be educated with the images we capture inside and outside of the mouth at the same appointment. We can even shoot a patient's new smile during a try-in, and show them the after-picture for approval before we bond the restorations to the teeth. Digital photography is encouraging dentists to hold themselves to higher standards than ever before.

Take away my digital camera and you might as well take away my drill. – *JO*

Local Anesthesia

Dentists used cocaine for local anesthesia in the 1840s. With better technology and legal (and ethical) ramifications, we've moved on. Products like Lidocaine and Articaine have not only saved patients' gums, but also their tear ducts. – *CP*

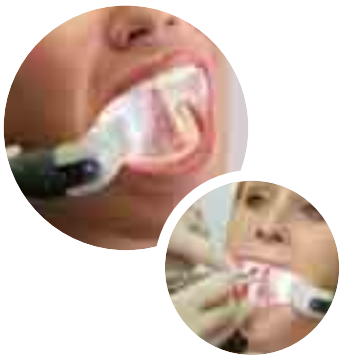
#12

#13 Internet

The "dot-com boom" shook the business world. Between the rapidly changing stocks in '96 and '97 and the dawn of social media giant Facebook in 2004, the field of dentistry had little choice but to jump on the bandwagon. Dental practices now sport Web sites, Facebook fan pages, Twitter accounts and blogs. It's a whole new era of social media and Internet publicity nowadays, and if you're not sure what we're talking about, Google it (or go back and check out *Dentaltown Magazine's* Social Media Focus in the September 2010 issue). – *CP*

#14 Isolite

Tired of the shadows created in the mouth from the overhead operatory light, Dr. Thomas R. Hirsch set out to create a solution by putting the light source where he needed it most – inside the patient's mouth. By combining intra-oral illumination with the ability to aspirate and retract, the Isolite dryfield illumination system was born. – *ML*



Dentaltown

#15

We promised ourselves we wouldn't cry... Dentaltown hasn't ever thought of itself as a "game changer," yet we made your list. In 1999, Dr. Howard Farran had an idea to create a Web site for the dental profession. The site would know no boundaries. It wouldn't care if you were from Toronto or Hong Kong or Sydney, Australia. Dental professionals would enter a chat room, post an X-ray or a photo or a case history and ask colleagues from around the world to discuss the case. The Web site would be a way for dentists to connect with their peers and save one tooth at a time. And for more than 11 years, via Dentaltown.com, no dentist has ever had to practice alone since. Connecting thousands of dentists around the world, becoming the proving ground for products and services and even inspiring some Townies to start their own dental companies, Dentaltown remains the largest and most vibrant community in the dental profession. We don't always like to toot our own horn, so thanks for doing it for us. – *BL*

#16 Clear Aligners

Braces came into play in the early 1900s, and the methods of moving teeth stayed relatively the same until the introduction of Invisalign in 1997. Gaining FDA-clearance to market in 1998, Invisalign changed the "how" and "who" in moving teeth. ClearCorrect has since followed in their footsteps.

After impressions of the teeth are taken, data is sent to respective labs, where computer software generates a series of clear plastic trays for teeth retention. The easy process provides adults (and now teens) with the means of straightening their teeth without the hindrance of unaesthetic metal braces.

Not only did clear aligners change how teeth are straightened, it opened the door for general dentists to facilitate minor orthodontic work. It also provided high schoolers a nice respite from the classic nicknames, "metal mouth" and "tin grin." – *CP*

#17 Electronic Reminders

Piggy-backing on the e-prefixes of the dot-com boom, electronic reminders, or e-reminders, show up in patients' e-mail inboxes and on cell phones to not only jog their memory to schedule a recall appointment, but also to confirm appointments they've already made. They eliminate the expense of postcards and postage stamps, they allow patients to reply to confirmation text messages, and most importantly, they meet patients' where they're at, which as it turns out, is no longer at the mailbox. – *CP*

continued on page 97

Scientific Metals Delivers Big Scrap Returns to Dentaltown Readers

Here's What Some of Dentaltown Readers are Saying

"I received a check in about a week for an amount that greatly exceeded my expectations! I feel very lucky to have seen the article in Dentaltown that inspired me to call you. I will use no other in the future."

Tim Muscaro DDS Tampa, FL
August 2010

"Dave you're awesome! The guy that comes around every so often usually leaves me about $1500 for this much metal. Thank you for the $3,500 check which is at least double what I would usually get. You have my business from now on."

Dr. Paul Barganier DDS Birmingham, AL
August 2010

"The staff told me they were expecting anywhere from $400-$600. We got a check from Scientific Metals for over $1200.00. Thanks Scientific Metals."

Dr. George Doskoris DDS Beverly Hills, MI

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Featured on the Cover of Dentaltown Magazine, July 2010

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#18

Metal-free Restorations

They replace pre-existing porcelain-fused-to-metal (PFM) crowns and bridges, provide beautiful smiles for our patients, and help avoid the need for aggressive preparations. Aesthetics might be the primary driving force for metal-free restorations, but it certainly is not the only one.

Metal-free materials can also be used for multi-unit bridge applications. The bridge applications utilize a zirconium-oxide substructure which does introduce some opacity, but usually provide far superior aesthetics than we have traditionally seen with metal.

Metal-free restorations present the opportunity to be more conservative in preparation design. This is especially true with the lithium disilicate (e.max) and leucite-reinforced (IPS Empress) ceramics that can be as thin as 1mm on the facial and lingual of full coverage crowns and the translucency of the material allows placement of a supragingival margin. These materials can also be bonded using dentinal adhesive systems and resin cements, so retention can be enhanced and eliminate removal of healthy tooth structure.

Many of these materials are "wear-friendly" when opposing natural enamel, unlike most of the powder-liquid ceramics placed on metal copings with PFMs.

The decade-long search for metal-free indirect restorations has resulted in a much prettier outlook on dentistry. – *DH*

#19

Power Toothbrushes

Whether the brush head is straight, round or with multiple heads, power toothbrushes provide uniform bristle movements that far exceed what can be done in the same amount of time with a manual toothbrush. The timer introduced with single brush-head power toothbrushes addresses two areas of failure with manual toothbrushes: brushing long enough and brushing throughout the mouth. The timer assures brushing lasts two minutes with a signal to move from mandibular linguals, to mandibular facials, to maxillary facials and finally, maxillary linguals. New powerbrush designs with multiple brushheads reach maxillary, mandibular and occlusal surfaces at one time, reducing brushing time while insuring all surfaces are reached. In terms of being proactive about oral health care, power toothbrushes have brought more power to the tooth brusher. – *TO*

#20

Dr. Frank Spear

Frank Spear, DDS, MSD, is most known for his contributions as a leader and educator in aesthetic and restorative dentistry. In 1994, Dr. Spear founded The Seattle Institute of Advanced Dental Education, now renamed Spear Education, and has expanded to the Scottsdale Center for Dentistry. Dr. Spear challenges dentists to provide better patient care by teaching how to treatment plan and problem solve in a logical manner. "I don't think you will find anyone who isn't happy with their educational experience with Frank," says Townie "socalsam." – *ML*

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#21 Whitening

Whitening has made cosmetic dentistry or appearance-related dentistry affordable. Prior to teeth whitening, to obtain a really great smile veneers or crowns had to be placed, which was not practical or affordable for many patients.

Now patients can have bright smiles for a very minimal cost and with a non-invasive procedure. When patient's started to learn about whitening options, it brought in patients that had not been to the dentist in years, ultimately giving dentists a second chance to educate patients on the importance of consistent dental visits. Whitening helped to brighten dentistry's future in more than just shades of white. – *DH*

#22 Dr. John Kois

John Kois, DMD, MSD, director and founder of the Kois Center, serves dentists through continuing education courses. He and his team provide an intimate environment for learning about current clinical dental topics. "He changed the way I viewed dentistry in the first 10 minutes of his TxPl I course," says "rochdoc," on the message boards of Dentaltown.com. And if all that isn't enough, according to Townies, the institute's bathrooms are apparently worth a visit as well. – *CP*

#23 NTI

Invented by Dr. Jim Boyd, the NTI-tss is an FDA-approved dental solution for the prevention of migraines, tension headaches and TMJ related pain. This appliance has a design that utilizes a patented discluding element to provide protection of muscles, joints and teeth by suppressing parafunctional intensity by 70 percent. Fabrication of this appliance can be accomplished chairside or with an approved lab. The response from patients and dentists has been very positive, which is one of the reasons this appliance received so many nominations for our list. (And check out our interview with Drs. Boyd and Andrew Blumenfeld about the NTI-tss in this issue!) – *TG*

#24 Microscopes/Telescopes

The dental microscope provides perfect coaxial light and affords multiple magnification levels from 3X to 24X. The impact on dentistry is quiet yet profound. Between 1990 and today, the number of endodontists using microscopes has increased from one percent to 90 percent. What does that mean for non-endodontists? Well for starters, complex endo done without a microscope can be considered as a "second-class treatment." And with the majority of endodontics being performed by GPs, not endodontists, you are likely to see more and more microscopes in hometown dental offices. Bottom line: if you enjoy endo, you will eventually buy a microscope. Period. And then you will probably begin to use your microscope for many non-endo treatments… partly because you'll be in love. – *D. Clark*

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#25 Fluoride

In high doses it is hepatotoxic, but the trace amounts found in many public water supplies make teeth resistant to cariogenic acids. This allows fluoride to prevent decay as well as remineralize incipient lesions.

Baby boomers have come to expect that they will retain their teeth for their entire lives. Unlike their parents who might have believed that everyone will eventually need dentures, boomers have decided to spend significant time and money in preserving their dentition. Fluoride in all its forms has been a powerful weapon in the fight to preserve our smiles.

Since the early days of fluoride the effect has been astounding. Edentulism in people 45-54 years of age in the early 1960s was around 20 percent, but by the late 1980s the number had dropped to about nine percent.

Fluoride has brought dental medicine a long way in the last 60 years. The CDC was justified in naming water fluoridation one of the top 10 public health achievements. Fluoride will continue to protect our smiles and form the cornerstone of the minimally invasive dental medicine practice of the future. – *WK*

Power Scalers

The technology adapted to power scalers includes magnetostrictive, piezoelectric and sonic, to remove hard and soft dental deposits, both supragingival and subgingival. Although first developed in the 1950s as a failed drilling instrument for caries excavation, it was adapted for plaque and calculus removal. Power scalers prove to be a faster, more comfortable deplaquing and calculus removal method for patients and clinicians who appreciate less stress to hand and arm muscles and faster deposit removal. – *TO*

#26

#27 Sealants

Deep pits and fissures on occlusal surfaces of posterior teeth are risk factors for caries that toothbrushing cannot keep clean. Pits and fissures can be completely sealed with either filled or unfilled sealants that effectively keep out sugar, bacteria and the acid responsible for dissolving enamel. Sealants are applied routinely in the dental office and in public health school sealant programs across the country. Preventing occlusal caries is a significant step in helping patients achieve the goal of living caries-free – and as a result, maybe a bit more carefree as well. – *TO*

#28 Apex Locators

If you are still depending on radiographic measurements for root canal therapy, you should really reconsider. With electronic apex locators the basic principal is the measurable electrical resistance in the biological tissues in and around a tooth. An entire root canal can be done with a great deal of confidence with only two X-rays – one at the beginning and end. The electrical circuitry is more accurate than an X-ray because it does not depend on the angle of the head of the X-ray machine, the placement of the film or sensor, or the position of the patient. X-rays require time to set up, take and develop, not to mention the cost. In addition, there is a huge reduction of ionizing radiation for both the patient and the office staff – a wonderful benefit for pregnant patients, as well as those recently exposed to radiation for cancer treatment and tests.

All in all, electric apex locators have become an essential instrument to dentists. As with most dental instruments there are several apex locators on the market. They've certainly improved since their inception in terms of type of electrical current being generated, ease of use and accuracy, as well as shape, size and cost.

They might not be new to dentist's armamentarium, seeing that they've been around since the 1960s, but apex locators like the Root ZX, or its dinosaur cousin the Neosono-D have played a large part in root canal therapy – then and now. – *MG*

#29 NiTi Endo Files

Nickel titanium (NiTi) files have given both specialists and general practitioners alike the ability to routinely create shapes once only imagined with hand files.

The importance of NiTi rotary files goes back to the basics of why we shape a root canal. We shape a root canal to increase the efficacy of our irrigation agent and to expedite obturation.

They have changed endodontic therapy because they have allowed us to significantly improve patient care and to accomplish it in a predictable, expeditious manner. – *KK & DB*

#30 Practice Management

The days of eugenol smell and the little lady behind that ghastly glass barricade are long gone in dentistry.

Practice management has deconstructed and repaired many design, treatment and financial barricades over the last 30 years.

Yet, the major hurdle conquered has been patient fear. Efficient systems eliminating almost all reception room waiting and providing quick treatment protocols have been a godsend. The advent of stronger and virtually painless injections and better office ambiance increase real patient comfort. Most of all, team harmony and positive attitude have crushed the fear quotient.

Practice management has brought the fun factor to dentistry. – *D. Carlsen*

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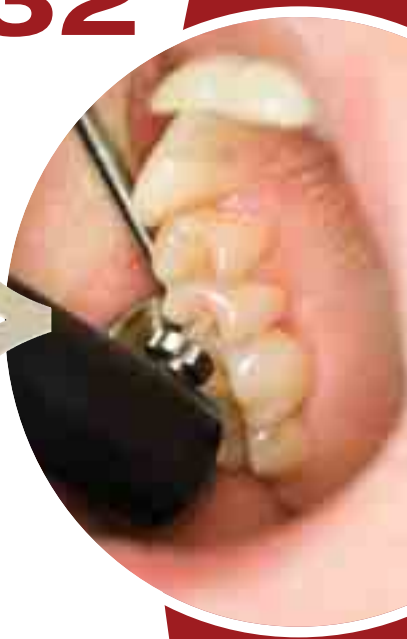
#31 Dental Hygienists

Irene Newman provided preventive and periodontal support services to dental patients for Dr. Alfred C. Fones in Bridgeport, Connecticut, in 1906. Since then, the dental hygienist has been crucial to dentistry – as an oral health coach of the dental practice, providing education, motivation and prevention as well as periodontal therapy. The dental hygienist frees up the dentist to provide dental restorative and specialty care while answering patients' questions about treatment and proposed cosmetic options. With a healthy mouth, patients can consider elective dental care. – *TO*

#32 Caries Detection



Caries detection has come a long way from an oral examination with a mirror, probe and X-rays. Film speed went higher and higher with an associated loss of resolution. The loss in resolution was associated with that required to diagnose an interproximal lesion at about the time it would be deemed ready for restoration. This led to many occlusal lesions being missed until they were nearly pulp exposures. Technologies developed over the last 10 to 15 years have seen early accurate diagnosis of occlusal lesions become a simple clinical reality. This early detection allows for minimally invasive repair of the fissure structures before the biomechanical integrity of the tooth has been compromised, thereby reducing the long term sequelae for the patients.

The first effective technology was the DIAGNOdent from KaVo that utilizes laser fluorescence to detect damage to enamel in the walls of the fissures. There are now several similar products on the market as well as imaging systems such as quantitative laser fluorescence and techniques using light fluorescence and imaging software to highlight areas of fissure demineralization. The ability to diagnose early and accurately lead to the development of techniques like micro air abrasion and the use of fissureotomy burs to carefully dissect out the demineralized tooth structure and avoid compromising biomechanical stability.

White spots and cavities are simply the signs and symptoms of a bacterial infection, or diseased biofilm which is known as caries. True caries diagnosis is the detection and diagnosis of a biofilm that has reached a point where the bacterial population is such that it can damage the underlying tooth structure. The selection pressure for the development of a cariogenic biofilm is low pH. Utilizing this phenomenon, a simple 15-second biofilm fluorescence test known as CariScreen has been developed that detects the presence of disease levels of acidogenic, aciduric bacteria in the biofilm, rather than waiting to clinically observe the damage the diseased biofilm is causing to the teeth. – *GM*

#33 Triple Trays

Commonly referred to as Triple Trays (a trademark of Premier), quadrant impression trays have infiltrated the profession so deeply that they are commonplace. Their ability to capture prep, opposing arch and bite registration in one impression had never been done before. While there are still some non-believers, the quadrant impression tray has become standard of care for most single tooth restorations. – *TG*

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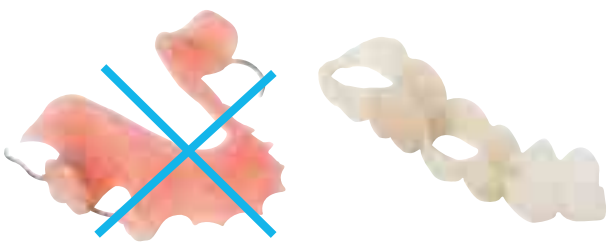

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#34 Curing Lights

1980 was the last period of time that restorative dentistry was performed without curing lights. To do an anterior restoration, dentists mixed Concise and had about 30 seconds to place it in the restoration before the material started to set. This was not always feasible and because of that, composite restorations did not last very long. UV-cured material was introduced – Nuva Fil, then Prisma Fil. By the mid-80s, every anterior restoration was done with a curing light. That total change in how anterior dentistry was done took less than five years. Now of course, the majority of posterior restorations are done with the use of a curing light – from veneers to porcelain crowns, to bonding agents. Needless to say, dentistry took an exponential leap forward with the introduction of light cured materials and the modern curing light. – *HG*

#35 Veneers

Patients can now achieve the smile of their dreams without the time required for orthodontics or the need to aggressively prepare the teeth for full coverage crowns. Many dentists now see dentistry as a means to improve their patients' self-image, rather than just eliminate disease and alleviate pain.

New techniques and materials are changing people's lives, and it's no wonder many clinicians now enjoy going to work to share these advances in technology with their patients. You are better at things that you truly enjoy. Not only are patients enjoying their new smiles, but as a direct result of utilizing porcelain veneers, dentists are enjoying it too. – *DH*

#36 Handpieces

Remember the belt-driven handpieces of the old dental office? – the ones that could hardly cut through enamel and amalgam. Air driven highspeeds revolutionized dentistry. Not only could you easily drill through all materials with precision, but there was less vibration and increased patient comfort. Now, one step further are electric handpieces. They generate much more torque with less vibration. Without the evolution of handpieces, we'd be hard pressed to do veneer preps… or any precision restorative work for that matter. – *HG*

#37 OSHA…

In December 1970, Richard Nixon signed a bill under the Occupational Safety and Health Act essentially making gloveless wet-finger dentistry obsolete. OSHA was burdensome in its early years. Dentists were required to wear gloves, masks, and make sure the sterile environment was up-to-code. Dentists had to have more significant training, better communication and legal documentation, all at their own expense. It took years to see the benefits. But now, although the legalities still occasionally prove taxing, every time you slip on a pair of gloves, you prevent transmitting HIV/AIDS, hepatitis and other blood-borne pathogens. You are more aware of the chemicals in your products and you are more careful about the environment in which you practice. Not only are you protecting patients, but you're protecting yourself – certainly a change for the better. – *CP*

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#38 Marketing and Advertising

Long gone are the days of opening up shop, hanging a shingle and waiting for dental patients to flood your waiting room. They need to know you exist, what kinds of services you provide – and even more, who you are as a person. And as marketing has changed, so has your involvement with it. – *BL*

#39 Practice Web Sites

How does a patient choose between two doctors with the same academic and practice experience in the same area? If we had the answer, we'd tell you. However, we do know that good reviews and a prominent Internet presence can't hurt.

Since the advent of practice Web sites, they have varied drastically from each other. Some dentists want templates, others want to create their sites custom. Some pay the big bucks, and some want to attempt the effort themselves. Web sites range from minimal "business-card-like" templates, to flashy strobe-light ads and features, to a more education-based approach. Whatever your preference, style or budget, there are options. And your site, depending on the quality, is likely to be the catalyst in driving patients either in or out of your doors. – *CP*

#40 Cosmetic Dentistry

Cosmetic dentistry created a shift from patients seeking need-based dentistry to desiring straight, healthy pearly whites. Patients who avoided the dentist for years started calling because they wanted a nicer smile. We have reality TV shows like *Extreme Makeover* to partially thank for this.

The consumer looking to have cosmetic dentistry is actually looking for a dental office that has a different aesthetic as well. So dentists are changing everything from office décor, to the clothes on their backs all for the psychology of patients' treatment decisions. Patients seek dentists who are up-to-date with the latest techniques and equipped with the latest gadgets in hopes of achieving the perfect smile. Aesthetic complacency is being challenged, as dentists are given more tools to help provide uncompromised cosmetic results with more conservative techniques.

Cosmetic dentistry has not only revolutionized the way we practice dentistry, but the manner in which we present and perform it. Today, most every dentist advertises general and cosmetic dentistry, but must continue to be aware that the word "cosmetic" is not just a descriptive adjective, but a constantly evolving expectation. – *JO*

#41 Pankey Institute

In the 1930s, Drs. Pankey, Mann and Schuyler developed a comprehensive system for diagnosis and treatment of complex restorative cases, including occlusal management. After four decades of trial improvement, many long-lasting cases were documented. Starting in 1970, their seminal occlusal studies were advanced by The Pankey Institute and Dr. Peter Dawson. In their continuum courses, more than 20,000 dentists have traveled to South Florida and learned that, with centric relation as a reference point, one can develop harmonious functional contacts and anterior guidance in excursions. When you want to learn about the complex concept of occlusion, you go to the horse's mouth. – *MM*

#42 Insurance

Dental insurance, once only a luxury to the wealthy, became a common supplement to general health insurance in the 1970s. As the connection between oral health and system health became more prominent in health studies, dental insurance became more prominent as well. Initially the goal was to make affordable health care available to people who would normally not seek care due to costs.

The average maximum coverage from dental insurance providers averages about $1,500 per year, and has not increased or accounted for inflation since insurance's introduction to the dentistry scene in the '70s. This lack of coverage limits what dentists can provide, since prices for supplies, equipment and time have increased significantly.

As a game changer, insurance has dual-citizenship in both negative and positive territory. It's is just one more area in which dentists and patients alike must weigh the cost of treatment to the quality. – *CP*

#43 Online Continuing Education

It's easy to continue with the status quo once you are out of school. It's easy to find yourself 30 years later still using the same techniques, tools and equipment as you did when you first started… It's easy, unless you're proactive about not getting stuck. Thankfully dentistry as a profession has taken a stance on making continuing education a priority; to always staying current on information and techniques.

By means of video, Webinar and PowerPoint presentation, among many other mediums, you can complete your CE requirements right from the comfort of your own home. Not only are they available 24 hours a day, but you can complete them in your underwear nonetheless! – *CP*

#44 Corporate Dentistry

Although the term is newly coined, corporate dentistry has been around for the better part of the 20th century, and made popular by Aspen, Western, BrightNow and Heartland, to name a few.

Many just-out-of-school dentists who don't want to run their own businesses or don't have the means of starting their own practices find the option to work for a corporate dental practice attractive. Corporate dental practices streamline accounts payable and accounts receivable, payroll, supply and equipment procurement and marketing. It's all very appealing to a dentist who has no interest in maintaining the business side of a practice.

However, with options comes controversy.

They provide options for dentists, yet take options away from others. They provide quality care at decreased cost, but opponents say they might not have the same one-on-one relationships with patients. Sounds like a mixed bag of treats… and one thing Dentaltown is happy to remain a forum in which the debate can continue. – *CP*

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#45 Patient Financing

Rising overhead for dentists creates rising costs for patients. These increased costs come with the need to adapt. Flexible patient financing has opened up a whole new avenue for people with limited or no insurance to still receive the care they need, and for you to still be paid. Third-party patient financing solutions like CareCredit, ChaseHealthAdvance, and Citi Health Card assist in providing an affordable plan to patients seeking more flexible payment options. If patients can afford care, you get patients through your door who might not have normally sought dental care and you get paid for your services. It's a win-win-win. – *CP*

#46 CBCT

From airway analysis, preprocedure outcome prediction, periodontal status, tooth and implant assessment and positioning guidance, surgical assessment, appliance preparation, facial pain patients and so much more, Cone Beam Computed Tomography (CBCT) is a quantum leap for dentistry.

Adding the third dimension facilitates a confidence that has been eluding practitioners. The unlimited opportunities that CBCT offers will be guided by our imaginations. Along with optimal care, CBCT is a key component in eliminating malpractice cases through facilitating a transparent understanding and meaningful communication with the patient and the various health care providers involved with treatment. CBCT is a 360-degree turn for dentistry. – *DM*

#47 HIPAA

August 21, 1996: The Health Insurance Portability and Accountability Act becomes law.

It's more than just having firewalls and not detailing to Mrs. Jones your draining of a purulent fistula on Mrs. Fillmore last week. It's more than handing out a never-read form that you might have noticed in 2003. It's important to your patients' security.

So please, at your earliest convenience, Google *HIPAA Administrative Simplification Regulation Text March 2006* and merrily browse segments like the following from page 37:

(B) The covered entity is responsible for complying with §164.316(a) and §164.530(i), pertaining to the implementation of policies and procedures to ensure compliance with applicable requirements of this section and subparts C and E of this part, including the safeguard requirements in paragraph (a)(2)(ii) of this section.

(C) The covered entity is responsible for designating the components that are part of one or more health care components of the covered entity and documenting the designation in accordance with paragraph (c) of this section, provided that, if the covered entity designates a health care component or components, it must include any component that would meet the definition of covered entity if it were a separate legal entity. Health care component(s) also may include a component only to the extent that it performs:

(1) Covered functions; or

(2) Activities that would make such component a business associate of a component that performs covered functions if the two components were separate legal entities.

And you all thought Dentaltown was fascinating... HIPAA is the hippest thing to happen to dentistry since, well, OSHA. – *D. Carlsen*

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#48 Posterior Composites

Placing Class II posterior composites was nearly impossible to accomplish in a predictable fashion until the advent of devices designed specifically for creating a reliable contact. Since composite cannot be placed in the same fashion as amalgam, we needed something to provide a firm contact with the proper shape. Leave it to dental inventors to develop these great solutions. The items that we use in our practices every day include: Composi-Tight by Garrison, V3 Ring by Triodent, Palodent by DENTSPLY Caulk, Omni-Matrix by Ultradent and many more. – *TG*

#49 Sedation Dentistry

Nitrous oxide was first used as an alternative to local anesthesia when a young dentist from Connecticut, Dr. Horace Wells had his tooth extracted by his associate, John Riggs in December 1844. Today inhalation sedation, nicknamed "laughing gas," along with oral sedation and intravenous (IV) sedation have provided dentists with the ability to complete procedures faster and more efficiently. Many patients with a high dental anxiety and fear, a severe gag reflex, and even those with a difficulty getting numb from local sedation benefit from oral-conscious sedation. A dental procedure that once took an hour to complete and now can be completed in minutes might not be a "laughing" matter, but is certainly something to smile about. – *ML*

#50 Sleep Medicine

Do a root canal and you might save a tooth; make an oral device for obstructive sleep apnea (OSA) and you might save a life. Although effective in treating sleep apnea, CPAP machines have poor patient compliance… which is why it was exciting in 2006 when it was announced that qualified dentists could administer oral appliance therapy for the condition.

Dentists play a large part in diagnosing and treating sleep apnea. So ask the STOP questions when doing patient evaluations. **S:** Do you **snore** loudly? **T:** Do you often feel **tired,** fatigued or sleepy during daytime? **O:** Has anyone **observed** you stop breathing during sleep? **P:** Do you have or are you being treated for high blood **pressure?** Positive responses to two of these questions indicate the patient is a higher risk of OSA than average. Further evaluation with an Epworth Sleepiness Scale or Berlin Questionnaire can help a clinician isolate patients who need attention.

It affects up to nine percent of males and four percent of females globally. So now that we have the power to do something about it, don't hit the snooze button on dealing with patient's sleep apnea in your practice. – *MG*

Contributors (as indicated by initials): *Dr. Dennis Brave, Dr. Douglas Carlsen, Dr. David Clark, Dr. Thomas Giacobbi, Dr. Michael Glass, Dr. Howard Goldstein, Dr. Glenn Hanf, Dr. David Hornbrook, Dr. Chris Kammer, Dr. William Kisker, Dr. Kenneth Koch, Marie Leland, Benjamin Lund, Dr. Donald Machen, Dr. Graeme Milicich, Dr. Mark Murphy, Trisha O'Hehir, Dr. Jason Olitsky, Sandy Pardue, Chelsea Patten, Dr. Jay Reznick, and Dr. Glenn Van As.*

What game changers did we miss? What made the list that you don't think should have? Comment and discuss with your fellow Townies on the message boards of Dentaltown.com n

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~ Melinda Marino, DDS, San Diego

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The 2011 Chicago Dental Society Midwinter Meeting

Great Expectations: A Dental Continuum

The Chicago Dental Society is hosting its 146th Midwinter meeting February 24-26, 2011. As one of the largest dental exhibitions in the United States, hundreds of manufacturers, suppliers and labs set up to provide you with a one-stop shop to view new products, learn about improving technology and purchase for your practice.

Registration

- Go to www.cds.org/mwm_2011 and click "Attendee Pre-registration."
- Preregister online by January 31, 2011, for a discounted rate.
- Prices vary according to profession, membership and student status.

Continuing Education

Thursday-Saturday, February 24-26

- View courses at www.cdscatalog.attregistration.com/Catalog/cdsCourseCatalog.aspx
- Not all courses have handouts, but those that do will be available via PDF download, rather than paper copy. Paper copies will not be available onsite.
- Check classroom numbers online as they become available in mid-January.

They will also be in the official program presented onsite.

Exhibit Hall

Thursday-Saturday, February 24-26
9 a.m.-5:30 p.m.

The exhibit hall, featuring nearly 600 different participating exhibitors, is located on Level 3, Hall F of the McCormick Place West Building at 2301 S. Indiana Avenue.

Special Events

Tickets are needed for all special events, regardless of whether there is a fee attached.

Opening Session – Featuring John Pinette

Thursday, February 24
Reception: 4:30-5:30 p.m., Program: 5:30-7 p.m.
McCormick Place West, Skyline Ballroom E (W375)
Price: $10
Event Number: SE1

A Touch of Glamour – Fashion Show and Luncheon

Friday, February 25
11:30 a.m.-2:30 p.m.; 11:30 a.m. cash bar reception
Chicago Hilton & Towers, Grand Ballroom
Price: $65
Event Number: SE2

Friday Night Concert – Featuring Dennis DeYoung and the Music of Styx

Friday, February 25
Doors Open: 8 p.m.; Performance: 9 p.m.
Park West, 322 W. Armitage
Price: $35
Event Number: SE3

The President's Dinner Dance – Honoring Dr. and Mrs. Ian Elliott

Saturday, February 26
Reception: 7-7:30 p.m.; Dinner: 7:30 p.m.
Chicago Hilton & Towers, Grand Ballroom
Price: $100
Black tie optional
Event Number: SE4

Sites in Chicago

The thriving metropolis of Chicago offers endless options for entertainment. Here are a few goings-on during the Midwinter Meeting.

A Little Bite of Chicago – A Tasting Tour

Between Berghoff beer and hot dogs, Chicago will tickle your taste buds.

Thursday, February 24, 11:15 a.m. to 2:45 p.m.

Price: $80, includes tasting opportunities, lunch and transportation.

Broadway in Chicago

Want a night out on the town? Go see a show.

Million Dollar Quartet
Thursday, February 24, 7:30 p.m.; and
Friday, February 25, 8 p.m.
Apollo Theatre
Price: $55

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Les Miserables
Thursday, February 24
7:30 p.m.
Cadillac Palace Theatre
Price: $55

Working
Friday, February 25
8 p.m.
The Broadway Playhouse
Price: $84

BIN 36 Wine School

Learn about wine and enjoy wine and cheese combinations.
Friday, February 25
1:30-4:30 p.m.
Price: $99

Scoozi! – Hands-on Cooking Demonstration

Try your hand at Italian cooking.
Saturday, February 26
11:45 a.m.-2:15 p.m.
Price: $98, includes lunch

Second City and Deep Dish

Enjoy two of Chicago's most famous institutions – deep-dish pizza and Second City Theatre.
Saturday, February 26
5:45-10:30 p.m.
Price: $95

Sweet Home Chicago Blues Evening

Enjoy mouth-watering soul food and live blues music.
Saturday, February 26
7:45 p.m.-midnight
Buddy Guy's Legends
Price: $110

For more information about the Midwinter meeting visit: www.cds.org/mwm_2011/ n

OHI Success Stories

by Trisha E. O'Hehir, RDH, MS, Hygienetown Editorial Director

Oral hygiene instructions (OHI) are more about life coaching and self-esteem than simply plaque removal. When your instructions and coaching are successful, you improve oral health and you also change lives.

Researchers conclude that those living at low social economic (SE) levels will have poor oral hygiene and consequently, more dental disease. Here's my theory: after years of providing oral hygiene instructions to people of all income and education levels, it's the other way around. People living at low SE levels often feel hopeless, and feel their lives are out of their control. OHI provides an opportunity for people to learn something about themselves that they can control – their oral health. When they understand the disease process for caries and periodontal disease and they are shown easy, predictable ways to control bacterial biofilm in their mouths, and even easier ways to measure their success, amazing things happen beyond the teeth and gums. Self-esteem is increased and this leads to other positive changes in life.

Many years ago I treated a man with poor oral health and low self-esteem. His poor oral hygiene matched his slovenly outward appearance. Giving him the knowledge to change his oral health and coaching him as to the products and techniques that fit best into his life improved more than just his oral health. Gaining confidence in his ability to control his oral health spilled over into other aspects of his life. He started showering and cleaning up before he came to his appointments. Next, he was doing better at work and to my surprise, he was going back to school.

Gaining confidence in one area of life – oral health – can impact an individual's overall self-esteem. This isn't unique to my experience. Many clinicians have seen this happen for their patients as well. The focus of our work is improving oral health, but if you look closely at your successes, you'll see that you are changing lives too. This is what keeps us motivated – seeing the life changes in our patients. We talk about the oral health changes, but we observe changes that go far beyond the mouth.

Research by Dr. I. MacGregor and his team confirms a link between self-esteem and oral health behaviors, but just the other way around. In a paper published in the *Journal of Clinical Research,* a group of 41,142 students, ages 12 to 16 years, from 244 schools completed a questionnaire about self-esteem, brushing, flossing and dental visits. Frequency of toothbrushing and dental visits were correlated with self-esteem. From Dr. MacGregor's perspective, high self-esteem is what leads to more positive dental health behaviors. From my experience, I have to politely disagree with Dr. MacGregor, as it seems to me it is actually the reverse. The frequency of dental visits and oral health instructions might in themselves lead to an *increase* in self-esteem.

Clinicians see changes in patients as the result of good dental care and effective oral hygiene instructions. As a person's oral health improves and they realize they do have control, their self-esteem improves as evidenced by their overall grooming and outlook. In this instance, the "locus of control" has been shifted from external, in which individuals think they have no control, to internal, where they perceive they do have control over their own oral health.

Share your OHI success stories in the Hygienetown message board titled: You change lives with OHI. And remember, you do change lives! n

Trisha Live

Here's where you can catch Trisha live! To schedule Trisha to speak at your next national, state or local dental hygiene meeting, e-mail trisha@hygienetown.com.

January 29, 2011
Drs. McCawley & DeTure n Fort Lauderdale, Florida

February 26, 2011
Make Yourself Indispensable n Spokane, Washington

March 12, 2011
Make Yourself Indispensable n Portland, Oregon

March 24-26, 2011
Thomas P. Hinman Dental Meeting n Atlanta, Georgia

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Look for additional content in the Hygienetown Magazine *digital edition.*

Perio Reports Vol. 23 No. 1

Perio Reports provides easy-to-read research summaries on topics of specific interest to clinicians.

Perio Reports research summaries will be included in each issue to keep you on the cutting edge of dental hygiene science.

Tongue Cleaning Reduces Bad Breath

Everyone has bad breath sometimes, and some people have chronic bad breath all the time, from 25 to 50 percent, depending on the population. Morning bad breath is due to overnight dryness when saliva flow is at its lowest, enhancing the growth of oral bacteria. Bacterial biofilm accumulates on and around the teeth, and also is part of tongue coating, especially on the dorsum of the tongue. Eating and drinking in the morning tends to eliminate overnight bad breath, but sometimes it is a chronic problem.

Ninety percent of bad breath can be attributed to oral causes including caries, periodontal disease, poor oral hygiene and tongue coating. The gold standard of measuring bad breath is organoleptic testing or smelling the person's breath. It is also measured by the level of unpleasant smelling volatile sulfur compounds (VSC) in the mouth air.

Researchers at three universities in The Netherlands reviewed the research to determine if tongue cleaning with a scraper or toothbrush in addition to regular oral hygiene would reduce oral malodor. Of the 405 studies and abstracts their search produced, 22 full-text articles were read and 17 of these were excluded as they didn't match the established criteria they were looking for in the studies. The five studies that did fit all criteria were evaluated and compared, showing that tongue scraping or brushing does reduces oral malodor. These studies did not evaluate chronic bad breath.

Clinical Implications: Results of this systematic review suggest that cleaning the dorsum of the tongue with a scraper or brush will reduce oral malodor.

Van der Sleen, M., Slot, D., Van Trijffel, E., Winkel, E., Van der Weijden, G.: Effectiveness of Mechanical Tongue Cleaning on Breath Odour and Tongue Coating: A Systemic Review. Int J Dent Hygiene 8: 258-268, 2010. n

Jawbreakers Have Erosive Potential

Many factors influence dental erosion, including dietary acids found in carbonated beverages and acid candies. When sour candies are dissolved in water, the pH drops to between 2.3 and 3.1. Enamel dissolves at a pH of 5.5.

Using a questionnaire, researchers in The Netherlands asked 300 children between 10 and 12 years about jawbreaker consumption. Two-thirds of the children reported eating jawbreakers, with boys (73 percent) eating them more than girls (60 percent). Eighteen percent reported having eaten one or more in the past week. Most of the children reported holding the jawbreaker in their cheek and keeping it in their mouth more than 15 minutes. Some reported playing a game of who could hold it in their mouth the longest.

To test oral pH, dental students were recruited (as the Medical Ethics Committee prohibited children from participating). Dental students tested four jawbreakers from Zed Candy in Dublin, Ireland: strawberry, jumbo, fire and sour. The jumbo jawbreaker was 31mm in diameter and the others were 23-24mm in diameter. All contained citric acid. Salivary flow increased nine to 14 times baseline levels within the first minute of sucking the candy and remained high for the three minutes it was in the mouth, returning to baseline levels by six minutes. All but the fire jawbreaker lowered salivary pH well below 5. They returned to neutral pH by eight minutes.

Clinical Implications: Ask your child patients about their sour candy consumption, including how long they hold a jawbreaker in their mouth. The longer they have it in their mouth, the longer their teeth are exposed to dangerously low pH levels, despite increased salivary flow.

Brand, H., Gambon, D., et al: The Erosive Potential of Jawbreakers, A Type of Hard Candy. Int J Dent Hygiene 8: 308-312, 2010. n

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Azithromycin Enhances SRP Outcomes

Periodontal disease is associated with a multi-species bacterial biofilm. These bacteria trigger an inflammatory response that ultimately causes destruction of connective tissue and bone. *P. gingivalis* is one of the subgingival bacterial species that is often found in chronic periodontitis cases.

Mechanical disruption of bacterial biofilm with scaling and root planing (SRP) is an effective way to eliminate periodontal pathogens, control tissue destruction and prevent further infection and inflammation. Several systemic antibiotics have been tested in conjunction with SRP to amplify eradication of specific pathogens.

Researchers at Complutense University in Madrid, Spain compared SRP alone and SRP plus three days of systemic azithromycin in patients with chronic periodontitis testing positive for subgingival *P. gingivalis.* SRP was provided under local anesthesia by perio graduate students using both power and hand instrumentation in two 90-minute visits within one week. Follow-up visits were scheduled at one, three and six months. Oral hygiene instructions were reviewed at each visit.

There were 13 subjects in the SRP group and 15 patients in the SRP plus azithromycin group. Probing depth reductions and clinical attachment level gains at six months were both 0.8mm in the test group and 0.3mm in the SRP only group. Both groups showed significant reductions in bleeding on probing after treatment. Microbiological testing revealed a significant reduction in the detection of *P. gingivalis* in the azithromycin group compared to the SRP only group.

Clinical Implications: For patients who test positive for *P. gingivalis,* taking systemic azithromycin in conjunction with SRP might enhance reduction of bacterial counts.

Oteo, A., Herrera, D., Figuero, E., O'Connor, A., Gonzalez, I., Sanz, M.: Azithromycin as an Adjunct to Scaling and Root Planing in the Treatment of Porphyromonas Gingivalis-Associated Periodontitis: A Pilot Study. J Clin Perio 37: 1005-1015, 2010. n

Statin Drugs Enhance Bone Formation

Statin drugs are used to control blood cholesterol levels by reducing the liver's ability to produce cholesterol. This is done by blocking an important protein needed in this process, HMG CoA reductase. Other benefits have been reported from taking statin drugs that impact growth factors and proteins associated with bone regeneration. Animal studies show increased mandibular bone growth with protective effects on tooth attachment and alveolar bone. Topically applied statin drugs following tooth extraction in rats showed stimulated osteoblast formation compared to controls.

Retrospective studies of humans with periodontal disease who were taking statin drugs found shallower probing scores compared to similar controls not taking the drug.

Researchers at the University of Guanajuato in Leon, Mexico compared the effects of 20/mg/day atorvastatin (ATV) and a vitamin placebo following SRP. Placebo pills contained vitamins B1, B6 and B12. Subjects were blinded to their assigned medication. SRP was done by quadrants with one visit per week.

The 38 patients were seen every two weeks for three months. Baseline levels were similar for test and control groups for BMI, blood glucose, triglycerides, cholesterol, HDL and VLDL. At three months, both groups showed significant improvement in clinical indices. The distance from the CEJ to the alveolar bone crest according to digital radiographs was decreased 0.7mm in the ATV group compared to an increase of 0.1 in the vitamin group. Mobility was reduced more in the ATV group. This group also showed lower cholesterol levels than the vitamin group.

Clinical Implications: Take a close look at your patients taking statin drugs. Those with periodontal disease might be experiencing some osseous benefits.

Fajardo, M., Rocha, M., Sanchez-Marin, F., Espinosa-Chavez, E.: Effect of Atorvastatin on Chronic Periodontitis: A Randomized Pilot Study. J Clin Perio 37: 1016-1022, 2010. n

Sealants Versus Infiltrants

Despite a decline in caries in industrialized countries, caries on approximal surfaces remain a significant problem. Reports suggest rates as high as 81 percent of five years olds have non-cavitated approximal enamel lesions and 96 percent of adolescents have one or more past or active carious lesions. Adolescents at high risk for caries average four lesions. Surfaces of early, non-cavitated enamel lesions are 10 to 50 times more porous than intact enamel. Traditional preventive measures that promote remineralization include oral hygiene, fluoride and nutritional counseling, but many don't comply. Sealants and infiltrants provide a means of stopping demineralization and in some cases, promoting remineralization. A sealant will cover over the non-cavitated lesion, providing a diffusion barrier. An infiltrant will penetrate into the lesion, replacing lost minerals with a light cured, low-viscosity resin. This provides mechanical support to fragile enamel while blocking caries progression.

Researchers at the University of Campinas in Sao Paulo, Brazil reviewed the literature comparing sealants and infiltrants for the treatment of non-cavitated, approximal lesions. It is difficult comparing lab and clinical studies as the lesions are not actually the same. Lab studies provide a starting point, but more clinical studies are needed comparing sealants and infiltrants on smooth surfaces. Findings suggest that fluoride should not be used prior to treatment, as fluoride hardens the surface of the enamel and does not penetrate to the depth of the non-cavitated lesion.

Clinical Implications: Sealants are best used in pits and fissures, while light-cured infiltrants provide deeper penetration in smooth surface, non-cavitated lesions without leaving a surface margin.

Kantovitz, K., Pascon, F., Nobre-dos-Santos, M., Puppin-Rontani, R.: Review of the Effects of Infiltrants and Sealers on Non-Cavitated Enamel Lesions. Oral Health and Prev Dent 8: 295-305, 2010. n

No Benefit from Higher Concentration Chlorhexidine

Chlorhexidine (CHX) has long been considered the gold standard in oral rinses for the control of bacterial plaque and inflammation. CHX was first used to control gingivitis and is also used now following SRP and periodontal surgery. It is also used effectively to control MRSA infections in critical care units and to control and prevent oral mucositis in bone marrow transplant patients.

A new formulation of CHX is now available over the counter in Switzerland. Parodentosan contains 0.05 percent CHX plus peppermint, tincture of Myrrh, sage oil, sodium fluoride, xylitol, water, glycerine and alcohol. Researchers at the University of Bern compared this new formulation to Plakout, the standard Swiss 0.1 percent CHX rinse. The comparison was made in a group of 45 subjects undergoing periodontal surgery. Test and control rinses were bottled identically and labeled simply "Test Solution B" or "Test Solution C." Rinses were randomly assigned and all subjects were instructed to rinse twice daily for four weeks following surgery.

Clinical and microbial evaluations at four and 12 weeks showed no differences in probing depth changes or subgingival bacterial counts between the two groups. The only difference observed was for tooth staining. At 12 weeks, staining in the Parodentosan group showed an increase of seven percent, compared to an increase of 37 percent in the Plakout group. None of the study subjects complained of tooth staining during the study.

Clinical Implications: For Swiss clinicians, Parodentosan CHX rinse might be as effective as Plakout rinse, with less staining of tooth surfaces.

Duss, C., Lang, N., Cosyn, J., Persson, R.: A Randomized, Controlled Clinical Trial on the Clinical, Microbiological, and Staining Effects of a Novel 0.05% Chlorhexidine/Herbal Extract and a 0.1% Chlorhexidine Mouthrinse Adjunct to Periodontal Surgery. J Clin Perio 37: 988-997, 2010. n

Dental Hygiene Consultants

by Trisha E. O'Hehir, RDH, MS

Dental hygiene consultants provide guidance for hygiene department growth, and consequently overall practice growth, with a focus on accurately diagnosing periodontal disease and providing appropriate treatment planning, follow-up and patient care.

I recently had the opportunity to interview two independent practice consultants who are also Townies. Sarah Cottingham owns BCS Leadership, LLC, and Rachel Wall owns Inspired Hygiene. Both are committed to helping others reach their potential by providing leadership and systems to provide high quality dental hygiene care. Sarah and Rachel have a lot in common. They both graduated from dental hygiene in 1991, have young families, own their consulting companies, are speakers and also fit clinical practice into their busy schedules. They strive to do their best and to help other hygienists and dentists provide the best possible care for their patients. The dental hygiene profession is lucky to have young, dedicated and innovative hygienists like Sarah and Rachel blazing the trail that will move our profession ahead.

How did you get started in consulting?

Cottingham: My first involvement with consulting was not planned; it just evolved and snowballed into my current BCS Leadership position. Besides providing clinical dental hygiene back in the early 1990s, I started managing a dentist's practice and learned about various aspects of the business. During these early years, I had the pleasure of being on a team receiving coaching from consultant Patty Hill. Later, I joined Patty in the BCS Leadership consulting company and worked with her for several happy and productive years before her recent passing. With her blessing and encouragement, I purchased the company and carry on the company's work.

Wall: Sometimes circumstances in life just line up and the result becomes perfectly clear. It started with the "seven year itch" in my hygiene career after working clinically and as a manager in both private and university practices, when I was sure I knew it all, had seen it all and dental school was the next logical step. I completed all the prerequisites, had great letters of recommendation, yet was rejected three years in a row! Getting ready for another round of dental school applications, my best friend, running buddy and hygiene colleague was diagnosed with osteosarcoma. As she went through chemotherapy, our days of running turned into lunch in her hospital room. She knew my lifelong goal was not to become a dentist, but to be able to do more as a dental professional. She could see I was miserable, and encouraged me to take time off from applying to dental schools and instead take an honest look at the career and personal growth opportunities available to me as a hygienist. I focused my energy on learning as much as I could about advanced hygiene duties, the perio-systemic link and personal development. In 2000, I began working as a trainer for a practice management coach and I loved it! In 2004 I started my own company, Inspired Hygiene.

What is the primary focus of your DH consulting?

Cottingham: BCS Leadership works with dental practices from the ground up. The dental hygiene department is a passion of mine since that is where my roots are. Our primary focus is to get dental hygienists, doctors and teams to

really look at, understand and value the hygiene department to the overall financial wellness of the practice. The financial wellness of the practice is impacted by first getting the hygiene department to understand, accurately assess, enroll and inspire patients to make the right decisions about their periodontal health. I encourage hygienists to take a much more serious approach to being a front line health-care provider and wellness specialist!

Wall: Although we occasionally touch on general practice management issues, I am a hygiene profitability expert and coach. We help dentists, hygienists and entire teams recognize their power to positively impact their own careers, their patients' well-being and to reap financial rewards as a result of delivering high quality care.

Who is your primary market?

Cottingham: BCS Leadership works with medical and dental practices. We have worked with dentists, specialists, chiropractors and naturopaths to name a few.

Wall: We work exclusively in the dental market with dentists, hygienists and dental teams who are not tapping into their full potential for patient service and profitability in hygiene.

What services do you provide?

Cottingham: Our services include:

Practice analysis – understanding all aspects of the practice, the good, the bad and the sometimes ugly!

Leadership programs – ranging from one-day *Success in Motion* to 12- to 24-month intensive training and mentoring programs.

Hygiene success programs – involving onsite evaluations of the hygiene department and hands-on, over-the-shoulder style coaching; programs can range in length from one day to 12 months. The training is customized based on the skill level and development of the current hygiene department.

Mentoring – one-on-one programs for those professionals who are inspired to achieve greater levels of personal success.

Training DVDs, CDs and Webinars – providing science, information and coaching to help teams achieve their very best.

Wall: I believe that every client has different needs and learns differently, so Inspired Hygiene offers a variety of training opportunities at all price points. We provide:

Coaching and consulting services – private, in-office consulting following my 10-step *Hygiene Productivity System.* Training focuses on clinical hygiene skills, perio diagnosis, enrollment and treatment. Our program helps hygienists become partners in building the practice through enrolling patients in needed restorative dental care, bringing in new dental hygiene services to the practice and becoming involved with internal marketing.

Virtual coaching – our *Kick Start Program* combines in-office, Web and telephone coaching to focus on one or two areas in the hygiene department.

Periodontal education – this eight-week education program provides the science and the protocols necessary to implement or refine a perio program.

Hygiene analysis report – this is a place to start, finding out how the hygiene department is doing and what steps are needed to move forward.

High performance hygiene mastermind – each month teams participate in tele-classes, telephone coaching and access to our resource library.

How is the DH profession doing today compared to when you graduated from school?

Cottingham: Back in the stone ages, when gloves were seen as a nuisance and not a necessity, dental hygienists were working hard to make a mark in the dental community as more than "the person who cleans my teeth," as in many cases they are still trying to do today! The difference is that today we, as a profession, *do not have a choice.* We now have to own the responsibility that we have with our patients and their entire overall health. Now, the scientific information about the mouth-body connection is so overwhelmingly significant that we can no longer look the other way. The hygienists of today will have to stand up and make a mark in the medical and dental community about our impact on patients' health, and educate the public. The public is now one of educated consumers, and as a profession we must change the way dental hygienists are seen – from "the person who cleans my teeth" into the age of "oral health care wellness providers." The success or failure of a movement like this starts with *us!*

Wall: The whole oral-systemic link has brought a new level of importance to the oral health profession. I think we are being taken more seriously by our peers and if we want to collaborate with the medical community, we must confidently step into this new role.

What is one of your funniest consulting stories?

Cottingham: When working with a dental hygienist, she took a panoramic radiograph of a patient that had a full upper denture and we had to act like there was nothing weird about the X-ray.

The other one was when a hygienist that I worked with told me she had a elderly patient that she took around the corner to take a pano, and she said "I'll be right back, I need to get the machine ready." He apparently thought that meant he had to "get ready," because when she came back he had dropped his pants around his ankles and was hanging onto the pano machine… She had to continue without a peep. Needless to say, there were tears from laughter after that one!

continued on page 122

continued from page 121

Wall: Most of my funny stories are related to all the travel I do and getting lost on various expressways across the country!

How about one of your most inspiring consulting stories?

Cottingham: I was working with a hygienist who began to really evaluate X-rays. She uncovered a cyst that the doctor had overlooked. It was a very aggressive-style cyst that was caught at a critical time! Life saving!

Wall: I recently had a dentist client of mine tell me that because of the training we did with him and his team, he now feels "more like a doctor." He's now taking his role as health-care provider more seriously and that has empowered him to have the confidence to diagnose dental and perio disease earlier and keep searching for ways to deliver the highest level of care possible. I routinely have hygienists tell me they've been rejuvenated when we're able to get them out of the "prophy rut" and start using their critical thinking skills in diagnosing and treating perio disease and becoming a partner in enrolling restorative care.

What do you see in the future of dental hygiene – down the road 10 or 20 years?

Cottingham: I see the profession turning into a leveled delivery care system. There will be mastery level hygienists and then there will be technicians with a limited scope of practice. The mastery level hygienists will be performing more wellness checks and being in direct relationship with primary health-care providers and specialists; serving a bigger need than just "cleaning" teeth.

Wall: I think the advanced hygiene practitioner position is an absolute must to reach areas that are underserved. I hope that I and my fellow consultants will be able to empower more doctors and hygienists to see each other as colleagues rather than employer/employee and will decide to partner to continually elevate their level of service and productivity within their practices.

Who coaches you to achieve your best? Since others hire you for your consulting, do you hire a coach or consultant to help focus your career?

Cottingham: I have several times in my career, from working with personal coaches to mastery level Neuro Linguistic Programming (NLP) trainers. If you expect to perform at an elite level, you must train like the elite athletes! It is a journey, never a destination.

Wall: Absolutely! If I'm going to ask a doctor to invest in our coaching program for his/her business, I better be willing to invest just as much time and money in my own business.

I believe it's important to continually learn and improve in clinical and dental business knowledge, but also in innovative ways to work with clients and deliver our speaking, coaching and training products.

I've worked with many coaches over the years, some in dentistry, and some not. I seek advice from experts in the areas of coaching, speaking, leadership, business development and marketing. This has helped me develop a business that offers a wide range of services at various price points, and to be aware of the elements within a practice that affect the success of the hygiene department. So while I might not coach a dentist on his/her marketing, I know how marketing affects hygiene and I'm able to analyze that for my clients.

What message would you like to leave with our readers?

Cottingham: Each of us has the ability to alter and enhance each and every person that we interact with every day. It is time that we take this responsibility extremely seriously and get the training we need to take our own skill and knowledge to the next level. The better we become, the bigger impact we make for others. You are the instrument of change, go use your gifts!

Wall: My message would just be for dentists and hygienists to keep an open mind when it comes to developing your practice and your careers. Look where you can support each other and your patients. Docs – empower your hygienists to help you build your practice by supporting them in their personal and career development. Hygienists – supporting the health of your practice through high-level service, education and co-diagnosis is the best path there is to job security. n

Author Bios

Sarah Cottingham, RDH, BS, graduated from Northern Arizona University in 1991. Her passion for helping people achieve optimum wellness has led her down a path of continuing education, including the use of the perioscope and lasers. She now shares her skills and expertise as a writer, speaker and practice consultant in BSC Leadership, LLC. To contact Sarah, e-mail sarah@bcsleadership.com or visit BSC Leadership's Web site at www.bcsleadership.com.

Rachel Wall, RDH, BS, draws from her 20 years of experience as a hygienist and practice administrator to deliver to-the-point consulting, articles and speaking programs. Inspired Hygiene's programs include in-office coaching, a free weekly e-zine, the High Performance Hygiene Mastermind group and the new High Performance Perio Webinar series. To contact Rachel, e-mail rachel@inspiredhygiene.com or visit Inspired Hygiene's Web site at www.inspiredhygiene.com.

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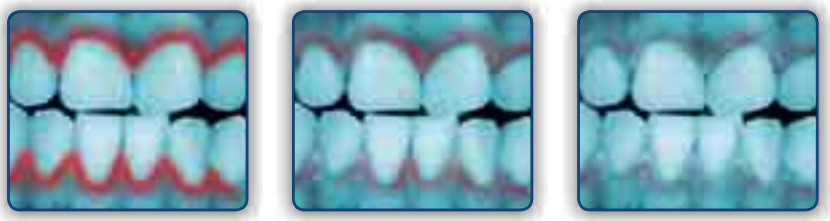

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Another Very Interesting Perio Case

The patient has periodontal disease yet was referred for orthodontic treatment. Instead, the patient saw a hygienist who provided periodontal endoscopy treatment, and who is now asking fellow clinicians to weigh in on identification of complicating factors in the case.

periopeak
Posted: 10/31/2010
Post: 1 of 31

Here is a case I recently treated that has me stumped. Female non-smoker, early 50s, good health, no obesity or poor lifestyle issues with diet, etc., low stress, family history of periodontal disease, she is peri-menopausal but has reported having perio problems for many years. She admits to poor lifestyle habits many years ago when in college. For malocclusion she wears a night guard faithfully and has for years, no TMJ issues, no pain and she has always had professional care.

Patient was referred to periodontist by her general dentist. A excellent local periodontist recommended ortho followed by LANAP after ortho was complete. This had me baffled, especially since I was taught to address disease and chronic inflammation and infection before doing ortho (FYI this periodontist has an endoscope and did not suggest perioscopy to the patient prior to ortho).

I took probe in photos to document actual probe depth and attachment loss.

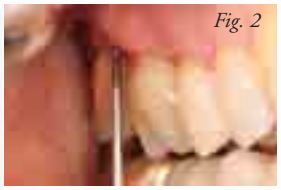

Fig. 1: Probe in a buccal Class II furcation (which was filled with heavy calculus), it was undiagnosed.

Fig. 2: Probe in a deep line angle defect on the distal root of #3; this was also not diagnosed. Heavy subgingival calculus the entire circumference of distal root extending from furcation interproximal and lingual.

Fig. 3: 7mm #4 straight lingual pocket filled with heavy calculus.

Fig. 4: Line angle pocket on #4 distal measuring 9mm – filled with heavy calculus.

Fig. 5: Not the greatest probe angle, but you can see the depth on 12M, this was charted as 6mm by the periodontist; it was filled with heavy calculus. #11 distal also had a 9mm defect. I do not have a photo.

There are carved out root defects on #3 mesial, #11 mesial, and #14, #15 interproximal near the CEJ. Upon diagnosis with endoscope I found something I had never seen and still do not know what to make of it. They were just round carved out areas, no decay at all (although there was a distinct enamel fracture line on #12 mesial, but did not extend beyond the CEJ). Etiology unknown.

Open contact between #11 and #12, recurrent decay #29 distal, #30 mesial, open margin #19 distal. Heavy calculus throughout. LR quadrant 4-5mm generalized with moderate BOP (bleeding on probing), LL quadrant 4-8mm pockets with

moderate BOP. No suggestions given to patient by the periodontist other than orthodontics. No determination of any underlying cause other than malocclusion.

Patient chose not to have DNA pathogen test. She does not do antibiotics, is very holistic in her approach and takes supplements routinely. She chose neutraceutical option over synthetic Periostat for host modulation, as well as increased dose of vitamin C. Her PST test was negative.

Treatment plan: Full mouth RPE was completed and patient is to stay on host modulated therapy until six-month re-evaluation. In the meantime her general dentist knows about the restorative issues. We might recommend a full year to 18 months of healing before ortho is initiated. Since patient had heavy calculus, line angle and interproximal defects I can only assume that doing ortho would have exacerbated these defects. Any thoughts? What is the current standard of care for ortho/perio etiology? Do we do ortho first, or do we address active periodontal disease and decay first? I would appreciate all input on this case. ■

Join this active, ongoing discussion online at Hygienetown.com to read questions and suggestions made by other Townies.

Interesting Perio Case

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Cavitron Used on Implants?

The debate continues as to which instruments can be used on implants without damage to the abutment.

shazammer1
Posted: 3/18/2010
Post: 1 of 16

Trisha, did your Perio Reports summary in this month's *Dentaltown Magazine* make it okay to use regular Cavitron tips on implants or did I read it wrong? No need for plastic anymore? ■

timothyives
Posted: 3/19/2010
Post: 2 of 16

I've been using ultrasonics on implants for a few years now. I used to work in a periodontal and implant practice and the general thoughts were:

a. If there is calculus around an implant it needs to be removed as a matter of priority.
b. Plastic implant scalers are a nightmare to use.
c. There is no evidence that scratching titanium creates a problem.
d. We all know of the benefits of biofilm removal with an ultrasonic. ■

skr RDH
Posted: 3/19/2010
Post: 5 of 16

The word from periodontists I know is that it is much more important to get the calculus off than to worry about scratches to the titanium, so they endorse using metal scalers and metal ultrasonic tips on implants. My wife (the dentist) still tries to get us to use manual titanium implant scalers on them. ■

shazammer1
Posted: 3/19/2010
Post: 6 of 16

I know there are plastic Cavitron tips, but I think they were about $170 last time I looked and the doc's eyebrows went way up. So I am using the lame-o plastic scalers. ■

JGonzalesRDH
Posted: 3/20/2010
Post: 9 of 16

Our rep came in with the titanium manual scaler. I tested it on out titanium crowns, same material we use for the abutments, and guess what... nice sized gouges in the titanium. Didn't purchase them. You are fine to use metal scalers around the crown, but I have always been told to avoid the abutment with metal instruments for fear of creating a defect that would allow for a bacteria cesspool and thus, chronic inflammation. To be honest, I hear so many different theories that it's confusing. Just the other day our oral surgeon said not to probe around the implants unless there was radiographic evidence suggesting peri-implantitis. Aggh! That's a bummer, because that's one of the tools I use to disrupt biofilm. I've seen quite a few implants over the years, never one with calculus and hope I never do! ■

trishaohehir
Posted: 3/23/2010
Post: 10 of 16

In the *Perio Reports* summary you mentioned, a power scaler wasn't used. But as was said before, it's more important to remove deposit from implants if there is infection than to worry about the instrument leaving a scratch. Looks like the plaque and calculus are attaching just fine to a very smooth surface!

The clinical implications of the research are that the laboratory findings suggest very little difference between instruments used on implant surfaces. The real test is how the tissue responds clinically, which depends on both instrumentation and daily oral hygiene. ■

thedivag
Posted: 3/27/2010
Post: 11 of 16

I have used the "special" ultrasonic tip for implants and found it to be very beneficial. Yes, it was not cheap but implants are becoming much more common and it is important to have the right tools to maintain them. I feel since my doctor encourages patients to do implants in place of bridges and partials, we should provide a safe way to clean them. Let's be honest, it's $170 versus $3,000 the patient spends on an implant and crown. My doctor felt the same way – it was definitely worth the expense. Plus it speaks volumes to your patients about the importance you put on all their teeth. ■

njmiller
Posted: 3/29/2010
Post: 12 of 16

I am asked about using ultrasonics on implants at nearly every course I present. In my humble experience, the magnetostrictive implant scalers (Dentsply, Parkell, MadUltrasonics) with the wrenched on plastic tip are only useful on exposed framework-type implants. They are useless on most single tooth implants as there isn't much room in the sulcus to manipulate them. Some of the piezoelectric designs (Satelec, EMS) have a little more merit as they are thin enough to get subgingivally.

What I have done for years, but can't make a blanket recommendation for everyone to do (I do not know what type of power scaler you are using, what kind of skill level you have, what kind of tips you are using, what type of implant, etc.) is to place an unactivated thin (perio style usually numbered 100 by most companies) tip into the sulcus around the implant, place gentle pressure on the gum tissue with it (not the implant itself), then activate the tip with low power and move it around the sulcus to irrigate and affect any biofilm in the sulcus.

Most sources I've contacted or refer to indicate there is little need to do anything on most implants that appear osseointegrated via radiographic evaluation with consistent bone levels and have a clinical appearance of healthy gingiva. Hope this helps and doesn't serve to confuse! ■

jkwan
Posted: 6/23/2010
Post: 13 of 16

We (our hygiene staff and myself) have been using tunable magnetostrictive microultrasonic metal instruments to clean around implants since 1991. I have used them in non-surgical and surgical treatment of periimplant problems for even longer. ■

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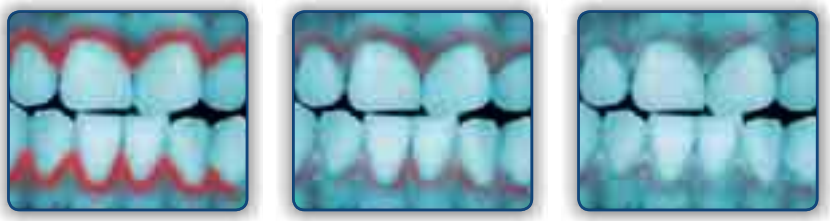

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