I A C A
THE INTERNATIONAL ASSOCIATION OF COMPREHENSIVE AESTHETICS
-THE AESTHETIC OCCLUSION CONNECTION-

# Newsletter

volume 5 issue II

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## 2011 Annual Conference

San Diego, California

July 28 - 30, 2011

2011 IACA Newsletter
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## PRABU'S POINTS

Why did we need to start a new organization - IACA? No other organization existed in dentistry to meet the needs of dentists that wanted a truly comprehensive approach to aesthetic dentistry. An organization was needed that would bring experts knowledgeable about all the factors including occlusion, cranio-cervical-mandibular posture, airway, etc. so that our members will be "comprehensive" in their treatment approach to benefit their patients.

Recent developments have highlighted the vital role of IACA in promoting this comprehensive approach and protecting our freedom to practice in such a way.

The American Association for Dental Research – AADR – which is a predominantly academic group – created a position paper on TMD in March 2010. This was essentially a rehash of old beliefs that were resurrected after a failed attempt decades ago to assert it. It is based on the psychosocial paradigm of TMD and discounts bio-electronic measurements. It has already been used by insurers to deny benefits to suffering patients that were helped through neuromuscular dental treatment. This was published in September 2010 issue of Journal of the American Dental Association with the proposal that it be made the "standard of care." Nearly 300 letters were written to the editor vehemently protesting this - which was 3 times the usual annual volume of mail. Those that don't have the ability to help these patients suffering with TMD should not put roadblocks in the way of those of us that can and do help TMD patients every day.

The letter that I sent to the President of ADA on behalf of IACA and its members is posted below.

This incident especially highlights the vital role of IACA. If not us, who would be the advocate for a Comprehensive approach to aesthetics? All the more reason that IACA has to continue to grow and continue to advocate for the patients who would be denied this help!

Come join us with your families…and bring a dentist friend…to find YOUR place in the sun….in sunny San Diego….at the Manchester Grand Hyatt, July 28-30, 2011.

– Prabu Raman, DDS, MICCMO, LVIM

## NOTES FROM YOUR EDITOR

*Dan Jenkins, DDS, FICD*
*American Association of Dental Editors, Certified Dental Editor*

### Keeping it Positive

Recently a major dental journal in the USA published a piece that said it was announcing a new standard for TMJ Dysfunction therapy. This was written by the chair of a committee from a small group of dentists who apparently utilized their dental political connections to accomplish this. This "new standard" is the bio-psychosocial philosophy that was suggested over twenty years ago by the same author and group. While this would have been acceptable for someone to promote their own philosophy this piece also denigrated other TMJ Dysfunction philosophies and essentially promoted their philosophy as the only proper way to treat TMJ Dysfunction.

In response to this, the IACA called for a letter writing campaign to protest this injustice. Neither the IACA, nor any other dental organization, was asked to review, comment, or write their own position paper regarding their own philosophy. Other dental organizations involved with TMJ therapies also wrote in. Within the first few weeks IACA members had sent in over two years worth of letters to the editor compared to the journal's normal response! We did great!

While several members had their letters published along with the author's response to those letters, there are still several issues remaining. This is an ongoing issue and there may be more letters to write. I would like to emphasize that unlike the author's negative comments that were published we will stay with a positive message of education.

Staying positive is in keeping with the basic tenants of the IACA. A positive atmosphere is one of the things that new attendees of the IACA annual meetings most commonly mention. Not only that, but each year there are indeed speakers of various treatment philosophies presenting their position. We can learn from each other and it is important to understand various views.

CONTINUED PAGE 4

### the board of directors

| | |
|---|---|
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| Mark Duncan | Jim Harding |
| Dan Jenkins | Chong Lee |
| Drew Markham | Manisha Patel |

# Smile Design

Dr. Shahin Safarian

Limiting your education means limiting your ability, plain and simple. For so many practicing dentists, procedures are carried out the way they were taught. But if they weren't taught everything, then how could they possibly know that there could be a better, more efficient way of doing things? Case in point: veneers. Everyone learns the ins and outs of veneers in dental school, or so they think. Being that veneers fall on the cosmetic side of dentistry, they can be a real moneymaker and as such, when the quality of your product rises so does the price tag. Now let me tell you all a little secret, growing your business means optimizing your quality of work and when it comes to veneers, the industry (as a whole) is grossly under prepared.

Veneers are all about looks – to the patient. As dentists, we all know that looks can be as deceiving as a veneer itself and without attention to detail, functionality goes right out the window. With proper preparation, diligent planning, evolved methods and an eye for detail, veneers can be both aesthetically pleasing and functionally sound. To better paint this picture, I'd like to revisit one of my past cases, a patient seeking 10 veneers to close the gaps.

***Preliminary Stage:***

It's all about preparation and when it comes to veneers, you need to know what the finished product will look like before you place a single veneer in someone's mouth. Let me start by saying that one of most helpful tools to a dentist is a camera. Taking good, high-resolution photos not only help you chronicle the case properly but they serve as a current visual for open cases (see Figures 1 and 2).

Figure 1

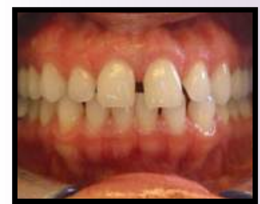

Figure 2

Impressions are pretty standard but standard methods yield standard results – we can do better. If you want to gain a reputation for placing top quality veneers then you need to go above and beyond. First, always take a symmetry bite and be sure to address the canting of the jaw; straight veneers on a crooked bite aren't doing anyone any favors. Second, make good and thorough use of your lab. Keep an open dialogue and stay involved from start to finish. Lastly, have your lab make an ideal wax up. It will ALWAYS help to have something three dimensional for reference.

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# Abstract Alley

## *Prevalence of temporomandibular disorders in obstructive sleep apnea patients referred for oral appliance therapy.*

Cunali PA, Almeida FR, Santos CD, et al, J Orofac Pain. 2009 Fall; 23(4):339-44

**AIMS:** To evaluate the prevalence of pain associated with Temporomandibular Disorders (TMD) in obstructive sleep apnea syndrome (OSAS) patients referred for oral appliance therapy.

**METHODS:** Eighty-seven patients (46 men and 41 women), between 18 and 65 years of age, with an apnea-hypopnea index (AHI) of > 5 and < 30 (events by sleep hour), and body mass index (BMI) of =or< 30 Kg/m(2) were evaluated according to the Research Diagnostic Criteria for Temporomandibular Disorders (RDC/TMD) to determine the presence of signs and symptoms of TMD. Statistical analyses included correlations assessed by Pearson's test.

**RESULTS:** Fifty-two percent of patients presented symptoms of TMD. Thirty-two patients (average age 47 +/- 11 years, AHI 17.3 +/- 8.7, BMI 25.9 +/- 3.8 kg/m(2)) completed the study. According to the Scoring Protocol for Graded Chronic Pain (Axis II-RDC/TMD), 75% of the patients presented chronic pain related to TMD, categorized as low disability grade I (< 50 points for pain intensity, and < 3 disability points). The most common TMD diagnosis was myofascial pain with and without limited mouth opening and arthralgia (50%).

**CONCLUSION:** The high prevalence of TMD in the current study indicates that patients with OSAS referred for oral appliance therapy require specific evaluation related to TMD.

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## *The Electromyographic Activity of Masseter and Anterior Temporalis During Orofacial Symptoms Induced by Experimental Occlusal Highspot.*

Li, J., Jiang, T., Feng, et al, (2008), Journal of Oral Rehabilitation, 35: 79–87. doi: 10.1111/j.1365-2842.2007.01750.x

The aim of the present study was to investigate the short-term impact of an occlusal high-spot on the occurrence of orofacial symptoms by collecting self-evaluation and using electromyography (EMG) evaluation. A rigid unilateral intercuspal occlusal highspot (A cast onlay of 0•5 mm) was placed on the right lower first molar of six adult volunteers (three males, three females), and remained for 6 days. All the induced orofacial symptoms were collected and the subjects scored the orofacial pain on a 10-cm visual analogue scale (VAS) during the placement of onlay. The surface EMG was recorded before the placement of onlay, during (on the 3rd and 6th day) and after the onlay was removed. Then the contractile symmetry of bilateral masseter (MAL, MAR) and anterior temporalis (TAL, TAR) was measured by using an asymmetry index. On the 3rd day of the placement of the occlusal highspot, all subjects complained of headache in right temporal region (meanVAS ± s.d. = 3•7 ± 0•5); the activity of TAR at rest position of mandible increased significantly (P = 0•027). In addition, on the 3rd and 6th day with the highspot the EMG activity of the tested muscles during

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## FUTURE IACA MEETINGS

**2011 Annual Conference**
Manchester Grand Hyatt
July 28 - 30
San Diego, California

**2012 Annual Conference**
The Westin Diplomat
July 26 - 28
Hollywood, Florida

**2013 Annual Conference**
TBD
July 22 - 24
Calgary, Alberta

**2014 Annual Conference**
Red Rock Casino & Spa
July 24 - 26
Las Vegas, NV

# "OH TWO...Ask Dr. Allman"

*Questions on Dental Sleep Medicine answered by Dr. Brian Allman, DDS, DABDSM, DAAPM, FAACP, FAGD, FASGD, FICCMO, FAAFO, FIAO.*

**Q. Brian, I've had a couple patients lately that do not have OSA, but get no stage III or IV sleep. They both feel they sleep terribly and never feel refreshed. The sleep center made recommendations for one to be put on an RLS medication and "Requip. " The other, to my knowledge, did now make a recommendation. What do you do in cases of no OSA, yet they're not getting good deep recovery sleep? Both suffer from depression, (probably in part to lack of Serotonin replenishing in deep sleep), are lethargic, etc. No other Med hx to be noted.**
**Where do I go from here?**

A. It is important to appreciate that there are many conditions which will suppress Stage III and Stage IV sleep. PTSD, chronic pain and drugs such as Methamphetamine and caffeine abuse can permanently alter brainstem control of sleep resulting in permanent suppression of Stage III and IV. Clinically, suppression of slow wave sleep is most often due to drug effects; past and present. Neurologic conditions such as Parkinson's and pain can also negatively influence these later stages of sleep.
My recommendation is to not try and treat such a complex and debilitating condition. Pursue further diagnosis and make sure you are dealing with ABMS boarded sleep specialists and AASM accredited sleep centers. Portable monitors, as prescribed by dentists and scored by an off-site "doc-in-the-box" is INAPPROPRIATE - PERIOD. Clinical examination by the diagnosing MD is essential to an appropriate diagnosis.

**Q. I have a patient who that I am treating for neck issues He is a mouth breather, admits to snoring, has narrow max and mandibular arches with forward head posture.**
**What is my first step in getting him to someone to be evaluated?**

A. Review your patient's medical history and evaluate for the comorbid clues for sleep disordered breathing. For example, what medications have been prescribed and for what reasons? Also, does the patient also exhibit or complain of excessive daytime sleepiness, hypertension, or obesity? Is there a familial history of OSA, MI or early death? Assuming your patient is a likely OSA sufferer, refer him/her to a board certified medical sleep specialist for evaluation. Your referral would include the suspicious history, (snoring, EDS, waking un-refreshed), and a request for evaluation.

Once you learn the OSA "constellation of symptoms" you will confidently be able to screen and appropriately refer patients for evaluation.

Keep on learning!
Brian

*ABSTRACT ALLEY* continued from page 2...

maximal voluntary contraction (MVC) was significantly reduced; the asymmetry index of bilateral anterior temporalis during MVC was increased significantly (P3rd = 0•028; P6th = 0•046). A unilateral occlusal highspot may make the ipsilateral anterior temporalis become tenser at rest position. Furthermore, the activity of bilateral anterior temporalis becomes more unsymmetrical during MVC although there are inter-individual differences between subjects. The changes in muscular activity may have some relationship with the occurrence of tension-type headache in temporal region.

*Smile Design* CONTINUED FROM PAGE 2

### Preparation & Temporary Stage:

Once all of your preparations have been made, step one is having a stent made of the ideal wax up from your lab. It just gives you a more accurate cut. That being said, the amount of severity of cuts will differ from case to case and this is a prime example of how proper preparation can serve you well. After prepping, the next step is crucial: matching shades. Matching stump shades to ingot shades requires exact precision and once again, good photography is essential here (see Figure 3). After taking a final impression, you'll want to take another symmetry bite, as angles can sometimes shift after preparation (see Figure 4).

Figure 3

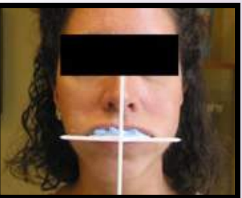
Figure 4

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# LIFE TO THE FULLEST

**Drew Markham, DDS, LVIF**

Never before in my career have I seen such a broad range of experiences within the dental profession. We have all seen and heard stories about dentists who are thriving, and those who are seriously considering bankruptcy. These stories all come from dentists who are brilliant and passionate professionals. We can discuss the possible reasons for these wild fluctuations in success from regional economic factors, to not offering a wide enough range of services, to dropping insurance in a poorly planned manner. However, the fact remains that this keeps the focus squarely on the dollars, and can take a deeply personal toll on the individual who feels that they don't stack up to those dentists who are in a more economically sound position.

When I was going through a difficult week about a month ago, a question popped into my head that wouldn't go away. "Why is it so easy for us to point out to others all that they have to be thankful for, yet we so quickly let our own focus drift to the negative things such as difficult patients, debt, and other stressful issues?"

Fortunately, my difficult week led into a week in Las Vegas with my family. We spent the first three days together visiting Death Valley, and Zion National Park, and such staggering scenery provided real perspective when I kept trying to answer my question. In a very real sense, being immersed in areas that are formed over millions and millions of years makes one realize that maybe our problems aren't as important to the big picture as they seem. This is not a new idea, but when I was climbing crevices with my two sons into areas hundreds of feet above the ground, probably higher than we should have gone, I didn't have any debt, no patients were complaining about my care, and I was able to enjoy some of those "life moments" where you remember where you were, what you heard, and what you felt for the rest of your life. While cliché, there is not a price tag that you can place on those moments.

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## *Smile Design* CONTINUED FROM PAGE 2

Using your temporary stent, make the patient's temporary. Once again, take pictures. Between the time you place the temporary and the time you place the final restorations, anything can happen. Quality photos will help you find any subtle changes that you may have otherwise missed (see Figures 5 and 6).

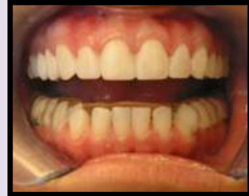
Figure 5

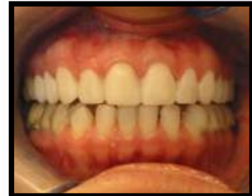
Figure 6

Before sending the patient on their way, mandate the use of hydrofloss until the veneers are on. Not being able to floss makes them more prone to inflammation and bleeding. During the final tacking process, blood can contaminate the bond and negatively affect its strength. Be sure to keep in contact with your patient and diligently note any issues or concerns prior to undergoing the final placement.

### *Final Delivery:*

When the time comes to deliver the final veneers, you'll want to be sure you've covered all your bases. Proper planning and execution of all your preliminary phases will ensure that you and your patient are both ready to move forward. At this point, there should be no unaddressed issues as everything should have been covered and tested with the temporaries.

After you section off the temporaries, vigorously clean the stumps with peroxide. Be sure to rinse and dry. I like to adapt the veneers one at a time and (using a mirror) get verbal approval from the patient. Keep in mind that this is, after all, a cosmetic procedure and the patient is your customer. Once they approve, it's time to move on to application.

Have your assistant apply Kerr Silane Primer to the internal surface of the etched veneers. Don't be afraid to utilize your assistant – that's why they're there. It never hurts to be efficient. Next, apply a rubber dam. You'll need a nice dry area to work in (see Figure 7).

Figure 7

Figure 8

Once the teeth are isolated, you can begin the etching process. I start from the back and do teeth in sets. The size of your set will vary depending on the number of veneers you're placing but in this particular case, I did sets of 4. Use phosphoric acid (35-38%) on enamel and dentin and hydrofluoric acid (9-10%) on porcelain if lab has not etched.

Have your assistant remove the etching gel with high-speed suction, then, rinse the teeth in the same order that you etched them. Again, use high-speed suction (be sure NOT to use regular air suction as it can result in desiccation). Apply Superseal desensitizer for 30 seconds on each tooth. Now it's time to apply some bond. I prefer OptiBond Solo Plus. Air syringe vigorously so that it doesn't settle too quickly and always, remove your dental light or the bond will cure and the veneer won't set properly. I like to dry seat the most posterior teeth because the rubber dam can force them forward and when you get to the end, you may find it pretty difficult to get the last veneers on.

When you're ready, begin the cementation process and start with 8 & 9. You will take tooth # 8 in your hand as your assistant

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## *Keeping It Positive* CONTINUED FROM PAGE 1

I certainly hope that the journal I refer to above will allow an actual scientifically written paper to be published by them to allow their membership to review a different philosophy than was presented as a new standard for all of dentistry. That article, when written, will be a very positive science focused paper and not one that knocks other philosophies. This paper's references will be from varied sources from around the world as well as clinical examples. Whatever is published, the IACA Newsletter will also publish the unedited version with all references included so our members can review it too.

At the 2011 San Diego IACA meeting I am sure we will be discussing this still. We are on a mission to include even more new attendees and members at this meeting. We are going "home" to where our first meeting was held. The amazing growth of IACA will be evident to those of us who attended that first meeting.

I know, each year we say that the upcoming meeting is "the best yet" and "one you should not miss." But, both statements have been true...have they not? As Editor, I not only get to collect comments about the meetings, but I also get to read other reported comments. I would say the only complaints I have seen are that members want more and not less of what we are already doing. Frankly, if we all could afford it I think we would just spend a week hanging out at IACA meetings because of the camaraderie and great speakers. Traditionally, dentists tend to keep to themselves in their own offices and hardly speak to other "competing" dentists. However, at the IACA meetings dentists quickly learn that they are not in competition with each other. (Although, sometimes I think Brett Taylor in Sydney, Australia is after my patients!) Once this is realized, the dentists and team members really open up and discuss the whole gamut of dental issues. The IACA meetings set such an example of international accord that the whole world should study the IACA and follow our example.

If you have not already signed up for the San Diego meeting – sign up now! Sign up now so you can start making your plans for the experience. Sign up now so that if another meeting or event should be planned in your life, you can speak up and say "I'm already committed to going to San Diego for the best dental meeting on earth at the end of July. You need to schedule that at another time for me to attend." Sign up now so your team can also schedule their life schedules and so you can plan together on how it will all work for you and your team. Sign up now so that when the schedule comes out, you and your team can have a real enthusiasm boost in planning who will attend what courses at IACA San Diego. Sign up now so you and your friends can plan together on what to do and when you can get together.

Sign up now for IACA San Diego because... (You fill in the blank for YOU!)

## LIFE TO THE FULLEST CONTINUED FROM PAGE 3

After those three days, I was then fortunate enough to instruct Core II and V for the remainder of the week. It never gets old to see so many patients' lives transformed at one time. It is also a constant reminder of the power we have in our profession to affect those around us. I am going to assume that all of the dentists reading this article have completed at least one life changing case. If we did nothing else for the rest of our careers, could we not look back on just that one moment, and feel proud that we had made a significant contribution to humanity? As an instructor at LVI, I am entrusted with the tremendous responsibility of nurturing and guiding the enthusiasm of those dentists who have invested so heavily in themselves in the pursuit of continuing to provide that life-changing care. We don't reach everyone, however, for those that we do, we are not only helping to create passionate, life-long learners, but professionals with the ability to literally change the culture of their communities. What if we really took that to heart, and tried to not only change the lives of our patients, but actually changed the life of even one colleague?

So how is this able to help someone going through tough times? I hope the answer is about trying to gain clarity by giving ourselves permission to occasionally get some distance. It doesn't have to be an extravagant vacation or another course at LVI, (although those aren't bad options!), but we need to periodically step back and view ourselves from a different vantage point. It is far too easy to keep one 's self completely intertwined in the web of team issues, financial issues, and other "stuff. " I realized last week that having passion for my profession through my association with LVI has allowed me to become more passionate about other things such as my appreciation for nature, and being able to share that with my family. I look forward to many future explorations close to home and abroad to continue to share with my family all that life has to offer – and again, allow for the appreciation of what a privilege it is to be a dentist, and trying to live life to its fullest.

These are sentiments that I believe I share with the entire Board of the IACA. We are passionate about dentistry and life in general and want to share our experiences with others. We also believe that anyone who has been to an IACA meeting understands how those emotions are drawn out of us when listening to inspirational speakers and sharing stories with our colleagues from across North America and the world! For at least three days in San Diego, we have the opportunity to step back and gain perspective from a supportive and understanding gathering of dental professionals and their families. ***But that is not enough!*** One of the strongest character traits amongst our members is leadership. What I would ask is that all current members exhibit their own piece of leadership within the IACA in order to expose and invite someone they know to San Diego, and allow them to stand back from their own lives and recognize how much is available to them in dentistry and beyond! Try to find someone who is struggling, and maybe even cover their registration fee as a way to pay if forward. Give them the opportunity to observe our passion, and our knowledge, and change their lives the same way we can for our patients. We are already changing the lives of our patients daily – now, let's change the lives of our colleagues as well!

Cheers!

fills it with cement, then the same thing with tooth # 9. Keep Q-Tips handy to blot any excess cement. Seat the veneers with your thumb and index finger to help reduce the risk of micro-leakage. With your free hand, place the tip of the curing light against the veneer with incisal pressure – halfway on the veneer and halfway on the gum. This will ensure proper fitting. On the dentist's cue, the assistant will cure the veneer for 3 seconds. Only do the tops of the veneers for now, curing the sides may interfere with the placement of the rest of the veneers.

In this particular case, I tacked my veneers in this order: 8 & 9, then 7 & 10. They were followed by 6, 5, 4 and finally 11, 12, 13.

Once all the veneers are in place and cured along the gum line, go back and clean excess cement with a rubber tipped instrument. Then, re-cure the Buccal, Lingual and Occlusal of each veneer before removing the rubber dam. Once the dam is out, be sure to remove any excess cement. When the veneers and cleanliness of the patient's mouth are satisfactory, take X-rays.

Before sending the patient home, explain the importance of proper care and cleaning. I suggest that they use knotted floss and catch any excess cement that may be left over. Take pictures of the final product, just to keep on record (see Figure 8 and 9).

Schedule a post-op appointment for a week later.

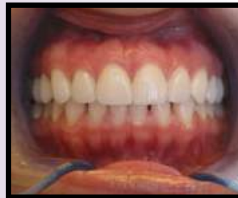
Figure 8

Figure 9

### *Building Your Business:*

When you get right down to it, dentistry is a business. As a dentist, you are also a businessperson. Love it or hate it, that's the nature of our profession. Cosmetic work is where the bigger money is and a solid reputation as a good cosmetic dentist will ensure a healthy and sustained income for your practice. Beauty is a booming industry and patients (customers) appreciate good work and are willing to pay appropriately. In my own career, I've come across a few basic principles to keep in mind to help grow your business and expand your client base.

Do good work. This goes without saying but holds particularly true when it comes to cosmetic dentistry. Word of mouth and patient referrals are the best way to gain new patients. A happy patient is typically willing to spread the word. If your work turns out exceptionally well, then ask your patient to vouch for it. Have a professional photo taken of your patient and post it on your website along with before and after photos. Have an impressive website that promotes your practice. Visuals, testimonials and smart SEO will help a lost future patient find you.

Dentistry can be a scary field (for you and your patients) but it doesn't need to be. LVI, for instance, can supply any dentist with the training and techniques necessary to provide your patients with the best and most informed dental procedures available. In the end, it's about being the best dentist you can be through providing the best care and patients do notice.

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