IACA
The International Association of Comprehensive Aesthetics
HOLLYWOOD, FLORIDA 2012
The Aesthetic Occlusion Connection

NEWSLETTER
Volume VI, Issue II

IACA

2012 IACA Newsletter
Presented By:

Randy's Raves

WOW, what a day! October 29, 2011, a date that will be remembered in IACA history. It started out as an annual board meeting and turned into an entirely new direction for the IACA and its members! It turned from a two page boring agenda, to a hundred pages of a brand new vision for what can be done for you doctors by your organization – the IACA – the most energetic, upbeat, informative organization in dentistry.

Let me just say that you will be delighted with the results. We will have new scientific programs, research, a credentialing process for fellowship, mastership, and diplomat, an annual meeting schedule that you will find most appealing for family and social time, a life enrichment program, an increased cosmetic spectrum of case presentations, and more neuromuscular education. We have decided, as an organization, to implement the suggestions from all of you to make your organization more appealing, and much stronger in the credibility arena of non -associated dentists. Given time, everyone will want to be a member and join us on the progressive front of dentistry. Look for our weekly newsletter that begins our only membership drive! We know with the changes we've made that you will want all your friends to join! Take time to read each weekly article to find out, in detail, the changes we've made and why everyone should be involved in this organization.

Randy Jones, DMD, LVIM President IACA 2012

2012 Board Of Directors

Dr. Randy Jones
Dr. Prabu Raman
Dr. Dan Jenkins
Dr. Anne-Maree Cole
Dr. Mark Duncan
Dr. Drew Markham
Dr. S. David Buck
Dr. Joe Barton
Dr. Dianne Benedictson
Dr. Jim Harding
Dr. Chong Lee
Dr. Manisha Patel
Dr. Sholina Kherani

OH TWO?
Ask Dr. Allman

Questions on Dental Sleep Medicine answered by Dr. J. Brian Allman, DDS, DABDSM, DAAPM,

Q
I have a sleep patient who I have been treating for about 20 weeks and usig a Smonomed. Initial PSg has AHI of 21 with a 39 REM AHI. Consists of 28 obstructive and 52 Hypopneas. Mean SpO2 is 88 with Nadir of 79. 87.1 % in 80-89% SpO2 range. Arousal Index of 23.5. He does reach each stage of sleep although not to the ideal percentages.

This week we did a Level 3 take home test to check his progress: After having it scored: AHI was 33 but only 1.3 obstructive apneas and 30 hypopneas on average. Stayed in the 90-100 % SpO2 range for 95.6%. Cardiac was WNL on both studies.

Although the AHI seems to be higher in the follow up, the number of apneas decreased significantly yet there were significant hypopneas. Also, he did maintain above a 90% SpO2 level throughout the night with a mean of 92%. He states he is feeling unbelievable evey day and is dreaming like crazy. He wore his CPAP routinely before the appliance and states he feels much better than with the CPAP. Diving into these numbers show some interesting facts. Do you feel this is somewhat representative that the patient's values increased - but is doing much better? I do understand the Level 3 study does not compare to the in-lab study but what are any of your thoughts?

A
This is a great scenario which will force you to look a little deeper into the data that you have collected. Evaluate the length of the hypopneas now. I am curious as you list the number of apneas- and hypopneas with MAD as 1.3 and 30 which is an improvement over the prior apneas and hypopneas of 28 and 52, respectfully. You should determine what that means. Also, your O2 sats. are better suggesting your treatment is helping him. Lastly, remember , just as with the case I presented on the Online Sleep Academy , consider the PSG AHI NREM and REM as an average which is what your Level 3 instrumentation provides. The big difference is the fact that we can't stage the percentage in each sleep stage with a Level 3 instrument. When you start to really evaluate what is being measured, as with K-7 EMG instrumentation, you start to dissect the true meaning of the numerics.

Brian

Abstract Alley

Sahag Mahseredjian, DMD

Interrelationships between dental occlusion and plantar arch.

Cuccia AM, J Bodyw Mov Ther. 2011 Apr;15(2):242-50. Epub 2010 Dec 9

The aim of this study was to evaluate the influence of different jaw relationships on the plantar arch during gait.168 subjects, participating in this study, were distributed into two groups: a control (32 males and 52 females, ranging from 18 to 36 years of age) and a Temporomandibular joint disorders group (28 males and 56 females, ranging from 19 to 42 years of age). Five baropodometric variables were evaluated using a baropodometric platform: the mean load pressure on the plantar surface, the total surface of feet, forefoot vs rearfoot loading, forefoot vs rearfoot surface, and the percentage of body weight on each limb. The tests were performed in three dental occlusion conditions: mandibular rest position (REST); voluntary teeth clenching (VTC); and cotton rolls placed between the upper and the lower dental arches without clenching (CR). The variables were analyzed through repeated measures ANOVA. The Mann-Whitney test was used to compare the postural parameters of the two groups.

As to the intra-group analysis of the TMD group, all posturographic parameters in both lower limbs showed a significant difference between REST vs CR and between VTC vs CR - except for the percentage of body weight on each limb. The control group showed a significant difference between REST vs VTC, REST vs CR and VTC vs CR in the mean load pressure on the plantar arch, forefoot surface, rearfoot surface and total surface of feet. The mean load pressure on the plantar arch in VTC, and the forefoot and total surfaces of feet in CR were significantly higher in the TMD group in both limbs. The results of this study indicate that there are differences in the plantar arch between the TMD group and control group and that, in each group, the condition of voluntary tooth clenching determines a load reduction and an increase in surface on both feet, while the inverse situation occurs with cotton rolls. The results also suggest that a change in the load distribution between forefoot and backfoot when cotton rolls were placed between the dental arches can be considered as a possible indicator of a pathological condition of the stomatognathic system (SS) which could influence posture.

CONTINUED ON PAGE 4

EDITORIAL

Dan Jenkins, DDS, LVIF, FACD, FICD, CDE-AADE

Certified Dental Editor - American Association of Dental Editors

NMD…Future of Dentistry?

For the last year the IACA members have been involved in an important part of neuromuscular dentistry history. Twenty-five years ago the battle against NMD opponents had to be fought by a small group of dentists and the Myotronics company. There are a few veterans of that battle still around and I must say it has been such an honor for me to actually meet and listen to their stories.
This year, the battle was fought by over 300 IACA members who bravely stuck their names and their necks out to voice their opposition to the same recurrent philosophy. I would bet that all the letters that were sent are still on file and our names are on a "list!" I found it interesting that a reference to the IACA by an ADA official was that we are "a small but well organized and vocal group!" Imagine what they would say if our IACA numbers equaled the number of dentists who are neuromuscularly trained?

Today, I checked over the California House of Delegates materials and found no reference at all to any TMD guidelines that were proposed to be a resolution for this session. Again, the IACA members were successful in appealing to reason with logic and science. Other dentists found out that they have a lot in common in philosophy with the neuromuscular dentists.

I could hope that this would be the last of the affronts to NMD. I could hope that the IACA will be the leader in keeping contacts with larger dental organizations who might have misguided zealot members who wish to abuse their positions of power or influence over other dentists.

Of course, a major mark in NMD history was the TMD Panel "discussion" at the annual ADA meeting in Las Vegas. I had goose bumps the whole meeting while I sat up there taking pictures. I was so happy for Norm Thomas to experience the day he probably thought would never come – NMD presented at ADA! I was so proud of our IACA immediate past-president Prabu Raman to present his clinical cases – in seven minutes! I have asked Mark Duncan to write his synopsis on the panel below.

The truth is that while this was an historic event in neuromuscular dentistry history it really is historic for all of dentistry! Many treatment philosophies have taken years to be tolerated and then finally accepted in dentistry. Even the concept of prevention of gum disease took over forty years to be accepted before the end of the nineteenth century!

One of the basic tenants of the IACA is being open to learning. Another tenant is the use of science in determining treatment. At times with the "art" of dentistry these may seem at odds with each other. If a new treatment philosophy comes up will we maintain an open mind…or will we fight it like NMD has been fought for the last forty-plus years?

If a new device, the "XMP-40" comes along that is not a neuromuscular low frequency tens based device but succeeds in aligning the craniomandibular system properly in ten minutes and randomly controlled trials demonstrate its sensitivity and specificity…how quickly will IACA members accept it? Would we accept it more rapidly if the ADA council on scientific affairs is a proponent of it or would we tend to reject it?

One of the new goals of the IACA board is to develop scientific research and study within the IACA. If we are to be ready for the future with an "XMP-40" we must be up on the concepts and parameters of scientific research – or we may be like the same rejecters of current NMD science!

2011 ADA Annual Meeting Occlusion Panel Debate

..Observations from the floor.

By Mark Duncan, DDS

It is remarkable what a group of driven and dedicated people can accomplish and there are examples of remarkable achievement all over the world. The Great Wall of China… Pyramids are all over the planet… the city of St Petersburg… and the skylines of almost any major city. Driven by passion some of the most amazing things have been accomplished and have endured time for the rest of us to enjoy. For dentists, a couple of more personally touching examples are LVI and the Neuromuscular Dentistry. In spite of overwhelming opposition, for 40 years the NM battle has been fought and the right to provide physiologically based dentistry has been granted for generations to follow. For years this war was battled out behind the scenes of the politics and out of the reach of the average dentist; and were it not for LVI, that flame may well have burned out.

Because of the tenacity of Dr. Bill Dickerson and what he has created with LVI, there are thousands of dentists providing millions of people with the benefits of proper muscle physiology. However, undaunted by the success found by thousands of dentists, there are self-appointed guardians of ancient and ignorant occlusal religions or philosophies who are determined to squash any advances in thinking. It seems the logic behind this unabashed denial of the science and success of thousands of practicing dentists is something along the lines of "I can't believe it so it can't be." These "scientists" are using studies that are decades old to support the idea that NM evaluation and dentistry is wrong. But, the tides are changing!

In the most recent ADA meeting, there was a panel of dentists who were put on stage to debate this very issue. This sprung out of the dedication and tireless work of a couple leaders in dentistry who witnessed the aggressive bullying tactics of people who refuse to fairly evaluate the science in the literature. Dr. Charles Greene wrote an opinion piece and passed it off in JADA under the guise of a standard and tried to say that TMD is self-limiting. The response by the LVI alumni and IACA Board and membership was overwhelming!! The response to that single article flooded the editors at JADA with more feedback than they have seen in an entire year regarding everything they have published! And to help to find the truth, they boldly constructed a panel of experts in occlusion. But, human nature is a very funny thing indeed!

In the audience of a debate on the most critical fundamental aspect of dental care, the room was only moderately filled. Most of the people in the audience seemed to be ready to defend their idea of what was right while the people on the stage each reported their thinking and perspective. The panel itself was an interesting mix of positions. With people with zero experience to those with decades of science and practical understanding of the science and success that so many find with NM dentistry. The interesting thing is the approach of the ones who have no formal training or experience in NM dentistry. On one hand there were doctors like Henry Gremillion and Gary Klasser who not only teach the joint based decision models are correct to the exclusion of any other approach, they have also historically been aggressively anti-Neuromuscular. On the other hand there was a representative from the insurance industry and an Oral Surgeon who both took the stance that they cannot comment as an expert relative to a subject they are not expert in! Very refreshing indeed to see the likes of Dr. Jim Swift who teaches Oral Surgery at University of Minnesota essentially say that he is impressed with and hopes to find some answers in Neuromuscular Dentistry.

Another interesting and very encouraging observation was that the dentists on the floor who were asking questions of the panel fell into three categories. There were a few dentists who appeared to be looking to put a nail in the coffin of NM; who asked questions designed to trap the NM dentist by some 30+ year old study that claimed that they cannot have success. These were amazingly well handled by the NM representatives on the panel, Drs. Norm Thomas and Prabu Raman, citing both literature and a well-documented practical clinical history of success. While that portion of the audience was disheartening, it was very nice to hear the tact and class with which the NM dentists on the floor who asked fair and open questions of the panel. From dentists like Drs. Chris Chui and Terry Yackovich and Ed Suh, the questions were guided at increasing understanding and knowledge. And as encouraging were those dentists who fell into the third class; although a small group, they were interested in additional knowledge.

In all, it was an interesting debate more for the political reasons underneath the debate than for the actual content of the debate. Dr. Thomas, as is typical, delivered discussion of the profound scientific foundation for NM dentistry. Dr. Raman, as is typical, delivered a shining example of what a well-trained practicing dentist can do. Unfortunately, as is also typical, it was obvious that Dr. Gary Klasser, a detractor of NM dentistry was actively disengaged in the discussion. I eagerly await a day where the science behind NM dentistry is critically reviewed by the profession as that is the day that will allow the masses to appreciate what we have come to know as the amazing power we hold in dentistry!

Practice Swings HELPFUL TIPS FROM PRACTICE CONSULTANTS

One of the most important things you can do for yourself is to have a momentary goal. You should have an annual goal. A Monthly goal. A daily goal and MOST IMPORTANTLY- an HOURLY goal.
Ashley Johnson, JD; Ashleys Coaching

"The less you are aware, the more Normal your patient appears." Having your hygienist aware of risk assessing to a level of molecular and DNA testing takes your Perio Practice to the next level. Your patient may appear to be bleeding "just a little bit" but in reality they may be infected with Tannerella and she is just watching it or excusing it or letting them go home and "brush more - floss more."
Jill Taylor, RDH, BS, LVI Hygiene consultant

"Work Smart, not hard. It is not about how many patients you see in a day. It is about the procedures you perform for those few that you do see."
Sherry Blair, LVI Director of Team Programs

Here's something interesting to consider: Jeff Bezos, the 5th most powerful CEO in the world and his executive team at Amazon spend 4 hours every Tuesday reviewing their strategy (not budgets or operations, just strategy). How about your leadership team? Take the time for your practice strategy. Considering studies show that 70% of poor business performance is a result of poor strategy, while only 4% is as a result of economic conditions, it makes good sense to spend some quality time setting your strategic plan. You and your team will enjoy how energizing the process is since you are focused on the positive. My clients report "it gives the bottom line a serious boost. "
Ginny Hegarty, SPHR
Dental Practice Development, Inc.

The International Association of Comprehensive Aesthetics
1401 Hillshire Drive, Suite 200, Las Vegas, NV 89134
866.NOW.IACA or www.theIACA.com

Abstract Alley - CONTINUED FROM PAGE 2

The researchers concluded: "Therefore the use of posture monitoring systems during the treatment of stomatognathic system is justified."

Tinnitus with Temporomandibular Joint Disorders: A Specific Entity of Tinnitus Patients? Vielsmeier V, Kleinjung T, Strutz J, Bürgers R, Kreuzer PM, Langguth B.,Otolaryngol Head Neck Surg. 2011 Jun 25.

Tinnitus is frequently associated with temporomandibular joint (TMJ) dysfunction. However, the nature of the relationship is not fully understood. Here the authors compared 30 patients with a confirmed diagnosis of temporomandibular joint dysfunction and tinnitus to a group of 61 patients with tinnitus but without any subjective complaints of TMJ dysfunction with respect to clinical and demographic characteristics. Study Design. Case-control study. Setting. Tertiary referral center. Subjects. Tinnitus patients with and without TMJ dysfunction presenting at the Department of Prosthetic Dentistry and the Tinnitus Clinic at the University of Regensburg. Results. Tinnitus patients with TMJ disorder had better hearing function lower age, and lower age at tinnitus onset and were more frequently female.Their subjectively perceived tinnitus loudness was lower and more of them could modulate their tinnitus by jaw or neck movements. These researchers concluded: "Classical risk factors for tinnitus (age, male gender, hearing loss) are less relevant in tinnitus patients with TMJ disorder, suggesting a causal role of TMJ pathology in the generation and maintenance of tinnitus. Based on this finding, treatment of TMJ disorder may represent a causally oriented treatment strategy for tinnitus."

FUTURE IACA MEETINGS

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

2013 Annual Conference
Telus Convention Centre
July 22 - 24
Calgary, Alberta