IACA
The International Association of Comprehensive Aesthetics
Hollywood, Florida 2012
The Aesthetic Occlusion Connection

NEWSLETTER
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IACA

2011 IACA Newsletter
Presented By:

PRABU'S POINTS

LOOKING BACK AT THE 2011 IACA

As I look back at the IACA 2011 in San Diego with the benefit of a few weeks' time, I am flooded with a wide spectrum of emotions and thoughts.

I am proud of the IACA board and team for the quality of the 2011 conference. We heard from so many members and exhibitors that this was, by far, the best conference they have ever attended. The physicians that participated in the sleep apnea panel expressed the same sentiments. They were blown away by the positive high energy level and quality of presentations. The fact that this panel was the first of its kind in dentistry and medicine was not lost on them.

I am grateful to Dr. Bill Dickerson who gave us the inspiration and support to start the IACA seven years ago in San Diego. I am grateful for the support of the members as well as partners and exhibitors without which the IACA would not exist. I am grateful for the tireless IACA team members who made it possible for the IACA board to take the bow.

I am impressed that the IACA grew in this new economy while all other conferences shrank. It is particularly impressive that 81% of 2011 attendees who had previously attended another IACA had registered for the IACA 2012 in Hollywood, Florida.

I am optimistic about the future of the IACA under the leadership of Dr. Randy Jones as President and Dr. Dan Jenkins as President Elect in the coming year. I am also filled with optimism that due to the outrage expressed by the IACA members to ADA after Dr. Greene's misguided article, the IACA has become "Neuromuscular dentistry's voice to ADA". I will have the honor of representing the IACA at the science forum on TMD during the annual meeting of ADA. I am very hopeful this will be a new beginning for NMD in its dealings with ADA.

I am also sad that there were not more dentists in attendance. Considering the thousands of dentists trained in NMD and the hard work the IACA has done to protect their freedom to practice NMD, we should have seen ten times the number attending the IACA conferences. Considering the leading edge nature of the IACA in all of dentistry, we should have seen 100 times the number of new members joining the IACA. I am sad that every doctor who has ever personally experienced an IACA conference has not made it a priority to schedule the IACA first on their calendars every year and plan everything else around it.

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RANDY'S RAVES

LOOKING AHEAD AT THE 2012 IACA

Florida? In July? HOT? You've got to be kidding! No we are not kidding, and yes, it's going to be hot! Hot on the new topics everyone wants to learn about. Hot on the trail of success. A hot facility. Hot speakers. And hot on excitement.

We will have speakers talk about: Gossip and conflict resolution, botox and dermal fillers, how to turn your practice around in a down economy, brainstorming with your team, increasing your office exposure, epic lessons in how to talk to your patients, and about twenty-five more to choose from.

For all of you who are signed up for the IACA 2012 in Hollywood, Florida, you are not going to be disappointed. We will be at the Westin Diplomat Hotel. Every year each meeting has gotten better and better. We continue to grow and increase our position as a dental organization. But I will say this: "Numbers speak volumes. Everyone outside of our organization will become more and more aware of us as we become larger in our enrollment. Numbers carry weight in our dental organizations". So spread the word. Invite a colleague. Our mission now is to grow in a structured, organized way to make ourselves an industry standard of excellence.

Hollywood, Florida: Stroll down the quaint, brick lined sidewalks and shop at trendy boutiques, art galleries, and specialty shops, as well as dine in gourmet bakeries. The Art & Culture Center of Hollywood is simply a great place to stop in for a change of pace and a new perspective. And for the spouses: An outdoor swimming pool is open for guests of the hotel. Guests can also enjoy the following spa/wellness facilities: sauna, on site spa services, full-service health spa. Body and facial treatments are offered on request. A rejuvenating massage can be really enjoyable after a long day of sightseeing or business meetings.

Hope to see you and a friend there – NO EXCUSES!

Randy Jones, DDS, LVIM
IACA President

Practice Swings HELPFUL TIPS FROM PRACTICE CONSULTANTS

Start rating your patients. I teach the A-B-F categories. Rating them will help you in several ways. It will let you see what kind of patient base you have vs. what you think you have and it will help you learn which patients value what you have to offer.

Remember - there is nothing more frustrating than presenting the "right dentistry" to the "wrong patients."

Ashley Johnson, III, JD

A picture is worth a thousand words! Are you and your team picking up your camera 100% of the time when you are educating your patients or are you telling me I "need" something without showing me?

Sherry Blair

Lasers used regularly in your hygiene program not only reduce plaque build-up, but they set your office apart from other "regular" dental offices

Jill Taylor, RDH

Abstract Alley

Sahag Mahseredjian, DMD

Role of Sensory Stimulation in Amelioration of Obstructive Sleep Apnea

Mak Adam Daulatzai, Sleep Disorders, Volume 2011 (2011), Article ID 596879, 12 pages doi:10.1155/2011/596879, http://www.hindawi.com/journals/sd/2011/596879/

Obstructive sleep apnea (OSA), characterized by recurrent upper airway (UA) collapse during sleep, is associated with significant morbidity and disorders. Polysomnogram is employed in the evaluation of OSA and apnea-hypopnea number per hour reflects severity. For normal breathing, it is essential that the collapsible UA is patent. However, obstruction of the UA is quite common in adults and infants. Normally, important reflex mechanisms defend against the UA collapse. The muscle activity of UA dilators, including the genioglossus, tensor palatini (TP), and pharyngeal constrictors, is due to the integrated mechanism of afferent sensory input to motor function. Snoring is harsh breathing to prevent UA obstruction. Unfortunately, snoring vibrations, pharyngeal suction collapse, negative pressure, and hypoxia cause pathological perturbations including dysfunctional UA afferent sensory activity. The current paper posits that peripheral sensory stimulation paradigm, which has been shown to be efficacious in improving several neurological conditions, could be an important therapeutic strategy in OSA also.

The pharyngeal upper airway afferent inputs, mediated by the trigeminal (V), facial (V11), glossopharyngeal (IX), and vagus (X) cranial nerves, terminate in the nucleus of the Solitary Tract (NTS) and the trigeminal nucleus [120]. The nucleus solitary tract (NTS) is an obligatory relay for gustatory and several other sensory afferent inputs [121, 122]. It is the first CNS site for synaptic contact of the primary afferent fibers from the lungs as well. The afferent nerve fibers via above-mentioned cranial nerves project from the pharynx and tongue to the NTS, and synapse with second order sensory neurons in this nucleus. Thus the NTS neurons receive inputs from several receptor types from tongue and other oro-pharyngo-laryngeal regions [121, 122]. Fibers from the NTS ascend to the thalamus and then project to the insula (gustatory cortex) and the amygdala, which in turn have reciprocal projections to the NTS; thus responses to gustatory stimulation can be recorded from both NTS and the insular cortex [123]. Furthermore, there are direct projections from the principal trigeminal sensory nucleus [124–127], and from NTS [128], to the hypoglossal nucleus. Thus the signal processing at the NTS determines several reflex outcomes.

OSA is characterized by sensory receptor dysfunction, which adversely impacts several brainstem nuclei including trigeminal, NTS, and hypoglossal. Conceivably, all receptors may not become dysfunctional in all components of the UA, and the OSA patients do possess functional sensory-

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EDITORIAL

Dan Jenkins, DDS, LVIF, FACD, FICD, CDE-AADE
Certified Dental Editor - American Association of Dental Editors

Why Bother?

Dr. Smith was busy seeing patients when his loyal office manager interrupted him and in a very disturbed voice whispered a message into his ear. "Dr. Smith…there are some police and state board officials at the front and they want you to come up front and talk to them NOW!" That caused Dr. Smith's eyes to widen like a harvest Moon and his knees to knock like a diesel engine that needed its injectors cleaned.

He swallowed hard and tried to catch his composure as he seemed to float up to his own front desk. There he saw a man in a suit staring him down and a uniformed policeman doing the same – no smiling going on here.

The suit said, "Dr. Smith?" "Yes…how may I help you," Dr. Smith answered. "Dr. Smith do you use a piece of equipment like the one on this paper?" Dr. Smith looked at the paper and saw a picture of a device he had been using for some time that he felt was helping his patients overcome pain and suffering. He was quite proud of his advanced care of his patients and of the success he had. He didn't mind the harassment from his peers in his community and figured they were just jealous of his success.

"WELL Dr. Smith…do you use this equipment in this office? Do you have it here now?" The suit was becoming quite insistent and nasty in the tone of his voice. Dr. Smith handed the paper back to the suit who was from the state board and said, "Yes…I do use this device … and my patients are quite pleased with it." The state board suit said, "Are you not aware that this equipment has been banned and you are in violation of State Code section 12345 as well as 67890? I demand you turn over your equipment right now. Here are my papers giving me the authority to take possession of it and have it destroyed."

Dr. Smith could not believe this could happen…but, it did. This is a true story of what happened in the 1930's to many medical doctors who were using Ozone therapy to treat their patients for various maladies. The doctors who were using it were not a strong group. They enjoyed practicing independently and did not pay much attention to what was going on in the inner circles of the politics of the AMA. But, the editor of the Journal of the American Medical Association had a vengeance to eradicate the Ozone machines and had managed to have them labeled as dangerous and many were confiscated directly from medical offices.

One big reason membership in the IACA is important is to maintain each dentist's right to practice TMJ Dysfunction and other dental treatments in a way each dentist sees fit to do. This last year occlusion based TMJ philosophy dentists have come under attack by the AADR through the Journal for the American Dental Association – by one of its editors, Charles S. Greene, DDS. Hard to believe this is so similar to the story above, huh? The AADR is an academic group that only has a membership of a few hundred. There are over twenty thousand occlusion based TMJ dentists. How is it that such a few members of the AADR can affect so many other dentists of a different philosophy?

The association of the AADR group within the ADA over a long period of time has allowed many of them to have influence to allow them to publish their papers in JADA. I'm sure when many of the AADR members were first appointed to committees they did not seem to be so radical. However, over a period of time they could be more open in their opinions – especially as more joined. Eventually, they were able to manipulate an entire committee. When I was in the Navy I received some training in which it was pointed out that this is the same

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OH TWO?
Ask Dr. Allman

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

Q: What is the most comfortable MAD device to use in conjunction with a CPAP mask? I have found the wings of a Somnodent to press inside the cheeks when a mask is also used.

Is it best to try to switch to nasal pillows, or is there an oral appliance that works best in conjunction with a CPAP mask?

A: The mask the MD recommends is important. We find that the nasal mask (not pillows) works very well. Also, you can reduce the fins and/or use an adjustable Herbst which doesn't put pressure on the drape of the lip.

Q: I have a patient with an AHI of .5, but an RDI of 15.8. Do any of you know if this is a problem for medical insurance companies? I have a letter of medical necessity from the MD for an Oral Appliance, but is it considered OSA when the AHI is under 5, but the RDI is over 15?

A: Yes, UARS is in the continuum of sleep-disordered breathing pathology. The discrepancy between the AHI and the RDI suggests that hypopneas are more of an issue than apneas. Unfortunately, both have the same effect- fragmented sleep, EDS, SNS overload, cardiovascular sequelae, hormonal dysregulation and epithelial dysfunction. As long as you hold an appropriate prescription for OAT you are in the driver's seat.

Keep on learning!
Brian

Education in the Dental Arena

By: Dr. Terence Yacovitch, Montréal, Quebec

Practices without effective team and patient education combined with outstanding internal communication suffer from lost profits, poor productivity and poor employee morale.

The whole team knows it, feels it, when a smooth, productive day has ended.

The atmosphere in any clinic is founded upon the relationships and emotions shared between the Team, the Doctors and their Patients. Great energy comes with the confidence displayed between all as the "job gets done!" All players knowing exactly what is expected of them, all working in harmony and backing each other up as true professional teams do!

In order to solve many business problems, employees need to be able to collaborate and communicate effectively based upon consistent common knowledge.

Good communication skills encourage employees to work more effectively, solve problems together and work efficiently towards a common goal: outstanding patient care.

Proper education of the TOTAL team about all services available gets both the Team and the Doctors conversing with the same message.

Team perceptions and why those perceptions may vary should be

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Why Bother? - *CONTINUED FROM PAGE 2*

technique that some "anti-USA" groups use to take over what was a "pro-USA" organization. If the members of the pro-USA group did not care to participate and guard their own philosophy then the next thing they knew – they really did not want to be a member any longer.

Apathy can develop in many ways and it hurts any cause worse than if someone is opposed to an organization. At least if someone is opposed it can cause a dialogue to develop. With apathy…people do not want to even bother to discuss the issue. They may see a problem and just say, "Why bother?"

Thankfully, the members of the IACA have demonstrated they are not an apathetic group by the 320 letters that they sent to the JADA Editor regarding Greene's article last September promoting AADR's "standard of care" for TMJ Dysfunction.

Now, the State of California is where the battle has come. The California Dental Association is promoting new TMD treatment guidelines for their Peer Review council to adhere by when they are reviewing complaints about a member's treatment of TMD. These guidelines are right in line with the Greene/AADR "standard of care." On top of that, these guidelines were put in surreptitiously after the committee decided they could not come to a consensus on a guideline. The next meeting these guidelines were there! (Some things just never change.)

While many CDA/IACA members are contacting their CDA representatives about this, it is important for ALL IACA members to keep these events in mind. It is also important for ALL dentists who have similar TMJ Dysfunction treatment philosophies as the IACA to join and become active members. There is indeed strength in numbers. There have been over nine thousand dentists that have been trained in the IACA philosophy of neuromuscular and cosmetic dentistry. If the membership of the IACA was even half of that you can see how that would appear compared to a little group of three hundred AADR members – who a LOT of people don't even like!

If the IACA annual meeting was attended by four thousand dentists and their team members the attendance would be over ten thousand! Think about that? There are many other dentists who should be members of the IACA but do not even know about us…or even how much FUN we have at our meetings.

I encourage our current members to seek out those who have already had training in neuromuscular and cosmetic dentistry as well as seeking other occlusion based TMJ Dysfunction dentists to consider joining us. With strength in numbers none of us would have to even consider we would someday be in Dr. Smith's shoes over his treatment "device." So…"Why Bother"… because we want to continue to practice what we feel is the best TMJ Dysfunction philosophy for our patients in pain.

By the way…that JAMA editor was promoting drug therapies as the "cure all" to be used – sound familiar?

Thanks to many IACA members contacting the CDA trustees the Peer Review Guideline was unanimously voted to be sent back to the committee. Unity still works! It IS worth the bother! Thank you especially to David Miller who was relentless with his contacts!

Abstract Alley - CONTINUED FROM PAGE 2

motor reflex and afferent discharges found in arousal and wakefulness. Consequently, a combination of diurnal sensory stimulation protocols encompassing olfactory, gustatory, and different types of somatosensory (e.g., tactile, temperature, and pressure) need to abe applied, in a unisensory (unimodal) and multisensory (multimodal) manner; conceivably this should strengthen and upregulate the diverse sensory receptors, enhance peripheral and central neuronal excitability/synaptic transmission, causing an increase in genioglossal function. Several studies described above show that the multisensory stimulation is more effective than just the unimodal.

The present paper seeks to highlight the importance of damage in peripheral sensory elements that cause dysfunction in the afferent portion of the "sensory motor" loop; the resulting dysfunctional motor efferent responses, may be an equally critical factor in the genesis of recurrent UA collapse—causing repeated hypoxic, hypoxemic, and hypercapnic events in OSA.

Surface electromyographic assessment of patients with long lasting temporomandibular joint disorder pain.

Tartaglia GM, Lodetti G, Paiva G, Felicio CM, Sforza C., J Electromyogr Kinesiol. 2011 Apr 2.

The normalized electromyographic characteristics of masticatory muscles in patients with temporomandibular joint disorders (TMD) and healthy controls were compared. Thirty TMD patients (15 men, 15 women, mean age 23years) with long lasting pain (more than 6months), and 20 control subjects matched for sex and age were examined. All patients had arthrogenous TMD according to the Research Diagnostic Criteria for TMD (RDC/TMD). Surface electromyography of masseter and temporal muscles was performed during maximum teeth clenching either on cotton rolls or in intercuspal position. Standardized EMG indices and the median power frequency were obtained, and compared between the two groups and sexes using ANOVAs. During clenching, the TMD patients had larger asymmetry in their temporalis muscles, larger temporalis activity relative to masseter, and reduced mean power frequencies than the control subjects ($p<0.05$, ANOVA). In both groups, the mean power frequencies of the temporalis muscles were larger than those of the masseter muscles ($p<0.001$). No sex related differences, and no sex group interactions were found. In conclusion, young adult patients with long lasting TMD have an increased and more asymmetric standardized activity of their temporalis anterior muscle, and reduced mean power frequencies, relative to healthy controls.

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Prabu's Points - CONTINUED FROM PAGE 1

I am happy that I got to see so many friends and colleagues that I have not seen for some time. After hours parties, dinners with friends, visits to various destinations in beautiful San Diego and the amazing closing events on the flight deck of aircraft carrier USS Midway constitute happy memories for my wife and me. We will always cherish these memories that bring a smile to our faces. For that, we thank you.

Prabu Raman, DDS, LVIM
IACA Past-President

Education in the Dental Arena - CONTINUED FROM PAGE 3

addressed for flawless patient communication by all parties involved.

The process could start and be refined with question and answer sessions at team meetings by reviewing the most common enquiries made with reception and non-clinical personnel.

Educating communication skills can be a challenge. Some individuals have great skills by nature. Others may need nurturing or coaching to find within themselves the words that they feel comfortable expressing.

Pre-scripted phrasing just does not work. We have all been exposed to telemarketers using such standard verbiage.

Compose for your team, four or five alternate dialogue phrasings for services available. Let them then put into their own words what you have shown to be "samples" or "examples." Ensure that you have patient information videos or "clips" focused on these specific treatment possibilities to enlighten team and patients about your services.

Appeal to the "scientific," to the "visual," to each of the various learning styles we know patients can present. Some enjoy all the details, some wish we would just "cut to the chase."

Educate your patients in multiple locations. In the waiting room, in the treatment rooms, with your treatment coordinator and with your hygienists. Use your web presence to continue, or start the learning process!

Share what works, discuss what was uncomfortable. Find common ground with what follows the practice philosophy best. Reduce stress for all involved in the decision process by using ALL your information capabilities. Your patients should fully and clearly understand their treatment choices. Support their decisions 100%, as long as they know full and well the consequences and details of their choices.

Please understand that each dental office is a living, working "laboratory" where learning is constant and evolution is inevitable.

The practice and art of dentistry do not only encompass clinical treatment, but interpersonal capabilities. Success only happens when the patient feels totally comfortable saying "Yes" to proposed treatments. Use multimedia formats to inform your patients about all the services you offer. Studies have shown 80% of people are visual learners, capture their attention. Do not forget the other 20%, feed them with written messaging also.

By developing better "listening" skills, Doctors become more responsive, present with the individual, showing their caring, and being intuitive to patient wants and needs. Patients SO appreciate the empathetic dentist.

Remember, today, so much is founded on relationships that are built on comfort and trust.

Until the pencil hits the paper again, keep focused on excellence in all parts of your life.