Catalyst
PAClive Newsletter

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PACIFIC AESTHETIC CONTINUUM VOLUME 2 Winter 2003

Changing Practices

The Facility Facelift

Edward Lowe, BSc., DMD
Vancouver, British Columbia
Clinical Director, PAClive

As I stood in front of the mirror the other day at 5 am and began my morning get up and go routine, I looked carefully at my face and noticed the small crow's feet at the corners of my eyes and a few gray hairs establishing their prominence at the my hairline. At 42, I am not one to fuss over my age... I am a firm believer in aging gracefully. A few wrinkles and gray hairs add character to a man.

Front Desk Area (before)

In our eternal quest to stay youthful, many men and women seek an aesthetic makeover (a new hairstyle, wardrobe, manicure) or surgical intervention (facelift, tummy tuck, breast augmentation). The clients often leave happy if not ecstatic, proudly displaying their metamorphosis like a butterfly from its chrysalis.

As a clinician who provides comprehensive aesthetic and cosmetic restorative dentistry with an emphasis on adhesive procedures, I have had the privilege of watching many patients undergo a dramatic change in self-confidence and attitude after a smile has been altered. It may be something as simple as whitening the teeth or a diastema closure. Or it could be more involved, such as gingival crown lengthening or a smile rejuvenation with porcelain restorations. Sometimes they come in looking like Quasimodo, the Hunchback of Notre Dame, with bad teeth and low self esteem, and leave strutting like a peacock with feathers in full regalia.

One area of the dental practice which often gets neglected and adds so much value to your patient's perception of quality is the appearance of the office itself. Believe it or not, patients want to feel like they are in the right place. If they were in the wrong place, they would not have made an appointment to see you. Sure, your patients will always see you for your personality, team, customer service, and skills. However, an awesome looking facility puts you over the top.

When I sat down on my own leather couch, I looked at my dental office and realized that it *looked* like a dental office. It had a lot of clutter and wear-and-tear. It was almost as bad as a typical medical clinic! It was not the office of my dreams. I had two choices — build a new office or surgical intervention.

Front Desk Area (after)

A new office would mean that I needed to move and sell my existing office. I would have to secure a new location and finance the construction. The nice thing was my practice would not be interrupted as the new facility was being built. The not-so-nice thing was the $400,000 CN price tag that went along with creating the new office. On top of that, I liked my location and had positioned myself comfortably in the neighbourhood.

Beacause of the expense and hassle of moving offices, the surgical intervention appealed to me. The first thing I did was write down a plan

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PACIFIC AESTHETIC CONTINUUM

2003 Course Dates & Venues

Digital Dentistry Program

Session I
Los Angeles, CA
Date: March 21 - 22

Session II
Los Angeles,CA
Date: July 25 - 26

Session III
Los Angeles, CA
Date: October 17 - 18

Ultimate Occlusion Program

Session I
UOP San Francisco, CA
Date: April 4 - 6

Session II
UOP San Francisco, CA
Date: August 1 - 3

Session III
UOP San Francisco, CA
Date: December 5 - 7

Functional Advanced Anterior Program

Session I
UOP San Francisco, CA
Diagnostic:: July 11 - 13
Prep: August 8 - 10
Seat: September 12 - 14

Functional Anterior Program

Session I
UOP San Francisco, CA
Prep: January 31 - February 2
Seat: February 28 - March 2

Session II
UBC Vancouver, BC, CANADA
Prep: March 28 - 30
Seat: April 25 - 27

Session III
UOP San Francisco, CA
Prep: October 10 -12
Seat: November 7 - 9

POWERPAC Program

Session I
UOP San Francisco, CA
Posterior: June 27 - 29
Anterior Prep: July 18 - 20
Anterior Seat: August 15 - 17

Session II
West Palm Beach, FL
Posterior: October 3 - 5
Anterior Prep: November 14 - 16
Anterior Seat: December 5 - 7

For further details or to register:

Call 800-616-1553 or in Canada, 310-845-8200.

The Incredible Lightness of Being… in CR

Steven Lamberg, DDS
Northport, New York
Ultimate Occlusion Program Co-leader

Long-term success of our restorative dentistry is critical for peak performers. It will reduce stress, add value to the patient, and help maintain an expected level of profitability. Many gorgeous cases do not have legs, and that creates a negative impact on one's joy of dentistry, to say nothing of how it affects the doctor-patient relationship. Longevity of the dentistry is a core value in successful practices. Achievement of this goal is based on an understanding of occlusion and predictably managing expectations. The starting point for evaluating the occlusion is examining the TMJs, and, after that, it's all about condylar position in the fossa, namely centric relation.

Two features must be addressed when finding CR. First, one must de-program the muscles in order to allow the condyles to find their home in the absence of engrams, and second, one must appreciate the need to have a stable bone braced position in the absence of inflamed or compressed retrodiscal tissues that might change over time, effecting a change in the occlusal relationship. Some common ways that dentists find the home of the condyles are the following: bilateral manipulation, Lucia jig, leaf gauge, ball bite or mandibular Lucia jig, chin point guidance, and the Kois deprogrammer. This article explores the pros and cons and versatility of these techniques.

Bilateral manipulation has been popularized by Pete Dawson and the Pankey Institute. It requires the dentist to place the thumbs above the symphisis and the remaining fingers on the posterior mandible and then to effect a rotation, down in front and up in back, causing the head of the condyles to seat in the most superior anterior position in the glenoid fossa. Consider this one of the most reliable techniques for recording CR when used with Delar wax and it is the only technique that can be used to load test the joint as well. It is a bit tricky at first, but after teaching it for three years I have seen virtually all dentists learn this in one day…even some chiropractors!

The Lucia jig is an anterior deprogrammer that is fit on the upper centrals. The ball bite is a Lucia jig for the mandible. Care must be taken to keep the small AP line contact on a flat plane to prevent pushing the condyle back. Just tell the patient "forward, back and squeeze." It's simple, but takes a few minutes to make. It can be used with elastomeric material to record CR.

The leaf gauge and chin point guidance are still used by some to record CR, but they have a tendency to distalize the condyles and, therefore, they are not recommended.

A recent innovation using a modified Hawley appliance seems to offer the best of all worlds. Called the Kois Deprogrammer after its developer, this technique requires virtually no time to have made and is not operator-sensitive. Just send out upper and lower models to the lab and request that they be mounted in MIP and a small anterior stop be built behind the upper centrals. The patient is instructed to wear it for approximately one month, which serves to deprogram the muscle engrams and, in some cases, allow the retrodiscal tissues to "relax" as well. This is the only technique that recognizes the impact of the tissues behind the disc to prevent one from getting an accurate CR record right away. Additionally, it functions like a Lucia jig but has the advantage of being able to record CR at a OVD that is the least open. If you are not recording a kinematic hinge axis, this may be significant. But the coolest thing about this appliance is that you can also use it as a jig for equilibration by using the anterior stop to spot in the posterior teeth. It doesn't get any easier.

Longevity of the dentistry is a core value in successful practices.

Today, there are lots of choices available to find and verify CR. It is a position that is used to evaluate the occlusion and it is the treatment position that will provide a long-term stable result. To practice dentistry without understanding this is like gambling. More joy awaits you as your dentistry becomes more predicable. You will have time to make more patients happy and probably be more profitable as well. That makes everyone happier.

What Teaching Teaches Me

Richard A. Cordano, DDS
Yuba City,California
PAClive Clinical Faculty

I was having a conversation with a dental student about treatment planning a case he was doing in the clinic. He had noticed a crack in the mesial marginal ridge on a premolar with an existing DO amalgam restoration. He naturally was concerned and asked his instructor how this should be treated. The instructor's response was, "Anytime you have a DO amalgam in a premolar you can expect to see a crack in the mesial marginal ridge. This is not something to be concerned about and it does not require treatment." Eight years ago, I also thought cracked teeth were an acceptable part of doing traditional dentistry. I really didn't have any solutions to those types of daily problems we all find in traditional dentistry. That has all changed for me now.

Interestingly, eight years ago, I didn't want to talk about dentistry outside the office. It was not as rewarding of an experience as I had hoped for when I started practicing, I felt stagnant and non-progressive. In that frame-of-mind, my main focus became, "When can I retire?" I think that is a fairly common experience for most doctors practicing traditional dentistry. However, my attitude and thinking are completely different after becoming involved with programs like PAClive, I am now excited about what I do everyday. Here's an example: a few years ago I was sitting on the beach in Maui, Hawaii with my family (where I go to get away). By chance, I met Derric DesMarteau, another clinical instructor, walking on the beach. In what seemed like an hour (my family says it was 3 hours and they are probably correct), we discussed everything ranging from new technologies to prep design (complete with drawings in the sand). Eight years ago, I would not have believed I could be this excited about dentistry. There was a time that I planned to retire at 45. I now have plans to work as long as I can because I enjoy it.

As a clinical instructor, a common question I am asked is, "Do you do a lot of cosmetic dentistry?" My response is, "What is your definition of

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Dental Insurance in the 21st Century — It's Your Choice

Michael Dolby DDS, FAGD
Phoenix, Arizona
PACteam Faculty

For the majority of dental offices throughout the United States, one of the most frustrating aspects of running a dental practice is jumping through the sometimes endless hoops that the dental insurance companies demand. The frustrations dentists feel towards dental insurance has been brewing for years and, with each passing year, it has become more and more challenging to create a profitable practice. To make matters worse, the inefficiencies and frustrations dental insurance companies create are being directed to you know who! What's an office to do?

A popular remedy many "dental consultants" have been promoting is the complete removal of dental insurance from your practice. After all, this makes perfect sense. You have a third party institution that makes it difficult, very difficult at times, to receive reimbursements. They position you, the doctor, as the villain because your fees are above the usual and customary, and in some cases dentists are even being removed from the member listing because they perform too many "high end" procedures. To make matters worse, if you happen to live in Minnesota, you may be labeled as a "non-prime" dentist. Rest assured, Delta Dental will make sure all your patients are aware of your new title! So this idea of completely removing yourself from the insurance triad sounds simple and very tempting; however, remember what your mother told you, if it sounds too good to be true, then it probably is. Extreme caution must be considered when making this bold move to completely eliminate your office from the insurance game. There are some serious consequences to consider.

For the average dental office in the United States, there is No such thing as an "Insurance Free" dental practice, at least one that is still in business. However, there are many dental practices that have made a conscious choice in how they choose to handle dental insurance reimbursements. They are referred to as the "Insurance Independent" dental office.

Today, there are three types of dental practice insurance models to be considered: the Insurance Dependent, the Insurance Hybrid and the Insurance Independent Practice. Let's discuss each of those:

Insurance Dependent: This practice relies heavily on the participation and association of different dental insurance plans. The majority of new patients arrive because your office is among a list of dentists they must choose from and collections are highly determined by the insurance plans you are affiliated with.

Insurance Hybrid: This practice relies on a blend of insurance dependence and independence. New patients come from a combination of your association with the insurance plans and referrals from existing patients. Collections are more predictable than the Insurance Dependent practice; however, insurance reimbursement frustrations are an everyday event.

Insurance Independence: This practice operates independently from any outside insurance influence. Within this environment, contrary to popular belief, the challenges associated with dental insurance claims have not been eliminated; however, the dentist's position in the Insurance triage has been greatly improved. Collections come strictly from the patient, while allowing the insurance company to directly reimburse the patient.

Each one of the insurance models I have listed can operate in a profitable manner and all three have their challenges that must be considered. Dental insurance by NO means is an evil thing; in fact, without dental insurance millions of Americans would go entirely without dental care. Dentists must realize they have the right to choose what environment they would like to operate in, contrary to what the insurance industry is telling us. The Insurance Independent environment can and does exist. I have operated in one successfully for over 4 years now.

If you are considering making a change in the way you handle dental insurance, make sure you completely understand the environment you have chosen. All have their unique challenges. Eliminate the idea of completely removing yourself from the insurance game. Your only outcome from this move is the unemployment line!

If you would like additional information on making the move to Insurance Independence, please feel free to call on me at any time.

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What Teaching Teaches Me

cosmetic dentistry?" I used to believe that cosmetic dentistry was a superficial make over to change the appearance of a smile or individual tooth. My time as a clinical instructor has given me a new definition: cosmetic dentistry is superior dentistry. It is superior dentistry focused on maintaining the integrity and strength of the natural tooth, while producing an aesthetic result. This mind-set allows me to do adhesive "cosmetic" dentistry in my practice day in and day out because I truly believe I am giving my patients a superior service. I now have the materials, technologies and skills to overcome the "cracked mesial marginal ridges" of traditional dentistry.

Now that I have gone through a metamorphosis of my own, it has become very rewarding to work with doctors that are in the same position I used to be in and see them go home with renewed enthusiasm for the profession. This enthusiasm is contagious and I am able to take my share home with me. Another benefit of working with these doctors is that they become part of a network of like thinkers that is literally spreading to all parts of the country. Talking with them on the phone or seeing them at meetings, it is obvious that this type of dentistry is not just a niche for certain markets but something to which any doctor in any part of the country can convert their practice.

The days of stagnation and non-progression are gone. As new technologies are introduced, new materials and techniques are discovered, PAClive continues to change and move forward. I (along with all the other PAClive instructors) am continually challenged to be better, and learn more which in turn, is keeping me happy, motivated and has breathed new life into my career.

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Enrollment Strategies from PAClive Hygiene

Vicki McManus, RDH
Atlanta, Georgia
PAClive Hygiene Faculty Co-Director

Shifting your focus from needs-based dentistry to wants-based dentistry is a process. Hygienists can face several challenges when speaking with patients of record about "new" and "innovative" treatment options. The primary two obstacles to increased enrollment of aesthetic care are:

1) Time within the appointment
2) Comfortable way to introduce the topic.

Many of you attending PAC~Live Hygiene have learned our full examination protocol which organizes the structure of the recare visit to incorporate a variety of diagnostic and case presentation opportunities. In this article, we will focus on ways to incorporate cosmetic questions into your daily routine.

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You may be thinking that you'll need a lot of new high-tech equipment to sell cosmetics. While this may be helpful, it is not necessary as an initial step. The two pieces of equipment that you will need are a hand-mirror and a shade guide.

After completion of medical/dental histories, intraoral camera tour and radiographs, get in the habit of doing a "color assessment" for each patient. With the patient looking into a mirror, simply say to them, "We now know that teeth can change color over time. What I'd like to do now is to assess the current color of your teeth. I'll need your help with this part." This immediately gets the patient involved in their care and gives you an opportunity to comfortably bring up non-invasive cosmetic procedures.

Each hygiene operatory should be equipped with a shade guide. Set it up from lightest to darkest and make sure that your shade guide also includes newer 'bleaching' colors. Holding the shade guide so that your patient can see the colors and having them help you select the appropriate shade gives them an idea of what their teeth could look like. If they have interest in whitening, they will naturally bring up the topic with you and you'll have permission to ask other questions. These might include: "Is there anything else that you might want to change about your smile? Or "If there were a way to straighten your teeth in as little as two visits, would you be interested?"

It is always easier to discuss uncomfortable topics like discoloration, open spaces and malodor when the patient brings up the subject first. Incorporating something as simple as a shade guide analysis is a great way to create consistent inquiries into all of your aesthetic services. Here are a few tips and pointers in gaining proper shades:

Shade Guide Selection and Set-up:

Chromascop™ by Ivoclar/Vivadent: This is a beautiful shade guide set up by color groups and then arranged by hues (light to dark)

Vita® Shade Guide: This is a standard shade guide and the most popular. You can put this into any order, either by letter or by groups, lightest to darkest.

Bleach	White	Yellow	Orange	Gray	Brown
010	110	210	310	410	510
020	120	220	320	420	520
030	130	230	330	430	530
040	140	240	340	440	540

Tips for shade selection:

White	Yellow	Orange	Gray	Brown
B1	B2	A3	A4	D6
A1	D1	B5	B6	C4
A2	E1	E2	B4	C3
C1	C2	E3	C6	D4

For the most accurate results, the colors in the room should be neutral and so should the patient's clothes. Cover colored clothes with a neutral (gray) cloth, and have your female patients remove lipstick.

- Make sure teeth are not dehydrated.
- The mouth of the patient should be at eye level.
- Determine the amber or gray color type of the patient.
- Determine the base shade of the patient and remove corresponding shade group. (Chromascop).
- Determine the shade intensity within the shade group.
- Compare the selected shade once again with the natural tooth.
- When taking a smile shade during the comprehensive exam, use the canine tooth for the base shade when possible.
- Note range of shade, striations, and color banding or mottling. Close inspection will reveal a blending of several colors.

To extend the value of the process, send the patient home with their own sample shade utilizing a paper shade guide such as Discus Dental's pro-pack paper shade. (Bonus: this pack also includes a tongue scraper, which will enable you to bring up the conversation of breath management!)

Holding the shade guide so that your patient can see the colors and having them help you select the appropriate shade gives them an idea of what their teeth could look like.

Vicki McManus, RDH is the Director of Hygiene Mastery and a faculty member with PAClive. Visit her team at www.HygieneMastery.com

Long-Term Provisionalization for Complete Mouth Rejuvenation

James H. Hastings, DDS
Sacramento, California
PAClive Clinical Faculty

When making a diagnosis for restorative treatment, often more than one dental discipline is needed to successfully treat the case. Endodontics, periodontics, orthodontics, oral surgery, or a combination of any, may be needed for optimum results before proceeding with the restorative/prosthodontic solution. The astute clinician has a team of specialists that he or she has established good working relationships with, and with whom communication is frequent, to maintain updated information and to help in treatment planning with specific cases. We ought to be in agreement by now that cosmetic dentistry is far more than six minimally prepared veneers bonded to the upper front teeth. Cosmetic dentistry has become a "… prosthodontic discipline requiring comprehensive treatment planning"[1]

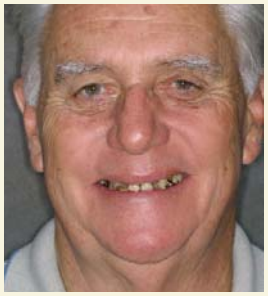

Fig. 1
Pre-treatment portrait

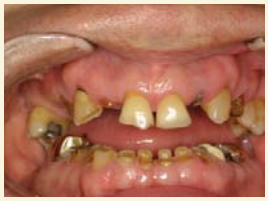

Fig. 2
Pre-treatment condition

This is especially true where there are complications from excessive tooth wear, where several teeth are missing, and where vertical dimension of occlusion has been lost. Restoration of these cases can take time, and the treatment plan may need modification as the case develops.[2]

In order for the final treatment plan to be executed successfully, it's prudent to place the patient in provisional restorations that will closely resemble the final desired result. This gives the patient and the clinician ample opportunity to evaluate the patient's tolerance for the new dentistry and for adjustments to be made to the treatment plan before the time and financial investment is made in the definitive restorations.[3]

At PAClive, we are especially interested in this approach. It allows us the opportunity to evaluate joint stability, anterior guidance, function and aesthetics. The "approved provisionals" are duplicated and the final result should closely resemble the final prototype. In the case profiled here, our patient was referred by a general dentist whose practice emphasizes complete denture services. The patient is a relatively healthy 65 year old. He was formerly occupied as a police officer, had been injured on the job, and, in recent years, other medical matters had taken priority over his dental needs. His medical history includes previous back and leg injuries, multiple spinal surgeries,and a daily dosage of prescription analgesics for pain control.

Our patient presented with severely worn dentition, several missing posterior teeth and an inability to chew effectively. *(fig. 1, 2)* He also reported that he was reluctant to smile due to the appearance of his teeth, and that he had become discouraged, thinking that his only option was the complete denture service. The referring dentist noted that the remaining teeth have good stability and bone support; he was unwilling to commit the patient to removable appliances. The referring dentist had prescribed a removable overlay splint to open the vertical dimension and test the patient's tolerance; however, the patient was unable to wear the splint long enough to get home with it.

Our assessment showed that there was probably enough remaining tooth structure to consider adhesive dentistry. The reasonable approach was to develop a wax prototype from a mock-up, centric relation bite record and facebow transfer, then to transfer the prototype to the mouth in one appointment. The questions that remained were twofold:

1) Could our patient tolerate going from virtually nothing to a functional dentition all at once?

2) Would the bisacryl provisionals that resulted be strong enough to withstand the kind of forces that our patient was accustomed to placing on his dentition?

We felt that if this long-term provisional approach were successful, it could be used diagnostically for a long period of time, would be easily repairable, and could be used to maintain stability of the occlusion while the definitive treatment was being sequentially carried out. Since full-mouth rejuvenation was the obvious definitive solution, it would be essential to test our theory in the patient's oral environment.[4] Since there was a minimal amount of tooth structure remaining in several areas, especially the lower anterior segment, it would be necessary to bond the provisionals in place, and to splint them together in several areas. The upper lateral incisors were planned for later removal; it would be necessary to make two separate removable bridges from the canines to the central incisors so that tooth removal, ridge augmentation and tissue manipulation could be facilitated.

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Labrotory Phase

Standard complete records were made for the laboratory, including composite mock-up of the central incisors to full contour, impression of the mock-up, incisal matrix of the mock-up, facebow transfer, Accu-Gelô (Ivoclar-Vivadent, Amherst, NY) impressions of upper and lower arches, and centric relation bite registration as taught at the PAClive occlusion course. The laboratory prescription included instructions to wax up the case to full contour, providing an arbitrary c.e.j to c.e.j. measurement of 14 mm which fell within normal limits for this patient's Class 2 Angle classification of occlusion.[5] Photographs were sent as well.

The laboratory returned the prototypes with Sil-Tech (Ivoclar-Vivadent) matrices with the wax-up. *(fig. 3, 4)* The matrices would allow easy transfer of the wax prototype to the mouth after preparation.

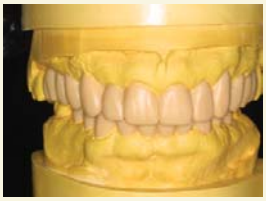

Fig. 3
Diagnostic waxups

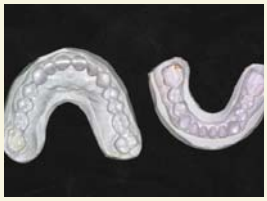

Fig. 4
Sil Tech matrices

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The Authentic™ Pressed Ceramic to Metal Inlay Bridge: Strong, Conservative and Beautiful

Nelson Rego CDT, Rego Laboratories
Downey, California
PACLab Co-Director

The loss of a posterior tooth results in a cascade of consequences if its replacement in the dentition is not expedited. The tooth loss may be due to caries, peroiodontal disease, fracture or the tooth may be congenitally missing. The penalties for leaving an edentulous space include tipping and drifting of the adjacent teeth, loss of occlusal function and supereruption of the opposing teeth, as well as overload of one side of the dentition and its subsequent burden on the temporo-mandibular joints.

Inlay bridges have been used for posterior tooth replacement in the years prior to adhesive dentistry. Failures were often related to loosening of the cemented bridge or fracture of the inlayed abutment teeth due to translated occlusal forces. Premolar retainers were particularly susceptible to fracture if over prepared. However, with the new pressed ceramic to metal bridges, the retainers can now be bonded. This avoids the problem of fractured retainers as well as improving the strength of the abutment teeth.

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The patient is a 35 year old male who presented in the spring of 2001 with a missing upper right first molar #3. *(fig1)* He had considered an implant, but the position of his maxillary sinus required sinus lift surgery with did not appeal to him. The choice of a pressed ceramic to metal inlay bridge was presented as a treatment option with conservation of tooth structure and aesthetics in mind. The fact that his second molar #2 had a small amalgam and the second premolar was a virgin tooth weighed heavily in the assessment and was selected by both patient and clinician as the restoration of preference.

The shade of the patient's teeth were recorded and mapped prior to tooth preparation. Photographs were taken of the teeth were taken to offer the ceramist a view of the landscape prior to tooth preparation and dehydration and sent along with the impressions to the laboratory.

After model fabrication and blockout, the preps were evaluated for line of draw, prep divergence and adequate reduction. *(fig. 2)* Authentic pressed ceramic to metal bridges require minimum reduction of 1.5 mm occlusally and 2.0mm buccal-lingually. The alloy of choice for inlay bridges is chrome-cobalt. It is lightweight, extremely strong and rigid. To provide stability during the pressing of the Authentic material, a T-bar shaped heat sink is place on the lingual of the pontic. The pontic was designed within conventional ceramo-metal parameters. *(fig. 3)* The metal skeleton was cast and finished using stones and carbides with the connectors being reduced to 1.5mm. To ensure good translucency and aesthetics, the metal is kept along the floor of the preparations. *(fig. 4)*. The framework is opaqued in the traditional manner using high fusing opaque shade 120. *(fig. 5)* The opaqued framework was placed on the working model and a full-contour wax up was fabricated. *(fig. 6)* Occlusion and function are evaluated and the wax up was sprued and invested. After the bridge was pressed and divested, the pressed ingot material is cut back to allow layering of body and incisal porcelains *(fig. 7)* using a Perladia Brandywine wheel. The gingival of the pontic was layered using a 1:1 mixture of dentin body 120 and transparent orange. The enamel was layered using a segmental technique with white, transparent and transparent opal colors. *(fig. 8)* Secondary anatomy was layered using incisal shade 57 and enamel pearl. To create invisible margins, a thin stratum of translucent porcelain was placed around margins thus creating a "chameleon" effect with the natural enamel. *(fig. 9)* The bridge was glazed and subtle occlusal pit and fissure stains were applied. *(fig. 10)*

Upon return from the lab, the restoration was tried in for fit and bonded with a dual cure resin cement. The use of a metal primer on the metal portion of the restoration is optional. The final restoration exemplifies the term "state-of-the art aesthetics". *(fig. 11,12)*.

The Authentic pressed to metal bridge offers clinicians a new and exciting option in conservative treatment planning while utilizing a proven fused to metal system. The amalgamation of metal and pressed ceramics allows for marginal integrity that heretofore was only possible with resin inlays and onlays. With its aesthetics on metal, the dilemma of envisioning the outcome of combination cases involving all ceramic and metal-ceramic restorations will cease to exist.

Say "Hello!" to a whole new world of possibilities!

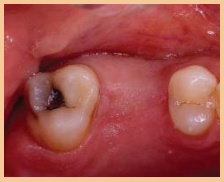

Figure 1

Figure 2

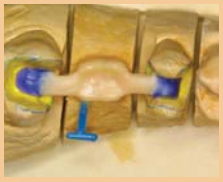

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

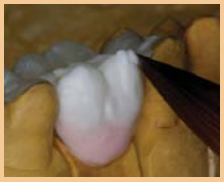

Figure 8

Figure 9

Figure 10

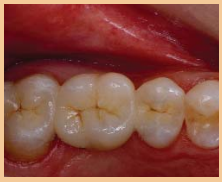

Figure 11

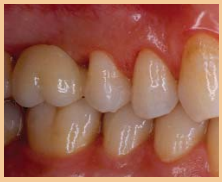

Figure 12

from page 5

Long-Term Provisionalization for Complete Mouth Rejuvenation

Preparation

The patient was scheduled for three hours. After preparation of the upper arch, the bis-acryl provisionals were made by injecting PerfecTemp (Discus Dental, Culver City, CA) into the Sil-Tech matrices and seating fully into the mouth. This was done in three segments for the upper arch. Each segment was allowed to cure for two minutes, then the matrix was removed. The provisional was removed and re-seated on the preparations until it was fully cured an additional two minutes. Since these provisionals were going to be bonded into place, they were removed and trimmed, polished and then tried in. All was satisfactory, so using cotton rolls as barrier devices, the teeth were etched and a bonding agent (Cabrio, Discus Dental) was applied accordingto the manufacturer's directions, and light-cured. Resin cement (Variolink, Ivoclar) wasapplied to the internal surfaces of the provisionals, they were pressed into place, excess cement removed and they were light-cured. Similar procedures were done for the lower arch. The lower anterior segment (canine-to-canine) was splinted together. Oral hygiene instructions were given at this visit, as significantly more time would be needed for proper home care. Correct c.e.j to c.e.j. measurement was verified. *(fig. 5, 6)*

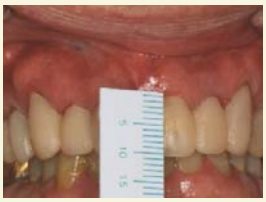

Fig 6
c.e.j. to c.e.j. measurement at MIP

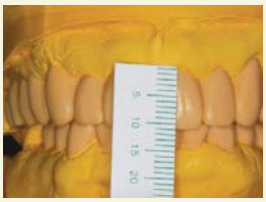

Fig. 5
c.e.j. to c.e.j. measurement on waxup

It was anticipated that our patient would return for follow-up, and that corrections would be necessary at this time. Indeed, at the next visit one week later, our patient reported that he had virtually no problem adjusting to his new provisionals, but that the lower left premolar segment had debonded. We rebuilt the second premolar with a custom fiber post and core using FibreKor (Jeneric Pentron) and Variolink, plus light-cured hybrid composite. The remnants of the PFM on the first premolar were micro-etched and a new splinted provisional was placed here.

It's relatively easy to plan for periodontal treatment and prosthodontic treatment, while at the same time maintaining a functional and aesthetic occlusion.

The second follow-up showed us that the long-span bridge on the upper right side had inadequate strength and it had fractured. This was not surprising considering the span, the forces of occlusion and the material used. A new bridge was made and reinforced with Ribbond (Ribbond, Seattle WA), using the bridge beam technique described in the manual supplied with the material.[6] Oral hygiene techniques were again reinforced.

At the third follow-up appointment, the upper anterior segment was removed and two removable bridges were made so that future periodontal work could be done, as already described. The new bridges were cemented with TempBond Clear (Kerr Corp., Orange, CA)

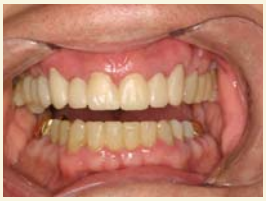

Fig. 7
Final 1:2 retracted

Our patient reports that he "enjoys eating salad again, and smiling." *(fig. 7, 8)* The next phase of treatment will be periodontal treatment in the upper anterior segment, followed by definitive restorations in the upper arch. Final choice of modality of treatment and materials will be determined by our experience with the current provisionals.

This approach of long-term approved provisionalization is a rational method to aid in diagnosis and treatment. Use of a combination of segmented provisionals, some removable and some bonded, allow the clinician the luxury of time and the latitude of different modalities of therapy. It's relatively easy to plan for periodontal treatment (tooth removal, ridge augmentation, and implant placement) and prosthodontic treatment, while at the same time maintaining a functional and aesthetic occlusion.

Fig 8
Final portrait

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Dr. Hastings is a clinical faculty member at the Pacific Aesthetic Continuum. He is an accredited member of the American Academy of Cosmetic Dentistry, and practices in Sacramento, CA.

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from page 1

The Facility Facelift

of action and asked myself some questions. What did I want to accomplish and what was my budget? Next I sought professional help. I enlisted the assistance of an experienced interior designer who was highly recommended to me. Listen, I can design smiles and teeth, but I'll be the first to confess that where to put a lamp or a picture is not my forté!

Linda McLachlan and I spent time together and our personalities clicked. I loved the ideas she had and we set about working with a contractor to finalize the blueprints, budget, and timing. The work would take three weeks to complete. It involved moving a wall to create a larger reception area and literally building a new front desk area. Luckily, most of the existing cabinetry in the operatories could stay. The investment of the whole project would run about $70,000 CN.

I had been saying for the last two years that I was going to renovate. At last I was finally taking action and doing it!

PAGE 8

After packing up and boxing everything in the office that wasn't attached and placing it in storage, the contractor and his cronies came in and literally stripped the office naked. Here are some of the highlights of what greeted me 3 weeks later:

The existing carpet in the reception and hallway were replaced with slate tiles. This opened up the hallway whose end was accented with a decorative silk hanging on a chocolate brown wall.

Marble refreshment area with stainless fridge, a dedicated area with a courtesy phone. Sheer linen drapes vs metal vertical blinds — light colors opens up the room and adds light and yet maintains a private ambience. Color coordinated artwork — with a dental theme. Halogen vs Fluorescent lighting — softer, warmer, glowing light. Maple wood laminate cabinetry vs gray laminate — rich and vibrant vs. flat and blah. Marble front desk with decorative halogens — the Wow! effect.

Removal of bulkhead over front desk — makes reception room bigger. Flatscreen TV — for patient education and entertainment. Silver fern green and taupe vs. baby blue with navy blue trim makes space larger and brighter. Cork floor tiles in operatories — soft on the feet, water resistant, attractive. Marmoleum in high traffic areas — lab and behind front desk.

Custom made furniture vs leather couches — chairs allow for personal space. Re-upholstered dental chairs and relaminated millwork — economical.

Removed and relocated sinks — no need for 2 sinks in each operatory. Matching accessories — wastebaskets, soap dispenser, towel holder, etc. Bathroom-removed closet and installed wall mirror with light sconces — add stainless sink and high-end faucet with a tile backdrop.

The final result exceeded my expectations. What I observed in the weeks following the facility facelift was interesting, to say the least. The team was excited and proud to show off the office and conduct tours. The patients walked in and were impressed with improvements. The changes were so dramatic that some weren't even sure that they were in the right office. Some patients brought their friends in to see the office and some wrote down design ideas for their own homes.

We noted a significant increase in case acceptance and patient referrals. I'm curious whether this was due to our enthusiasm or their increased perception of value. I conclude that it is probably due to a change in attitude of both the vendor and the customer.

Have you ever heard this? The occasional patient would say that I must be making too much money to have this nice office. My response is never centered on an apology or a justification for my achievements. An amusing reply from me would be something like, "Thanks and I need more money. Now if you'll only get your smile design started, I can put a bar in my reception room." Your patients want you to be successful. Success breeds success. No one likes emulating failure. This quote summed it all up for me.

For of all sad words
of tongue or pen,
The saddest are these,
"It might have been."

John Greenleaf Whittier

If you've ever dreamed about a facility facelift for your office, don't wonder… just get it done.

After all, goals are dreams with a deadline!

Ponzu!

Charlotte Collins, DDS
San Fransisco, California
PACLive Attendee

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Reservations: 415-775-7979

Looking to experience San Francisco's variety of ethnic dining, but short on time? Ponzu offers a grand tour of the Far East. It will appear that you have stepped into a lounge filled with beautiful people when you enter Ponzu.

Don't be fooled! It is the soft lighting created by hand-blown amber glass lanterns, the yards of saffron and claret colored velvet drapes, and the subtle rhythmic music spun by the in house DJ that makes everyone look stylish.

The menu is equally seductive. The broad range of appetizers can satisfy cravings from Tokyo to Bangkok. The Lazy Sushi arrives as a do-it-yourself assortment of sushi accoutrements. The Thai Summer Rolls are mammoth and served with a tamarind dip--nothing dainty as spring about them! Entrees are nicely proportioned for one, but are suggested to be shared family style. The Flat Iron Steak dish consists of thin slices of perfectly marinated beef served with "things Korean": Kim Chi, and vegetables. The Red Curry Chicken is an explosion of spices. Too hot? Cool it down with the sublime Miso Sea Bass served on a bed of Haas avocados. The desert menu pays homage to Asian artistry and delicate detail.

Arrive early and enjoy complimentary treats that are creatively matched to happy hour cocktails.

The Official PAClive Full Mouth Restaurant Classification* (on a scale of 1 –5): *5

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