Attendees of previous years’ sessions presented by Meg Soper have had so much fun that the Pacific Dental Conference has her returning this year — for the fourth time.

But this time Soper is doing what might best be described as a stand-up health-care routine.

“It’s going to be a stress-busting, laughter-filled hour that will set the tone for the final day of the conference,” Soper said.

Acknowledging that dentistry can be extremely stressful, Soper said: “We have to be able to laugh at ourselves and at what life tosses our way. And we can bring that energy with us to our relationships and to our dental practice.”

Soper offered this guarantee to all attendees, especially spouses: “You will remember it for quite some time!”

“The ‘Saturday Morning Breakfast’ will be filled with a huge amount of positive energy,” Soper said. “It will be geared toward all members of the dental team — and spouses. I hope to see a lot of partners/spouses in the room on Saturday.”

Soper has worked as a health-care professional, stand-up comic and keynote speaker, all while also raising a family. Along the way she learned many powerful lessons about the importance of life balance. Those lessons are what enable her to work effectively as a motivator, life-balance coach — and comic.

“I know the work dental professionals do is sometimes stressful, with challenging time constraints and the odd, demanding patient,” Soper said. “So this hour is a friendly poke at some of that stress and a fun, packaged reminder that laughter really is the key to ‘letting it go.’”

PDC's exhibit hall offers seemingly limitless selection

By Robert Selleck, Managing Editor

The thousands of feet of aisles in the Pacific Dental Conference Exhibit Hall abound with “educated-shopper” opportunities that otherwise would be impossible to create on your own. The product demonstrations, hands-on testing and other in-person chances to directly assess the latest in dental products and services seem limitless. Here are a few examples a quick tour of the exhibit floor revealed on Thursday.

Joe Andrasko was in the Carestream Dental booth, No. 928, providing live presentations on CS Solutions, Carestream’s comprehensive system of tools and resources that simplifies and improves efficiencies with restorations — with single-visit scanning, designing and milling — in-house or with your lab.

Victor Bianchi was showing visitors how easy it is using just hot water to custom fit the Larell One Step Denture. He said the denture system is a perfect match with OCO Biomedical’s immediate-loading implantology on small-diameter implants, which takes only an hour. The resulting breakthrough: chairside dentures on implants in just two hours. “It’s a match made in heaven,” Bianchi said. “It adds business to your practice and serves your anatomically and financially compromised patients.”

In the Patterson Dental booth, see AISLES, page 3

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scenes from around the PDC

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‘Occlusion is for everyone’

Key principles equally applicable to single crowns or full-mouth restorations

By Robert Selleck, Managing Editor

Many dental professionals when hearing the term “occlusion” or “occlusal dysfunction” immediately think of full-mouth reconstruction, rehabilitation or some other intensive case. John Kois, DMD, who has earned a global reputation for his knowledge of and teachings on occlusal dysfunction, wants to end that.

“The problem is,” Kois said, “that patients who receive that level of dentistry are a small percentage of a typical practice’s patients. In reality, occlusal concepts apply to all of your patients.”

Simply put, Kois said, “Occlusion is for everyone.”

And that’s the heart of his presentation, “Functional Occlusion,” on Saturday from 10 a.m. to 12:30 p.m. and continuing from 1:30 to 4 p.m. Kois spoke with today prior to his PDC presentation.

Can you summarize your session?

The core of the presentation involves shifting perception to understand that emphasis needs to be on the physiology of the occlusion, not on the mechanics. Once we understand this, and what we are really trying to treat, there may be some simpler solutions we can generate. A big problem is that most dentists were trained to diagnose occlusal problems by looking only at patient morphology.

My presentation highlights the difference between a morphologic occlusion and functional malocclusion. Just because the occlusal relationships do not appear to be ideal, that doesn’t mean a patient can’t have a healthy functional occlusion. Treatment can achieve what seems to be a morphologically ideal occlusion, but the patient ends up being miserable, with discomfort and instability in tooth position. Why is this? My presentation answers that question.

So, sometimes what seems to be dysfunctional occlusion is better left alone, and what appears to be acceptable occlusion might not be what it seems? What are we dealing with a system that does four things: It chews. It swallows. It breathes. It speaks, and it’s involved in breathing. When there’s a problem with any one of those four things, the system has to adapt or work around the problem. The process of adaptation, the patient may develop symptoms — or ways of compensating for the problem that are normal to the body but abnormal in the way we examine the patient.

So what we’re really trying to do when we see occlusal problems is reduce adaptation or the rate of adaptation, which represents compensation by the body. When we look at it this way, often these are not true diseases; they are what the body does to make the system work better. The human body is always trying to heal itself. That’s what homeostasis is all about. You’re always trying to correct things so that you can function in a more protected way. Weightlifters get callouses on their hands. That’s not called callous disease. That’s a response to the roughened equipment and doing things in a different way that prompts a response from the body. You may not like callouses, but they’re not a disease, they’re normal.

With occlusal problems, it’s very important to identify the occlusal concept that is present. It’s a common mistake to assume that because the occlusion looks normal, it’s okay. Sometimes what the patient is presenting as a problem is related to malocclusion, and sometimes it’s related to occlusion. By clarifying these concepts, we can refer patients to the appropriate treatment.

For a real “wow-factor” demonstration, be sure to visit National Dental Inc. in booth No. 1319, where Annette Tindall, with Zeiss, will help you test out the Cinema ProMED, powered by the Zeisscinemizer OLEn. The 3-D multimedia video glasses can help reduce anxiety in your patients and improve their overall experience visiting your practice. And they would be pretty cool, too, for your flight home.
OCCLUSION

similar. The body is responding to something that it doesn't like, and what we see is not the disease. We have to respond to what it is that the body doesn't like in order to figure out how to treat the signs or symptoms that we see. One of the biggest problems for us as a profession is recognizing what the real problems are — in other words — diagnosis, rather than just treating signs and symptoms as they appear in the mouth.

Is there data on the impact of occlusal dysfunction on restorative success?

There is, but what many people don't always understand is how that impact results in different modes of failure. So when porcelain chips, or when the external surface of the restoration becomes otherwise compromised, it is obviously very possible that occlusion could be a contributing etiologic component. But there are many other modes of failure — often not directly recognized — that may be creating muscle dysfunction, joint problems or even recurrent decay under the restoration.

What we have to realize as a profession is that recurring decay under the crown and bridge often is due to aberrant wear, especially in areas that they can't see, they won't understand what that means. But what if we use specific data instead of general concepts and explain it like this: “It should normally take 100 years to lose a millimetre of tooth structure. If you have a healthy occlusion, you should not really wear out your teeth. When patients present with discomfort, muscle aches or joint concerns, they are already aware that there is a problem. But if a patient presents with a loss of tooth structure progressing much faster than normal, the patient may not be aware of it. They don't see or feel the problem. When you tell patients that they have severe wear, especially in areas that they can't see, they won't understand what that means. But what if we use specific data instead of general concepts and explain it like this: “It should normally take 100 years to lose a millimetre of tooth structure. Based on how much structure is missing here, you've lost more than three millimetres, which should have taken more than 300 years — or represents 300 years of use. I am concerned for you because you are only 56 years old. And I'm concerned with how long your teeth will last.”

What we are trying to do is get dentists to recognize how they can conceptualize occlusal problems in the mind of the patient. Because unless the wear creates an aesthetic problem, most people are unaware until they can see it or they have symptoms from it.

Is the entire presentation on diagnostics, or are treatment strategies covered?

The treatment that is outlined will be based on the three Ps: position, place and pathway. Where do you position the jaw relative to the head? How do you make the teeth fit together properly so they have equal simultaneous contact, which we call place? How do you not interfere with the envelope of function — or create a new envelope, which we call pathway? Those Ps can be accomplished by appliances, fibrillation, orthodontics, surgery or full-mouth reconstruction. Depending on the problems that the patient presents with, treatment may require a specialist.

Can treatment for occlusal problems occur simultaneously to restoration work?

The key in practice is to understand potential problems with occlusion, even before you begin treatment. And this doesn’t necessarily require a functional analysis. To make it a little more confusing, sometimes what we see doesn’t even reflect that there are occlusal problems. For instance, if a patient presents with wear, you cannot tell by looking at the teeth if the wear represents a previous occlusal problem that doesn’t exist anymore — or a current problem. In the previous situation, even though patients may look as if they have an occlusal problem the risks would be much lower. If the problem is active, you can’t just repair worn teeth and expect success if you haven't resolved why the teeth are worn down.

Again, understanding the mechanical aspects of occlusion that we were taught in school isn't enough. You need to understand the physiological dynamic relationships that actually create the problems. Right working, left working and protrusive or linear movements don’t reflect what people actually do with their teeth. If this is all we’re really doing when we’re rebuilding occlusion, it’s not enough to resolve such problems if you later encounter failure that you did not expect.

It’s extremely frustrating to manage someone's occlusion in a way that you believe everything is correct and done appropriately and still have a problem. Why did that happen? Is it that we made a mistake? Is it that we really didn't do it properly? Or is it that there is something more to the problems we are treating that we haven't yet learned to understand?