Dr. Fay Goldstep offers tips and tricks of minimally invasive dentistry

Predictable, proactive and profitable dentistry

By Kristine Colker, Managing Editor

Dr. Goldstep, you are presenting a DTSC Symposia session called “Predictable Proactive and Profitable Minimally Invasive Dentistry.” Would you give us a brief overview of your session?

We are working today in what I think is the “Golden Age of Dentistry.” We have the technology and techniques that finally enable us to treat our patients with a medical, not a surgical, approach.

This session will highlight the techniques that make this possible. Our patients are seeking minimally invasive options and searching out the dentists who provide them. This session will show the attendees how to take this gentler, patient-friendly dentistry to a level that makes it predictable, proactive and even profitable.

When we talk about minimally invasive dentistry, what are some examples of this and how do you see those techniques benefiting patients?

Minimally invasive techniques are conservative. The medical approach helps the patient preserve healthy oral tissues and new bioactive materials can actually promote healing.

For example, we are now able to map the early incidence of decay on the occlusal surface and evaluate the areas that need treatment. This real-time map shows both the location and severity of the decay. Then very conservative preparation techniques such as fissurotomy burs (S.S. White) or microabrasion selectively remove only the decayed areas. We restore with Beautifil Flow Plus (Shofu), a bioactive glass ionomer material that adapts into all surfaces of the tiny preparation. The bioactive glass ionomer’s remineralizing properties promote healing.

You talk in your session about how minimally invasive dentistry can also be more profitable. Can you explain how this is possible?

Minimally invasive dentistry absolutely improves the practice’s profitability. In today’s economically challenging times, we are competing more and more for patient dollars. Minimally invasive procedures are appealing to patients. They seek out the dentists and practices that provide these treatments.

Minimally invasive dentistry is easier and faster. Although it takes less time and involves less stress than conventional treatment, it is similarly billable.

If attendees are interested in going to your session, is there anything they should be aware of ahead of time?

This session introduces the “Perimeter Prep,” a predictable, highly conservative, direct restoration repair. It is a great technique to get you started with minimally invasive dentistry.

If attendees are interested in going to your session, is there anything you hope they should be aware of ahead of time? Is your session aimed at specialists or is it more of a general topic?

The session is geared to dentists and hygienists. Both will come away with the tools and materials that would be good to start with. This thinking must change. Fortunately, there are dental manufacturers that are helping us change by providing the tools and materials to heal and not just amputate oral tissues.

If there is one thing you hope attendees to your session come away with, what would it be?

Open your mind. Treat your patients the way you would like to be treated. You will be rewarded with a thriving, predictable, profitable practice with patients for life.

About the speaker

Fay Goldstep, DMD, has been a featured speaker in the ADA Seminar Series and has lectured at the ADA, Yankee, AADC, AGD and the Big Apple dental conferences. She has lectured nationally and internationally on CONSERVATIVE Dentistry, Innovations in hygiene, dentist health issues, magnification and office design. Goldstep has served on the teaching faculties of the postgraduate programs in esthetic dentistry at SUNY Buffalo, Universities of Florida (Gainesville), Minnesota (Minneapolis) and UMKC (Kansas City). Goldstep sits on the editorial board of Oral Health Magazine (healing/preventive dentistry) and Dental Tribune, U.S. edition. She is a fellow of the American College of Dentists, International Academy of Dental Facial Aesthetics and the Academy of Dentistry International. Goldstep has been a contributing author to three textbooks and has published more than 20 articles. She has been listed as one of the leaders in Continuing Education by Dentistry Today since 2002. Goldstep is a consultant to a number of dental companies and maintains a private practice in Toronto, Canada.

Dr. Fay Goldstep talks to today about what to expect from the symposium.

In her session, she will focus on “patient friendly” direct restoration repair instead of indirect replacement as a predictable, minimally invasive option. On the proactive front, easy and effective bioactive sealants can be placed without the need for etching. Bioactive restorative materials enhance the healing of teeth and reduce restorative failure.

Goldstep talked to today about what to expect from the symposium.

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Dr. Ron Kaminer talks tips and tricks of minimally invasive dentistry

By Kristine Colker, Managing Editor

TODAY from 12:45 to 1:45 p.m. in aisle 5000, room 5, Dr. Ron Kaminer will present “Tips, Tricks and Techniques to Maximize Success” as part of the DTSC Symposia.

In his session, he will focus on the new materials that can make traditional restorative techniques easier and more efficient. The program will cover the 10-minute bonded post and core; heavy flow flowable composites and their application in routine dentistry; and esthetic temporaries for crown and bridge.

Kaminer talked to today about what to expect from his symposium.

Dr. Kaminer, you are presenting a DTSC Symposia session called “Tips, Tricks and Techniques to Maximize Success.” Would you give us a brief overview of your session?

There are a lot of great new products in dentistry. This program will be fast paced and loaded with pearls that the doctor can immediately implement in their practice.

The pearls will lead to greater efficiency, great productivity and better dentistry.

Your session focuses a lot on new materials and how they can help with day-to-day techniques. What are some of the newest materials that have really impressed you and helped you the most in your practice?

The new highly filled flowable composites have really made an impact on restorative dentistry. Easier to place than traditional flowables, they are a must in every dentist’s arsenal. A new material that will make splinting of teeth easier to do than ever before will be presented, as well as the 10-minute bonded post and core. Lots of fun stuff!

When it comes to new materials, do you like trying them out or do you prefer to stick with what you know? Why is that, do you think?

Change is critical to success. It is always easier using what you always used. But dentistry is always changing; we must not resist change.

In your session, you’re going to be going over a lot of techniques in a short time. Could we get a sneak peek of what some of these techniques are and what attendees will be learning about them?

I hate giving away my pearls in advance, but let’s just say every attendee will walk away with at least one pearly that they can immediately implement in his or her practice.

If an attendee is interested in going to your session, is there anything he or she should be aware of ahead of time? Is your session aimed for specialists or is it a more general topic?

This is a program for day-to-day, bread-and-butter dentistry aimed at the GP.

Your session is sponsored by VOCO. How did you begin working with the company and what is it that you like about its products and services?

All of VOCO’s products are well thought out before coming to market. They are far bigger in Europe than here in the United States but are rapidly gaining market share because once you try a VOCO product, you fall in love with it, in my opinion.

If there is one thing you hope attendees to your session come away with, what would it be?

New products and materials require careful evaluation before incorporating them into one’s practice. But if the technique and product make sense, then change is important to success.
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Dr. Mike Rethman speaks on fluorides and non-flouride interventions for caries control

By Kristine Colker, Managing Editor

TODAY from 2 to 3 p.m. In aisle 5000, room 3, Dr. Mike Rethman will present “Fluorides and Non-Flouride Interventions for Caries Control — An Overview” as part of the DTSC Symposia.

In his session, he will focus on non-fluoride anti-caries adjuncts in the context of fluoride anti-caries strategies, including problems associated with recommending the use of non-fluoride adjuncts.

Rethman talked to today about what to expect from his symposium.

Dr. Rethman, you are presenting a DTSC Symposia session called “Fluorides and non-Flouride Interventions for Caries Control — An Overview.” Would you give us a brief overview of your session?

Fluorides have long been recommended as key parts of anti-caries programs. Recently, non-fluoride regimes have gotten increasing buzz. In the wake of chairing a recent ADA expert panel and evidence-based review of the literature on the latter, I’ll report what we found in the context of the concepts and effectiveness underlying the use of fluorides and other anti-caries methodologies.

Could you talk a little more in-depth about non-flouride anti-caries adjuncts and some of the issues surrounding them, including problems with recommending them? Fluorides help. Sealants help. Some non-flouride adjuncts also appear effective. Patients at low risk for caries may need no interventions, others might benefit from all. Every patient is different and because the literature reports average responses, clinicians need to remain aware that no patient is average.

How do non-flouride anti-carries adjuncts fit in treatment protocols compared with fluoride-based interventions? Are there any positives or negatives associated with one over the other?

In my opinion, non-flouride anti-carries adjuncts are best considered as adjuncts to fluorides and sealants for reasons I’ll discuss in my talk. Head-to-head comparisons could tease out the comparative and/or additive effects but such studies are unlikely.

If an attendee is interested in going to your session, is there anything he or she should be aware? Is your session aimed for specialists or is it a more general topic?

It’s a topic of interest to all dentists and dental hygienists who treat patients. Your session is sponsored by Colgate. How did you begin working with the company and what is it that you like about its products and services?

Colgate is a highly reputable company that sponsors many speakers and conferences worldwide with no expectation of gleaning anything more than the respect of participants. And Colgate has earned my respect. But to drill down a bit, I’ve had sessions sponsored by close to a dozen companies over the years. Crucial to me is that a sponsoring company expects nothing more than an arms-length treatment of a topic. That’s what I endeavor to provide, and it’s all Colgate expects.

If there is one thing you hope attendees to your session come away with, what would it be? I’d like for attendees to be better at contextualizing the barrage of promotional information that they receive every day.

About the speaker

Mike Rethman, DDS, is a board-certified periodontist with more than five years of general practice experience. He is also a dental research scientist and a former director of the U.S. Army Institute of Dental Research, as well as a past-president of the American Academy of Periodontology.

About the speaker

Mike Rethman, DDS, is a board-certified periodontist with more than five years of general practice experience. He is also a dental research scientist and a former director of the U.S. Army Institute of Dental Research, as well as a past-president of the American Academy of Periodontology.
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Dr. Mark Duncan talks about ‘Dentistry’s Dirty Little Secrets’

By Kristine Colker, Managing Editor

TODAY from 3:15 to 4:15 p.m. in aisle 5000, room 3, Dr. Mark Dun-
can will present “Dentistry’s Dirty Little Secrets: What Is It That We Don’t Know?” as part of the DTSC Symposia.

In his session, he will focus on some of the hidden connections between a healthy and pain-free patient and what issues 80 percent of adult patients present with. There are so many issues that patients suffer with that are den-
tally related but are totally missed because they don’t know to talk to their dentist about them. Duncan talked to TODAY about what to expect from his symposium.

Dr. Duncan, you are presenting a DTSC Symposia session called “Dentistry’s Dirty Little Secrets … What Is It That We Don’t Know?” Would you give us a brief overview of your session?

For sure! I will focus on the things that patients will present with that generally are not seen as our first concern. We have amazing training in dental school and can do some absolutely astounding things for our patients, but there are still some very troubling issues with dental care today. The most commonly occurring infectious disease on the planet is per-
odontal disease with an incidence of more than 80 percent. We understand better how to address and manage – and even prevent and heal periodontal disease. We also can perform genetic tests from their spit and see if possible our patients are.

All the while there is another foundational issue that we are all but totally ignoring – and that is the way that the bite fits. To be clear, when I am talking about the bite, I mean two different things at the same time. No question we need to have proper tooth-to-tooth bearing or micro-occu-
sion – but actually more importantly, we must provide proper jaw-to-jaw relationships, or macro-occlusion, that will allow the mandible to func-
tion correctly.

Providing our patients with the proper macro-occlusion is of para-
mount importance. This is the rest of the foundation in that, like peri-
odontal health, it is only when the jaws are functioning in a way that is comfortable for the entire system that we are not forced to deal with consequences of muscle discomfort and poor posture.

My dental school training, like per-
haps all dentists, covered a lot of these issues but was not clear in why they were important. Or perhaps I was not ready to understand the intricacies at such an early stage in my career. However, I was also trained that things like bruxism were idiopathic and totally untreatable. “Don’t know why it happens and we can’t do any thing about it.” To my surprise, when I utilize balance in the entire system that not only do I have an effect on brux-
ism, but I can eliminate it predictably!

The position of the lower jaw in space was treated as if it were an iniviolate relationship and that we were forced to deal with whatever is happening when the patient presents, or we refer them out for orthognathic surgery. The reality is there is a non-
surgical modality that is not only more conservative and predictable and comfortable, but may well save the patient’s life! The lower jaw pos-
ture is directly and inextricably con-
ected to the airway, and we are pro-
fessionally bound to help protect that for our patients. This is a new topic in mainstream dentistry; however, it is perhaps the most important aspect of our patients’ care.

In your session, you talk about how so many issues patients suffer with are actually dental-related, yet these issues are constantly overlooked. Why do you think this is, and what do you think needs to change in the dental industry to make a difference in uncovering these issues?

Dental schools are built with the pur-
pose of creating dentists. In order to create dentists, the schools must have them ready to pass board exams. The reality of this process has two major impediments to routinely producing progressive dentists with respect to technological advances. To start, there is still only the same four years in which X-train the students. There is vastly more material, but the same amount of time.

Secondly, many of those exams are still holding on to very old concepts. While gold foil is no longer a part of the process, neither is a conservative adhesive onlay. Neither is bite diagno-
sis based on muscular comfort in addi-
tion to tooth and bone relationships.

As students, we do address signs and symptoms, but their attached meaning is often lost. Perhaps we are simply not quite ready as students. Perhaps we would be better served with a more contemporary system of exam and licensure. Perhaps both.

It seems a lot of the issues go untreated just because patients don’t know to mention them. Are there any things clinicians can begin looking for or doing in order to help their patients communicate better and get help for some of their medical issues?

We have trained our patients how to be patients and what to expect for years. We made it OK for them to allow their benefits manager at their insurance company to decide which treatment is the most cost-effective for them.

Well, most cost-effective for the insurance company. But as dentists, we made it acceptable for our patients to allow their insurance plan to benefit to determine which option to pursue.

Dental insurance is much like a rebate and the amount of service ren-
ted is generally not vastly different than the amount paid in premiums. The point or goal of these plans is not better health care, but rather a modest baseline level of care as a benefit to employees and still allow for a profit for the insurance company. The most important thing we could do is step outside of the insurance benefits – start talking to patients about what we see and what we can do to help them.

Our patients have a huge variety of dental issues and concerns and there are so many new and innovative approaches to delivering dental care today. However, we need to know how to discuss those in a safe environment with our patients.

It continually amazes me how much patients will censor what they tell us and how tainted our perspec-
tive is as a result. The biggest hurdle is getting them to tell us the whole story. For years, our focus has been on the teeth, things we can take X-rays of. The X-rays show something bad, we treat it. If not, we don’t. We literally cannot have a profession that largely focuses on mechanical repair of the hard tissues. Our patients are so much more.

Some of the most critical things to assess are not even in the mouth! With a thorough cranial nerve exam or adequate muscle palpation exam, we can tell so much about the state of affairs for our patients’ health.

Our bodies are very intricately connected, and it is our responsibility to outline these and determine where there may be issues or consequences that our patients struggle with.

For instance, if a patient were to somehow tell his or her dentist that he or she has lower back pain or numb fingertips, would we know how to respond to that? I know in my own career, I would have had to suppress a laugh if a patient had sug-
gested to me he or she was walking funny or fingertips were numb and it was from their bite.

Not the case any longer! As a pro-
fession, we need to know how all the pieces interconnect. Learning those connections will enable us to commu-
nicate them will be a huge thing for our patients. Imagine if we was no longer a reason for anyone to take imi-
trex or other migraine medications …

Do you have any specific examples of screenings that have led to saving a patient’s life?

The easiest one to incorporate would be the Eppworth Sleepiness Index. Perhaps a bold statement, but medi-
cine cannot treat sleep apnea as effectively without a dentist as it can with. We cannot make a legal diagno-
sis of sleep apnea, but this is such a pervasive and serious problem that it is irresponsible to not screen for it. It is irresponsible for our profession to not make sleep dentistry a routine part of practice. It is more important to live than to have white teeth. We are lucky enough that we can help to support both!

If an attendee is interested in going to your session, is there anything he or she should be aware of? Is your session aimed for specialists or is it a more general topic?

There is no reason why every dentist or dental health professional would not get something from the discus-
sion. Of course, any interaction like this is a two-way street. It is not my mission to convert anyone – but rather to open eyes to what we have seen work time and time again.

It is not what I was taught in dental school, but it happens that it works significantly better in my hands. I see the same from the thousands of dentists I have know who have taken a similar journey.

The bottom line is ours is a very
young profession with lots left to learn. There will hopefully always be more to discover and more to learn, so the most important thing we can have is an open mind! Any dentist or dental health care professional should be able to gain from the discussion.

Your session is sponsored by LVI, of which you are the clinical director. How did you begin working with LVI and can you tell us a little more about it for those who may not know?

LVI is an amazing place that continues to grow and evolve. It was created out of the frustration of one dentist with dental practice. Feeling forced to do what every dentist did, he was becoming burned out and bored. Then one of his mentors helped him to realize dentistry is about options as much as anything and that he could always refer away the treatment he didn’t enjoy doing. That spilled into esthetics, and the treatment of esthetics led to the inevitable quest for a better system of understanding occlusion.

As it happened, the study of neuromuscular dentistry was well under way in the year 2000, and it was a platform from which LVI could evolve and grow. Teaching neuromuscular occlusion at LVI with the benefit of the live patient courses, the field of NM grew more quickly in the decade plus than it had in the previous 30 years, and now it is a very predictable and methodical process of evaluation and data gathering to support decisions in patient care.

This perspective has led to thousands of dentists from across the globe implementing NM in their practice and helping their patients to enjoy a higher quality of life. Better management of the micro- and macro-occlusion led to more predictable and more pervasive healing, and along with that, came the painfully obvious management of airway.

Thirty years ago a dentist helped to develop a pacifier and nipple for babies that supports proper growth and development of the dental arches. This undeniable connection to the airway led to the inclusion of airway in the workup of patients.

While we obviously are not able to make the diagnosis of medical issues, it is irresponsible to not have a dentist on the team that is managing these patients. The statistics are staggering. With more than a third of male adults in North America being affected and our increasing girth as a population, this is a health-care issue that must be addressed. While there are a number of opportunities to learn about sleep disturbances and airway, most are focused on a particular appliance or an arbitrary starting point. The programs at LVI include discussion of sleep issues, starting at the very first one, Core I.

Airway issues are what created malocclusion to begin with, so it is only appropriate that dentistry join in the management of airway when our patients need it. The beautiful thing is dental support will help in nearly every patient who suffers with obstructive sleep apnea (OSA).

If there is one thing you hope attendees to your session came away with, what would it be?

The most important thing I would like to leave with the attendees is the appreciation for the huge impact we can have on our patients. Dentistry is an amazing profession, and we can do some incredibly good things for our patients and never do anything we weren’t taught in dental school. However, in Jim Collins’ book, “Good to Great,” the single biggest obstacle to attaining greatness is simply being good. It is easy to be good at dentistry. I hope in some way I encourage or inspire someone to step forward and start the quest to be great!

We have an opportunity to help patients live significantly better lives. We can end migraine in the majority, if not all, migraine sufferers. We can catch periodontal infection and reverse it before the entire body is affected and slips into metabolic syndrome. If we screen for OSA, those eight yes/no questions may not only save the life of a patient, but end the needless suffering of so many. We have control of the reins of so much for our patients, but we must look beyond the “pano and four bitewings”!

Is there anything else you would like to add?

Only the obvious. I am full time faculty and clinical director at LVI. No question my perspective has been modified by my association with LVI going back to about 1999.

I have seen some amazing dentists as I have tried to grow my skills and knowledge, both at LVI and other places. I have witnessed the way education changes the dentist and affects the patients from every angle, and I have no doubt any dentist who truly cares to deliver the best for his or her patients must be aggressive in his or her education.

Dental school quite simply isn’t enough. There are a few places where comprehensive care is addressed; however, I am not aware of any that combine the balance of hard and soft tissues (and in particular, muscles) with the business and communication skills, along with leadership development and, finally, live patient education. It has been said “you can’t be down on something you aren’t up on,” and regardless of what you have heard about LVI or neuromuscular dentistry, we are making peoples lives better.