



Continuum

Aurum Ceramic / Classic - Keeping You on the Leading Edge of Dental Technology and Aesthetics

Volume 19, Issue 3 • September, 2006



**Who is
Dr. Lucy Hobbs
and Why is She
so Important?**

*The "Shady Side" of
the Prep Appointment*

**Accurately
Transferring the
Horizontal and
Sagittal Relationships
of the Maxillary Arch
to an Articulator**

Plus

**Articles on
Marketing,
Technology, Finance,
Leadership
and more!**

Dentistry courtesy of
Drs. Danielle D'Aoust and Daniel Gallagher.
Restorations fabricated by Aurum Ceramic.
Photography courtesy of Paul Ducharme.

Aurum Ceramic/Classic Achieves DAMAS Certification

Aurum Ceramic/Classic Dental Laboratories is pleased to announce it has achieved DAMAS and ISO9001:2000 certification for all of its laboratories across North America. Developed by the Dental Laboratories Association, DAMAS (Dental Appliance Manufacturers Audit Scheme) is a sophisticated quality management and production system for laboratories. Essentially an independent assessment carried out by an external Certification Body, DAMAS ensures consistent quality and high standards that satisfy Food & Drug Administration requirements for Good Manufacturing Processes. All DAMAS laboratories institute a quality policy, undertaking management reviews and internal audits to verify that the systems in place are working correctly. While assisting Aurum Ceramic/Classic in building quality assurance into every aspect of our day-to-day operations, the assessment checks that every member of our team complies with process checks throughout the manufacturing procedure.

With DAMAS, everyone benefits!

The laboratory has reliable quality procedures, improved controls and enhanced traceability . . . our dentist clients can be confident that Aurum Ceramic/Classic is adhering to all regulations relating to labwork and the production of dental appliances . . . and patients have the reassurance of excellent quality craftsmanship.

DAMAS – A Profile

- ISO9000 is a general standard for all industries.
- ISO13485 and ISO9001 are extended versions of ISO9000 specifically aimed at dental appliance manufacturing in a mass production environment.
- Both ISO9000 and ISO13485 are full-blown QA systems that were felt to be over prescriptive for the “custom made” dental laboratory.
- DAMAS Standard originally introduced in Britain as an alternative to ISO9000 and ISO13485.
- DAMAS introduced to North America in 2004 by the National Association of Dental Laboratories.
- DAMAS satisfies all FDA GMP requirements and offers more flexibility in a dental laboratory environment while achieving the same high quality and accountability end results as ISO9000 and ISO13485.



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Who is Dr. Lucy Hobbs and Why is She so Important?



Heidi Dickerson, DDS, LVIM

Dr. Lucy Hobbs was born on March 14, 1833 in Constable, New York. She taught school for ten years in Michigan before moving to Cincinnati in 1859. Lucy was intrigued by the advancements in medicine and applied to the Eclectic College of Medicine. Because she was a woman, Lucy was turned down for admission to the school. Unstoppable, determined, and driven...Lucy continued with private studies and under her mentor's suggestions, decided to look into dentistry as a profession. When she applied to dental school, she was denied admission... once again due to her gender. She apprenticed herself to a graduate of the Ohio College of Dental Surgery and opened her own practice at the age of 28 in Cincinnati, in the year 1861. Lucy moved her practice to Iowa where she lived from 1862-1865.

In July of 1865, the Iowa State Dental Society accepted her as a member and

Lucy Hobbs was the first woman in U.S. history to earn a doctorate in dentistry!

she was sent as a delegate to the American Dental Association convention in Chicago. This act alone showed that she was considered equal to her male colleagues. In the fall of 1865, she was admitted to the senior class of the Ohio College of Dental Surgery. In February 1866, after receiving credit for her years of private practice, she earned her degree. Lucy Hobbs was the first woman in U.S. history to earn a doctorate in dentistry! Moving to Lawrence Kansas in 1867, she continued her long and successful career in dentistry until her retirement from practice in 1886.

We've Come A Long Way, Baby... since the times of Dr. Lucy Hobbs!

Since the middle of the 1970's, women have attended dental schools and began dental practices in increasing numbers.

According to the ADA's Dental Workforce Model, the number of female dental graduates in 2003 was 1,755, which represented 39.5% of the graduating class. Currently women make up 14% of the general dentists in the United States. And, the forecast is that 29.2% of active private practitioners will be female by 2020.

However, many female dental students still face obstacles and the narrow mindedness of some of their male colleagues. When I entered dental school in 1990, our class was approximately 45% female. It was the first class to have such a high percentage of

women. I remember when we had our first Operative Lab...an older, male instructor walked up to me and said, "you should not be here...you should be at home having babies." He continued by saying that he "was not going to make it easy on me". Hard to believe? I was shocked as well. This incident proved to start a chain of unfair treatment that was later remedied by the Dean of the school. What did it show me? It showed me that women were not considered equal by some male colleagues. In many ways we had to prove ourselves more than the male students. Personally, it made me strive to prove in all aspects; from the classroom to the clinic that I was equal...I could hold my own. Fortunately, I find my colleagues now to be open minded and accepting of women in the field. Most male dentists have great respect for their female counterparts.

Is there a level playing field between female and male dentists today? Let's see what the statistics show. In a study done by del Aguila, Leggott, Robertson, Porterfield, and Felber, they found that there are no differences between male and female dentists in the number of procedures per patient, income per patient or income per day of work. Frequency distributions of various services were highly similar for both groups. Multiple regressions models showed no influence of gender on total income. One difference was in the mean and median of numbers of days worked. In females, these days were 10% lower than their male counterparts. This difference was consistent with the finding that female dentists treated approximately 10 % fewer patients, performed 10% fewer procedures, and had a combined income of about 10% less than that of male dentists. The conclusion to their study was that practice patterns of male and female dentists were equivalent in this population. Should the dental work force and practice patterns remain unchanged in years to follow,



Photo of Dr. Lucy Hobbs courtesy of Watkins Community Museum of History.



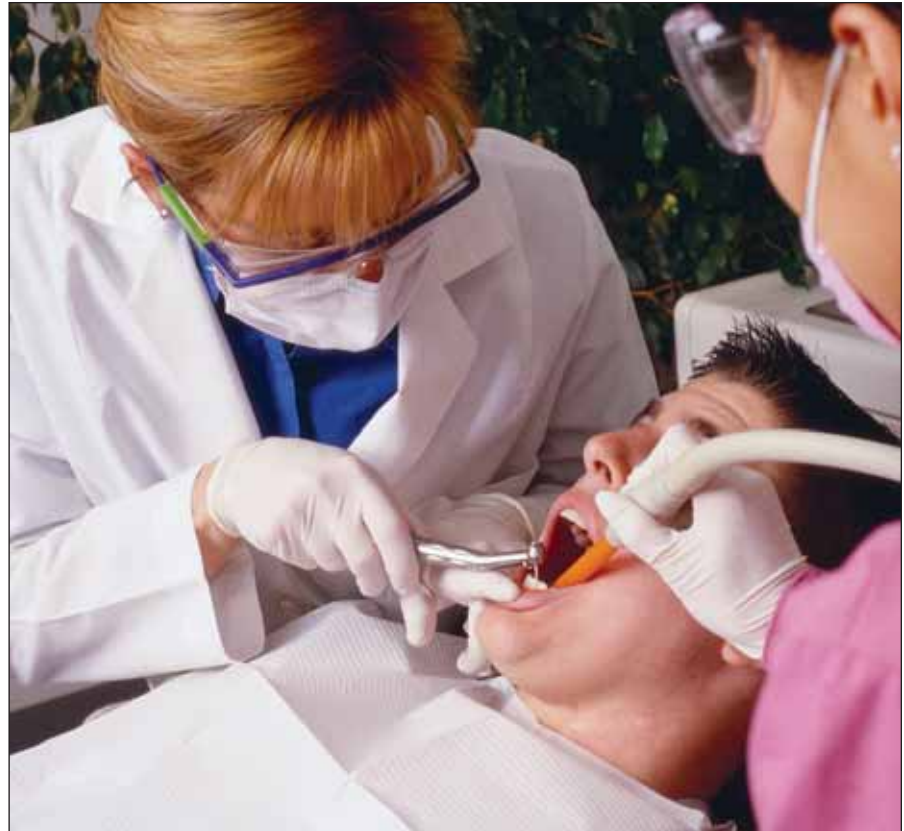
Pre-Running Water — Pre-Electricity Era of Dentistry.



Typical foot pedal engine of the late 1800s and early 1900s.

the total number of patients treated per dentist will decrease slightly as women make up more of the proportion of dentists.

We have just read that women walk toe to toe with men in our field. We work just as hard, are as productive, and make as much money in proportion to the time worked. Where does the difference lie? According to the Journal of Dental Education (Vol 66, No. 12), female dentists were more likely to refer to specialists than male dentists. Specifically, they were more likely to refer LARGE MULTI-UNIT FIXED



Modern dentistry.

Because of Dr. Hobbs we call ourselves “doctors”

CASES, crowns and bridges, single-root endodontics, and surgical extractions.

We have seen this to be the case at the Las Vegas Institute For Advanced Dental Studies. Our alumni base consists of approximately 15% women and rising. This statistic shows that of the 14% of women dentists out there, these dentists see the need for advanced training in aesthetics and occlusion. They also see the benefit of live-patient training. They are building their skills and confidence in order to handle the treatment planning and execution of these large cases themselves instead of referring the cases out. They are learning that “they can do it”...because they CAN!

So here is my message for all of the women dentists out there... Dr. Lucy Hobbs is one of the most important people we should know. Because of Dr. Hobbs we call ourselves “doctors”. Because of her, we have fulfilling jobs that are both win-win for our patients

and ourselves. Because of her, we are treated as equals in our field by most of our male colleagues. And because of her, we should continue on our journeys to be the best Female Dentists we can be. Don't be afraid of handling big cases or doing complex procedures. Our female graduates are handling these types of cases all the time.

What can you do if comprehensive dentistry interests you? One place you can learn this type of rewarding and gratifying type of practice is at the Advanced Functional Aesthetic course at LVI. That is what got me comfortable doing the type of dentistry that I now enjoy, even though I had been through many other educational programs, I was not confident with the execution of the difficult cases.

Feel empowered ...if I can do it...so can you...and for the sake of your patients...you should!

Dr. Heidi Dickerson is the Vice President of North American Operations at LVI Global. She lectures internationally on Aesthetics and Neuromuscular Dentistry. At LVI, she educates and mentors students through her lectures and clinical teaching to be the best dentists they can be.

Historic photos courtesy of Dentistry Canada Fund Museum in Ottawa.



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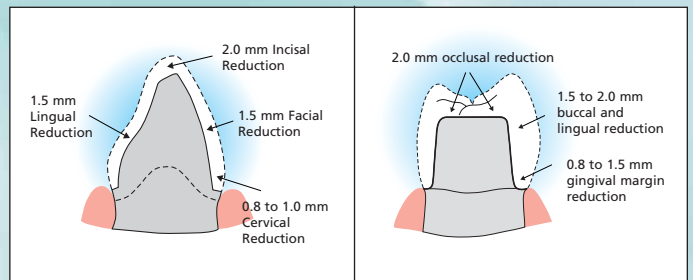
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- Precise chamfer margin preparations.
- Conventionally cemented with your favourite C&B cement. *Note: Cements with higher expansion rates (e.g., hybrid ionomer cements) must NOT be used.*

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Surgical Guides and Appliances

Chad Congo, DT



Many restorative headaches in implantology have been the result of poor treatment planning and little or no communication among the restorative team. Ultimately, it is the patient who suffers in the long term. Often, preliminary discussion and a surgical guide could have avoided many of the difficulties and instead provided an esthetic and predictable result.

There are as many surgical guide designs (appliances, stents or templates) as there are implant companies to choose from. The complexity of the surgical guide varies as well. In this article, we will discuss some of the differences, touch on some unique techniques and focus on the more effective virtual treatment-planning software that will be the standard of care in the future.

The least expensive and most basic type of template is the vacuform, or suck down version, where a vacuform is taken over a model and a small pilot hole is placed. They can be easily fabricated in the doctor's office. However, these are not stable and many labs no longer fabricate them. Nevertheless, they do provide minimal guidance. There is a vacuform /suckdown technique that is effective and can be fabricated in the doctor's office. This is a unique system designed by Dr. Leo Malin (www.nis-inc.us) that incorporates an adjustable cylinder that will rotate 10 degrees in any direction (Figure 1a). A tomograph is then taken to ensure the cylinder is in the correct position, then glued into place (Figure 1b). This technique is effective with a single implant.

A step up from this is a clear acrylic type of guide. The model is sent to the lab to fabricate a stronger, more stable guide. There are a variety of ways to treat the implant site, such as leaving it as a solid acrylic site so that the doctor can create his/her own pilot hole. Some guides are drilled with a 'best guess' pilot hole, or the entire buccal or lingual

is relieved to allow for freedom of the doctor to maneuver the drill once surgery commences. There are also a myriad of ways (wires, ball bearings, metal and plastic guide cylinders, gutta percha, or barium infused or coated teeth) to treat the acrylic to allow measurements to be made for radiography to assess the site for tissue or bone depth and angulation. As there are so many ways and techniques to create these guides, it is very helpful to communicate your preferred method to the lab. The difficulty with these types of guides is that the lab is placing the tooth where it should go for esthetics and function, but of course has no idea where any vital structures are (i.e. mandibular nerve, sinus, bone density or availability). It is simply a guess. It is reasonable to expect that only a doctor trained in placing implants can properly assess these variables. For this reason, many guides are rendered useless when these variables do not allow for the lab's 'ideal' placement. This is where frustration sets in as angulation or depth issues are presented when the patient is healed and ready for the final restorative phase.

For fully edentulous patients, the existing denture or a duplicate of the denture can be utilized with pilot holes drilled in the desired area. This is very effective. Bone screws can be used to retain or secure the denture during surgery where necessary. Again, there are multiple ways to prepare the denture for surgical use depending on doctor's preference.

Another system that employs a unique technique is the 'BASIC' implant system (www.basicdentalimplants.com), which involves tissue mapping. The implant area is probed and the tissue depth assessed in five or more different areas from buccal to lingual to give an idea of the amount of bone available (Figure 2a). The information is transferred to the stone model (Figure 2b). A nylon/plastic guide is placed in the proper position according to the tissue

map (Figure 2c). A 1:1 periapical radiograph is then used to assess the landmarks, such as mandibular nerve, sinus, etc.

There are newer cutting-edge techniques utilizing diagnostic software such as Nobelguide, Simplant and coDiagnostiX® software, which are now available, and are revolutionizing pre-op diagnosis and treatment planning for patients. These allow for a thorough pretreatment plan that will precisely guide surgery to place the implant exactly where it is required and let a doctor know whether the patient has enough bone to place, or whether bone grafting will be required, etc.

For the Nobelguide, Simplant and coDiagnostiX® techniques, the lab fabricates a CT scanning appliance. The patient has a scan performed. In the case of Nobelguide, the doctor uses the software to treatment plan in-office, and Nobel biocare fabricates the surgical appliance in Sweden. Simplant treatment plans and creates the appliance at Simplant.

At the Las Vegas Institute implant program taught by Dr. Leo Malin, the coDiagnostiX® IVS system is utilized to teach a comprehensive implant placement protocol. A CT scanning appliance (Figure 3a) is fabricated in the lab on a model, and sent back to the doctor. The patient is then scanned in office using a computerized tomography unit (if available), or the patient is sent to a clinic or hospital. The information is stored on a disc in DICOM format and the doctor utilizes the treatment planning software to virtually place the implant three-dimensionally. All factors can be evaluated in minutes including bone depth, quality, density, shape, etc. as well as structures such as incisive canal, sinus, cortical plate, mandibular canal and any anomalies. Once the treatment plan is finalized, the software-provided coordinates are printed and sent to Aurum Ceramic/Classic to fabricate the surgical appliance. These coordinates



Figure 1a

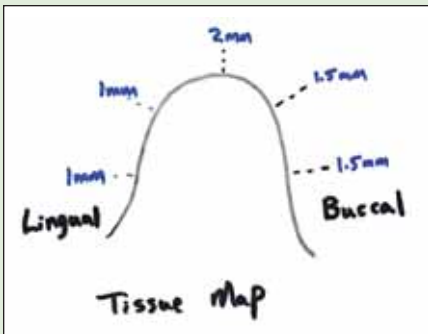


Figure 2a



Figure 1b

allow the scanning appliance to be set up on a Gonyx milling machine, and the holes to be drilled at the precise angle and placement prescribed. This protocol assures that the patient is properly assessed and treated with precision and accuracy, resulting in the highest quality product.

These techniques add a few hundred dollars to the overall cost; however, as patients become more informed and are presented with technology that will give them the best possible result, many will opt for what is in their best interest. Virtual treatment planning software coupled with precision surgical guides will be the standard of care in the near future. Word of mouth is a powerful referral program and nothing spreads this faster than a successful esthetic and functional prosthetic result that patient, doctor and lab can all be proud of.



Figure 2b



Figure 2c



Figure 3a

Figure 1a - Adjustable cylinder from NIS technique.

Figure 1b - Cylinder super glued into place, after adjustment.

Figure 2a - Tissue Map.

Figure 2b - Information transferred to stone model.

Figure 2c - Nylon/plastic guide in position.

Figure 3a - CT scanning appliance with holes drilled at precise angle and placement prescribed.

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Valplast, Flexite and NaturalFlex II

A Full Range of Flexible Removable Partial Denture Options

Gary Wakelam, RDT, CDT



For decades, the traditional metal partial was the treatment option of choice for partially edentulous patients. However, these metal partial dentures could be brittle and stiff, resulted in tissue irritation and had a high incidence of breakage. Even more important, today's patient demands a cleaner, brighter and more perfect appearance in their restoration – a result that metal often cannot provide. Now, Aurum Ceramic/Classic helps you meet that demand with a range of materials supplying more attractive and fully functional removable alternatives to traditional metal partial dentures: **Valplast, Flexite and our own exclusive NaturalFlex™ II**. These materials can and are being used in applications such as removable flexible partial dentures, preformed partial denture clasps, fibre reinforced fixed partial dentures, temporary crowns and bridges, provisional crowns and bridges, obturators and speech therapy appliances, orthodontic devices, occlusal splints, sleep apnea appliances and implant abutments.

Today's Thermoplastics - Clinically Proven Advantages

Unlike early versions of flexible partials (which exhibited excessive rigidity, opacity and/or unnatural esthetics), today's thermoplastic resins tend to have a predictable long-term performance. They are stable and exhibit high creep resistance and high fatigue endurance as well as excellent wear characteristics and solvent resistance.

Fully hypoallergenic/biocompatible, thermoplastics have no metallic taste and reduce patient thermal sensitivity. Typically without free monomer, they also have almost no porosity, reducing biologic material build-up, odours and stains and ensuring higher dimensional and colour stability. Thermoplastics are more flexible and stronger than acrylics while elastomeric resins added to the various formulations create greater flexibility, reducing fracturing. Virtually unbreakable, they are lighter than their predecessors and blend seamlessly with the natural tissues for excellent esthetics. The injection process used in fabrication and the strength of the materials allows the prostheses to be made very thin, eliminating the heavy, bulky feeling of earlier versions and providing ideal adaptation to hard and soft tissues.

Tissue-borne restorations' strong, durable clasps snap securely and comfortably into place around the existing dentition and the gingival, utilizing soft tissue undercuts for retention. Unlike traditional metal-based partials, there is little or no tooth preparation necessary. Flexible partials can be constructed from two good impressions (or models), an accurate bite relationship and a note on the desired shade. For distal extension cases, it is imperative to have either the wax bite rims that were used to verify occlusal dimension or to do a wax set-up try-in.



Three Different Options

NaturalFlex II

- Exclusively from Aurum Ceramic/Classic. Based on acetyl resin technology.
- Super strong, lightweight and translucent.
- Superior flexibility. Unsurpassed durability.
- Widest range of esthetic options with 22 colour-stable shades (including 3 bleached shades and 3 pink hues).
- Flexible for a comfortable fit – without having to warm appliance.

Valplast

- Nylon based thermoplastic.
- High memory flexibility that's retentive and comfortable.
- Appliance must be warmed prior to insertion.
- Lifetime warranty against breakage from manufacturer.

Flexite

- Nylon based thermoplastic material, fabricated like a cast metallic partial.
- Memory comparable to precious wire, yet is flexible.
- Can be repaired and relined in operator or laboratory with own material or with regular acrylic (use of acrylic will result in loss of some of partial's flexible properties).

Adjustment Tips

When necessary, adjustments can be made in the operator with either stones or rubber points. Rubber points and wheels will provide the smoothest surface (especially when adjusting the peripheral edges of the prosthesis) and are ideal for accessing undercut areas. Carbide or acrylic burs are not recommended, as they tend to melt rather than cut the materials.

Accurately Transferring the Horizontal & Arch to an Articulator

William G. Dickerson, DDS, FAACD, LVIM;

Norman Thomas, DDS, Ph. D. (U.Bris); F.R.C.D. (C); F.A.D.I.; M.I.C.C.M.O.



William G. Dickerson



Norman Thomas

The Problem With Subjectivity

For decades, dentistry has used various ways to transfer the relationship of the maxilla to a working articulator. It is imperative that the models mounted on the articulator accurately represent the way the arch appears in the mouth in relationship to the pitch (sagittal) and the roll (frontal). This allows the dentist and technician to accurately determine how to build the case for full mouth reconstruction and for aesthetic cases.

The ideal reconstruction cases are to create an occlusal plane horizontally and sagittally perpendicular to the long axis of the body and level so the occluding forces are down the long axis of the teeth and the musculature of mastication are even in resting contraction for muscles physiology. If uneven unilateral contraction must occur due to a canted occlusal plane, antagonistic muscles will also have to contract unilaterally causing postural imbalance and hypertonicity, resulting in chronic pain.

Probably the most common way has been using the Face Bow Transfer. The problem with the Face Bow Transfer is what reference points does one use for marking the horizontal plane? The Campher plane is normally pitched and the horizontal aspect is subjective. There is also the Fox Plane. I know my denture training was with the use of the fox plane. Again, the Fox Plane is subjective and can be off due to the improp-

er head position or inaccurate reference points used for determination of what is "level".

In neuromuscular dentistry, we strive for excellence by reducing the subjective to a minimum and looking for objective constructs.

The HIP Plane

Another option has been the use of the HIP plane. That plane uses three reference points to create a plane in both horizontal and sagittal relationships. Two of the reference points are the hamular notches just behind the tuberosity and the third is the incisive papilla (hence, HIP). The HIP is essentially objective because it depends upon minimal correlation of force determinants as gravitational force upon facial development which is also the basis of postural physiology.

The hamulus (H) is formed by the fusion of the downward and posterior extension of the sphenoid bone, the pterygoid plates, with the tuberosity of the posterior extension of the maxilla. The incisive canal (IP) is found at the line of fusion between the maxilla and premaxilla (nasal capsule) and hence forms the forward and downward extension of the maxilla from the sphenoid bone. Thus the hamulus and the incisive canal delineate the downward extension of the maxilla from the base of the skull and therefore logically act as a satisfactory reference for the occlusal plane. Posteriorly, the sphenoid bone extends through the sphenoid-occipital synchondrosis to the base of the occiput to form the joint between the cranium and the vertebral spine; the atlanto occipital joint.

In a related study by Dr. Thomas, 140 patients were subjected to I-Cat scans at LVI to assess the reliability of HIP for mounting casts on an articulator. Using this HIP plane as the base horizontal reference for the plane through the inferior surface of the occipital condyle was generally placed

at the horizontal level of the alveolar crest of the anterior maxillary teeth. Thus the HIP is a stable reference plane for deriving the occlusal diagnosis and for purposes of occlusal reconstruction.

Foundation of Study

For the past 6 years we have evaluated the HIP mountings of the diagnostic casts using a Symmetry Bite (Clinicians Choice). This involved over 500 cases. What we have found is that about 95% of those cases showed a level Symmetry Bite when placed on the HIP mounted diagnostic models, indicating that the ROLL aspect of the HIP mounting was correct (or matched the Symmetry Bite) 95% of the time. What was not clear on the other 5% is if the HIP was inaccurate because the Symmetry Bite was not done correctly (as it's subjective in nature). However, this continual study did not measure if the PITCH aspect of the mounting was correct.

In neuromuscular dentistry, we strive for excellence by reducing the subjective to a minimum and looking for objective constructs.

It was just assumed that if the ROLL aspect was correct, then the PITCH aspect should be correct.

The problem with determining the accuracy is that one verifies it with a subjective bite. Trying to align the horizontal plane increases the element of human error due to head position, eyes

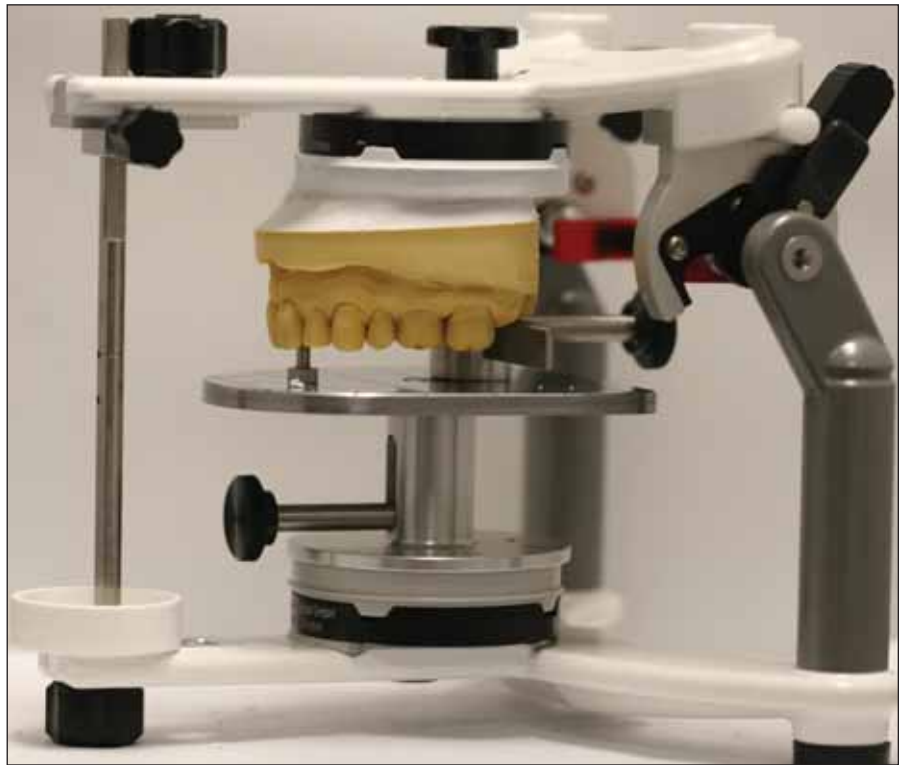
Sagittal Relationships of the Maxillary

being off, etc. However, using a vertical component bite (Symmetry Bite – Clinicians Choice), all the doctor has to do is make sure the vertical component runs down the long axis of the face (between the eyes, center of nose, and middle of chin). Because of the automatic 90 degree component of the Symmetry Bite, the horizontal plane will always be 90 degrees to the long axis of the face, which is exactly where it should be. The point is, verifying the horizontal axis is easier with any device that has two perpendicular arms, and when the doctor makes sure the vertical one is centered down the long axis of the face. The problem with using only the horizontal plane is the patient's head position can distort the actual reality of level. It is why bubble levels won't work when used with horizontal components. The bubble level is dependent on the head being perfectly straight with no head tilt, a subjective position. One can level the Fox Plane and bubble but if the head is slightly tilted, the horizontal aspect (roll) of the mounted case will not be accurate.

The question with the HIP plane has been the sagittal aspect (pitch) of the occlusal plane that has not been quantitatively verified. The HIP plane helped eliminate the element of human error for the horizontal (roll), but no study that we knew of has been done to verify the sagittal aspect when the horizontal aspect was verified as level.

The Study

After completion of restorative treatment in LVI's Full Mouth Reconstruction Program, sagittal and frontal views of the patient were taken with the Fox Plane placed against the maxillary teeth to verify final pitch and roll of the patients' maxillary arch. Impressions were then taken of the patients' finished cases, making sure the hamular notch's were verified in the impression. The models were poured and mounted on an occlusal plane analyzer using the HIP to



Mounted model on LVI Stratos occlusal plane analyzer (888 584-3237).

mount the models. It was a blind study where the technician mounting the cases, using the HIP landmarks only, did not see the pictures of the patients from which the models were taken. A total of 70 cases were evaluated.

This is purely a study to see if the finished cases from the Full Mouth Reconstruction Program at LVI, when mounted using the HIP plane, matched the appearance (pitch and roll) in the mouth when compared to a horizontal plane. If they do match, it would indicate that the HIP is a viable and accurate way to transfer the maxillary model.

Results

Seventy (70) cases were evaluated. In sixty-six (66) cases, the HIP mounting accurately represents the Pitch and ROLL aspect of the maxillary arch that exists in the patient. In four (4) cases,

the results are very close but inconclusive as it appears the fox plane plate was not accurately placed against the occlusal plane on the models. This does not mean that these four were wrong or did not match the HIP, it just meant that an EXACT determination could not be made either way. In the author's opinions, the models pitch and roll did match the pitch and roll in the patient's mouth.

Conclusion

In conclusion, with these 66 subjects, the HIP mounting procedure is an accurate way to transfer the models to the articulator and represent the pitch and roll that exists in the patient's mouth.



Prior to treatment.



Teeth restored with Cristobal + crown and inlay.

The following case was completed during a recent Advanced Posterior Aesthetics course (with Dr. Ronald Jackson) at the Las Vegas Institute for Advanced Dental Studies.

“This patient presented with a deteriorating 3/4 gold crown on #36. As is evident in the before photo, a root canal had also been performed on this tooth in the years after the crown had been placed. Tooth #37 had recurrent mesial decay and a failing composite restoration. Tired of “chipped” unsightly restorations, the patient wanted metal-free solutions.

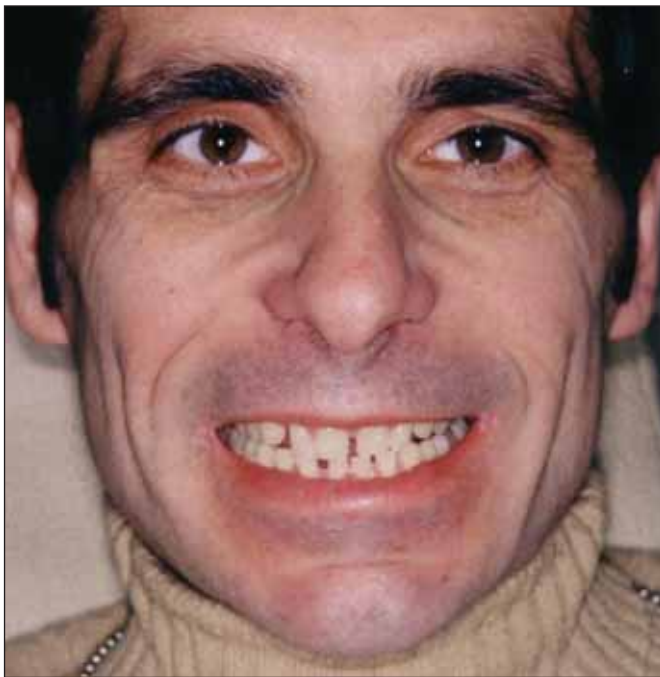
We began by removing the gold crown and prepped for a full Cristobal+ crown on #36. On #37, we removed the old composite restoration, removed the decay and placed a Cristobal + Inlay. The patient was amazed by the dramatic change to what ‘looks just like natural teeth’ as well as the smoothness of the final surface to the tongue.”

Dr. Dana Bailey

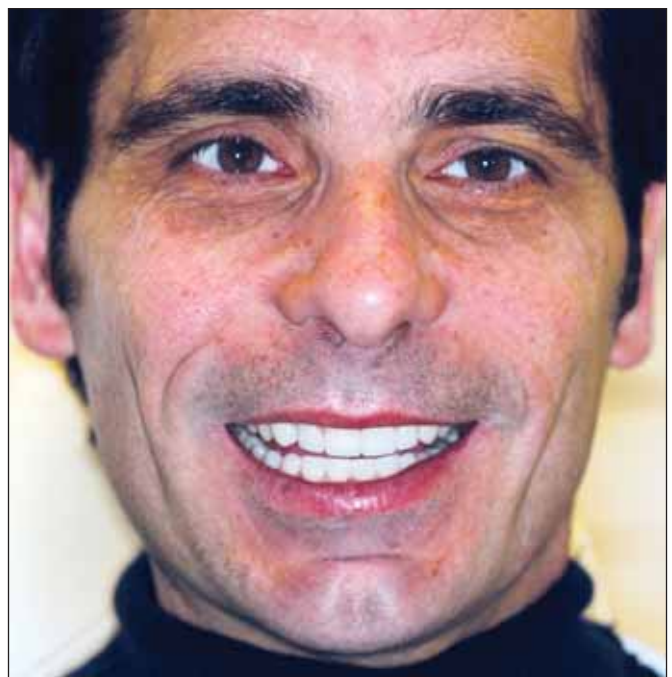
Restorations fabricated by Aurum Ceramic/Classic.

Dr. Dana Bailey graduated from the University of Saskatchewan College of Dentistry with distinction in 1976. He currently maintains a general practice in Kindersley, Saskatchewan. Dr. Bailey is a graduate of the Advanced Posterior Aesthetics course at the Las Vegas Institute for Advanced Dental Studies (LVI). He is also a member of the CDA and the Saskatchewan Dental Association.

CASE SPOTLIGHT



Full face prior to treatment clearly showing multiple diastemas.



Full face three years after veneer placement.



Close-up of smile prior to treatment.



Smile restored with IPS Empress veneers.

“This patient was extremely unhappy with his smile, primarily due to the multiple diastemas that had bothered him all his adult life. We explored the possibility of opening his vertical dimension as part of his treatment plan but after seeing diagnostic wax-ups for diastema closure with and without opening the VD, the patient opted for the latter course of action. His teeth were prepared for 16 IPS Empress® veneers (# 14-13-12-11-21-22-23-24-44-43-42-41-31-32-33-34)

crafted by Aurum Ceramic/Classic’s Advanced Esthetic (AE) Team. Integrity temporaries were placed until the actual seating day. After seating, this patient was also willing to wear a night guard to protect his teeth if grinding re-occurred. This case was seated 3 years ago and patient is extremely comfortable and satisfied with the result. He says, ‘It’s the best thing I ever did!’.”

Daniele Larose, DMD

Restorations fabricated by Aurum Ceramic/Classic.

Dr. Daniele Larose graduated from the University of Montreal’s School of Dental Medicine in 1997. She is in private practice in Ville St. Laurent (a suburb of Montreal) where she focuses on Cosmetic Dentistry. Dr. Larose has completed several courses at the Las Vegas Institute for Advanced Dental Studies (LVI) including Advanced Anterior and Occlusion I. She is also a member of the CAED (Canadian Academy of Esthetic Dentistry) as well as the provincial associations ODQ and ACDQ.

The “Shady Side” of the Prep Appointment

Trish Jones, RDH, BS
 Technical Advisor, Aurum Ceramic @ LVI



Two of the most important things to be accomplished at a smile design seat appointment are often the most overlooked during the prep appointment. There are many factors to consider in creating a new smile, but as a laboratory, we find the notation and communication of shade and shape is often overlooked. While we all want great preps and clear impressions to allow us to deliver incredible new smiles to our patients, shade and shape are just as, if not even more, critical to actually meeting that goal. So let’s examine a few ideas to make the “shading taking, smile design” preparation appointment special.

It is highly recommended to have a baseline shade of the patient’s existing smile on record. This can be documented by pre-operative photos. Often, the patient wears temporaries of a whiter/brighter shade for the three weeks while their final restorations are being crafted. While you may have fabricated fantastic temporaries, the patient may or may not notice a difference when the final restorations are placed. Somehow we have lost the “wow” factor. This is where it is handy to show the patient his or her original smile and point out the improvements that have been made in shade and smile design. Patients can also be disappointed if the final shade ends up being darker than the temporary shade. Again, show the patient his or her pre-op shades and they’ll see the difference that’s been achieved.

It is beneficial to take 10-15 minutes of the prep appointment prior to prepping and make it into a smile consultation. This is the time to discuss with the



Take a baseline shade prior to prepping and anaesthesia.

patient the shade desired and shape. Of course, this can be confirmed with the temporaries and adjusted as needed; however, it is not uncommon to find discrepancies between what the patient desires and what the dentist prescribes. Let’s remember that we start off an aesthetic case with verbal communication. Whatever we can do to move that discussion on to a “visual” rather than “verbal” basis is critical to a successful final result and a happy patient.

Here are a few helpful hints that we have found will help you and your patients get the results you both desire:

- If the patient is wearing bright colours (such as orange or yellow), drape them with a neutral grey towel when taking a shade. This helps prevent the shade tabs from picking up the yellow tones in the clothing and fooling the eyes.
- The teeth/preps should be moist when the stump shade is taken. If they are desiccated, they will appear lighter than what they actually are.
- Determine the base/main shade of the restoration, depending on stump shade and the patient’s aesthetic shade desires, and determine from that how much blending is needed.
- Determine special characteristics such as how much translucency, incisal characteristics (those on the incisal edge, such as notches), and amount of surface anatomy. Surface anatomy will have an impact on shade. A smooth surface will reflect more light, thus making the tooth appear larger and whiter. A medium surface will break up light, and heavy anatomy will make the tooth appear smaller due to less light reflecting from it.
- Make sure the desired length of the incisors is recorded on the lab prescription.
- Record the information on a colour mapping card and indicate teeth to be restored on the lab prescription.

- Utilize the checklists for appropriate patients. These are useful tools provided to you at no cost.
- If you are concerned with the shape or shade when you get the case returned to your office, try it in the patient’s mouth. If you evaluate the shade on the white stone models only, the restorations may appear yellow, while in reality this is not the case. They may also pick up hues from the die spacer, if the die model is used. The patient’s preps and tissues will give you the best try-in and evaluation of final shade.

As more and more patients are accessing aesthetic dentistry, it is important to be on the cutting edge and to be knowledgeable. But most of all, you must be able to deliver the results the patient expects, even though you may not agree. Whether it is a bleached white dazzling smile, or a natural genuine smile, as long as your patient leaves your office with a big smile on their face, we are all happy.



Bright clothing colours can convey false tones.



Neutralize any bright clothing by using a neutral grey towel.



This red collar can be distracting to the eye when taking a shade.



Colour perception is more predictable with neutral background.

Are we Destroying the Profession From Within?

It's Time to Take the High Road.

William G. Dickerson, DDS, FAACD, LVIM



As a profession we battle the false promises of insurance companies, the exposé's of uninformed reporters and our own inability to present a consistent value message to the consumer. These are troubling concepts for certain; however, they are not half as insidious as the attacks from within.

What am I talking about? I'm talking about the need for some dentists to criticize other dentists. I've seen dentists make derogatory comments about another dentist when in fact; they have made the same mistake in their own practices. I have seen dentists make a big deal out of a small occurrence that could have been easily corrected if the patient had gone back to the original dentist. I have seen dentists criticize other dentists simply because they made the mistake of being successful. All of this is done in a vicious attempt to criticize another dentists' philosophy, success, way of practicing or, even more disturbing, in an attempt to win the patient over to their practice.

There was a case that went all the way to court because the patient got microleakage under his temporaries, hardly a case of malpractice. However, the patient went to another dentist and instead of this dentist reassuring the patient that the microleakage problem would easily be taken care of when the final restorations were seated, he used the opportunity to criticize the first dentist in an effort to steal the patient.

Behaviour like this will backfire on all of us as it creates a pall of distrust over ALL dentists in the minds of the public. What the second dentist should have done was to reassure the patient and tell the patient to go back to the original dentist for follow up care. Then the second dentist should have called the first dentist to discuss the case and offer some help or support.

Dental Internet forums have made things worse. Hiding behind the anonymity of their computers, dentists find it easy to spew venom that they

wouldn't have the courage to say to a person's face. This unprofessional behaviour spreads like a virus to other dentists that frequent such forums, creating a plague that spreads to thousands. Such behaviour is NOT acceptable or professional.

What I find particularly troubling is the public bashing of other dentists from the podium and in professional publications. I am appalled by some of the self-righteous editorials claiming facts that are really just things they have "heard" or "think". Truth is, the attempt by these authors to discredit a dentist, organization, or philosophy is often based on insufficient, inaccurate and misinformed knowledge. I believe that **most** every dentist has his or her patient's best interest at heart. Yet some prominent dentists feel no remorse for publicly attacking a person, group or philosophy with whom they disagree even though they have not tried to find out for themselves **WHAT** that philosophy is all about. Not only is this unprofessional, it's just wrong and bad for EVERY dentist in North America. It smells of McCarthyism and it's wrong.

It saddens me that these so-called experts use their prominence to attack someone or something they disagree with, in this manner. Perhaps they have a vested interest in doing so, just like Pepsi may directly attack Coke. I find it particularly troubling when they question the "ethics" of a dentist for his or her personal beliefs, when the dentist they criticize is doing what he or she thinks **IS** the best thing for their patients. Who made them the moral police of dentistry? How do they know what these other dentists are really thinking? Should their ethics be questioned because of **THEIR** treatment philosophy by everyone who disagrees with them?

A dentist walked up to me at the recent meeting to tell me how disgusted he was with a speaker who used the podium in an attempt to discredit a few other notable speakers. What this speaker

didn't realize is that, although he might have been successful with a few, he actually discredited himself with the majority of dentists in the room. Another dentist came up to me and told me of another speaker who made comments that he **KNEW** were not true about another group or "camp". The comments caused the dentist to lose a great deal of respect for the speaker.

Even though I may express my beliefs about proper treatment and the philosophy of dentistry I believe in, I try to never attack another dentist personally. I will also never tell you that anyone that doesn't practice the type of dentistry that in my heart I **KNOW** is right, is in some way unethical or morally wrong. I truly believe that most of them are doing what they believe is right. I just think they are misguided or don't know what they don't know. Having said that, I am convinced that they believe they are doing the best thing for their patients. It would be nice if we could agree to disagree and be civil about it.

But the end result is that when a person of authority, or any of his or her followers, uses their position to discredit a dentist or group of dentists, it also discredits dentistry in general and hurts us all. The best thing for our profession would be if this nonsense stopped and we all could be respectful of each other's opinions, views and beliefs.

A perfect example of an organization that embraces this philosophy is the IACA (International Association for Comprehensive Aesthetics). At their annual meetings August 3rd – 5th in Montreal many had differing views, yet were able to present their side without personal attacks or innuendos. At the Q and A forum with a prominent CR gentleman and myself, we both showed that a dialogue can occur in a civil, educational and friendly manner. I hope to see all of you at next year's IACA meeting in Chicago (July 19th – 21st, 2007).

The Carriere LX Passive Self-Ligating Bracket



A Q&A Session with the inventor, Luis Carriere, DDS, MSD

Q. As the developer of the new Carriere Self-ligating Bracket, tell us what makes this bracket unique?

A. The Carriere Self-ligating Bracket integrates different design concepts with the primary goal of *benefiting the patient*. The main objective is to preserve a patient's periodontal structures without compromising the doctor's precision and control. The bracket does this with simplicity and minimalism.

Q. The goal in orthodontics today is low friction, low force. Does the Carriere LX system meet this goal? Please explain.

A. Yes, the system meets this goal by providing "a freedom of fit" in the bracket and archwire interface. In the body of the bracket, the mesial and distal edges of the slot have been carefully rounded for free sliding. The bracket wire interface has a four-wall design that converts it into a passive system. This, working together with the low force super-elastic archwires, provides synergistic action. The physiological orthodontic force on the periodontal structures results in a faster treatment.

Q. Compared to other self-ligating brackets in the market today, what makes Carriere LX better than the rest?

A. That question has to be answered by presenting the unique benefits to the patient and the doctor. Getting a bracket that is nickel free protects the patient. It is smaller and less complicated to wear, because the locking mechanism is in the front. This makes oral hygiene much simpler, and the bracket is more comfortable because it's anatomically contoured.

For the *doctor*, the locking mechanism is precise, gentle and free sliding. It can be easily opened with an explorer and closed by using finger pressure. This results in fast and easy archwire changes. The closing direction of the slide is in the gingival direction, which doesn't interfere with mastication. In severely crowded cases, especially in lower incisors, the opening of the slide towards the incisors makes it easier to insert the wire. The slide opening in the occlusal direction allows, if necessary, brackets with posts on the gingival side. The Metal Injection Molded (MIM) bracket provides maximum precision and strength.

Q. Carriere LX is a completely passive self-ligating system. What does that mean, and how is it different from a passive/active system?

A. In the Carriere LX, "passive" means that the four wall channel is the "built in" component and the bracket slot,

"loosely" contains the "built out" component, the archwire. The metal-to-metal contact allows the archwire to slide easily inside the Carriere LX with a free but controlled movement. Using progressively different sizes of super-elastic archwires, results in the periodontal supporting tissue having a healthier and faster response to the force. Less force in only one direction allows a smaller periodontal surface to be used which means less cellular activity there. Treatment time is safely reduced, and orthodontic results are achieved with maximum comfort for the patient. This benefits doctors, their staff, and reduces treatment costs. Our "passive" orthodontic philosophy can be "activated" when we are interested in using more force. This happens later in the treatment when larger rectangular archwires can be used.

At this level of treatment, brackets are properly aligned and there is no problem placing larger rectangular, super-elastic archwires in the bracket tunnel to "activate" the system. We can do this without losing the original spirit of keeping "free but controlled" close contact between the rectangular archwire edges and the bracket walls. This preserves the periodontium without binding, and permits free slide under control and precision of dental movement.

In this way, we take advantage of the "loose interplay" that we want between the "built in" and "built out" components of the bracket/wire binomial union. It is this unique condition that characterizes our passive Carriere LX system.

Q. For doctors using the Carriere LX, how does the treatment time differ over traditional bracket use? And why? In general, what treatment time can be expected using this self-ligating bracket?

A. Traditional brackets create additional strain on the periodontal structures. The tight binding of a traditional bracket to an archwire causes a "global state of war" in the supporting tissues. Each time a new archwire is used, the patient experiences pain and discomfort. If we tighten the archwire, this will cause more pain to an area that is already irritated.

Carriere LX applies gentle and consistent force to the teeth's supporting tissue that produces results, without harming the tissue. Bracket-wire friction is significantly reduced. There is no pain, and the patient is more comfortable. Plus, the smaller size and contoured edges add to the comfort.

Treatment time is reduced, on average, 35%. This percentage can rise in cases where a positive response is achieved sooner, and there is active patient cooperation.

Q. Tell us about the ease of archwire changes and what does this mean to the doctor?

A. The fourth wall bracket slide is placed in the front. The

design is so perfect it can be opened smoothly with a simple explorer and closed with a gloved fingertip. You know that it has closed securely when you hear the “click.” This precise mechanism makes it fast and neat to change archwires. Because it is so much faster, the doctor and his staff will save valuable time.

Q. What archwire sequence, shape, and design do you prefer?

A. The proper “sequence” is critical in using the Carriere LX for treatment. In order to get optimum results with our bio-mechanical system, the wires have to be placed in an ordered sequence. I begin with light, super-elastic archwires that deliver a very light force. This “wakes-up” the case movement and causes minimal periodontal reaction. Cases are started with a progression of round, super-elastic archwires. This promotes correction of rotations, cross bites, vertical and vestibulolingual movements (bracket alignment). Intrusion translation movements and torque are provided by edgewise type super-elastic archwires. Space closure is done with posted stainless steel archwires. The finishing details are taken care of with soft, edgewise CNA archwires. As an option, at the end of treatment, to promote better interdigtation, a final settling of the case can be done with round light stainless steel archwires.

Q. Of all the cases completed with Carriere, what impresses you the most about the system? Any common elements?

A. Cases completed with the Carriere LX exhibit surprisingly fast results with a longer span between appointments. Activations and changing archwires takes a shorter time.

Posterior bracket posts make it easy to insert any kind of elastic traction needed for the occasion. Patients love the pain-free comfort and tell us so. This is especially important for our adult patients. It’s very satisfying on a personal level and satisfying to the doctor professionally to be able to deliver a biologically safe and respectful treatment to the patient.

Q. What is the patient’s response to using a self-ligating system – and the low profile of Carriere LX?

A. The patient’s response to using the Carriere LX has been very gratifying. They appreciate the smaller brackets. It makes their day more pleasant, because food does not get trapped in them and they’re easier to clean.

The low profile and soft rounded edges and corner areas are much more comfortable. We hear a lot about this from our adult patients. In addition, because the locking mechanism is in front, patients easily understand how the Carriere LX works. This makes them feel more confident. Patients become more cooperative because, when they understand how it works, they can follow the logics of the treatment steps and the process that will lead to the results they are eagerly anticipating.

Luis Carriere, DDS, MSD is the inventor of the Carriere Self-Ligating Bracket (SLB). He received his DDS from the Universidad Complutense in Madrid in 1991 and an MSD in Orthodontics and Dentofacial Orthopedics in Adults and Children from the University of Barcelona, School of Dentistry, in 1994. Some of the prestigious highlights of his distinguished career include the Joseph E. Johnson Award from the American Association of Orthodontists in 1995, being a Guest Professor in the USA and Italy, and a member of the Editorial Review Board for the American Journal of Orthodontics and Dentofacial Orthopedics. He is a Member of leading international orthodontic associations, has published influential articles, and most recently, he won The International P/M Design Competition in 2004.

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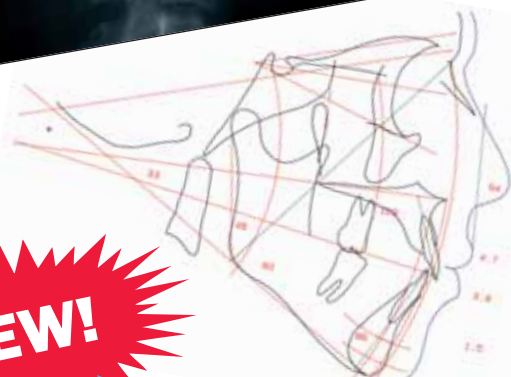
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Cosmetic Tooth Movement for Adults (Part 5)



Molar Uprighting to Enhance Restorative Result

Dr. Rob Veis

How often have you had patients come in and ask if you could just straighten one tooth to give them a better-looking smile? It's a fact that most adults are unwilling to undergo complete orthodontic care. Yet, many of them would love you to do something to improve the way their teeth look. Fortunately, there are many minor tooth movement procedures that you can do that will give your patients the esthetic result they are looking to achieve. In this, and succeeding issues of Aurum Ceramic Continuum, we will explore some of the more common orthodontic procedures used every day to help you give your patients the beautiful smile they want.

Perhaps the most common use of orthodontics to aid in restorative work is the uprighting of a tipped molar. All of us see mesially tipped molars on a daily basis. The typical clinical picture consists of extrusion and migration of teeth, accelerated mesial drift, uneven marginal ridges, angular bony crests, altered coronal to gingival form, food impaction, caries, periodontal disease, and ultimately posterior bite collapse with loss of the occlusal vertical dimension. Why then is treatment so often ignored? Worse yet, why are we tempted to place a bridge before returning this tipped tooth to its normal occlusal position?

Leaving a molar in the tipped position can have a profound effect on your prosthetic therapy. It leads to:

- Inadequate parallelism of bridge abutment teeth
- A poor occlusal plane
- A lack of interproximal space between teeth
- Adverse root proximity
- Faulty occlusal landmarks
- Excessive tooth preparation with potential pulpal involvement
- Inadequate pontic space
- Hard and soft tissue deformities of the periodontal structures
- Teeth that are more difficult to clean
- Bruxism and clenching habits
- Occlusal trauma

In this unique clinical example, the patient has had an implant placed ideally in the lower first molar position. Unfortunately, the implant space was not properly maintained with an interim bridge or partial. In less than eight months, the second molar drifted and tipped mesially making it impossible to restore the implant.

To correct the problem, a removable appliance with an

expansion screw was used to distalize and upright the molar. In four months, the second molar was back into its normal position and the space necessary to restore the implant was regained.



Second molar is impinging upon the space necessary to restore the implant.



Buccal view of the lost space due to the second molar drifting forward.



A sagittal appliance tipped the molar back to its original position regaining the lost space.



Occlusal view of the appliance in place during treatment.



Occlusal view of the treatment completed. The implant is once again restorable.

Dr. Rob Veis taught as a Clinical Professor in Restorative Dentistry at the University of Southern California Dental School for 12 years. Today, he guest lectures at both the University of Southern California and the University of California, Los Angeles on occlusion and Appliance Therapy.

In 1990, Dr. Veis joined the teaching staff at Space Maintainers and lectures internationally on the integration of orthodontics and Appliance Therapy into the general practice. He is co-author of the textbook "Principles of Appliance Therapy for Adults and Children", as well as author of The Practice Building Bulletin (with a circulation of over 15,000 dentists). Dr. Veis has been part of both solo and group practices and currently maintains a private practice in Los Angeles, CA.

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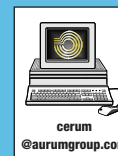
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The General Anti-Avoidance Rule: Part II

Thomas H. Olson, J.D., LL.M. (Taxation)



In my last article I discussed the general anti-avoidance rule (“GAAR”), and its use by the Canada Revenue Agency (“CRA”) to attack otherwise effective tax planning. Recently, Olson Lemons LLP was successful in defending one of its clients at the Tax Court of Canada from a GAAR attack by CRA. Crucial to our success in this case was the court’s recognition of the sophistication of the impugned tax plan, its proper execution and its meticulous and clock-work-like implementation.

To my knowledge this was the first court case where GAAR was used against a dentist. This is not because GAAR is not relevant to dentists; rather it is because dentists’ tax planning tends to be so full of holes that CRA is able to successfully attack it using other means. GAAR, as a provision of “last resort” will only apply if all other provisions of the Income Tax Act are complied with.

The courts have suggested over time that the following steps are required to

protect you from CRA’s non-GAAR and GAAR attacks:

1. You must have an effective tax plan that complies with all of the various provisions of the Income Tax Act and actually saves you taxes! Your standard, flavour of the month, herd-style tax planning, so often used by dentists, does not usually do this. An example of this type of deficient tax planning was the so-called “family trusts” that were once in-vogue. Often, these tax plans did not comply with all of the necessary legal requirements and sometimes did not actually save any taxes.
2. The proper legal documents must be “carefully, indeed meticulously,” drafted and executed to fully reflect the intended tax plan.
3. The dentist must act consistent with the spirit of the tax plan and the letter of the corresponding legal documents. For example, where technical services or hygiene companies are created, the dentist must treat such companies as separate businesses and legal entities.
4. The relevant tax returns, elections and other public documents must be filed accurately, completely and on time. The implementation of the tax plan must “work like clockwork”.

Some may question the transactional costs in developing and implementing an effective tax plan. In response, I would say that the overall costs of a failed tax plan, or no tax plan at all, may well be much higher than these transaction costs. In a recent decision of the Tax Court, the judge recognized the cost of retaining competent tax professionals is often much less than the cost of not retaining them: “I can only shudder to think of the enormous cost expended by him [the taxpayer] in money, time and stress that could so readily have been alleviated by relying on professionals trained to deal with accounting, tax and legal matters.”

In summary, a dentist’s tax planning should be effective, “follow the rules” and actually save taxes. The tax plan should be well-executed, accurately reflected in the accompanying legal documents and fully consistent with the behaviour of the dentist. All compliance reporting should be coordinated, accurate and timely.

As evidenced by Evans, doing the foregoing should fortify your tax planning from both non-GAAR and GAAR attacks.

Tom Olson was born in Brooks, Alberta. He received a Bachelor of Science degree, graduating Honours Summa Cum Laude from Brigham Young University. In 1980 he graduated with a Juris Doctor (J.D.) from Brigham Young University Law School. In 1985 he graduated from the University of Denver Law School in Colorado, receiving a Master of Laws in Taxation.

Tom Olson is principal of the law firm of Olson Lemons LLP in Calgary. Mr. Olson’s preferred area of practice is tax planning and tax dispute resolution. A significant part of his law practice is representing professionals in tax planning, tax audits, and appeals.

Plan to Attend:

“Ten Commandments of Taxation”

with Thomas H. Olson,
J.D., LL.M. (Taxation)

November 1, 2006 — Kelowna, BC
November 2, 2006 — Vancouver, BC
November 3, 2006 — Calgary, AB

For more information or courses in your area, please contact the Aurum Ceramic/Classic Dental Laboratories Continuing Education Department at 1-800-363-3989.

Dates subject to change. Please call to confirm course date.



Congratulations AACD Annual Smile Gallery Event Winners



(Left to right) Dr. Jodi Funk, Damon Liesse, Manager Aurum Ceramic Spokane and Tina Mahn, ceramist.

The management and staff at Aurum Ceramic/Classic Dental Laboratories is pleased to congratulate Dr. Jodi Funk (Spokane, WA) and Tina Mahn, ceramist at Aurum Ceramic Spokane on their Silver Medal-winning case at the 12th Annual AACD Smile Gallery Competition in San Diego, CA.

Taking place at each Annual AACD Scientific Session, the competition is open to all AACD members and showcases AACD members' clinical skills in cosmetic dentistry in a variety of categories. All entries are judged by an anonymous panel of Accredited AACD members with the event designed to provide intelligent and constructive comments to the Competitor to foster their growth and development in the art and science of cosmetic dentistry.



Before.



After.

UPCOMING EVENTS

Saskatchewan Annual Dental Convention

Saskatoon, SK, September 14 – 16, 2006

Canadian Dental Specialties Scientific Session

Montreal, QC, September 14 – 16, 2006

American Dental Association 147th Annual Session

Las Vegas, NV, October 16 – 19, 2006

Thompson Okanagan Dental Annual Meeting

Kelowna, BC, October 26 – 28, 2006

69th Annual Toronto Academy of Dentistry Winter Clinic

Toronto, ON, November 10, 2006

Chicago Dental Society Midwinter Clinic

February 22 – 27, 2007

LVI Global Extravaganza

Calgary & Edmonton, AB, March 16 & 17, 2007



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PRIORITIES 2006

Aurum Ceramic Dental Laboratories is proud to be a participant in the University of British Columbia's Partners in Excellence program.



Do You Really Need a Website?



Jo-Anne Jones, RDH

There are several reasons to seriously take a look at developing a website for your practice. We are in an increasingly competitive world where we need to have our presence known coupled with the fact that the general population is Internet savvy. If you question this fact, take a look at the number of computers that existed in your home 10 years ago and what exists presently. We've come a long way!

Your practice website will provide an opportunity for new patients who wish to check your practice out further or simply get more information. It also provides a source for your existing patients to check out information or answers to queries they may have. Potential patients 'scouting' the Internet will never know you exist without the presence of a website. We constantly need to be aware of the market we are serving and adjust to not only meet their needs, but also capture their interest.

Marketing your practice is an ongoing task and what better way to market your services than on your website. A website will always be available even when you're not! Patients can view a beautiful before and after gallery of a procedure they may be considering or obtain further information that enables them to make a decision on a choice of treatment. Your website is a constant promotional tool of not only your services, but also your location, your hours and most importantly your team. Website awareness needs to be constantly marketed on your letterhead, business cards and any other visual that you may select. One of my clients created a beautiful border around their reception area ceiling drawing awareness to their website.

If your website is comprehensive, patients will go there seeking information. The following are ways to utilize your website to facilitate convenience not only for your patients but for your team:

- Office policy information

- A dental dictionary placed on your website will help your patients decipher some of the confusing terminology related to their dental benefits and transfer some of the responsibility from your business team
- A form outlining questions your patients need to ask of their dental benefit provider could be downloaded from your website to assist them
- Patients may be able to pre-register and fill out new patient forms

This added convenience all add to the exceptional 'customer' service your practice is striving to provide.

Your website helps to support your image and the branding of your practice. Patients want to know that their dentist is confident about the dentistry he/she does plus aware of the technology around them and confident enough to use it. This goes with the whole perception of being updated. A website can level the playing field somewhat by providing an opportunity to compete with the multi-million dollar practice across the street.

The overall look and navigation around your website requires considerable thought. When considering the services of a web designer, ask to see the websites they have designed as well as references from clients. Are they familiar with the dental industry?

A designer may also help you to get your practice listed in the various search engines (Google, Yahoo, etc.) as well as help you to come out at the top of any search results lists. PageRank is a numeric value that represents how important a page is on the web. Google figures that when one page links to another page, it is effectively casting a vote for the other page. The more votes that are cast for a page, the more important the page must be. PageRank is Google's way of deciding a page's importance. It matters because it is one of the factors that determine a page's ranking in the search results. It isn't the only

factor that Google uses to rank pages, but it is an important one.

We do not recommend 'friend of a friend' approach to web design in order to save money. Hiring a reputable and experienced web developer will be a good investment in time and money. They know what it takes and their reputation is on the line.

The Internet is not going to go away. It now is not just a marketing tool; it is a necessity - a way to do business! Your website will be an investment in the attainment of your goals. Provide your patients with a reason to visit your website on a regular basis. Market it effectively and use it as a tool to provide your special patients with superb service!

Known for her warmth, enthusiasm and clinical expertise, Jo-Anne Jones' passion for the industry has led to several accomplishments in practice and as an educator. With over 27 years of experience and knowledge in the dental field as a Dental Hygienist, she has spoken across Canada, the U.S. and internationally and was a featured speaker at the World Aesthetic Conference in the UK in June of 2006. A Lecturer and Hygiene Practice Coach for ADEI, Anita Jupp & Company, Jo-Anne is a published author and is on the Advisory Board for the DVD Journal of Dental Hygiene in participation with the Canadian Dental Hygienists Association. She is also a regular contributor to RDH Magazine's electronic community.

Plan to Attend:

"Building A Magnificent Dental Hygiene Team"

with Jo-Anne Jones, RDH

October 20, 2006 — Ottawa, ON

For more information or courses in your area, please contact the Aurum Ceramic/Classic Dental Laboratories Continuing Education Department at 1-800-363-3989.

Dates subject to change. Please call to confirm course date.

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