Breaking down 3-D cone-beam technology

Dr. Mulvany promises ‘a common-sense, clinical, non-theoretical approach’

By Kristine Colker, Managing Editor

From 1:20 to 2:20 p.m. today, Damien Mulvany, DMD, MAGD, will present “Optimizing Your Practice With 3-D Cone-Beam Technology.” In the session, Mulvany aims to provide a clinically oriented approach to everyday usage of 3-D technology in the general practice. Through multiple case presentations, Mulvany will show how 3-D technology has improved his diagnostic capabilities, treatment outcomes, case presentations and profitability. This highly visual presentation is designed for doctors considering the purchase of this new technology or those wishing to advance their current skills.

Your DTSC Symposia session is titled “Optimizing Your Practice With 3-D Cone-Beam Technology.” Please tell us a little about what participants can hope to get out of it.

My expectation for participants is that they will leave the presentation with a clear understanding of the multiple, daily applications for 3-D cone-beam technology in a general practice. The presentation is purely clinical, showing multiple 3-D images of cases that most general practices encounter on a daily basis. Included will be evaluation of cracked teeth, endo situations, implant placements and trauma. Additionally, the ease of use and profitability will be addressed.

Could you go into a little more detail about what types of cases you will be showing?

The participant will see how 3-D can be used to facilitate diagnosis in evaluating clinical situations, which leads to more predictable and profitable treatment planning. One specific situation is the evaluation of a cracked tooth. The participant will see how the information rendered by the 3-D image changes the diagnosis initially suggested by the single periapical.

Would you say your presentation is geared toward a specific audience or is it more general?

The presentation is geared to practitioners with limited clinical experience with 3-D images, and no prior knowledge is required.

How did you get involved in cone-beam technology? What first made you decide to start using it?

After almost 30 years in practice, my partner and I committed to an extensive office remodel. Because we wished to upgrade our technology, we naturally looked at 3-D imaging. After extensive evaluation of all the major cone-beam companies, we chose the Suni 5x5 cm limited 3-D/pano/ceph unit.

Suni is sponsoring your session. How did you begin working with the company and what is it that you like about its products and services?

As I stated, we spent about six months looking at all of the available units. Suni was a late entry into our decision-making process, and we chose the unit based upon image quality, ease of use, cost and Suni’s service. Specifically, many of the other units seemed overly complicated. During our evaluations, we always had clinical staff members present because they would be taking the images. The staff overwhelmingly liked the Suni unit because of its ease of use and the simplicity of the supplied software.

Many of the other units required third-party software to fully use their systems, which seemed like an unnecessary expensive and additional time. My partner and I wanted to be able to have an assistant take a 3-D image with the same ease as a panorex. Not only has this been achieved, but the staff very quickly learned to manipulate the images to the best view, so that the doctors can do a quick clinical presentation to the patient with minimal effort.

It is important to note that we choose the Suni unit based on its merits before we agreed to do any promotion for the company. Since we started using the unit approximately 18 months ago, we have had no service issues, and the image quality has been beautifully consistent.

If there is one thing you could say to attendees to encourage them to come to your session, what would it be?

If you are interested in seeing a common-sense, clinical, non-theoretical approach to a complicated, expensive, new technology, then this presentation is for you. I will show attendees how to use 3-D to better diagnose, treatment plan, increase case acceptance and make it profitable.
BruxZir®: Scientific Validation

BruxZir exhibits higher light transmission, resulting in a more natural shade value.

Notice the natural color and translucency of BruxZir Solid Zirconia.

In a recent study at the University of Alabama at Birmingham to measure the volume metric loss of enamel, glazed BruxZir was found to be wear compatible with enamel and virtually identical to glazed IPS e.max®.

Ips e.max is a registered trademark of Ivoclar Vivadent.

BruxZir’s 50% smaller average grain size improves physical properties.

BruxZir is uniquely processed (patent pending) without hydraulic pressure or organic binding agents for smaller, more uniform structure, providing enhanced esthetics.

The antagonistic (Stellite balls) wear shows BruxZir only with 72±21 microns, which is significantly lower than Ceranoo® 2 (110±48 microns). The University of Tübingen study was run using an eight chamber Willytec Chewing Simulator at 1.2 million cycles.

Ceranoo® is a registered trademark of DENTSPLY Ceramco.

More brawn than beauty!

BruxZir®
SOLID ZIRCONIA CROWNS & BRIDGES

$99/unit™

✓ Ideal for bruxers and grinders who have destroyed other restorations thanks to its virtually chip proof durability.
✓ An esthetic alternative to metals with CAD/CAM consistency of contacts and occlusion.
✓ Conservatively prepare as thin as 0.5 mm with feather edge margins, much like you would cast gold.

Before

After

Before

After

The patient presented with a predominantly cast-metal bridge and desired a more esthetic option. A high-strength BruxZir bridge was prescribed.

The bridge fractured a porcelain ceramic crown on the second molar and chipped the first molar. Both crowns were replaced with BruxZir.

BruxZir is uniquely processed (patent pending) without hydraulic pressure or organic binding agents for smaller, more uniform structure, providing enhanced esthetics.

For more info: www.bruxzir.com

Call for case pickup
800•854•7256
www.glidewelldental.com

*Price does not include $14 round-trip overnight shipping.
The solution to the difficult Class II composite restoration

By Marc Gottlieb, DDS

Every month in almost every journal sent to restorative dentists, you will find an article on the restoration of the Class II lesion. They all describe and demonstrate how to eliminate sensitivity, minimize shrinkage or obtain the ideal flossable tight contact. This article will demonstrate through two case studies how to restore the difficult wide open Class II composite restoration.

We all want to know how to restore the tooth with a large failing restoration with a wide interproximal box or worse a fractured cusp. In the past, if the preparation wasn’t ideal the tooth received a crown because it was impossible to create the natural contours and tight contacts to bring it back to normal function.

Dr. Ross Nash in his recent article on the increasing demand for esthetic posterior restorations describes how to restore the Class II restoration using sectional bands, a wedge and a separating ring that goes over the tooth. This works really well with conservative lesions, but I spend half my time restoring failed amalgams with open contacts or fractured cusps.

Patients can’t always afford that crown or in many cases a composite restoration is a more conservative procedure. According to Dr. Patricia Manante Monteiro, et al, “resin-based composite materials are effective in Class II clinical situations.”

I will demonstrate using two case studies how to restore the difficult tooth with posterior composite utilizing the ABC Wedge (a better contact wedge) manufactured by Danville Materials in California. ABC Wedges were designed to work in pairs, maintain the normal contours of the tooth, establish broad tight contacts and work with all the currently available separating ring systems.

My first patient is age 55, a self-employed male with no dental insurance. He presents with a failing amalgam in a lower second molar and can not afford a crown at this time. Upon removal of the old restoration and decay, it was decided to restore this tooth with a posterior composite material utilizing the ABC Wedge. The ABC Wedge with a little imagination can be used to restore the difficult wide open Class II lesion. Larger MOD restorations and teeth missing a cusp can easily be restored.

Once again, the ABC Wedge was utilized to prevent the separating ring from crushing in the matrix, provide anatomic contours and avoid fracture of the lingual wall when placing the separating ring. In this clinical situation, the groove behind the ears not only directs the pressure between the teeth but it also secures the ring and prevents it from popping off the tooth.

A central groove is located on the back of the ears to line up the sectional separating ring and directs the forces interproximally for maximum separation. The tooth was easily restored in incremental layers, trimmed back and bite adjusted.

The second patient is a senior citizen with a lost filling in tooth #29, the lingual wall when placing the separating ring. In this clinical situation, the groove behind the ears not only directs the pressure between the teeth but it also secures the ring and prevents it from popping off the tooth.

This tooth was also restored with the ABC Wedge with a little imagination can be used to restore rotated teeth and because they are

---

See Dr. Gottlieb

Dr. Marc Gottlieb will present “A Game-Changing Approach to Difficult Class II Composites” today from 12:50-1:10 p.m. Bilateral winged wedges create more interproximal separation as well as creating “concrete formers” where most or all of a wall is missing, thereby creating biomimetic restorations quickly and predictably. All of the current matrix and ring systems ignore the common problem of large missing sections of posterior teeth. If most or all of the lingual or bucal wall of a posterior tooth is missing, the dentist usually resorts to the “old faithful” Tofflemire contoured band without amalgam, but do not promote good interproximal contacts when used with today’s composites. In addition, they don’t create a biomimetic morphology.

A new bilateral, winged wedge system answers all these needs.
WORLD’S #1 LASERS

Get a FREE iPad with every Picasso

Visit the Largest Laser Pavillion and meet the Masters of Laser Dentistry

Ross Nash, DDS
Larry Rosenthal, DDS
Greg Diamond, DDS
Howard Glazer, DDS
George Freedman, DDS
David Hoekstra, DDS
Fay Goldstein, DDS
Ron Kaminor, DDS
James Jesse, DDS
Glenn van As, DDS
Louis Chmura, DDS
Marty Zase, DDS

AMD LASERS™, LLC. www.amdlasers.com
7405 Westfield Blvd.
Indianapolis, IN 46240, USA
866.WWW.AMDL
866.999.2635

TELE: 317.202.2635
FAX: 317.665.4109
sales@amdlasers.com

BOOTH #4431

DENTISTRY TODAY
TOP 50 TECHNOLOGY PRODUCTS 2010

DENTISTRY TODAY
TOP 100 PRODUCTS 2010

DENTAL PRODUCT SHOPPER
BEST PRODUCT 2010

EDITOR'S CHOICE
2009

EDITOR'S CHOICE
2010

2010 REALITY
Four Star Award
Infection control and going green

By Noel Brandon-Kelsch, RDHAP

Infection control in the dental setting requires the clinician to weigh the benefits and risks of every task they perform. Practical applications for going green and “doing no harm” with infection control have to mesh. Small, eco-friendly changes in your infection control practices can save time, money and lives while helping the environment and the world.

What does going green mean?

For me, going green means that we make an attempt in our everyday activities to consider how the world and environment are affected by our actions. We then incorporate methods to limit the impact on the earth and make that our lifestyle.

Professor Chris Miller stated it best about the relationship between infection control and going green when he said, “Going green and infection control and safety are disease prevention and safety procedures and products that further reduce adverse health and environmental impacts.”

Incorporating the green concept into the dental office means we have to look at both the practice of dentistry and the practice of going green. Going green cannot overtake evidence-based practices that keep our patients and staff safe.

We are responsible for keeping a safe environment and not causing cross contamination. Our first focus has to be “do not harm.” When we choose products, we need to focus first on the issues we are facing as health-care providers and then on the issues of the very best product that allow us to limit our carbon footprint.

In making green choices, after discovering which products match our infection control needs, we have to research the methods the company uses to transport the item, the packaging, the contents in the item and how each product impacts the environment before, after and during use. We must make evidence-based decisions in going green in infection control.

It can be so simple

Each thing we do that reduces waste can make a difference. Here are some things you can do today:

• Buy instrument cassettes. They increase the longevity of your instruments life and reduce the risk of sharps injuries.

• Collect and recycle waste amalgam. It contains mercury, which can end up in wastewaters and can be highly toxic, especially to pregnant mothers and young children. (Dentists account for more than 20 percent of mercury pollution in the USA!)

• Install amalgam separators. They have been proven to stop more than 99 percent of waste mercury from entering our waters. This is going to be a requirement from the EPA in 2011.

• Look for products with green or greener packaging and look for suppliers that have established green initiatives. Tell manufacturers about your concern with over-packaging. Don’t buy over-packaged items and ask manufacturers to ship in bulk.

• Look for carbon neutral suppliers as a way to reduce your carbon footprint.

• When dealing with infection control, always ask yourself whether the green option contradicts the “do no harm” principle. Research pros and cons of the green alternatives by contacting suppliers.

• Recycle the foil from X-rays or other materials in your practice.

It’s not that difficult to make changes. Going green cannot overtake evidence-based practices that keep our patients and staff safe.

Dr. Marc Gottlieb was born and raised on Long Island, N.Y., and attended Union College in Schenectady, N.Y. He graduated, then received many academic scholarships, awards and fellowships. After graduation from dental school, Gottlieb went on to a two-year post-doctoral residency program at Long Island Jewish Medical Center. This unique opportunity provided advanced training in anesthesia, endodontics and all the specialties of dentistry. Gottlieb is currently on staff at Stony Brook University Hospital, maintains a full-time private practice, lectures all across the United States and has authored more than a dozen dental articles.

References


• Monteiro, Patricia Manarte DMD, MSc; Ph.D; Manso, Maria Conceicao PhD; Gavinha, Sandra DMD, MSc; Melo, Paulo DMD,Ph.D Two-year clinical evaluation of packable and nanostructured resin-based composites placed with two techniques. JADA 2010;141(3): 319–329
ANNUAL DENTAL TRIBUNE STUDY CLUB
SYMPOSIA AT THE GNYDM

MONDAY
NOVEMBER 29

FULL DAY SCHEDULE

10:00 - 11:00  Noel Brandon-Kelsch
ECO-FRIENDLY INFECTION CONTROL

11:20 - 12:20  Gregori Kurtzman, DDS
INCORPORATING NEW ADVANCES IN DENTAL MATERIALS AND
TECHNIQUES INTO YOUR RESTORATIVE PRACTICE

12:50 - 1:10  Marc Gottlieb, DDS
A GAME-CHANGING APPROACH TO DIFFICULT CL II COMPOSITES

1:20 - 2:20  Damien Mulvany, DDS
OPTIMIZING YOUR PRACTICE WITH 3D CONE-BEAM TECHNOLOGY

2:40 - 3:40  Edward Katz, DDS
IMPROVING PATIENT CARE WITH 3D CONE BEAM
COMPUTERIZED TOMOGRAPHY

4:00 - 5:00  George Freedman, Fay Goldstep and Edward Lynch
SOFT TISSUE LASERS AND CARIES DIAGNOSIS

5:10 - 5:30  Dirk Gieselmann
HOW A MMP-8 TESTING CAN CHANGE YOUR OFFICE

FIND US IN AISLE 6000, ROOM 3
WALK-IN’S ARE WELCOME!
Diode laser: Why do I need this?

By Fay Goldstep, DDS, FACP, FADE, and George Freedman, DDS, FAACD, FADFE

The 810 nm diode laser is specifically a soft-tissue laser. This wavelength is ideally suited for soft-tissue procedures because haemoglobin and melanin, both prevalent in dental soft tissues, are excellent absorbers.

This provides the diode laser with broad clinical utility. It cuts precisely, coagulates, ablates or vaporizes the target tissue with less trauma, improved postoperative healing and faster recovery times.

Given the incredible ease of use and its versatility in treating soft tissue, the diode laser becomes the “soft-tissue handpiece” in the dentist’s armamentarium.

The dentist can use the diode laser soft-tissue handpiece to remove, refine and adjust soft tissues in the same way that the traditional dental handpiece is used on enamel and dentin.

This extends the scope of practice of the general dentist to include many soft-tissue procedures.

The following procedures are easy entry points for the new laser user:

- gingivectomy
- haemostasis
- gingival troughing for impressions

The diode laser (Picasso, AMD LASERS) makes restorative dentistry a breeze (Fig. 1). Any gingival tissue that covers a tooth during preparation can be easily removed as haemostasis is simultaneously achieved (Figs. 2–6).

The restoration is no longer compromised due to poor gingival conditions. There is no more battling with unruly soft tissue and blood.

Excess gingival tissue can be readily managed (Figs. 7, 8) for improved restorative access to Class V prepara- tion (ezlase, Biolase Technology Inc.)

Gingival troughing prior to taking impression (Figs. 6, 7) ensures an accurate impression, particularly at the all-important margins, and an improved restorative outcome (Picasso, AMD Lasers). Packing cord is no longer necessary.

Diode lasers make restorative dentistry less stressful, more predictable and more enjoyable for the dental team and the patient.

Operculectomy, excision and/or recontouring of gingival hyperplasia, frenectomy

These procedures are not commonly offered or performed by the general dentist. They are examples of the expanded range of services readily added to the general practice. The dentist becomes more proactive in dealing with hyperplastic tissues that can increase risk of caries and periodontal disease.

A frenectomy (Fig. 12) is now a simple and straightforward procedure

Laser-assisted periodontal treatment

The use of the diode laser in conjunction with routine scaling and root planing is more effective than scaling and root planning alone. It enhances the speed and extent of the patient’s gingival healing and post-operative comfort. This is accomplished through laser bacterial reduction (Picasso, AMD Lasers), debridement and biostimulation (Figs. 13, 14).

A. actinomycetemcomitans, which has been implicated in aggressive periodontitis, may also be implicated

See Dr. Goldstep and Dr. Freedman

Dr. Fay Goldstep and Dr. George Freedman will speak on “Soft-Tissue Lasers and Caries Diagnosis” today from 10-11 a.m. This program focuses on these treatments: 15-second troughing instead of using retraction cord; and instant chairside gingivectomies, gingivoplasty, bacterial decantamination, LAPT, bio stimulation and much more. The CarieScan PRO is the latest and most accurate diagnostic tool for the clinical practice. The CarieScan PRO permits dental professionals to evaluate decay in teeth and provide information about whether the tissue is healthy, in the early stages of decay or already significantly decayed. The diagnostic results are displayed on a LCD screen and the clear numeric information is easily documented into the patient’s chart to monitor and assess disease status and progress (or improvement).

About the authors

Dr. Fay Goldstep has served on the teaching faculties of the post-graduate programs in esthetic dentistry at SUNY Buffalo, the University of Florida (Gainesville), Minnesota (Minneapolis) and has been a ADA Seminar Series speaker. He has lectured nationally and internationally on soft-tissue lasers, electronic caries detection, healing dentistry and innovations in hygiene and has published numerous textbook chapters and articles on these topics. Goldstep is a consultant to a number of dental companies, and he maintains a private practice in Toronto, Canada.

Dr. George Freedman is a founder and past president of the American Academy of Cosmetic Dentistry, a co-founder of the Canadian Academy for Esthetic Dentistry and a diplomate of the American Board of Aesthetic Dentistry. He is the author or co-author of 11 textbooks, more than 600 dental articles, and numerous webinars and CDs and is a team member of REALITY. He lectures internationally on dental esthetics, adhesion, desensitization, composites, impression materials and porcelain veneers. A graduate of McGill University in Montreal, Freedman maintains a private practice limited to esthetic dentistry in Toronto, Canada.
Introducing the NEW GXCB-500 HD — 
Advanced High Definition Cone Beam 3D

See the latest in 3D Imaging at Booth #4017

Most Flexible 3D Scan Formats

High-End Traditional 2D Pan Included

Fastest "Scan-to-Plan" Workflow

Gendex Dental Systems
www.gendex.com
Call toll-free: 1-888-339-4750
Understanding dental adhesives

By Gregori M. Kurtzman, DDS, MAGD, FACC, FPFA, FADI, DICOI, DADIA

“Not all adhesives are the same” is a good lesson to understand when performing restorative dentistry. Frequently, practitioners apply the methods to use one adhesive to all adhesives the encounter in rendering care to their patients. When this is followed, bond failure is often encountered and the practitioner blames the manufacturer’s product, not realizing the fault lies in not following the manufacturer’s instructions.

Adhesives basically fall into two categories: total-etch and self-etch. Understanding how each category is used is essential in achieving the predicted results. This has become more important to practitioners in the plethora of new materials entering the market, such as self-etch adhesives, self-etch flowable composites and self-etch resin cements.

Smear layer is the main difference between total-etch and self-etch materials. As we are aware, the smear layer results from preparation of the surface to receive the restoration. It is composed of dental debris, bacteria and other debris and is approximately 1 to 5 microns in thickness (Fig. 1).

When a total-etch technique is utilized, the smear layer needs to be removed to allow penetration of the resin into the dentin surface forming a hybrid layer with the dentin and achieve the bond. This is typically performed with phosphoric acid gel leaving a clean surface ready for application of the adhesive (Fig. 2).

In endodontic treatment, this may be performed within the canal system using irrigation with 17 percent EDTA liquid. Following application of the adhesive, a hybrid zone forms on the dentinal surface wherein a stress-absorbing layer results between the adhesive and dentin with the zone being a blending of adhesive and dentin (Fig. 3).

Self-etch adhesives are a different concept and they require the smear layer to remain. These materials forgo the acid etching gel and use a mild acid either as part of a non-rinse primer or combined as part of one-application material that has the adhesive combined and not a separate component. Removal of the smear layer prior to use of a self-etch adhesive has been shown to lower bond strengths. Self-etch adhesives are also associated with less post operative sensitivity than total-etch adhesives due to the plugging of the dentinal tubules with the smear layer.

So why use a total-etch adhesive then? Bond strengths are greater with total-etch adhesives then with the self-etch adhesives available. This becomes critical in specific clinical situations, such as luting of porcelain veneers. All manufacturers of self-etch adhesives and self-etch resin cements indicate that cementation of porcelain veneers is contraindicated with these materials and recommend the use of total-etch adhesives for this clinical application.

Additionally, with regard to resin cores, when a crown will be placed, it is my recommendation that if the core will be missing then 25 percent of circumferential tooth structure after crown preparation then a total-etch adhesive should be selected. Clinically, self-etch adhesives work predictably when direct restorations will be placed on teeth where the cusps are intact to resist lateral displacement of the filling material, small to moderate cores when there is minimal circumferential tooth structure missing after crown preparation, luting endodontic posts and cementation of crowns and inlay/onlays.

Another area of confusion for many practitioners is how wet or dry the dentin should be when using adhesive techniques. As the materials in use are composed of hydrophilic resins, some moisture is needed to pull the resin into the tooth’s surface. But how much moisture do we want? The goal is to have moist dentin without any pooled water or fluids on the surface. The dentin should have a glistening appearance when ready to bond to the surface. If it does not, then re-wetting the surface is suggested to maximize the bond strength after adhesion.

In conclusion, the practitioner needs to understand what type of adhesive they are using and follow the manufacturer’s instructions on its use. One can not expect to get the desired results if one doesn’t follow the product’s instructions.

See Dr. Kurtzman
Dr. Gregori Kurtzman will present “Understanding adhesives and how to incorporate new advances in dental materials and techniques into your restorative practice” today from 11:20 a.m. - 12:20 p.m.

About the speaker
Dr. Gregori Kurtzman is in private general practice in Silver Spring, MD, and is a former assistant clinical professor at the University of Maryland Department of Endodontics, Prosthetics and Operative Dentistry. He has lectured both nationally and internationally on the topics of restorative dentistry, endodontics and implant surgery and prosthodontics, removable and fixed prosthetics and periodontics, and has more than 170 published articles. He has been included in the “Top 100 Clinicians in Dentistry” by Dentistry Today since 2006. He can be contacted at dr.kurtzman@maryland-implants.com.

Diode "from page 16"

In systemic disease. It has been found in atherosclerotic plaque and there has been recent data suggesting it may be related to coronary heart disease.

The diode laser is effective in decreasing A. actinomycetemcomitans and thereby indirectly improving the patients’ heart health.

Laser education
Most diode laser manufacturers provide some education to get the new user started quickly and effectively.

The most comprehensive online diode laser introductory course with certification (which includes the science, safety and clinical procedures) can be found at the International Center for Laser Education at www.mdiasclasers.com under education: online courses.

This course provides everything necessary to get started with soft-tissue diode laser therapy. Advanced courses are available for more complex procedures.

The soft-tissue diode laser has become a “must have” mainstream technology for every general practice. The science, ease of use and affordability make it simple to incorporate. The laser is now the essential “soft-tissue handpiece” for the practice.

In fact, there is a case for having a diode laser in each restorative and hygiene treatment room. Restorative dentistry becomes easier, more predictable and less stress-filled.

Laser therapy expands the clinical scope of practice to include new soft-tissue procedures that keep patients in the office. The patient’s gingival health is improved in a minimally invasive, gentler manner.

Every time the dentist picks up the diode laser the question is: Where have you been all my life?

Fig. 4 (left): SEM of dentin following application of the adhesive on the dentin surface and the resulting hybrid zone. A= adhesive, D= dentin, H= hybrid zone. Fig. 4 (right): SEM of dentin following application of a self-etch primer to the smear layer fixing it to the underlying dentinal surface.
Aquasil Ultra’s **NEW**
Single Unit Solution
takes the “stress” out of taking single unit impressions.

When you’re taking a single unit impression, choose the perfect combination of Aquasil Ultra Materials. The Rigid tray material minimizes distortion inherent in the commonly-used closed-bite tray. The B4® Surface Optimizer helps the XLV (extra low viscosity) wash material get into hard to reach places like the sulcus. The convenient digit® Targeted Delivery System makes syringing precise and easy.

Visit www.aquasilultra.com to order the Single Unit Solution today.
Implant dentistry has become an integral part of the services we offer our patients on a daily basis. Twenty-five years ago, when we first began surgically placing dental implants, our major concern was getting the implant properly placed well within the confines of the jawbone. Of secondary concern was how the implant related to the final prosthetic outcome.

With advancements in surface technology and our understanding of osseointegration, we have increasingly become more concerned with the final esthetic and functional result and fulfilling the patient’s wishes and desires for a natural replacement of their teeth or teeth. This is often referred to as prosthetically driven implant surgery.

Our presentation reviews some of the techniques and procedures we use on a daily basis to achieve our goals. The use of radiographic guides in conjunction with radio opaque materials helps us locate the ideal placement for the implant in order to satisfy the patient’s particular needs.

We will discuss the fabrication of these radiographic guides, and how they are utilized in implant surgical procedures, and how they can help us determine whether implants are appropriate for a particular patient. This is a novel approach to hard- and soft-tissue imaging.

The presentation will be of value and interest to anyone who is either placing implants, intends to place implants or is actively involved in the treatment planning and restoration of dental implants.

Many years ago, we began using medical CT imaging in order to evaluate the hard tissue prior to surgery. The secondary software became a huge asset in planning, designing and communicating with both the patient and the restorative dentist. Although the quality of the medical CT is quite good, we became very concerned with the amount of radiation patients were receiving from a conventional medical CT image. That led us to research the use of cone-beam technology mainly because of its promise to provide excellent image quality as well as significantly lower radiation dosage.

Several years ago, we began researching the many machines available in the marketplace. We set up rather strict criteria for our purchase. At the very top of the list, occupying position number one, is image quality. We could not justify spending money on a machine that did not provide excellent, consistently readable images.

Of course, radiation exposure, field of view, technical support and ease of use of software were also critical to our decision making. After reviewing and examining many of the machines available, we chose Prexion CBCT. It has certainly lived up to all of our expectations and beyond.

As implant dentistry becomes more sophisticated and as patients become increasingly aware of the results that can be achieved, it becomes incumbent on practitioners to continue to research and develop new ways of simplifying the task of providing tooth replacement procedures. We want to share some of our horror stories and our success stories and talk about how “in-office” cone-beam scanning has improved our patient’s care. I believe that the attendees will find many of these techniques to be practical, useful, easily implemented and predictable in their daily practice.
Think all toothpastes work the same? Let’s take a look.

The evidence is clear.

Colgate Total® provides 12-hour antibacterial protection your patients can’t get from regular fluoride toothpaste.

Colgate Total® works 3 ways:

1. **Adheres** to hard and soft tissue: teeth, gingiva, cheeks, and tongue.
2. **Actively kills** plaque- and gingivitis-causing bacteria more effectively than regular fluoride toothpaste.
3. **Lasts** for 12 hours after brushing—even after eating and drinking.

www.colgateprofessional.com

References:

Colgate®
YOUR PARTNER IN ORAL HEALTH

Total®

Dramatization: Illustrating reduction of plaque bacteria 12 hours after brushing with Colgate Total® vs regular fluoride toothpaste.
If you enjoy a large and open-air type of venue, the Live Dentistry Arenas will suit you best. Sunday was the debut of not one but two Live Dentistry Arenas. Dr. Douglas Terry began the day in arena No. 1 with “Anterior Fiber-Reinforced Composite Resin Bridge.” Later in the day, arena No. 2 offered Dr. Brian Shroder with a presentation titled, “From Elastomeric Impressions to Digital Replication: It’s A Scanning Wand, Not A Magic Wand.”

If you prefer a cozier learning environment, then head over to aisle 6000, room 3, for the DTSC Symposia. The attendees who poured out of Dr. Martin Goldstein’s crowded lecture had positive things to say about the speakers and the DTSC Symposia platform in general.

“I learned quite a bit in the lecture. I don’t do as many composites, direct composite resins, so it was very interesting to me,” said Dr. Ophelia Jackson, who practices in New York. “It’s a really great format.”

Finally, if you want the most intimate of learning situations, you should head for one of the glass classrooms on the exhibit floor. These lectures offer a hands-on approach in a space that is well-insulated from the din of the exhibit hall.

For example, during his presentation in one of the glass classrooms on the exhibit floor, Dr. John Olmsted held the floor from 9:45 a.m. to 5 p.m. to discuss “R U Ready for the 2 NU R’s in Endodontics?” for rotary instrumentation and resin-bonded obturation.