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Volume 23, Issue 1 • Winter, 2010

Is The Economy Bringing You Down?

A Q&A Interview With Drs. Matt Bynum And Art Mowery

Valplast, Flexite and NaturalFlex II®

Extractions - Simple, Predictable and Profitable?

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Articles on Marketing, Technology, Finance, Leadership and more!

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Is The Economy Bringing You Down?

A Q&A Interview With Drs. Matt Bynum And Art Mowery

Toward the end of 2008, something happened around the country that has not been seen in some time. The economy began to crash and the markets around the world began to follow. What started as a mild change and slowdown in the economy, turned into media fodder and hysteria. The result as each and every radio and television anchorperson continues to focus attention on this downturn is fear. That's right, fear! When people are scared or acting out of fear they fall into a state of contraction where everything is held closer and tighter than ever before, while little is allowed both out and in.

So here we are with 2009 fading away on the horizon and a most uncertain 2010 peaking in around the corner. Is the fear still there? Has it impacted the dental profession as a whole? Is the ripple being felt through all practices and all regions of the country? And is there light being seen at the end of this proverbial tunnel of fear? We sat down to ask two of the leaders in management and practice success, Dr.'s Matt Bynum and Art Mowery, exactly what their thoughts were on the downturn of the economy and what trends or effects are they seeing in and out of the practice.

Q. What is the impact of a "down economy" on dentistry overall and your patients and practices in particular?

A. Our general overview of the current economic situation is that while it is still lingering like a dense fog, it is indeed beginning to lift. Toward the end of 2008, we really began to see the change occurring around us with our patients and the many dentists and dental offices we speak with across the country. Yet, while the slowdown was in its infancy, we kind of ignored the signs around us and pushed on as we always had with success here and there, but with an overall slide in our numbers. By very late 2008 and early 2009, we really began to see the effects of the spiraling economy on our patients. For the first time in our practicing life, we had patients coming into the office with stories of losing their jobs and mass layoffs in their textile and corporate worlds. As extremely kinesthetic people, these stories began to take their toll on us and on our dynamic teams. It began to be very challenging for us to look at our patients in our chair as they began to express their fear and frustrations. For the first time in our practice life, we began to see struggles over decisions to do work that was needed or to take the chance and put it off in hopes that the gamble would pay off. Patients began to delay appointments and ask to delay pertinent diagnostics like x-rays and on occasion, our exams. When this happens, you can either insist these diagnostics and restorative work be done or you can be compassionate and "let it slide" for this time.

We chose to take a slightly different approach on the entire situation and really grab hold of what was happening in front of our eyes. We empathize with our patients, as does our team. We truly are like family with most of them, so we decided to make some changes in how we might be able to help those around us who entrust their health to us and also provide us with our livelihood. Those people who were asking us not to take x-rays and to forego the exam were denied their request. That's right, we still performed the needed diagnostics, but we did so for free. They did not ask for this, but we provided this. We just explained that this economic time has everyone running scared and quite simply, we did not want to see anything happen to those we cared about because of a few dollars. While it may be little to some, it is not to others and each and every one appreciated our gesture. We did this for some and discounted restorative work for others in need so they could avoid pain and harm from doing nothing. We have always believed that, in order to be charitable, you must first be profitable. We have been blessed in the many years we have been practicing. As we discuss in our book (The Boomerang Effect), taking care of our patients is truly an honour and we are so grateful to be able to do so.

So to recap, yes the mood and the atmosphere are changing. While it may be slow, it is indeed changing. Where people could not access funds from banks and lending institutions for the last year, we are beginning to see this loosen up a bit and people are able to access desired funds. In general, the so called "bread and butter" treatments of our practices are being done as they are needed and the elective improvement treatments are beginning to make their way back as well. This economic climate will reverse itself, but it just may be a bit longer than most may think. The end result will be that practitioners will have to be more creative than ever before in order to thrive.

Q. What can the dentist do to offset this impact in terms of practice philosophy and promotion?

A. You know, that is a great question. We don't think there is any one golden bullet here and certainly we are not suggesting that everyone do the exact same thing. However, the one thing we will say here is that in times like these, people become more savvy and investigative in their needs. Because of this, dentists need to do things very differently than we have in the past. Today, it is imperative that we be more forward thinking, more pro-active and certainly more positive to what is going on around us. We must be the change we want to see in this time and in our worlds. We know that we tried to deny what was happening for some time, but no more. There simply is no way to turn your head away from what is happening.

We must be more forward thinking, meaning that giant corporate America is really no different than we are when it comes to getting access to money. The old days of tell them and they will do it are simply not here right now. While we do not think they are gone, they are definitely on a hiatus. We must make decisions that have calculated risk. We must get out of the "dentistry 101" model of practice and begin looking into the business and people model of dentistry. Now is the time to move beyond the current situation and to consider the effects of your planting seeds and taking actions today because what will emerge here in the very near future is dictated by what you do right now! You have to think ahead of the curve and possibly take some chances you may not be able to see clearly right now. Don't just jump right in without investigating, but grab the bull by the horns and do your research and ask around. Get out of your traditional dental thinking and step beyond the treatment room and confines of your office. What is it that people are asking for? What is it that people are looking for? What can you do to "get in"?

In our opinion, gone are the days of "jackpot dentistry". What we mean is that for many of us, all we have had to do was ask or even tell people what we do and how we can help and they took that at face value. Gone is 2007 where smiles thrived and elective dentistry was easy to get commitment on. Gone are the days of just filling out a credit form and before you know it, Bam! Magically money appears in your checking account. Today you have to be pro-active. You cannot rest on your laurels and you cannot just do what you have always done. The past is the past! The wait and see approach will not allow you to thrive so you must be better than you were before. You must be different, and you must take action. Immediate and unwavering action! You cannot be reactive any more. Reaction is a defensive stance to an oncoming event or action. Pro-action is staying ahead of the curve and not waiting for the climate or anything else to hit you first. For many, this is a time to shake the cobwebs off and get back in the game! Call it "stimulus packaging" or necessity, we don't care! But get back in the game and begin to set the future for yourselves and not have it dictated or handed to you, as you just may not like the result.

Be pro-active and forward thinking, be creative, but most of all, be positive!

Finally, we must remain positive in this endeavor and time of change. The pitfalls most enter into here are based on taking a victim's stance and a 'woe is us' attitude. You can choose to bury your head in the sand and ride it out or you can do something about what is happening in your office and with your patients. Either way, you have a choice! We are sure most have encountered the negative attitudes of the people you come into contact with in your office. Money is tight, jobs are being lost and stress is everywhere around us. Stay the course! Stay positive and upbeat. People want to be around those who can influence and lift them up at times like these. Empathize with your patients and be understanding, but stay positive.

In regards to practice philosophy, times like these often bring people to compromise. What we would strongly encourage here is to never compromise beyond your core beliefs and philosophies. Again, this is covered so heavily in our book because it rests at the very center of who you are as a person. If a procedure is requested of you that you simply do not believe in, then do not do it! Sleeping well at night can bring a peace that the money made from any procedure may never bring. Likewise, stay within the confines of your practice philosophy. Don't perform or recommend procedures that you simply do not like or believe in as well. Instead, be forward thinking and look for proper training in areas of demand and growth that will bring benefit to your patients, practice and team. For instance, implant placement and restoration may be a great place to start a new education and procedural advancement. The introduction of an intensive periodontal program for your hygiene team may be another avenue to look into. There are countless techniques and advancements happening all around you and maybe just that one implementation strategy will yield the return you currently need. We are not sure where continuing education fits into the scope of everyone's practice, but another key element to riding this wave and coming out on top would be to invest in education.

Improvements made to protocol and to procedure will enhance skill levels and in return referrals and patient retention and happiness. We would also highly consider investing in yourself and in your team. When tough economic times fall on us, we have an uncanny retreat mechanism that fires off in most of us. We pull back the reigns and slow everything around us down, especially when it comes to spending. This is a time to get your office up to and hopefully beyond par. Invest in programs for your team to educate them and teach them how to communicate better and in ways that patients understand and appreciate; nothing too invasive or challenging to learn, but simple identification traits and talking points to bring the relationship into control. This is money spent wisely and has potential to bring huge return. This is also one of the main focuses of our 2-day course taught at LVI. Remember that it is not what you do, but how you do it!

As far as promotion goes, this is the perfect time to jump ahead and gain top of mind awareness using practice promotion and marketing. Internal marketing efforts should be made to gain access to untreated procedures and to plant seeds of potential and future work. No hard selling need be done. Just the little things such as personal notes and contacts, emails of digital photos and untreated work, and special offers or promotions of services offered in the office. Consider the discounts and

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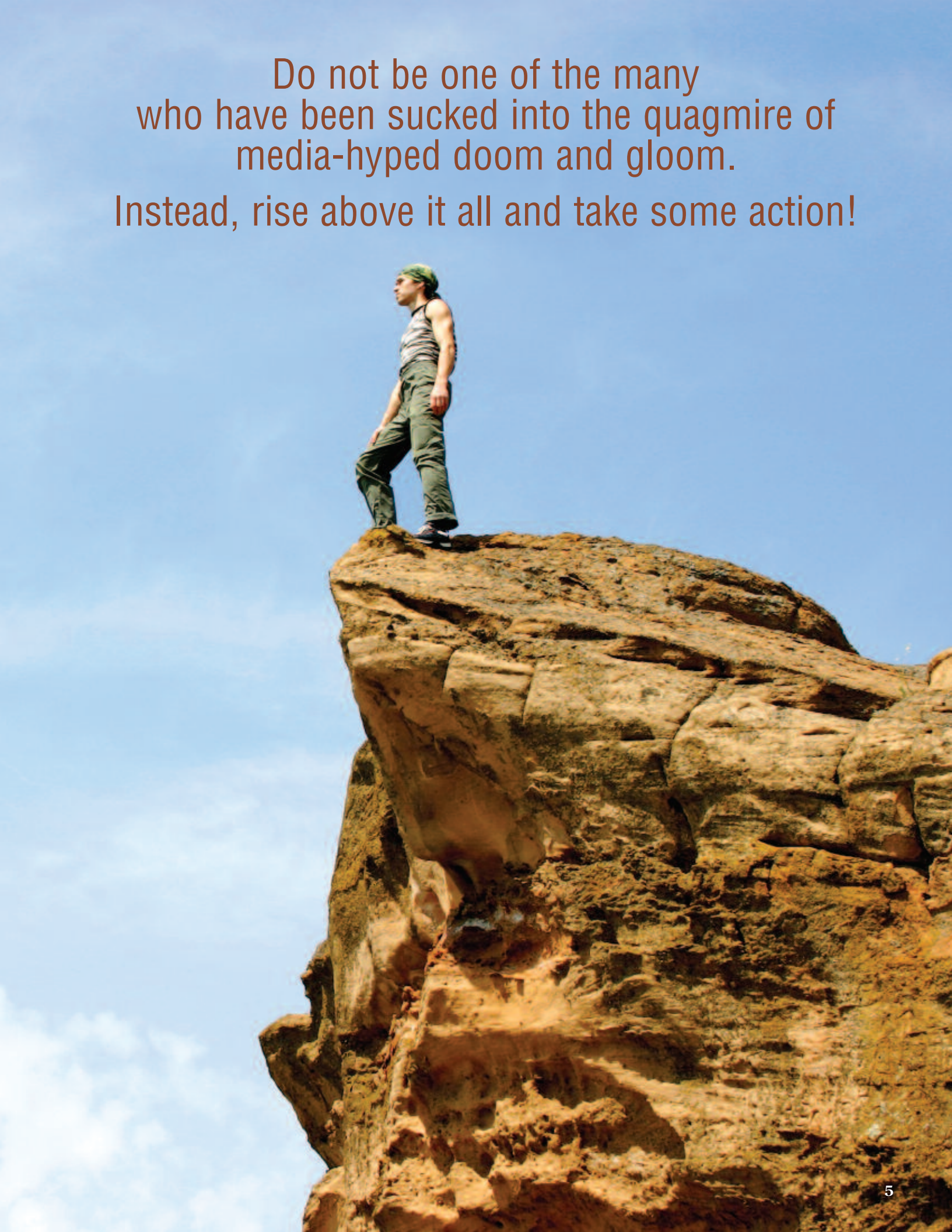
who have been sucked into the quagmire of
media-hyped doom and gloom.

Instead, rise above it all and take some action!



the return as opposed to the non-activity and no income from doing nothing as opposed to doing something. Would you give up $2,000 to make $15,000? Would you give up $5,000 to make $10,000? We are not suggesting you make deals across the board in your practice, but what we are suggesting is that you get to work! Stay sharp and keep your hands and handpieces moving. We would much rather be doing work and changing lives and impressions of the people around us than sitting at our office computers emailing and surfing the net! So figure out where your breaking point is and use it to scale back fees if needed to gain access to patients and work to be done. Consider it marketing. Seriously, how much do we spend on marketing efforts that yield moderate return? Can we switch our focus at a time like this and invest in the community of patients around us and use them as walking marketing efforts? We believe so.

External promotion or marketing should be a high priority right now. As the New Year approaches, people begin to let loose of funds and spending money from the holidays. It is both vital and imperative that you gain favour and top of mind awareness as they do. When this economic crunch slows down and the dust begins to settle, as it already is, you want to be the "go to" when people finally decide to make some change and search for something new. External marketing is one of the only ways to grab access to that. In times like these, marketing companies and media services are all scrambling just like you. That means they are willing to give to get as well. Some amazing deals can be found in television, radio, print and billboard marketing. Long-term commitments can lead to decreased cost and free services and goods. It is times like these that we find ourselves investing in our personal/practice brand and image. This is also a great time to change your brand and image to accommodate a new direction or focus. Again, the key here is to gain favour by truly separating your practice and your message from anyone else who might also want to do the same. However, it is critical that you step away from the "dental marketing 101" and into true business marketing.

Q. What are you offering to patients that meet their desires for improved function and esthetics that also fits their current economic realities?

A. While, over the past year, money has been hard to come by for many people, it still has not decreased or diminished the fact that people want positive change. We have had no fewer people walk through our doors wanting information and asking for possibilities of change than before. What has changed is their access to the funds. So as we outlined earlier, here lies the choice to compromise who and what you are and what you do or to find ways to be creative around what it is you do. We have never believed in compromising much from our core beliefs and philosophies, so we have chosen to be creative in the services we offer while expanding our offerings to better serve our patients and to keep that income here at home instead of referring it out.

Stand up and lead yourselves, your practices and your teams to success no matter what others are saying and doing around you.

For instance, we are not ones to offer direct bonded veneers for smile changes and feel there is no comparison to laboratory fabricated porcelain work. So being creative would be to pass on savings to your patients to push them over the edge and commit to treatment. An example is the Aurum 10 units for the price of 8 promotion. You can charge your patient the full amount, but why? If they have not said yes, there is a reason and more than likely it is financial. We have decided to use this incredible gift from Aurum to our advantage by offering a complete savings of these two units and saving the patient $3000. Talk about incentive! Since we implemented this, we have done more veneers and restorative cases in the last three months than in the previous six! Creativity such as this will allow your patients access to work because there is value and incentive all built into the procedure. Again, we ask what you would be willing to give up, in order to gain some financial return? Discuss this with your teams and decide how far you would be willing to go. Promote it if need be or use it on a case-by-case basis, but get in the game!

While "high end dentistry" numbers appear to be lacking, there is no decrease in the desire to have these procedures done. Access to them may be more challenging, but getting creative and using your relationships to create a "win-win" outcome is better than ever before. Don't give up on your patients and offer less of a treatment unless that is exactly what they want and is the only way they can acquire a result. Do not close your door on people who are trying. Find a way to get pro-active and creative in getting them off the fence and into your chairs! Develop incentive type programs such as this where the return is greater than sitting idle. We tell our kids when coaching them in baseball that they have to swing the bat in order to get a hit. Now we are telling you that you have to swing the bat in order to get a hit in your practices! You have to be forward thinking. Give people the option to say yes to the very best, but also give them an option to get a result and outcome worthy of your name by developing opportunities of change for a discounted fee, for less restorative work or possibly in phased therapy as opposed to doing it all in one shot. But do not compromise the final result unless you are both willing and that it is the only option available. Instead, create avenues to these outcomes and opportunities for them to take action. You will be amazed at how far this caring allows you to go in the eyes of a patient and friend.

Q. Are you seeing increased demand for any particular modalities in this economic climate either across the industry and/or in your practice?

A. In our practice, we are not seeing any increased demand for any one type procedure or specific area of concentration. We still believe people want to look their best and feel their best so the cosmetic and restorative want is still there. As a matter of fact, it is times like this that people want to feel something good about themselves because a lot of what is going on around them is not good at all. As we said before, it is the access to the funds to do so is what seems to be the slow down, not the want or desire to do so. We think necessity or "bread and butter" type work is maintaining status quo numbers, so in our practice alone

there is no real trend happening. Now, what we will say is that our patients want their services to be kept in house. That is, they want to have us or our team, provide the care or needed work or therapy for them instead of referring this particular work out.

One area to take notice of is TMD. As we all know, stress lends itself to clenching and grinding and hyper functional movements. With these come the signs of broken teeth, jaw pain, gum recession and the like. We are seeing a more educated patient enter into our practice in search of assistance for pain from TMD and the associations like headaches and neck pain. This economic trial is creating quite the stressful situation as far as individuals and family go. This stress leads to increased hyper function and discomfort and as a result more people are seeking help from these signs and symptoms.

To date the numbers in our practice have been steady with years past. This is due to our proactive marketing approaches, as well as the additional services we have provided through our commitment to continuing education. Most recently Implants, bone grafting, hygiene and endodontics. We feel our practices will continue to flourish and grow especially in the current climate. Why you might ask? It is because of what we would like to call the "Polarization of Dentistry". In the past everyone was able to be successful by virtue of being a dentist. Have a dental degree, do fine, be successful. The economic changes have exposed what we have always known and that is the business model of being in the middle and trying to make everyone happy and be everything to everyone struggles. If you are in the middle with your fees and service then no one is happy. The patient that wants services as cheap as possible is unhappy because they feel they are paying too much. The patient that wants high quality, high service is unhappy because they don't feel that they are getting the attention to them and detail that they are willing to pay for. It is for this reason that you must pick a side.

We have chosen to be high quality, high touch. Before, a lot of doctors chose to be in the middle and now many have gravitated towards the lower end. Unfortunately for most, the knee jerk response when things get tough is to cut back, accept reimbursement plans that they normally would not. They cut lab costs, cut supply costs, cut staff costs, and then they attempt to increase patient flow. When the dust settles they are spinning their wheels in a gerbil cage having created exactly what they hoped they never would have. This is the result of fear-based decisions. Fear-based decisions are those that move you towards what you don't want and away from what you desire. This is good news for those high service high quality practices that have not compromised their vision. What is considered the norm or the average regarding their dental experience will begin to drop. The bar will be lowered allowing those practices that held to their ideals to shine even more than they have by doing exactly what they have always done.

So follow our advice and heed our warnings. Do not be one of the many who have been sucked into the quagmire of media-hyped doom and gloom. Instead, rise above it all and take some action! Create what the future will look like for you and your practice and lay it out in succession beginning today and ending when you have reached your goal. Get back in the game! Be proactive and forward thinking, be creative, but most of all be positive! Your words and your actions just may begin to shape the face of what is happening around you. Stand up and lead yourselves, your practices and your teams to success no matter what others are saying and doing around you. And lastly, remember this: Love what you do; Love who you do it with; Love who you do it for . . . because everything else is just compromise!

Drs. Matt Bynum *and* **Art Mowery** *are Co-Authors of the highly anticipated personal and practice development book "The Boomerang Effect for Dental Professionals". They are clinical instructors and featured speakers at the Las Vegas Institute for Advanced Dental Studies as Co-Directors and Co- Founders of the "Achieving Extreme Success" lecture series. Both lecture internationally on various aspects of aesthetic and reconstructive dentistry, practice management, personal and practice motivation, and team building; and have published numerous articles on these subjects. They can be reached at www.bynummoweryway.com.*

For upcoming courses with Drs. Bynum and Mowery in your area, check out "Upcoming Courses" off the NEWS & EVENTS Menu at www.aurumgroup.com or contact the Aurum Ceramic/Classic Dental Laboratories Continuing Education Department at 1-800-363-3989 (email: ce@aurumgroup.com).

For more information, and dates, regarding the BMw course, please contact the Las Vegas Institute for Advanced Dental Studies (LVI) at 1-888-584-3237 or contact Dr. Bynum directly by email at Matt@DrMattBynum.com or telephone at (864) 414-9790.

Valplast, Flexite and NaturalFlex II®

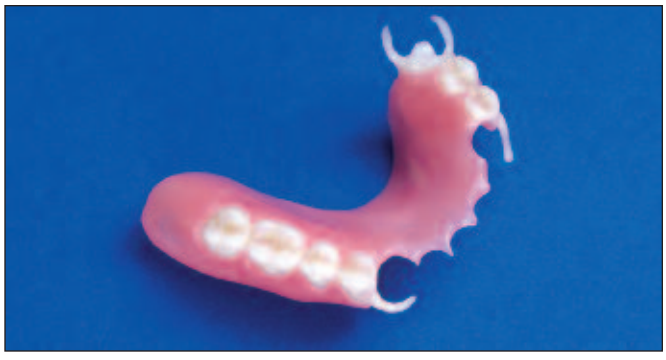
A Full Range of Flexible Removable Partial Denture Options

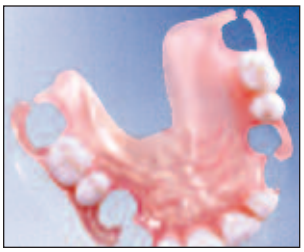
Gary Wakelam, RDT, CDT

For decades, the traditional metal partial was the treatment option of choice for partially edentulous patients. However, these metal partial dentures could be brittle and stiff, resulted in tissue irritation and had a high incidence of breakage. Even more important, today's patient demands a cleaner, brighter and more perfect appearance in their restoration – a result that metal often cannot provide. Now, Aurum Ceramic/Classic helps you meet that demand with a range of materials supplying more attractive and fully functional removable alternatives to traditional metal partial dentures: Valplast, Flexite and our own exclusive NaturalFlex II®. These materials can and are being used in a wide range of applications across dentistry including removable flexible partial dentures, preformed partial denture clasps, fibre reinforced fixed partial dentures, temporary crowns and bridges, provisional crowns and bridges, obturators and speech therapy appliances, orthodontic devices, occlusal splints, sleep apnea appliances, implant abutments and many more.

Today's Thermoplastics - Clinically Proven Advantages

Unlike early versions of flexible partials (which exhibited excessive rigidity, opacity and/or unnatural esthetics), today's thermoplastic resins tend to have a predictable long-term performance. They are stable and exhibit high creep resistance and high fatigue endurance as well as excellent wear characteristics and solvent resistance.





Fully hypoallergenic/biocompatible, thermoplastics have no metallic taste and reduce patient thermal sensitivity. Typically without free monomer, they also have almost no porosity, reducing biologic material build-up, odours and stains and ensuring higher dimensional and colour stability. Thermoplastics are more flexible and stronger than acrylics while elastomeric resins added to the various formulations create greater flexibility, reducing fracturing. Virtually unbreakable, they are lighter than their predecessors and blend seamlessly with the natural tissues for excellent esthetics. The injection process used in fabrication and the strength of the materials allows the prostheses to be made very thin, eliminating the heavy, bulky feeling of earlier versions and providing ideal adaptation to hard and soft tissues.

Tissue-borne restorations' strong, durable clasps snap securely and comfortably into place around the existing dentition and the gingival, utilizing soft tissue undercuts for retention. Unlike traditional metal-based partials, there is little or no tooth preparation necessary. Flexible partials can be constructed from two good impressions (or models), an accurate bite relationship and a note on the desired shade. For distal extension cases, it is imperative to have either the wax bite rims that were used to verify occlusal dimension or to do a wax set-up try-in.

Three Options Available

NaturalFlex II®

Based on acetyl resin technology proven in European dentistry for over a decade, NaturalFlex II® is lightweight, yet it is among the most resistant and stiffest non-reinforced materials. Featuring excellent tensile and shock strength, it is up to 20 times harder than restorations fabricated from standard acrylic materials. Tooth or tissue-coloured clasps can be created every bit as thin as those made from metal – without sacrificing function or longevity. The clasps virtually disappear in the mouth. And, the material can be used to fabricate practically invisible clasps on existing metal partials. With twenty-two colour-stable shades (including 3 bleached shades and 3 pink hues) to match conventional acrylic resins, NaturalFlex II® ensures super strong partial dentures with a perfect customized aesthetic match for each patient. Prostheses are flexible (without warming) for a comfortable fit. All of this means excellent patient acceptance.

Valplast

A nylon based thermoplastic, Valplast is available in one clear and three pink shades. Proven over 50 years of clinical success, the material has a high memory flexibility that's retentive and comfortable, perfectly suited to the variety of normal

conditions in the mouth. Valplast appliances must be warmed (by placing case in very hot tap water for approximately one minute, then allowing to cool until patient can tolerate temperature) prior to insertion. Every Valplast partial has a lifetime warranty by the material's manufacturer against breakage and fracture of the base material, assuming normal use.

Flexite

Also nylon based, Flexite is thermoplastic material with exceptional toughness and flexibility. Fabricated and fitting like a cast metallic partial, the prostheses' memory is comparable to precious wire, yet they are flexible. Available in one clear, two pink and three ethnic shades, Flexite has over 25 years of clinical history. Unlike Valplast, Flexite prostheses can be repaired and relined in operatory *or* in the laboratory either using its own material or with regular acrylic where a bonding agent is applied to non-flexing areas (NOTE: use of acrylic will result in loss of some of partial's flexible properties).

Contraindications and Concerns:

As with all dental prostheses, there are certain clinical situations where the use of flexible partials may be contraindicated. These include:

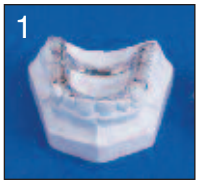
- Deep bites.
- Where there is little remaining dentition with minimal undercuts for retention.
- Where there is less than 4 mm of interocclusal space in the posterior area.
- Bilateral free-end distal extensions with knife-edge ridges on lingual tori on the mandible.
- Bilateral free-end distal extension on maxilla with extreme atrophy of alveolar ridges.

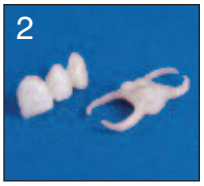
Technique Tips:

1. Take initial high quality alginate impressions for both maxillary and mandibular arches at the first appointment. Pour completed impressions in high strength laboratory stone to create accurate Study Models within 5 minutes of impression-taking. Take a bite registration. Provide a complete prescription including usual information pertaining to patient and treatment plan. Send prescription, study models and bite registration to laboratory.
2. At the second appointment, take a final impression using high quality alginate (NOTE: If the opposing model is damaged, take a new impression of this as well). Pour completed impression(s) in high strength laboratory stone within five minutes of impression-taking to create final Master Model. Select tooth shade and mould according to patient needs and established guidelines. Send complete prescription, master model, opposing model, bite registration, articulator and final design to laboratory.
3. Laboratory will return try-in. Examine laboratory-supplied try-in for selected shade, mold, esthetics and bite relationship.
4. At Final Insertion, find an easy path of insertion and insert partial into mouth [NOTE: If Valplast, warm appliance first by placing in very hot tap water for approximately one minute. Allow to cool just to point where can be tolerated by patient]. Evaluate occlusion, function and esthetics. Check lateral and protrusive excursions. Adjust as necessary. Apply pressure-indicating paste to tissue side of acrylic saddles. Reinsert partial into mouth, check for pressure spots and adjust. Demonstrate appliance insertion and removal to patient. Patient MUST be able to perform these before leaving office. Instruct patient in appliance management and care.

Adjustment Tips

Please remember that clasps have been crafted in the exact proportion for proper function. DO NOT reduce clasp thickness at chairside. This could jeopardize strength and/or retention. When necessary, adjustments can be made with either stones or rubber points. Rubber points and wheels will provide the smoothest surface (especially when adjusting the peripheral edges of the prosthesis) and are ideal for accessing undercut areas. NOTE: Carbide or acrylic burs are **not** recommended, as they tend to melt rather than cut the materials.





1 *NaturalFlex II® virtually disappears in mouth as shown by white clasp on model to the left.*

2 *Temporary and unilateral.*

3 *NaturalFlex II® partials.*

4 *Overlay partial.*

Three Different Options – A Quick Comparison

NaturalFlex II®

- Exclusively from Aurum Ceramic/Classic. Based on acetyl resin technology.
- Super strong, lightweight and translucent.
- Superior flexibility. Unsurpassed durability.
- Widest range of esthetic options with 22 colour-stable shades (including 3 bleached shades and 3 pink hues).
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Valplast

- Nylon based thermoplastic.
- High memory flexibility that's retentive and comfortable.
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- Memory comparable to precious wire, yet is flexible.
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Ultra Conservative
Ultra Beautiful

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- Our experienced and talented veneering specialists have perfected unique techniques that allow for subtle changes in customized contour, fit or shade.
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- Full palette of shades available. Far more resistant to staining and colour changes compared to traditional, thin feldspathic materials.
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Extractions - Simple, Predictable and Profitable?

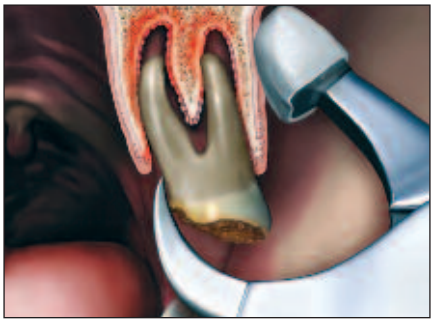
Sonia Leziy, DDS, Dipl Perio, FCDS(BC), FRCD(C)

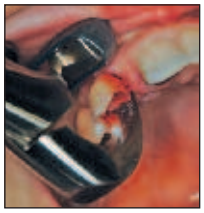
Extractions seem to be one of the most difficult procedures we do as dentists. Many dentists are uncomfortable performing extractions or refer them out because they can be challenging and unpredictable. We have all experienced the "snapping" sound of a fractured root tip or having to remove bone to access a compromised tooth. These events can make extractions unprofitable, disruptive to the treatment schedule, stressful for our patients and challenging for us.

Over two years ago I was introduced to a revolutionary new concept and tooling in exodontia, the Physics Forceps from GOLDEN/MISCH. I have extracted several hundred teeth with these instruments and the results have been impressive. I am able to extract teeth atraumatically, predictably and therefore profitably. Because of the biomechanical principles applied to these instruments, I no longer break root tips and I am able to more predictably preserve the ridge form, improving patient care. All of this has increased my confidence level in predictably extracting teeth without complications and in less time.

The biomechanical rationale of the Physics Forceps is that they act like a simple first class lever. One force is applied with the beak on the lingual aspect of the tooth or root. The second force is applied via the "bumper" which is placed on the alveolar ridge at the approximate location of the mucogingival junction (Figure 1). The handles of the Physics Forceps are not squeezed, just held, and a gentle but steady rotational force is applied through a small amount of wrist movement only (about 3 - 4° of rotational force). Then I apply a steady pressure in this position for about 1.5 - 2 minutes. As the instrument is allowed to do what it is intended to do, an element of "creep" allows the bone to slowly expand and the PDL to release. Once this occurs, the tooth will disengage and rise approximately 1 - 2 mm occlusally. The tooth is now hanging in the socket and can be delivered with a hemostat, rongeur or conventional forcep.

When I first saw these instruments, I was very concerned with potential damage to the buccal bone. As I learned and applied the proper technique, I experienced that I could actually preserve the bone while doing extractions (Figures 2 - 4). This is very important for immediate implant placement, and in general to maintain optimal tissue esthetics for conventional and implant based treatments. The reason that the buccal bone is not damaged is because the compressive force that is applied by the bumper actually supports the buccal bone. Furthermore, these instruments are effectively used as a lingual elevator with limited movement of 1 - 2 mm. They are not intended to deliver or fully extract the tooth. Adhering to the recommended technique, I have found that even with thin facial bone, I am able to preserve the bone.





Figures 1 and 2. The beak is placed on the lingual side of the tooth and the bumper acts as a fulcrum. Since there is only one point of contact, you eliminate root tip fractures as the tooth "rolls out".

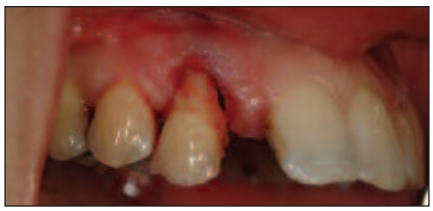


Figure 3. As the bone expands and the PDL releases, the tooth will disengage in the socket and preserve the buccal bone.

For my practice, the Physics Forceps have allowed me to:

- complete difficult extractions quickly and atraumatically
- extract teeth predictably — even teeth broken down to the gumline or endodontically treated teeth
- virtually eliminate the need for surgical flaps, intentional bone removal and the bone loss resulting from flap procedures
- help facilitate immediate placement of implants or other restorations
- reduce my stress associated with extractions
- change the way my patients perceive extractions — and my practice!

The Physics Forceps have been a welcomed addition to my practice armamentarium. Because they are simple, predictable and non-surgical, they have become my go-to instrument for even the most difficult extractions.

For more information on the Physics Forceps, please contact: NDI - (800) 392-1171.

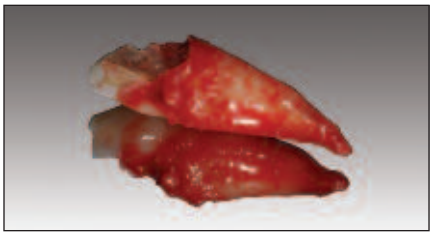


Figure 4. The tooth is extracted atraumatically, predictably and conservatively.

Dr. Sonia Leziy *is a Fellow of the Royal College of Dentists of Canada, a Fellow of the ICOI, and a member of the British Columbia Society of Periodontists, the Canadian Academy of Periodontists and the American Academy of Periodontists and the American Academy of Esthetic Dentistry. She has coauthored the textbook Multi-disciplinary Treatment Planning, published by Quintessence Publishing (2008). Dr. Leziy lectures internationally on the subject of implants and advanced esthetics/periodontal plastic surgery, and has been recognized among the top 100 clinicians in continuing education by Dentistry Today in 2007, 2008 and again in 2009.*

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** As reported in GFK.*

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[2] Reality is a registered trademark of Reality Publications.

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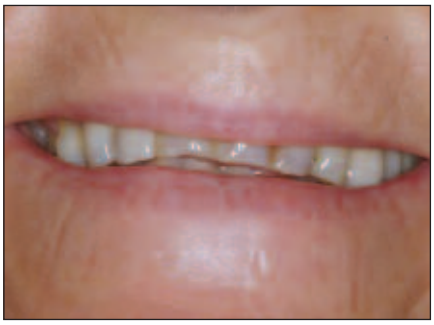
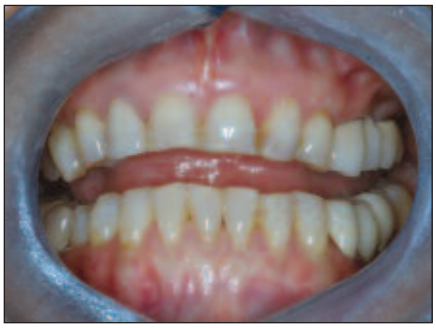
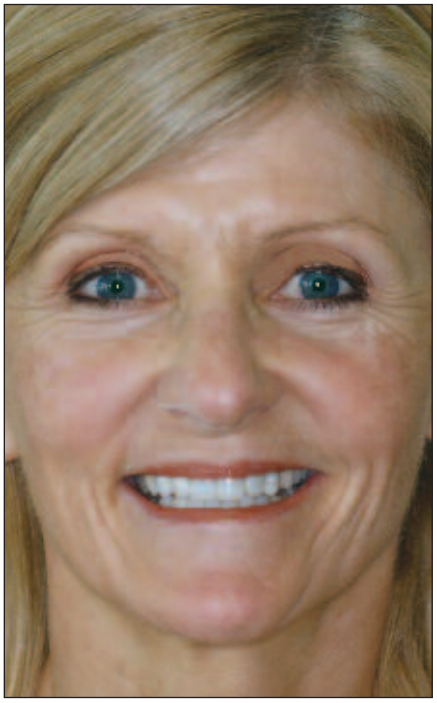


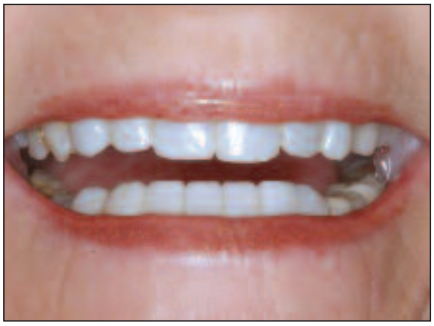
Close-up of pre-operative smile.



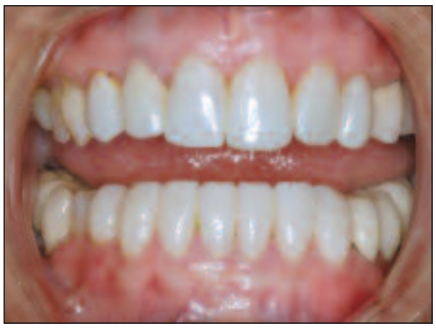
Retracted pre-operative smile.



Happy patient!



Close-up of new smile.



Retracted restored smile.

Full face Before.

"This patient first consulted with me a number of years ago regarding her aging smile. She did not like her worn dentition and wanted to look and feel younger. At that time, I proposed elongating her worn upper dentition with the use of composite in order to sculpt the smile in a pleasing way. To ensure strength and beauty, I layered hybrid and microfill composites in B1 and B2 shades. We also prescribed an occlusal splint to prevent her from grinding on her new veneers. She was very happy with her new look.

A few years later, she was ready to restore her lower anteriors as she wanted straight and very bright lower teeth to complete her "new look". She also wanted to restore the wear on the lower incisals caused by the many years of grinding. Since she had tiny restorations and small bottom teeth, I wanted to use a material that would be ultra-conservative and strong enough for her type of bite. Eight Cristal® veneers from Aurum Ceramic/Classic seemed to be the perfect choice. Obviously, shade match with the existing upper composite veneers was critical. This involved a great deal of discussion with the laboratory and many photographs. The Aurum Ceramic/Classic AE (Advanced Esthetic) Team put them all to good use in crafting veneers that matched the existing shade superbly. They fit perfectly and looked wonderful. Final placement of the restorations was a revelation: very minimal preparation (without anaesthetic) and no temporaries required. All that was needed for a great final result was a minor adjustment to the existing upper restorations. I added a little touch of sparkle (iridescent blue from Cosmedent) to the two upper centrals in order to match the bright and shiny colour of the lower Cristal veneers. I also lengthened the two upper centrals a bit to make them even more harmonious with her facial features.

The patient is ecstatic with her completed smile. I saw the patient again recently and she LOVES her new Cristal veneers. Extremely comfortable and beautiful."

Danièle Larose, DDS

Restorations fabricated by Aurum Ceramic/Classic.

Dr. Danièle Larose graduated from the University of Montreal's School of Dental Medicine in 1997. She is in private practice in Ville St. Laurent (a suburb of Montreal) where she focuses on Cosmetic Dentistry. Dr. Larose has completed several courses at the Las Vegas Institute for Advanced Dental Studies (LVI) including Advanced Anterior and Occlusion I. She is also a member of the CAED (Canadian Academy of Esthetic Dentistry) as well as the provincial association ODQ.

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Expand Your Treatment Options While Broadening Smiles

Based on the belief that a smile is optimized by an arch form that displays well-positioned anterior teeth, the first and second bicuspids, and the mesiobuccal surface of the first molars, this broader form archwire helps prevent dark corners in the posterior of the mouth thus presenting a wide smile.

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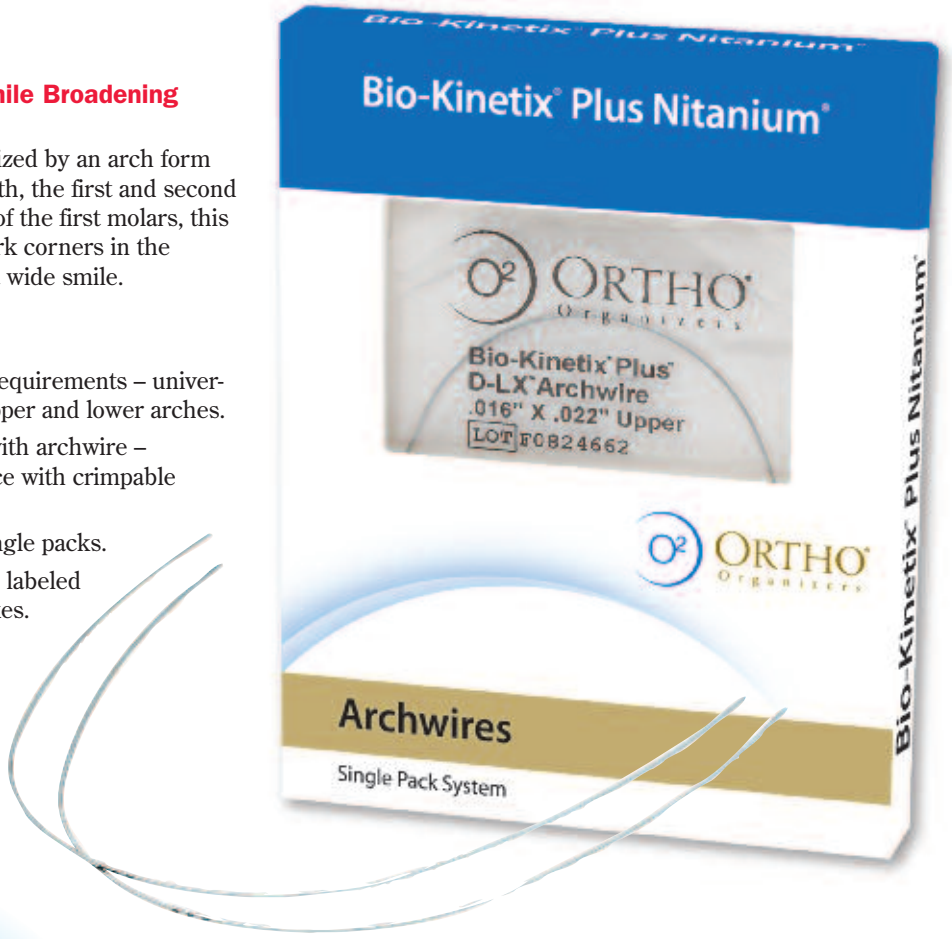
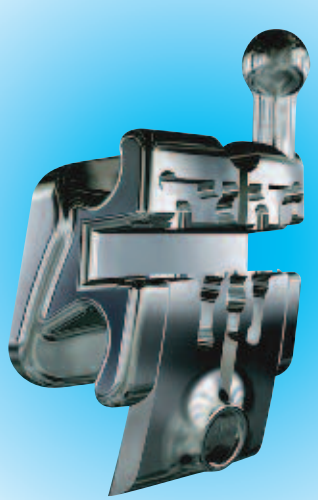
† *For hook and micro-stop options, please contact your local Cerum Ortho Organizers representative.*





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The "Next Big Thing" in Dentistry

Dr. Louis Malcmacher

I am asked all of the time what the next big thing is going to be in dentistry. What new technology or technology is going to change dental practice? We certainly have made huge advancements in a number of areas, such as restorative therapy, implants, and esthetics.

I believe the direction of the next great thing in dentistry is actually going to take place in the oral-systemic connection. Most dentists are familiar with this connection as being how oral health affects systemic health. I'm going to look at the oral-systemic connection from a completely different angle – the oral-systemic esthetic perspective.

We all can do a magnificent job of making teeth look great and giving people a healthy and beautiful smile. Esthetic dentistry has been an absolute boom over the last 30 years when it comes to such innovative techniques as teeth whitening and minimally invasive veneers like Aurum's Cristal® Veneers. Now that the teeth look good, what about the perioral areas around the mouth? If the teeth look good but we ignore the rest of the face, then we have really limited what we have done in esthetic and general dentistry.

It is time to seriously give serious consideration to extending the oral-systemic connection to the esthetic realms of the face which dentists are more familiar than any other healthcare practitioner. Dermal fillers are commonly used to add volume to the face in the nasolabial folds, oral commissures, lip augmentations, and marionette lines. As we age, collagen is lost in these facial areas and these lines start to deepen. These dermal fillers are injected right under the skin to plump up these areas so that these lines are much less noticeable. The face looks more youthful and esthetic and is the perfect complement to any esthetic dentistry. Botulinum toxin (Botox®) is used to relax the motor muscles that cause dynamic wrinkles in the skin which then smoothes out the skin for esthetic purposes. Botulinum toxin is also used to reduce the intensity of the muscles of mastication like the massetter and temporalis muscles, which then reduces or eliminates facial pain.

I have been trained and have had experience with botulinum toxin and dermal fillers for a while and these are very easy procedures to accomplish. We, as dentists, give injections all the time – this is just learning how to give another kind of injection that is outside the mouth but is in the same area of the face that we inject all the time. We also have a distinct advantage over dermatologists, plastic surgeons, medical estheticians, and nurses who commonly provide these procedures in that we can deliver profound anesthesia in these areas before accomplishing these filler procedures. I will never forget that during my training, my patients were completely comfortable during dermal filler and lip augmentation therapy because of my ability to deliver proper anesthesia to these areas. The patients treated by other health practitioners were quite uncomfortable and indeed this is one of the biggest patient complaints about dermal fillers.

Some Canadian provincial dental boards and many American state boards are allowing general dentists to provide botulinum toxin and dermal fillers to patients. Is there a market for these services? In 2008, close to 7 billion dollars were spent on botulinum toxin and dermal filler therapy in North America. Think about this – that was money spent on non-surgical elective esthetic procedures that could have been spent on needed or esthetic dentistry but the patient made a choice. Interestingly, these procedures become more popular in an uncertain economy because patients want to do something to look better that is more affordable than surgical esthetic options.

Like anything else you do, this requires some training and the learning curve is incredibly short because you already know how to give comfortable injections. I often give training sessions in botulinum toxin and dermal fillers and dentists are amazed how easy these procedures are compared to everything else we do. Finding practice models is easy - start asking family and friends who will fight to have you practice on them. If you want further proof, ask women in your practice if they have had or would like dermal filler therapy. You will be overwhelmed at the positive response.

The next big thing in dentistry? It may come as we start expanding outside of the teeth and gums into the oral and maxillofacial areas, which is within every dentist's skill set. All you need is knowledge and practice. Then, you will be able to deliver these new services to your patients and truly complement and complete your dental practice.

Louis Malcmacher *DDS MAGD is a practicing general dentist and an internationally known lecturer and author. An evaluator for Clinicians Reports, Dr. Malcmacher is President of the American Academy of Facial Esthetics. You can contact him at 440 892-1810 or email dryowza@mail.com. His website is www.commonsensedentistry.com where you can find information about his lecture schedule and botox and dermal filler training, audio cd's, download his resource list, and sign up for a free monthly e-newsletter.*

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Dates subject to change. For more information or courses in your area, call 1-800-363-3989 or email: ce@aurumgroup.com.

Editor's Note: Please check with your local Governing Board regarding offering Botox/Dermal Filler services in your practice.

This male patient first visited my practice in June 2009. At his initial appointment, he said, "I'm here because I don't have a great smile. I've spent a lot of money, had implants done but look at my smile after all the time and money, it looks terrible." As you can see from his pre-treatment photos, he was definitely a bruxer, exhibiting advanced wear with loss of vertical dimension and moderate to severe bite collapse anteriorly. However, he exhibited no neuromuscular symptoms. He presented with six implants, five of which had already been restored. He was also missing #2 - 6; the space had closed with #2 - 7.

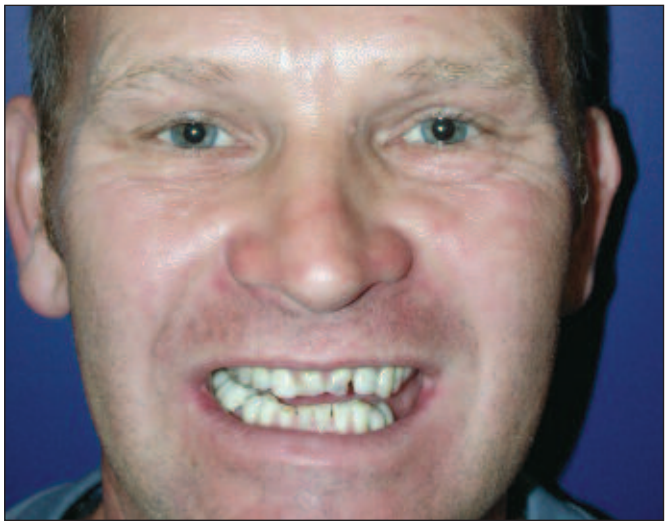
We began by determining his comfortable jaw position through a full K-7 Myobite work-up. His original CO was 12.5 and it was decided to open his neuromuscular bite to 17.5 mm. A Removable Lower orthotic was placed to correct his loss of vertical dimension and confirm the bite was now correct and comfortable.

Several months later, we began Full Mouth Rehabilitation by prepping and temporizing the entire upper arch and placing a Fixed Orthotic on the lower arch. Aurum Ceramic/Classic created a Diagnostic Wax-up as per their ACCES™ system, which the patient enthusiastically accepted. Even at this point, after viewing a Diagnostic wax-up and the temporaries, the patient was already extremely happy with the dramatic change in his smile he was seeing.

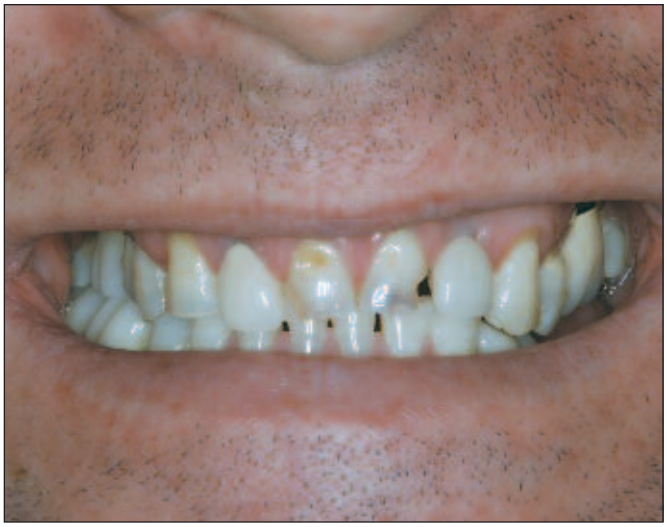
During the preparation and temporization stage, we removed all of the implant crowns and abutments but were able to use the existing implants themselves. New impressions were taken and the Aurum Ceramic/Classic Implant Team fabricated beautiful new custom abutments and crowns. Fortunately for doctor and patient alike, all existing implant crowns and the standard abutments were removed easily.

At the bonding visit, the patient had adjusted extremely well to his new vertical dimension and bite. All of the provisionals were removed from the upper arch; the new crowns were tried in (which the patient enthusiastically accepted) and then bonded to the prepped teeth. Three new custom implant abutments were placed and torqued and new crowns bonded to these abutments. Anterior teeth #1 - 4 to #2 - 4 were restored with IPS Empress Esthetic while IPS e.max crowns were placed on #1 - 7, #1 - 6, #1 - 5, #2 - 5 and #2 - 7 – all beautifully crafted by Aurum Ceramic/Classic. We then re-lined his lower Fixed Orthotic and equilibrated and balanced his bite. Based on the patient's preferences, his lower arch will be completed within the next 12 months. After the bonding visit, the patient looked in the mirror and said, "my bite feels great and I love them!"

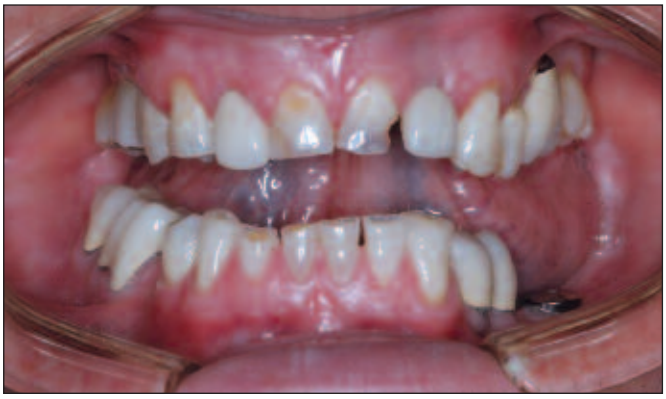
This case is a great example that patients with even the most dehabilitating bites don't have to commit to having both the upper and lower arch completed at the same time. Their treatment can be phased in over time, still with great results.



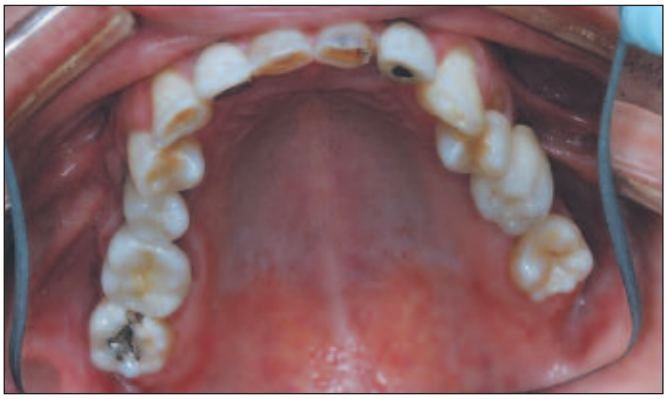
Full Face Before.



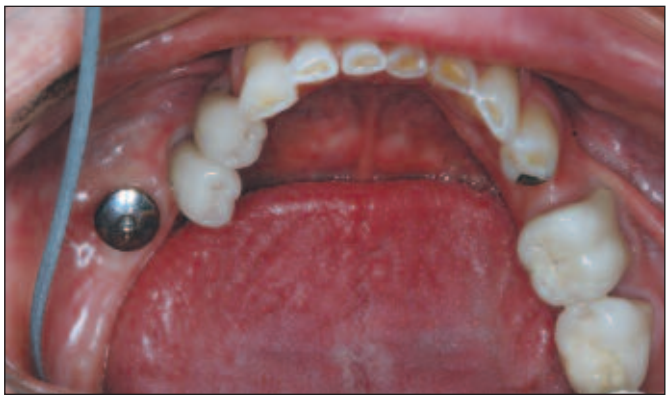
Smile Before.



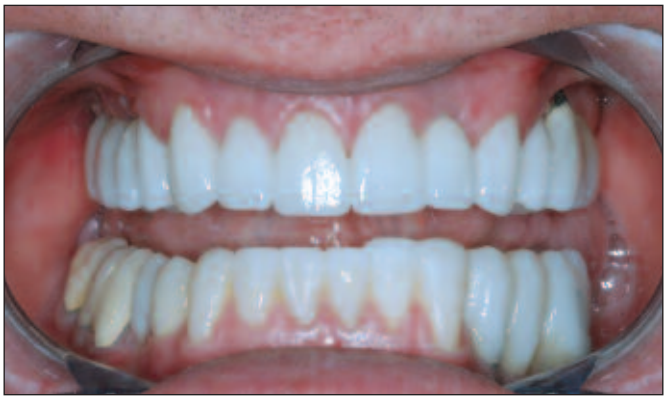
Retracted close-up of initial situation.



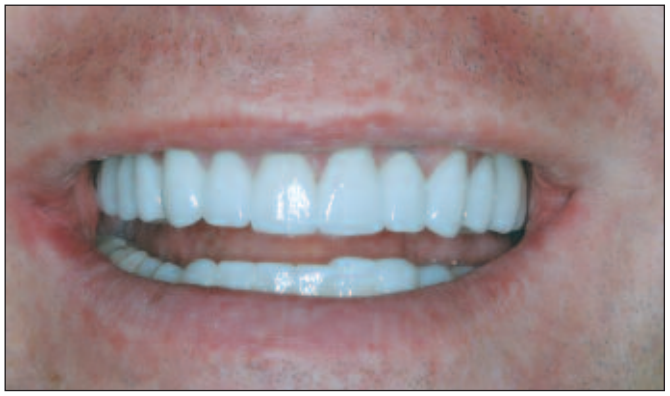
Upper arch prior to treatment.



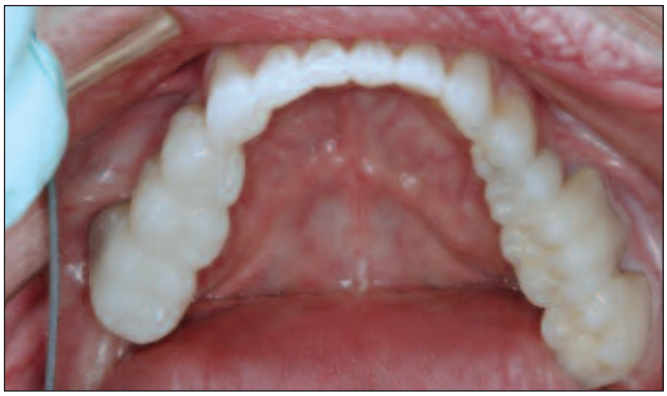
Lower arch prior to treatment.



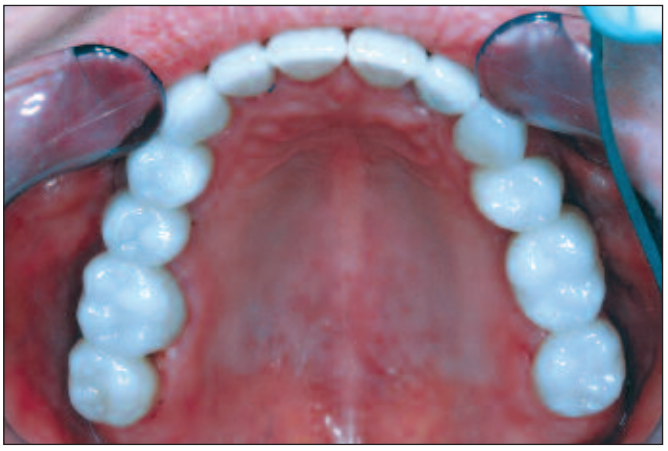
Retracted Smile – teeth apart.



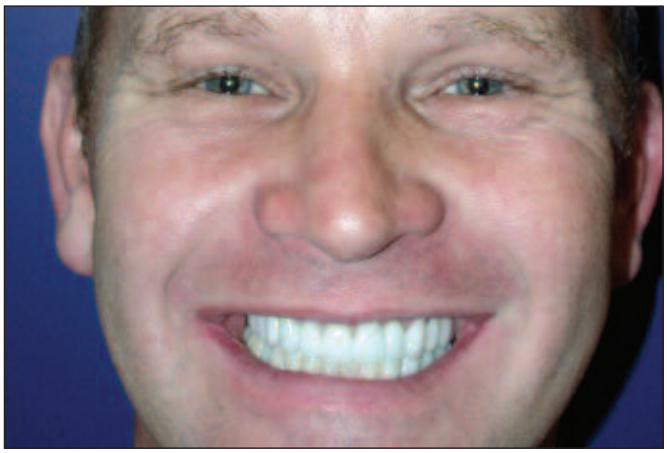
Smile After – teeth apart.



Lower fixed orthotic on unprepped teeth.



Restored upper arch.



Full Face After.

Restorations fabricated by Aurum Ceramic/Classic.

David I. Peck, D.M.D. graduated with honours from Northeastern University in Boston, MA with a B.S. degree in Pharmacy in 1979, continuing on to graduate in 1983 from the University of Medicine and Dentistry of New Jersey. He completed his general practice residency at Danbury Hospital in Danbury, Connecticut and regularly upgrades his expertise as a dentist by taking advanced dental courses at the Las Vegas Institute for Advanced Dental Studies (LVI) including Advanced; CARP; Occlusion 1, 2 & 3; K-7 Training; Scan Interpretation; Primespeak 1& 2; and CORE 1. Dr. Peck has also completed a course with Larry Rosenthal in Palm Beach, Florida and has been certified in laser treatment for cosmetic soft tissue re-contouring and periodontal therapy at the University of California at San Francisco.

Dr. Peck is in private practice in Springfield, MA with an emphasis on Neuromuscular and Cosmetic Dentistry. He is a member of the ADA, the Massachusetts Dental Society, the Valley District Dental Society, the AACD, and the Academy of Laser Dentistry.

All Toothpastes Are Not Created Equal

Are They Damaging That Beautiful New Smile?

Trish Jones, RDH, BS
Assistant Manager, Aurum Ceramic @ LVI

Have you noticed when you buy a new car, it usually comes with a brochure on how to take care of it? Or even more, the sales person goes over the features of your new car before you leave the facility? That is good customer service since the car is an investment that everyone wants to last for years to come. The dealership sure doesn't want to see you bring your car because of something that could have been prevented.

Now let's consider a newly restored smile. Shouldn't that be considered every bit as important an investment as well? How many of you go over how to take care of their new restorations with your patients? Do you give them a brochure on what home care products are recommended? If not, why not? Not only are you protecting the patient's investment, you are providing superior customer service, and you may be addressing future issues that could have been prevented by educating the patients on correct products to use, and ones not to use, right up front.

So, how do you go about it?

First of all, your office may want to think about adopting a home care regimen plan, if one isn't in place. From the laboratory standpoint, we want your patients to take care of their new restorations. Anything we can do to minimize remakes, we are all for it!

It happens all the time. A patient leaves your office and then calls back to ask if there is any certain kind of toothpaste they should be using? In case you are wondering, not all toothpastes are created equal, **and not all are good for dental restorations!** Of course, the dental toothpaste manufacturing companies don't want you to know that! The key questions we need to answer are: what should you recommend to your patients that is safe on dental restorations? And, perhaps even more important, what is unsafe?

Toothpastes are assigned a Relative Dentin Abrasivity (RDA) value using an ADA standardized test. The RDA value ranks how abrasive a toothpaste is on a scale of 1 to 250. Any value over 100 is considered abrasive. Abrasive and polishing agents are added to toothpastes to aid in the removal of surface stain, plaque and food debris. Whitening toothpastes have more abrasive formulations so stains are removed more efficiently and faster. Toothpastes that have FDA approval in the U.S. have to have a RDA Value assigned to them. But not all toothpastes disclose that information to the consumer, simply because it wouldn't be in the best interest of marketing those products. For instance, if a toothpaste whitens, brightens, removes stain, and has tarter control, it is most likely too abrasive for porcelain restorations. Plus, whitening toothpastes are not going to lighten the shade of a restoration!

Abrasive how, you ask? The more abrasive particles present (concentration), the hardness of the particle, the larger the size of the particle, and the type of abrasive particle (such as silica) can cause micro scratches on the surface of restorations over time. These micro scratches can dull the restorations, thus losing the luster and glaze. Most of all, micro scratches provide a rough surface for more plaque and stain to adhere to and, even more so, compromise the integrity of the margin of the restoration(s). Esthetic restorations may be unnecessarily damaged or prematurely worn, not to mention what these abrasives may do to enamel and dentin. Abrasive toothpaste may also contribute to increased sensitivity. The last thing you want to see is that unhappy patient walking through your door with dull or stained restorations, that are less than a year old and that are sensitive around the margins!

Certainly this might be remedied. The hygienist may need to schedule a "cosmetic polishing" appointment to restore lost luster, in addition to the patient's regular re-care appointment. This appointment would entail using diamond polishing paste to re-create the glossy finish. However, the situation might have been prevented entirely by providing post operative smile care instructions.

The exact brand of toothpaste you recommend is certainly your decision, but by following these guidelines, a protocol can be established:

1. Look for toothpaste with a low abrasive rating. If you do not know what the rating is, contact the manufacturer. A list of various current toothpaste ratings can be found at www.aurumgroup.com.
2. Be selective and educate your patients on why it is important to use certain paste for esthetic restorations.
3. Look for the ADA Seal of Approval. This means the toothpaste has been evaluated by professionals.
4. Customize toothpaste recommendations for your patients. Whitening toothpaste will not whiten esthetic restorations.
5. Create a brochure to hand to your patient at the restorative seat appointment. It shows you care about your patient's investment.

Protect those bright new smiles and instruct your patients on how to care for their beautiful restorations!

The Perio Tray®

The Perio Tray®, offered by Space Maintainers Laboratories - Canada, was cleared by the FDA in 2004 as a prescription medical device. Each custom-formed tray has a special patented seal that directs solutions of the clinician's choice into the gingival crevice or periodontal pocket. The frequency and duration of usage is determined by the practicing dentist based on individual patient needs.

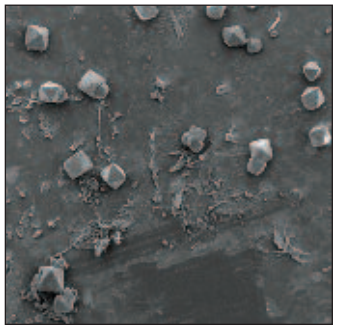
Independent analysis at the USC Center for Biofilms in 2006 demonstrates the efficacy of medicament placement into periodontal pockets via the Perio Tray®. An image from a scanning electron microscope shows that a tetracycline placed into a 6 mm pocket via a Perio Tray® remained at sufficient concentration to form crystals on the bottom of a carrier in the pocket.

A Perio Tray® fits each patient precisely. Models and probing charts are sent with a prescription to a specialized dental laboratory for custom fabrication of seals and extensions that correspond to the pocket depths for the greatest efficacy and comfort. Patients describe the Perio Tray® as comfortable, convenient, and easy to use. They especially appreciate its non-invasive technology.

The Perio Protect Method™ is a comprehensive treatment approach to help manage oral biofilms in periodontal pockets with minimally invasive dentistry. The Method combines the mechanical removal of biofilms (e.g. SRP) with a chemical therapy to disrupt biofilm growth. Research shows that when oxidizing agents are placed into periodontal pockets with a customized tray, the oxidizing agents dissolve the slimy coating of biofilms and alter the anaerobic environment of pockets to help eliminate anaerobic pathogens. Post-treatment results from these studies include reduced bacterial populations in the pockets, reduced bleeding on probing, and decreased pocket depths.*

For detailed information on the Perio Protect Method™, please consider attending a one-day seminar. Seminar registration information, locations, and dates are available on perioprotect.com or ce@aurumgroup.com. A self-study program is also available.

For more information on the Perio Tray®, please visit periotray.com or call your closest Space Maintainers Laboratories - Canada location TOLL FREE.



This image of tetracycline crystals that formed at the bottom of a carrier in a 6 mm pocket demonstrates that the Perio Tray® effectively places a solution into the periodontal pocket. The image is taken from a research poster presented at the 2007 IADR/AADR meeting.

* Selected articles and research data on the Perio Protect Method include the following: Schaudinn et al. Periodontitis: an Archetypical Biofilm Disease. J Am Dent Assoc 2009; 140: 978-986. Managing Periodontal Disease is a Patient Suffering from Renal Failure. Dent Today 2008;27(7);144-47. Wentz et al. Initial Study of the Perio Protect™ Treatment for Periodontal Disease. J Dent Res 85(A): 1164, 2006. Keller et al. SEM Results of Periopathogenic Control with the Perio Protect Method. J Dent Res 86(A): 1186, 2007. Steele et al. C-reactive protein changes during Perio Protect treatment of periodontal disease. J Dent Res 86(A): 1195, 2007. For a discussion of a different local oxygen therapy with positive research results, see Gaggl et al. Local Oxygen Therapy for Treating Acute Necrotizing Periodontal Disease in Smokers. J of Periodont 2006 Jan;77(1):31-8.

Plan to Attend:

The Perio Protect Method

Calgary, AB, February 26, 2010
Edmonton, AB, February 27, 2010
Victoria, BC, March 5, 2010
Vancouver, BC, March 6, 2010
Halifax, NS, March 26, 2010
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Treatment of Class II Division 1 Malocclusion Cases *(Part 1)*

Walt Pfitzinger, DDS, MS

Treatment methods for Class I Division 1 malocclusion can vary from the use of cervical headgear to bicuspid extraction depending on the nature of the case as well as the preferences of the treating dentist or orthodontist. This author has treated Class II cases using both fixed and removable functional appliances including the Harvold Activator, the Twin Block Appliance, the Herbst Appliance and at least four or five other appliances all designed to position the mandible in a forward position. Having tried many of these appliances over the years, I keep going back to the Bionator with evening and nighttime wear only for the functional aspect of the treatment. In this series of articles, we are going to discuss the use of the simple Bionator to treat Class II Division 1 cases that meet certain diagnostic criteria. These criteria include:

- Class II Division 1 cases with deep bites and a moderate to severe overjet.
- Cases that exhibit a retrognathic mandible as opposed to a prognathic maxilla.
- Cases that exhibit counterclockwise or horizontal growth.
- Cases that exhibit generally good arch form with no crowding in the mandibular arch.
- Patients that we believe will be co-operative (no day time wear is required).
- Cases that are actively growing (ideally treatment takes place during the pubertal growth spurt).

For more information on the Bionator, please call your closest Space Maintainers Laboratories - Canada location TOLL FREE.

Diagnosis and Case Selection

Standard orthodontic records need to be taken and evaluated. The case should exhibit a skeletal Class II malocclusion with a significant over jet and deep bite (a characteristic of horizontal growth). The cephalometric X-ray along with clinical observation can be used to substantiate this condition. The study models in Figure 1 shows a patient that exhibits both of these characteristics in that she has a deep bite and a 14 mm overjet.

Although clinical studies indicate that almost ninety percent of Class II malocclusions are the result of a retrognathic mandible, one can confirm this simply by observing the patient's profile when he/she shifts the mandible forward into a normal incisal relationship. The illustration in Figure 2 shows a Class II patient with a significant overjet positioning her mandible in a forward position. Notice the straight facial profile with this forward position. Had she had a prognathic maxilla, we would observe a convex facial profile.

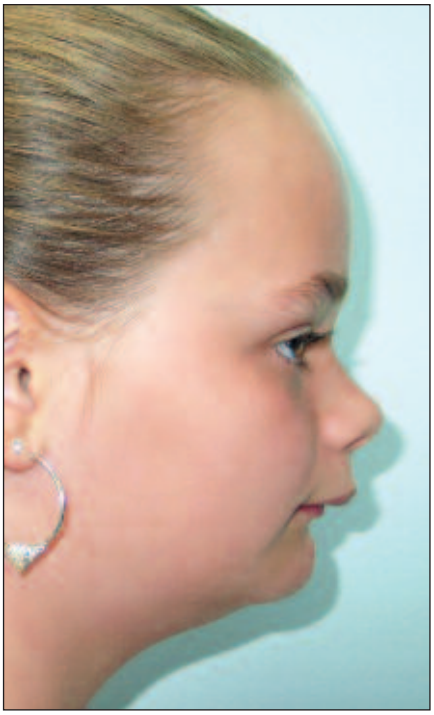
> Treatment should be done during the time the child is actively growing

We tend to select only those cases that show a non-crowded lower arch however many severe Class II Division 1 cases may show a narrow "V" shaped maxilla. If this is the case we can either pre-treat with an appliance using a transverse screw (as illustrated in Figure 3) or simply wait to correct the arch form with fixed appliances after finishing the functional part of treatment. Figure 4 shows a case in which the upper arch was expanded with the transverse appliance while at the same time the upper incisors were retracted using the Hawley bow. This appliance took place before the placement of the Bionator.

Finally, treatment should be done during the time the child is actively growing. This varies a great deal between children. Also, it should be noted that there is on average a two-year age difference between males and females regarding when they reach peak growth times. We find that we are starting girls in functional appliances around age 9-11, while in males we may not start until they are 11-14 years old. We use a radiograph of the wrist or more specifically the middle finger to determine the ideal time to begin treatment. Studies by physiologists suggest most growth hormone is released during the first few hours of sleep which is the reason why it is more important to wear the appliances during the evening and sleeping hours than during the day time.

This is just a brief overview of how we select cases for treatment with the Bionator appliances. The "Flow Chart" shown in Figure 5 is an illustration of how we make the decision in how to treat a given Class II Division 1 malocclusion. In the next article (Part 2), we will show a case that met these criteria for treatment and how the case was completed with two simple removable appliances.

Fig 1: Patient shows full step Class II Division 1 Malocclusion.



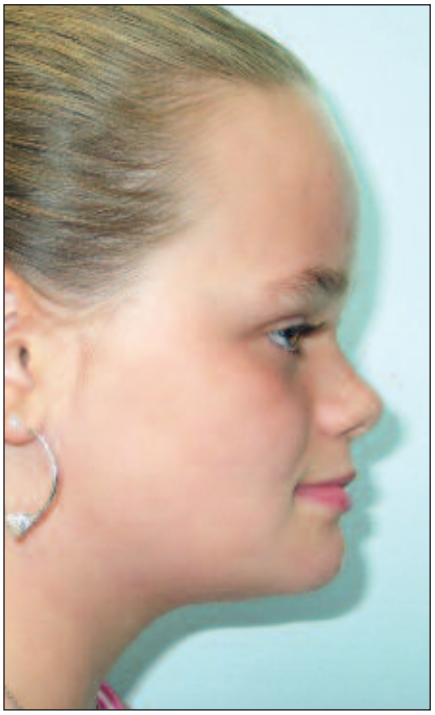


Fig 2: Class II Patient with Mandible Advanced into Normal Overjet.

Fig 3: Transverse Plate designed to Expand Posterior Segment and Retract Incisors.

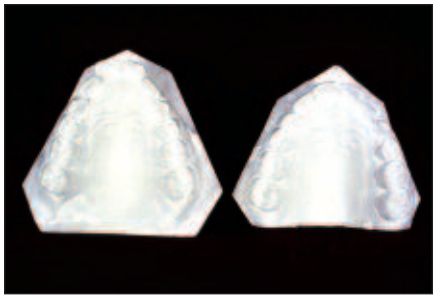


Fig 4: Results after Transverse Plate.

Walt Pfitzinger, *DDS, MS, began his practice of dentistry 35 years ago as a solo pediatric dentist. His practice has evolved into a group with four offices and consists of five general dentists, three pediatric dentists, an orthodontist, an oral surgeon, and an anesthesiologist.*

A graduate of St. Louis University School of Dentistry, Dr. Pfitzinger received his advanced degree in pediatric dentistry from Marquette University. Always a student, Dr. Pfitzinger continues to improve his practice and teaching. He actively participates in courses led by world-renowned specialists in appliance therapy both in North America, Europe and Asia. He brings first-hand knowledge on what works and what doesn't with explanations and examples. Although removable appliances are an important adjunct to early orthodontic treatment and minor movement in adults, he also practices using fixed Straight Wire mechanics.

Plan to Attend:

Minor Tooth Movement for Children and Adults

by Dr. Walt Pfitzinger

Toronto, ON, April 23, 2010
Sudbury, ON, April 24, 2010

For more information or courses in your area, check out "Upcoming Courses" off the NEWS & EVENTS Menu at www.aurumgroup.com or contact the Aurum Ceramic/Classic Dental Laboratories Continuing Education Department at 1-800-363-3989 or email: ce@aurumgroup.com.

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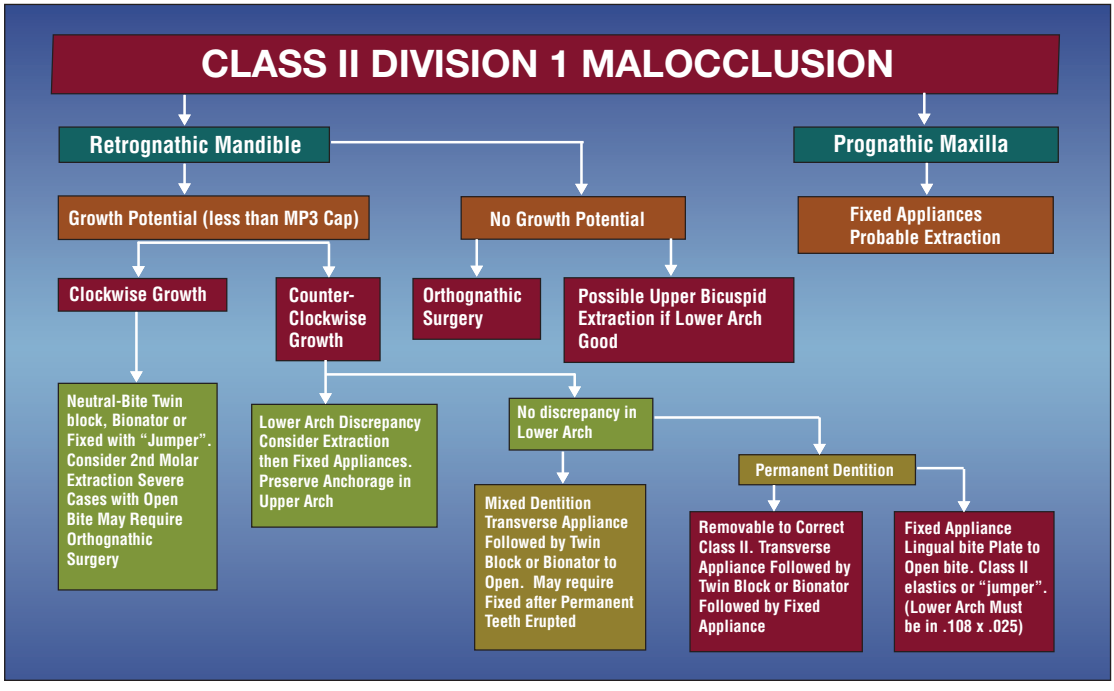

Fig 5: Flow Chart for Class II Div 1.

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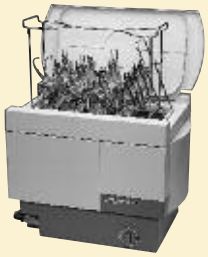
Protocol for Cleaning Orthodontic Pliers Prior to Sterilization

Dental Sterilizers do **not** run at temperatures high enough to damage Orthodontic Pliers. Rust and corrosion are actually caused by harmful minerals and chemicals that come into contact with these instruments. The heat generated by sterilization then accelerates the damage. Following these easy steps can help prolong the life of your valuable instruments and protect your investment:

Ultrasonically clean or hand scrub instruments in a biodegradable / no rinse solution

(Recommended product: *DMP-US Plus Ultrasonic Cleaning Solution;* a highly concentrated, no rinse formula that requires no distilled water and has a strong rust inhibitor). Do **not** use enzymatic cleaning solutions, as they will corrode your pliers.

- Add 1/2 fl.oz. (15 ml) of MPUS Plus per gallon of tap water.
- Change cleaning solution daily for best results.



Clean for five (5) minutes in a small capacity Ultrasonic Cleaner or twelve (12) minutes in a large capacity Ultrasonic Cleaner

(Recommended product: *DDUS60/DDUS60R).*

Let instruments drip dry or pat dry with a clean paper or shop towel.

Wipe mouth mirrors dry with a clean paper or shop towel to avoid spotting, or shake off excess moisture as they sit on racks.

- Do **not** rinse. Harmful minerals found in tap water can leave rust spots on your pliers.
- Use clean towels to dry instruments prior to sterilization.
- Detergent residue from towels can stain your instruments.

Lubricate hinged instruments weekly with a silicone lubricant

(Recommended products: *DSL16 Multi-Purpose Silicone Lubricant or DSY20 Syringe).*

- Lubricate between Ultrasonic Cleaning and Dry Heat Sterilization.
- Do **not** use oil-based lubricants as they are unable to withstand most sterilization temperatures and may "gum-up" in the hinges of your instruments as well as the sterilizer chamber.

Sterilize in a Dry Heat Sterilizer

(Recommended product: *DDS 7000*).*

- Do **not** use autoclaves (steam under pressure). Autoclaves will rust and dull orthodontic pliers.
- Do **not** use chemclaves (chemical under pressure) as they can dull orthodontic pliers.

Keep Your Sterilizer Clean

To keep your sterilizer in good working condition, follow these easy steps every other day:

- Spray 409®* or Fantastik®** on a paper towel or clean cloth and wipe down the inside and outside of the unit.
- For tough stains on inside of unit, use a teflon pad or stainless steel with 409®* or Fantastik®**.
- Please Note: All product recommendations are products available from Dentronix with the exception of 409®* and Fantastik®**. To maintain sterilizer performance we recommend annual servicing and proper maintenance.

* Formula 409 is a registered trademark of Clorox Company

** Fantastik is a registered trademark of S.C. Johnson & Son, Inc.

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www.aurumgroup.com

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Dentistry courtesy of Dr. Ronald D. Jackson, Middleburg, VA.
Restorations fabricated by Aurum Ceramic/Classic.
Photography courtesy of Larry Gatz.

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