Fall 2014
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Visions

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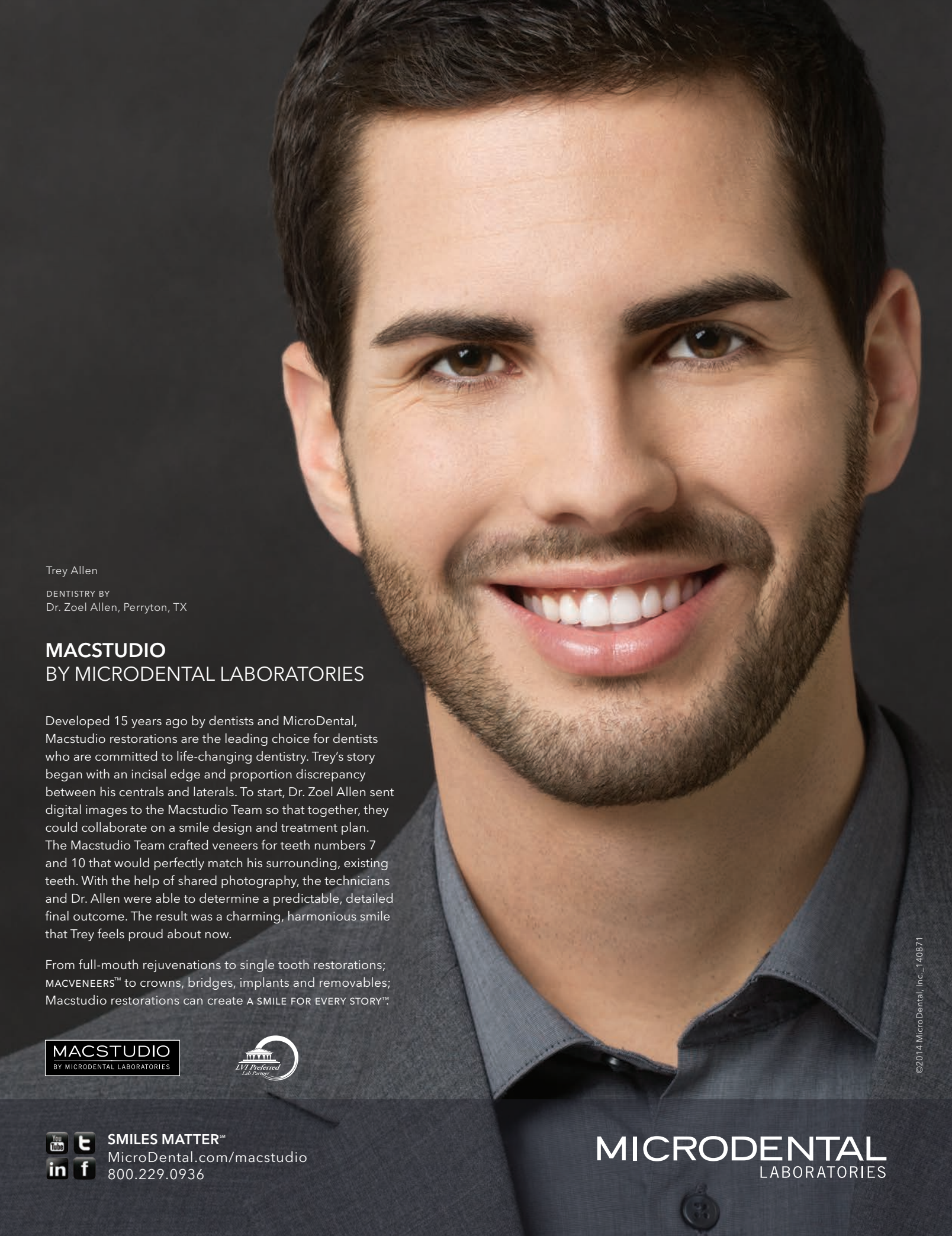
The Essence Of Health

Don't Be a Waldo

Your Perception Is Your Reality



Trey Allen

DENTISTRY BY
Dr. Zoel Allen, Perryton, TX

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Developed 15 years ago by dentists and MicroDental, Macstudio restorations are the leading choice for dentists who are committed to life-changing dentistry. Trey's story began with an incisal edge and proportion discrepancy between his centrals and laterals. To start, Dr. Zoel Allen sent digital images to the Macstudio Team so that together, they could collaborate on a smile design and treatment plan. The Macstudio Team crafted veneers for teeth numbers 7 and 10 that would perfectly match his surrounding, existing teeth. With the help of shared photography, the technicians and Dr. Allen were able to determine a predictable, detailed final outcome. The result was a charming, harmonious smile that Trey feels proud about now.

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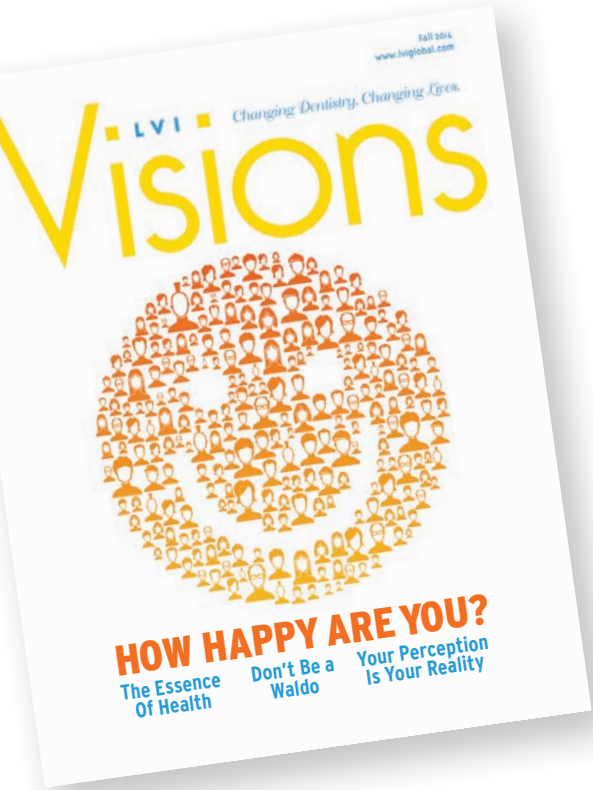

This issue of Visions is dedicated to your quest for HAPPINESS in your profession and life!

Go to www.lvivisions.com/contributor-bios to view complete bios!

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editor's note

According to a Harris Poll, only 1 in 3 Americans say they are 'very happy.'

The online poll of 2,345 U.S. adults used a series of questions to determine Americans' levels of contentment and life satisfaction. Only 33 percent of Americans said that they were very happy, the same as in 2011, however dropping from the 35 percent who reported being very happy in 2008 and 2009.

Many could summarize that the economy and stressors from it play a big role… however; there are so many other things in our lives that play into our feeling of overall happiness.

You may be surprised to learn that materialistic things rarely determine long-term happiness. Things may contribute to short term enjoyment but this is short lived. Happiness is determined by innate factors and perceptions, as well as experiences.

Our interpretation of life's events determines our personal happiness.

Basically it is an inside job!

Leo Tolstoy says, ***"If you want to be happy, be."*** I love that quote.

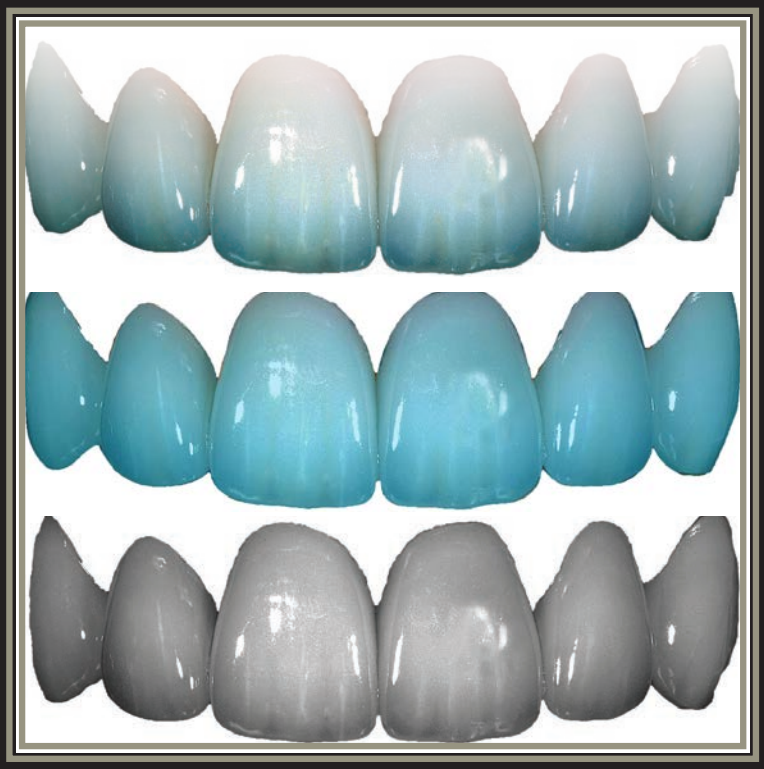
I hope this VISIONS helps you in your quest for HAPPINESS. Learning, improving, and applying new things that enable us as clinicians to help others can be a way to improve our happiness scores. Read on to learn some amazing things…

H. Dickerson, DDS

hdickerson@lviglobal.com

P R O T E C H

ADVANCING THE ART OF DENTISTRY



"Congratulations to Protech owner and master ceramist Duckee Lee CDT, LVIM for achieving your LVIM at this years IACA/ 2014."

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William G. Dickerson, DDS, LVIM, FAACD

How Happy Are You As A Dentist?

I just got back from the IACA annual meeting in beautiful Atlantis. There is no meeting in dentistry like this meeting with positive, happy, appreciative, compassionate and loving attitudes permeating the halls of the meeting. I know that sounds corny or insincere, but ask anyone who attended and they will confirm what I said. It seemed everyone there LOVED being a dentist.

It got me thinking about the difference between all of the dentists at the meeting and the average dentist in North America. The normal discontentment for those that choose our profession is nothing new. For many years, surveys have consistently shown that the majority of dentists would not choose dentistry again as their choice for a career if they could start all over again. In a recent "Jobs Rated" survey report, using the following criteria, Environment, Income, Outlook, Stress and Physical Demands; dentistry was 33rd. It was just below Museum Curator and just above Parole Officer.

What makes the difference between those that dislike being dentists and those that love being a dentist? Is it income? Is it patients respect or appreciation for what they do? Is it the elimination of insurance from their practice? Is it the corporate takeover of their practice? Is it the type of dentistry that they are practicing?

A survey was commissioned by the independent marketing firm, Strategic Dental Marketing (SDM), which is a nationally recognized research firm used by many of the top companies in the industry. E-mail invitations to take part in the survey were sent to **800** LVI dentists. They felt they would be lucky to get a **10%** response yet they got a **42%** response. This was the largest response they have ever obtained especially when it was not incentive driven. No one was given anything for taking the survey. It would have been higher but many thought that the survey was just spam and never opened it. Yet a huge percentage did and responded honestly to the anonymous survey. Here were just some of the interesting and eye opening results of this telling survey.

It has always been clear to us that the majority of LVI dentists loved their occupation, but the results of this survey were beyond my expectations.

97.7% of LVI graduates love being a dentist. Compare this to the average in our profession where **67%** wouldn't go into dentistry again. The difference is staggering and an indication that if someone doesn't like being a dentist, they can change that. Why? Because **92%** enjoy their profession more since they started LVI. This was a direct indication that something they learned at LVI had improved their feelings about what they do for a living.

The point is that there is no reason ANYONE should not love what they do for a living.

So what is the difference in the practices of LVI trained dentists and the average dentist? I interviewed **20** doctors to find out. There were several common themes among them all. For one, many LVI dentists have been able to wean themselves off Insurance. They feel more in control of their practice and what they do for a living. They also feel better about the quality of care they are providing their patients and it's more WANT BASED driven, meaning that the patients WANT the work they are providing. They feel more appreciated by their patients and satisfied with the work they are providing. And they are not in the normal rut of volume dentistry, instead working on one patient at a time, developing relationships with their patients, and being adequately compensated for their superior skills.

Over **83%** of LVI alumni have seen an increase in their incomes with the majority of dentists increase in income exceeding **25%** since coming to LVI. **30%** have increased income by more than **50%**. At first glance it might seem that the increase in income that occurred as a result of going to LVI might be responsible for the increase in enjoyment of their profession, but more people increased their enjoyment than those that increased their income. As they say, money does not buy happiness (although it may allow you to be miserable in a lot of nice places)!

80% of LVI dentists make more than the average dentist in the US or Canada. I felt this would be the case, and the fact that the average LVI dentists income is significantly higher than the average North American dentist is not surprising.

92.2% of the dentists were either extremely satisfied with their LVI education or very satisfied. **7.2%** of the remaining **7.8%** were satisfied. This result was phenomenal and looking at the results of those that increased the love of their profession after attending LVI, it is not surprising that they would be appreciative of that education.

97.4% of LVI graduates plan to take another course at LVI. This correlates closely to the numbers that were satisfied with their education at LVI. Many graduates talk about going to LVI to get their "LVI Fix," which is described as an increased enthusiasm for what they do for a living.

So the answer is, if you don't enjoy your profession of dentistry, there is hope. You DON'T have to feel that way. Ask yourself, what is it that you don't like and then work on eliminating that source of discontentment. If you want to do a particular type of dentistry, for example treating TMD or OSA, then get the proper training that will allow you to excel in that area. The confidence you will receive will make you feel good about what you do and help you enjoy your profession more. The point is that there is no reason ANYONE should not love what they do for a living. It's so sad to think that the majority of dentists don't enjoy going to work. It's sad because it doesn't have to be that way.

Amazing moments at the 2014 IACA in Paradise Island, Bahamas

Congratulations to The New LVIM's!

2014 LVIM's pictured here with Dr. Heidi Dickerson and Dr. Bill Dickerson.

From left to right: Dr. Christina Samra, Mr. Duckee Lee, and Dr. Karstan Lachman

2014 Aesthetic Eye Winners

LVI Core Case & People's Choice Award
Dr. Trey Carlton

Anterior Aesthetics Winner
Dr. Jeffrey Haddad

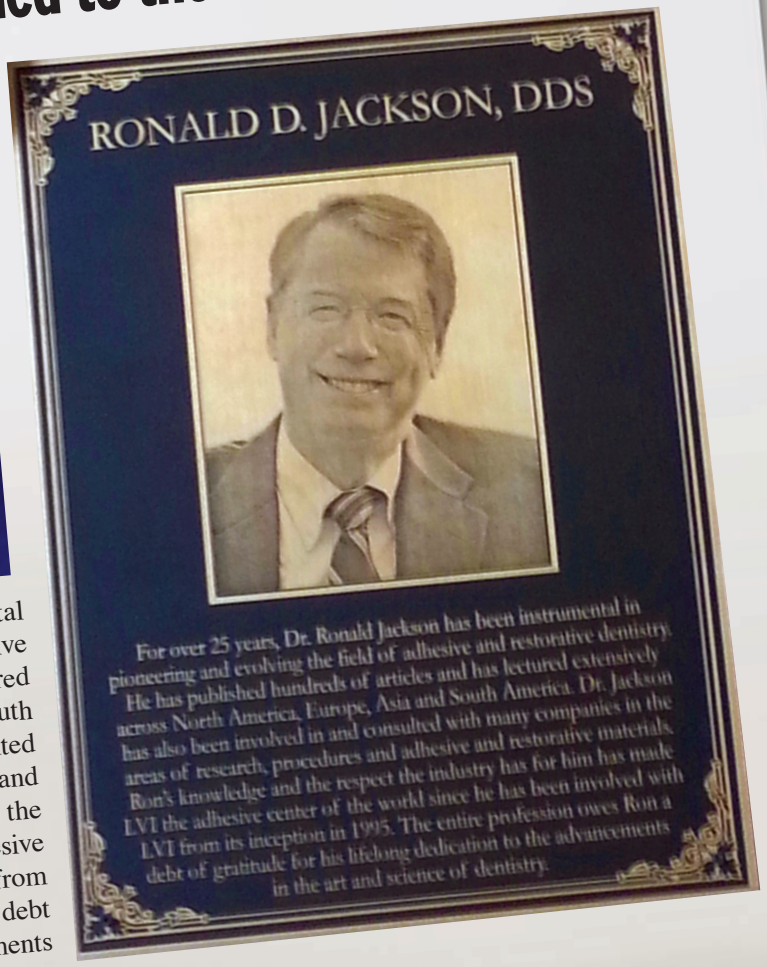
Glamour Winner
Dr. Nicol Cook

Full Mouth Aesthetics Winner
Dr. Pamela Marzban

EXTRA EXTRA

LVI ANNOUNCEMENT

Dr. Ron Jackson retires and is added to the LVI "Wall of Fame"



For over 25 years, Dr. Ronald Jackson has been instrumental in pioneering and evolving the field of adhesive and restorative dentistry. He has published hundreds of articles and has lectured extensively across North America, Europe, Asia and South America. Dr. Jackson has also been involved in and consulted with many companies in the areas of research, procedures and adhesive and restorative materials. Ron's knowledge and the respect the industry has for him has made LVI the adhesive center of the world since he has been involved with LVI from its inception in 1995. The entire profession owes Ron a debt of gratitude for his lifelong dedication to the advancements in the art and science of dentistry.

Drew Markham, DDS, LVIF, FIACA
2015 IACA President

Don't Be a Waldo

Dentistry is always changing, but there are a number of recent events that are happening right under our nose. Some of these changes are going to have a dramatic effect on how the average dental practice will look in the next decade. Much like the squeeze on the middle class, the average practice owned and operated by a solo dentist may disappear in the not too distant future. However, a select few will find ways to separate themselves from the pack and excel within the new economy of dentistry.

The pressures facing dentistry are varied – some are backed by big money, some are demographic in nature, but all are powerful.

1. **Insurance** – insurance dependant dentists continue to feel the screws tightening from big business and often lose the battle of perception waged through the media
2. **Corporate Dentistry** – dental chains are expanding with the support of billions of investment dollars and have economy of scale on their side (for those that treat dentistry as a commodity)
3. **Dental Tourism** – hundreds of thousands of US citizens are traveling abroad every year for the perceived cheaper fix
4. **Too Many Dentists** – dental schools continue to graduate the same number of dentists, while those nearing retirement are practicing longer – this is resulting in higher competition among dentists especially in urban centers

Everyone knows Waldo. He is the lovable cartoon character in the red and white striped shirt, glasses and toque (Canadian for winter hat) that hides in photos. It seems that he should be easy to find, but when he is placed in a picture with hundreds of other people and buildings, some of which have similar patterns, it becomes very difficult. Dentists always believe that they are doing things that stand out – but often those things are not nearly as unique as we imagine.

So how can we really stand out? How do we avoid getting swallowed up by the corporate giants?

First, we have to do a little work. You and your team need to have a crystal clear vision of the values of your practice. That should be summarized in a mission statement that everyone on the team knows forward and backward. That mission will dictate day to day decision making, training, and long range planning for your practice.

From there, the practice needs to have at least a few areas where they excel – and those areas need to matter enough for patients to want to come to your practice in the first place, or stay with your practice if someone else starts doing something that is unique.

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A few areas that your practice can stand out:

Clinical Skill

While most potential patients do not select their dentist based on the variety of procedures that they provide, there are some areas of practice that patients will seek out very specifically.

1. **Neuromuscular dentistry** – people are willing to travel hundreds of miles to have their chronic pain treated – Neuromuscular dentists are uniquely qualified to provide this care
2. **Implants** – demand for this procedure continues to grow and those providing both surgical placement and restoration are well positioned to benefit
3. **Sedation** – for extreme dental phobes, sedation is the first, last, and only thing that they are interested in from their dentist
4. **Orthodontics**, and to a lesser extent cosmetics, continue to make the list of procedures for which patients are seeking, specifically qualified dentists

Communication

This is a far more important means by which to make your practice stand out. It influences the image we project, and it plays an enormous role in any internal marketing strategy.

Far too often, it is mistakes or lack of education in this area that lead to patient dissatisfaction. We need to ask our patients more questions to uncover their specific objections. We need to show compassion and understanding when getting to know our new patients to establish trust. We need to do a much better job of communicating financials to our patients before treatment begins.

There are countless other examples, but a practice that exhibits great communication skills will in turn have stronger relationships with their patients who will be much less likely to leave for another practice for any reason.

Besides clinical skills and communication, there are a multitude of other areas that can be used to separate your practice from the others – advertising, branding and image, and amenities for comfort to name a few. But even with outstanding clinical skills, and fantastic communication, there is one thing that ultimately will determine how successful you can become – and that is…

Sincerity

Sincerity refers to action made without pretense, deceit, and hypocrisy and its utilization is in dramatic decline. Life gets much easier when you say what you mean. It may sound simple, but how often have we been fooled by someone who came across as sincere but ended up being a con artist. The good news is that over time, those not possessing sincerity will be revealed as deceitful people and will suffer the consequences.

How do patients judge our sincerity outside of face to face conversations? Patient's see sincerity in our actions – are our practices involved in the community? Do they walk the walk when it comes to helping others? When our patients and prospective patients feel that connection; it leads to loyalty, it leads to case acceptance, and it leads to fulfillment.
These sentiments are perhaps best articulated below.

"**Originality** is a by-product of sincerity."
-Unknown

"The secret of success is **sincerity.**"
-Jean Giroux

That is how not to be a Waldo.

Dr. Drew Markham pictured with his team.

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New Revenue Streams

Michael Reece, DDS

As a Clinical Instructor for LVI, I have talked to hundreds of dentists about a variety of topics in our field. The conversations usually start out clinical, with concerns about different techniques and ways to improve patient treatment. These conversations quickly evolve to the business side of dentistry and the main concerns are how to increase new patient flow and revenue effectively. I have learned through years of experience and owning my own business what works best for my practice. This includes adding new revenue streams such as implants, sleep dentistry, TMD treatment, and cosmetic dentures. The most recent addition of these has been NewYou dentures.

High end cosmetic dentures, **(i.e. NewYou dentures)** have been a major source of increased revenue as well as new patient clientele. With the "baby boomers" aging and the desire for improved esthetics increasing, there seems to be a stigma attached to getting conventional dentures. Our office sees an abundance of patients who have been wearing dentures, but are unhappy with the "denture look" that they have. The "denture look" is a sunken-in appearance with no facial support, which in turn, makes the patient look 10 years older. Every dentist knows that the edentulous ridge resorbs significantly when the teeth are lost, but dentists are taught to set teeth over this ridge when making conventional dentures. This is what causes the patient to lose facial and lip support. The most unique feature of the NewYou denture is that fact that we place the teeth where they were before the ridge was resorbed; giving the patient the full face and lip support they had before the teeth were lost. Most of the time, this makes the patient look 10 years younger!

As more NewYou dentures are being done in our office, we are seeing an increase in the number of new patients calling to set up consultations. People are falling into two categories; 10% who have worn conventional dentures but are unhappy with them, and 90% who still have their teeth, but know that they need to lose them. Over the last 2-3 years we have seen many people who would rather live with bad teeth than with good dentures, but once they realized there are options for a great denture, their outlook changes. This increase has led to several variations of the NewYou denture.

There are three types of NewYou dentures being done in our office; dentures without implants, implant retained dentures, and implant supported dentures. Patients that choose to have no implants placed are typically those who have worn conventional dentures and simply do not like the appearance or fit of their current denture. We call them "successful" denture wearers. They have become accustomed to having removable teeth and any adjustments that come along with them. Very few, less than 25%, of these people choose to have implants placed when they "upgrade" to NewYou dentures. When presenting the option of wearing dentures to someone who has teeth remaining, the treatment planning of NewYou dentures becomes more difficult. There are various reasons that dentures do not seem appealing. For starters, they must have teeth extracted. Many people have an emotional connection to their teeth and extracting them can cause hesitation. Secondly, function becomes a major concern. We have all heard horror stories about wearing dentures and so have our patients. Placing implants for the NewYou denture to connect to will help stabilize them and improve function. With the predictability of implants, an overwhelming majority of our cases choose to have implants placed for this reason.

When treatment planning these cases, all patients are told that they will get 2 dentures. We call the 1st denture a "healing" denture. This is placed immediately after surgery. This "healing" denture will be worn until the patient heals and any implants that are placed are fully integrated. This time period varies, but usually lasts 4-8

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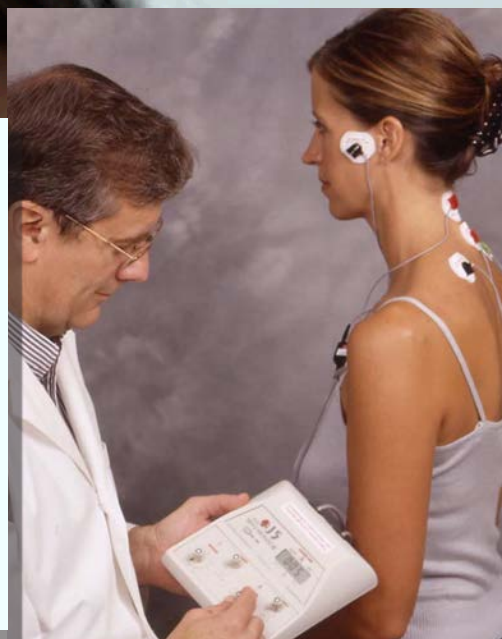

months. It is not uncommon for patients to change their mind and "upgrade" their finished prosthesis during this healing time. This is the first denture that these patients have ever worn and some decide that they want to remove the upper palate. Some decide that they want the stability of implants. All of these "upgrades" take an additional surgery, but the patients always feel good about their decisions. **Photo 1 and 2 (before and after)**

Our first implant option is the implant retained NewYou denture. Anywhere from 3-6 implants are placed on the maxillary arch and 2-4 on the mandibular arch. Adding more implants on the maxillary arch also allows for the removal of some of the palatal acrylic.

(Photo 6 and 7) The finished prosthesis connects to locators and the patient has the ability to take the denture in and out. This option is a good middle ground for patients who would like for of retention but still want the ability to take them out if needed. The placement of implants also helps retain the remaining bone. The ability to slow down the bone loss has always been very important to patients. There are several variations on the implant retained NewYou denture. Dr. Leo Malin and I discuss these in the Implant Restorative course that we teach together.

The second implant option is to do an implant supported NewYou denture. We like to place 5-6 implants on the maxillary arch and 4-5 implants on the mandibular arch. The finished prosthesis is attached to the implants and all of the maxillary palate can be removed. Patients like the idea of having teeth that are non-removable and function more like natural teeth. **(Photo 3, 4, 5)** It is easy for the treating dental office to overlook the emotional attachment that people have to their teeth. One of the reasons that these people put off their treatment so long, is that they don't want to feel "old" because they have lost their teeth. This non removable option can be very exciting to these type of people. Again, there are several different types of implant supported dentures; bars, non-removable, fixed hybrids, zirconia, etc. These are also covered in the Implant Restorative course. **(Photo 9, 10 – before and after)**

As the baby boomers are aging, we are seeing more and more of these patients. Baby boomers are not going to age "gracefully" and can find the money to invest in these restorative procedures. This has been a great new revenue source for our office. 2013 was our best year ever, and we are up 12% this year. This is a great revenue source for the dentist that is willing to take the time to be trained in these procedures.

Upcoming NewYou Dentures Courses

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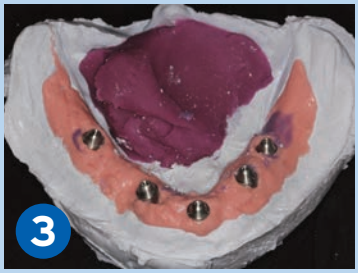
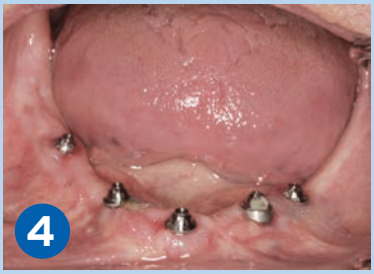
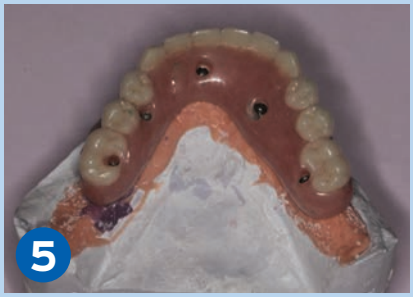
BEFORE AFTER







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Essence of Health

The greatest achievements and advancements in the future of healthcare will not be scientific ones or new technology. The greatest achievement is for US to learn to change our attitudes and behaviors in our own healthcare practices.

Heidi Dickerson, DDS & Jill Taylor, RDH

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet and in the cause and prevention of disease."

Thomas Edison

The challenge we face is to understand ourselves and govern our own health behaviors. The aim of healthcare should be preventative and not intervention as western medicine has become. Health care is like looking at an iceberg where the tip or 10% represents the doctor appointments, prescription medicines, medical tests, and medical procedures that are done to us; yet, 90% of that iceberg is what we don't see. This 90% comprises what we eat, how active we are, our state of mind, and how we relate to the world. That 90% is what is keeping that 10% afloat and it's what is missing in our lives.

Most chronic diseases that afflict us today such as heart disease, diabetes, obesity, stroke, lung cancer, and hearing loss are all caused largely by lifestyle factors. They are preventable with simple lifestyle changes!

90% of what we can affect can be found in the 7 points of good health. Hippocrates said, "The human being can only be understood as a whole." The **ESSENCE** of good health is dealing with the mind, body, and spirit and imparting ways to affect lifestyle behaviors.

E - Educate
S - Sleep
S - Simplify
E - Exercise
N - Nutrition
C - Create a Happy Place
E - Empower

It is interesting that the definition of doctor originates from the Latin word of the same spelling and meaning. The word is originally an agentive noun of the Latin verb docêre [do'ke:.re] or 'to teach'.

In the dental profession we are constantly educating our patients and ourselves. Thomas Edison stated that, "The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet and in the cause and prevention of disease."

A healthy brain function is paramount to this role. Alzheimer's is like diabetes of the brain. Insulin problems prevent brain cells from up-taking the important food for brain cells: glucose. However, what they have found is ketone bodies can be used as brain cell nutrients. Ketone bodies are produced from acetyl-CoA mainly in the mitochondrial matrix of hepatocytes when carbohydrates are so scarce that energy must be obtained from breaking down fatty acids. Long-chain omega-3 fatty acids are EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid). These are plentiful in fish and shellfish.

Coconut oil is a medium-chain fatty acid and goes directly to your liver to use as energy without an insulin spike. It is also a natural antibiotic killing both bacteria and virus. It has also been shown to help with brain health in Parkinson's, ALS, epilepsy, dementia, schizophrenia, and autism. Daily consumption of coconut oil can keep your brain healthy for a lifetime.

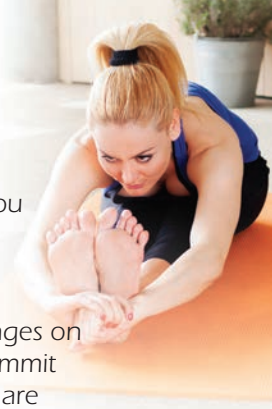
S - Sleep

Think about the last time you didn't get a lot of sleep. How did you feel? Sleep is necessary for our brain to relax, recharge, and repair. Our hearts, lungs, tissues, and muscles also need time to revitalize, reenergize and restore.

Studies show that rats die within 14 days without sleep. It is necessary for life. When humans don't get sleep we have drops in performance, lack of concentration, reduced reaction time, lapses in memory, mood swings, health issues, and so much more.

Of course as dentists we should first rule out OSA in our patients. Then we should suggest healthy ways our patients can increase the quality of their sleep. Let's go through a few of these.

Get prepared for sleep. Take a bath or shower to lower your core temperature. Read or listen to soft music. Dim the lights. Limit your screen time on computers, phones, and TV's before you head to bed as well.

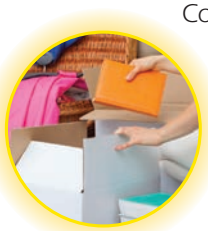


Limit your food and drink. Don't go to bed too hungry or stuffed. Limit your fluids, for your bladders sake. Be careful as to your consumption of nicotine, caffeine, and alcohol as these can hamper your sleep cycle.

Decrease the electromagnetic fields around your bedroom. EMFS decrease melatonin production. Melatonin is a natural hormone that is produced by our pineal glands. It allows the body to relax and triggers sleepiness at night. So check out your nightstand. If you have a computer, iPad, cell phone, and chargers on it...you need to unplug!

Lastly, get comfortable. Sleep in soft clothing and bedding. Your room should be between 68-72 degrees. Earplugs, eye masks, room darkening shades, and background noise can also be helpful. Look into using NuCalm and getting on a sleep protocol.

S - Simplify



Confucius has said, "Life is really simple, but we insist on making it complicated." Simplifying our lives is a challenge with the busy schedules we keep. To make this easy, concentrate on 4 things that can improve your life.

First identify what is important and eliminate all else. Make a list of your top 4-5 important things. What's most important to you? What do you value most? My top four commitments are making time for Exercise, Eating clean, Relationship deposits (partner, children, parents, friends), and Learning something new daily. Simplifying starts with these priorities, as you are trying to make room in your life so you have more time for these things.

Next we should evaluate our communication time. Our lives these days are filled with a vast flow of communications: email, IM, cell phones, paper mail, Skype, Twitter, forums, and more. It can take up your whole day if you let it. Instead, put a limit on your communications: only do email at certain times of the day, for a certain number of minutes. Only do IM once a day, for a limited amount of time. Limit phone calls to certain times too. Set a schedule and stick to it. If you really are a computer lover, you might want to check out RescueTime.com. It tracks how much time you are loafing around and how much time is actual work time.

Learn to say "No" more often when it infringes on what is important to you. Often we overcommit ourselves and then miss out on things that are truly important. Learn to say "No" by saying I "don't" rather than I "can't," to help empower your resolve. "I don't" is experienced as a choice, so it feels empowering. It's an affirmation of your determination and willpower. "I can't" is not a choice. It's a restriction; it's being imposed upon you. So thinking "I can't" undermines your sense of power and personal agency. For example if you are committed to exercising and someone asks you to do something during your scheduled workout time, instead of saying "I can't go," say "I don't miss workouts."

Finally to simply your life, start organizing the clutter around you. This might feel like a monumental task, so start small. Purge a shelf in your closet or garage. Take everything off and decide what stays or goes. Be merciless and make quick decisions. When you are finished, make sure you celebrate your accomplishment!

E - Exercise

You should exercise for one main reason...LONGEVITY.

About 1/3 of the elderly population over the age of 65 falls each year, and the risk of falls increases proportionately with age. At 80 years old, over half of seniors fall annually.

Those who fall are two to three times more likely to fall again. Falls are the leading cause of death due to injury among the elderly. Falls account for 25% of all hospital admissions, and 40% of all nursing home admissions. 40% of those admitted do not return to independent living: 25% die within a year. That statistic is shocking!

As we age we need to stay MOBILE. Studies show that moderate physical activity improves the independence and mobility of older adults. Focus on walking and lower body strengthening exercises to increase your mobility and strength for life.

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Other reasons to exercise through our life times are: Appearance, Increased Energy, Increased Endurance and Strength, Happiness, Less Disease, Longevity, Deeper Sleep, Stress Relief, Weight Loss, and Recreation.

N - Nutrition

Moderation in all things is a way to approach good nutrition. Fad diets are out. Knowing what foods can adversely affect you takes a more concerted effort. Fat was once the target of disdain but now gluten has come to the forefront as a cause of many side effects from irritable bowel, colitis, to just constipation and bloating. That isn't what this section is about, since most of us know about a healthy diet.

A visit to the doctor used to include: "stick out your tongue and say ah." With doctor's time being cut shorter and shorter, this isn't done with the same regularity. In the dentist chair we have the opportunity to see subtle changes and deficiencies in the body by inspecting our patient's tongue (and our own!). The tongue body should be light pale pink with flexible movement. The tongue coating should be thin and white.

For example, a red, inflamed tongue might indicate a lack of certain nutrients, especially B vitamins. B vitamins are needed for energy metabolism, cell growth, and the proper functioning of the nervous system. A pale tongue could mean that the blood is lacking in hemoglobin, the iron-containing protein found in red blood cells. Iron, found in red meat, shell fish, nuts and apricots, is essential for the formation of red blood cells and necessary for energy and vitality. If a tongue changes color or texture, a Chinese herbalist or naturopath may use tongue diagnosis to detect vitamin deficiencies, poor circulation, high cholesterol, allergies, or digestive problems. Tongue's body color helps determine chronic conditions, and the coating helps determine acute conditions.

A thick, yellow coating might indicate that there is too much "heat" in the body and to eat more cooling foods such as cucumber, watermelon, and green tea. The thicker the coating the more digestive issues are present, and digestive enzymes might be recommended. A thick, white coating might indicate that there is too much "cold" in the body and increasing warming foods such as garlic, ginger, and cinnamon would be indicated.

The tongue appearance can indicate that there has been a long-term period of deficiency in the body similar to a period of drought over a landmass. The ground will become extremely dry and start to crack. The tongue will look the same way. The deeper the fissures or cracks correlates to a more chronic condition that the tongue and body are experiencing. The body might be undergoing dehydration and long-term adrenal stress. Typically, the tongue is swollen in this state and the pressure causes cracking. Once the underlying issues have been addressed, the fissuring should begin to diminish. The treatment for this can include Vitamin A and digestive qi-energy tonics such as Ginseng, Astragalus, and Aswagandha.

C - Create a Happy Place

Definition: the mental or physical place you go to when you want to avoid the unpleasant or uncomfortable.

Everyone's happy place is different, and usually consists of the things that make them joyous. The one thing it isn't is anything or anyone that is negative.

You need time to refresh to be your healthiest... mentally and physically. Be selfish and allow some 'you ' time. This could be doing things you enjoy such as hobbies, sports, 'vegging out' and doing nothing, learning something new, going on vacation, having a massage, hanging out with friends, heading to your lake house or personal retreat, playing an instrument, gardening, walking the dog, and just about any activity you can think of that puts you in a happy, harmonious, state of mind.

Whatever your Happy Place is...you need to spend time there. As Leo Tolstoy says, "If you want to be happy, BE." Happiness is an inside job.

"If you want to be happy, BE."
Leo Tolstoy

E - Empower

Em·pow·er means to give (someone) the authority or power to do something. The essence to good health really is about empowering ourselves to live a healthier life. No one can do this for us but US! "Life has no remote, so get up and change it yourself." Tony Robbins has an excellent method to keep us on track with our lifestyle goals since this is about effecting a lifestyle change. RPM stands for Results/Purpose/Massive Action Plan.

Result:
What do you really want? What's the outcome you are after? What's the specific measurable result? The more precise your result is, the stronger it is. For example, there is a difference between "I want to lose weight" and "I want to lose 20 pounds."

Purpose:
What is your purpose? What are your reasons? The emotional quality of purpose will make what you will do sustainable and powerful. For example, if you want to lose weight –why? Because you will feel healthier, because you will fit better in your clothes, because you want to turn heads, because you want to lower your blood pressure, because... Your reason is what will keep you going and not give up.

Massive action plan:
What do you need to do to achieve your result? What is you massive action plan? This has to be not just one or two things, but brainstorm a bunch of ideas. For example, get a gym membership, make a grocery list of healthy foods, go through the pantry and throw out all the high processed, high sugar foods, set the alarm an hour earlier to go to the gym.

Hopefully we have EMPOWERED you to improve some areas in your life that need a little tweeking. When you reach the ESSENCE of health... you will truly know what it is to be yourself.

Whiplash and Motor Vehicle Trauma:
Injuries and Documentation

David Miller, DDS

Motor vehicle accidents (MVAs) are all too common in modern society. According to the Centers for Disease Control, MVAs are one of the leading causes of death and injury in the United States. More than 2.3 million adult drivers and passengers were treated in ERs for MVA injuries in 2009. The lifetime costs of crash related deaths and injuries among drivers and passengers were $70 Billion in 2005. Rear end motor vehicle accidents (REMVA) are among the most common type of accident. Whiplash is among the most common injuries. Although the medical/dental professions have recognized this injury since the early 1950's, personal injury litigation in this area rose and fell due to a lack of understanding of these injuries. Judges and juries witness a parade of experts opining on the plaintiff's medical status, while offering a variety of conflicting explanations of the symptoms, damages, and causation. Thus, the judge and jury must render verdicts based on opinions, not necessarily the facts of the case. Both doctors and patients can be confounded when the magnitude of symptomology is totally out of character with the minor damage to the vehicle. The converse is also true and confusing to all parties. There are many cases where automobiles have been totaled and the driver walked away with minor or superficial injuries. The rear end collision is not only the most common vehicular collision; it has the most potential to cause injury to the craniomandibular/temporomandibular/cervical complex. The rear end collision produces multiple forced hyperextension/forced hyper-flexion injuries, especially involving the cervical and temporomandibular joints. Multiple injuries are the result of repeated movements of the body during the accident. The various injuries caused by this forced acceleration/deceleration must be thoroughly understood by both the treating clinician to provide effective treatment, and the knowledgeable expert for documentation and analysis of said injuries.

This injury was first termed "whiplash" in 1928 by Crowe and described in detail in 1953 by Gay and Abbott in the Journal of the American Medical Association. The injury has since been described in detail in various medical, dental, chiropractic and physical therapy publications. Interestingly, in the 1800s, rear end railway accidents led to the description of a similar injury termed "railroad spine." The numerous and variable range of "whole body" symptoms have been well documented in the scientific literature, but have only recently been causally linked.

FORCED HYPEREXTENSION: Upon impact, the flexing seat throws the body forward and upward with the head thrown backwards over the headrest until metastatic reflex contraction of the musculature occurs. Inertia keeps the mandible lagging behind the rest of the cranium as the neck hyper-extends. The anterior cervical musculature and all the soft tissues connecting through the hyoid bone and/or into the mandible stretch beyond normal limits resulting in sprains and strains of these tissues. The cranium reaches an endpoint of movement beyond the normal limits of cervical extension with stretching and crushing injuries to the C spine's bony, vascular and neural architecture, and concomitant myofascial damage. The sudden torquing of the condyle in the TM Joint causes its avulsion during the forced hyperextension; muscular strains and sprains occur, and the capsular, discal

collateral and checkrein ligaments tear as the meniscus is ripped from its normal position. The meniscus is ripped forcibly from its position in the joint causing permanent injury and irreversibly compromising joint function. At this point, the metastatic reflex forces the cranium forward forcibly slamming mandible and the maxilla (and the teeth imbedded in them) together. This wrenches the condylar head of the mandible to the back of the TM Joint crushing the neurovascular complex located at the back of the joint, just in front of the ear canal.

FORCED HYPER-FLEXION: The C spine and the head accelerate far faster than the torso during the forward phase of the movement. This forward movement continues until the mandible strikes an object, typically the chest. The cervical spine is forced forward in the extreme with resulting neurovascular, myofascial and bony injuries. The mandible, having been forced into tooth-to-tooth contact, is carried forward along with the cranium until the endpoint again hammers the teeth together and forces the condylar head to the rear of the TM Joint. Since the cartilage disc is no longer interposed between the bones of the joint, the mandible's condylar head acts as a mortar to the cranium's pestle to further crush the neurovascular tissue located at the rear of the joint space. The resulting hemorrhage in the joint initiates changes to the synovial fluids, lining and membranes; alters the synovial fluid content and function, and promotes adhesion formation.

WHOLE BODY LINKAGE: The "whiplash" sequence sketched out above is complicated by angular forces, with a concomitant increase in the magnitude and severity of the injury. This sequence of events normally occurs multiple times (bounce-backs). Since a whole sequence occurs in less than 1/5 of a second, it is common for the victim to be unaware of the movement until the third or fourth cycle. From even this abbreviated version of the whiplash event, it can easily be seen that all of the structural components of the craniomandibular/cervical complex are affected. The effects of the injuries are multiplied and the bio/physio/mechanics complicated by the omnipresent angular force vectors imparted by the impact. The collision will seldom impart purely linear forces onto the victim. Bodily rotations or the presence of a shoulder harness can further increase the angular component and hence the severity and complexity of the injury. The list of effected tissues includes the muscles and fascia, neural and vascular structures, tendons, ligaments and bone. The entire functional matrix, from skull to shoulder girdle and beyond, is so interrelated, that any unresolved damage to the matrix becomes mutually provocative to the rest of the matrix. Through muscle recruitment and postural accommodation, it is common for the untreated patient to experience a neuromuscular cascade of increasing dysfunction spreading from the head and neck downward through the spine to the hips and legs. Often, patients will come to our offices months or years after the accident and will have gradually become increasingly compromised to the extent that not only are they physically and posturally debilitated, but have become chronic pain patients, too.

CHRONIC PAIN OVERLAY: Chronic pain is generally defined as pain continuing beyond a few weeks. Chronic pain is more properly called "complicated pain." Chronic pain differs from acute pain in how patients deal with it psychologically. Acute pain generally provokes anxiety and fear; however, the time that the patient suffers is generally of short duration and is caused by a known problem. Because the source of the pain is known and has an anticipated end- point, major emotional disturbances rarely surface. Chronic pain is much more devastating to the patient. Pilling termed chronic pain "the ultimate stress." The complications of chronic pain are due to the patient's response to this prolonged stress. The patient's negative responses to the lingering pain increase in number and intensity the longer that the pain persists. A self-feeding cycle of reduced pain tolerance, increased pain awareness and increased stress from pain develops in these patients. Physiologically, the neural pathways moderating the perception and response to pain become more ingrained to the sensory input from the injured tissues. As more of the body's structural components are recruited to support and compensate for the injured and dysfunctional tissues, the existing stress-spawned neural pathways and the lowered pain thresholds facilitate increased pain perception in the recruited tissues. Additionally, the compensatory postural and functional movements quickly fatigue the muscular components forced to work in an asynchronous, dysfunctional manner. The emotional toll of the continued dysfunctional activity can be devastating on the patient. Hans Selye stated that all creatures reach the point of exhaustion if stress continues long enough. The stress response affects the entire body. The digestive tract is affected reducing the body's ability to provide nourishment just when the demand is greatly increased. The spastic, fatigued muscles function anaerobically thus utilizing the diminished nourishment inefficiently. The basis for the patient's complaints is physical, but the response becomes emotional. The psyche and the soma are inseparable.

Life's two major stressors are "change" and "loss." For the whiplash victim, there is the change from health to illness, from no pain to constant pain, from ability to disability. The losses mount: time away from work, family, friends;

financial loss from the accident, treatment costs, and possible litigation costs. The patients will "ping-pong" from one emotional state to another. Without intervention, they will endure an unending cycle of depression, anger, denial, guilt, and fear. Patients gradually withdraw from family and friends, from activities that sap their dwindling energy reserves. Often these patients will be attending the workplace solely for a paycheck to support their family. It is all too common for these victims to lose jobs and/or families as the victims withdraw inside themselves, husbanding their limited energy and coping unsuccessfully with their pain. The presence of chronic pain adds emotional and psychological stresses that not only strain the doctor-patient relationship, but also interferes with evaluating and treating these patients in an objective manner. Doctors treating these demanding and unpleasant patients often overlook the devastating affects of chronic pain on the patient and his/her relationship with family, friends and co-workers.

OBJECTIVE DOCUMENTATION: The major problem in most personal injury litigation is the subjective nature of medical opinions. Both plaintiff and defense produce a parade of medical experts, each one opining on the issues; typically causality, prior and current medical condition, and future physical impairment and treatment needs. These subjective opinions are normally at odds with one another, leaving the judge or jury weighing the theatrical skills of the experts and attorneys, rather than the science and facts of the case. Computerized diagnostic instrumentation is used to measure the function and dysfunction of the victim, and to do so in a scientifically valid and repeatable manner. Diagnostic, treatment and documentary predictability requires that the underlying pathogenesis must be assessed and determined. Craniomandibular disorders are initially classified as intrinsic (arthrogenous) or extrinsic (myogenous) in nature. Research has shown that over 90% of symptomatic patients have myogenous dysfunctions. These muscle-driven dysfunctions are usually precursors to intrinsic joint disorders. Objective documentation requires the ability to accurately record and reproduce data concerning the status of the craniomandibular complex. Fortunately, the instrumentation to perform such accurate measurements exists. The instrumentation consists of computerized Sonography, Electromyography, Electrognathography, TENS and Cone Beam Computed Tomography (CBCT).

CLINICAL AND FORENSIC APPLICATIONS: Practicing clinicians can routinely integrate various radiographic techniques ("plain" cervical films, computed tomography and MRI) with the computerized diagnostics, an extensive "hands-on" clinical exam, the patient's history and subjective complaints, and functional testing to determine the proper differential diagnosis and to develop an effective treatment plan.

CONCLUSION: The marriage of clinical, radiographic and computerized electrodiagnostic examinations provides the clinician with a comprehensive diagnostic view of the patient's physical injuries and dysfunctions, thus allowing appropriate and efficacious treatment regimens to be initiated. Attorneys are provided with objective and accurate documentation of permanent injuries, limits of treatment, and ramifications of the injury. Computerized diagnostic equipment married to forensic techniques can be used to both provide evidence of or to dispel claims of trauma related injury. Efficacious treatment and solid proof is provided the true victim, and no malingerer can fake Sonographic, EMG, or EGN data. This methodology allows judge and jury to function as "triers-of-fact," not "triers- of-opinion." Subjective medical opinion is supplanted by objective medical science!

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ORTHODONTICS

CONVENTIONAL VERSUS NEUROMUSCULAR

Dr's David Buck and Tim Gross, co-directors of LVI's new Physiologic Orthodontics program, were asked, ***"What is the difference between conventional orthodontics and physiologic orthodontics?"*** Here are their answers:

David Buck, DDS:

Conventional orthodontic diagnosis depends on a static lateral cephalometric image that relates the jaws to the cranial base, and assessment of the dentition. What is not considered is the position of the cranium in relation to the rest of the body. We fully acknowledge that the posture of the mandible is affected by head position, notably forward head posture. Additionally, the maxilla may not be in harmony with the orthogonal posture of the cranium at time of diagnosis. Further, the status of the masticatory muscles is not considered in conventional orthodontic diagnosis, along with CBCT TM joint imaging of (adult) patients at presentation. Conventional orthodontics and the dental profession at large still minimally consider the functioning capacity of the airway. If we can accept that our modern diet and ubiquitous nature of allergies has caused craniofacial deficiencies in a high percentage of the population, then accordingly there is a high prevalence of malocclusions which are necessarily accompanied by airway problems, and sleep disordered breathing. Neuromuscular orthodontic diagnosis therefore includes an airway assessment.

Thus in the vast majority of patients who start orthodontic treatments, the posture; TM joints; muscles of the head and neck; and sleep breathing problems may very well all be pathologic when treatment begins. Since the occlusion is being developed with the aforementioned factors in play, there is little chance that the orthodontic patient will have a physiologic condition of muscles, joints, posture, and airway at completion of care. Conventional orthodontics focuses on the interdigitation of teeth following Angle's classification scheme as the dominant influence on treatment decisions, with a much reduced emphasis on facial and soft tissue assessments and skeletal measurements. Neuromuscular orthodontic treatment starts with reversible corrective orthotic therapy to stabilize all factors which would contribute to a non-physiologic outcome. Once the system unwinds and is stable, active tooth movements can begin knowing the proposed final outcome before irreversible treatment commences.

It is been my clinical experience that the protocol of conventional orthodontics with simultaneous activation of all the teeth in a non-physiologic muscular environment greatly increases the risk of unwanted intrusive movements that lead to compressed TM joints, posterior hypo-occlusion, and an overall increased pathologic state of the Neuromuscular system. It is deceptive when examining these patients as the posterior teeth look to have normal clinical crown length, and the anterior coupling, and Shimbashi can appear normal. Intrusion just like extrusion moves the entire gingival/alveolar apparatus with the tooth maintaining existing clinical crown length. When the scope of examination is expanded to look at Neuromusclar aspects, the pathology becomes much clearer. In many cases although the dental vertical looks adequate, the skeletal vertical is definitely not. The cephalometric analysis used for Neuromusclar orthodontic diagnosis has a unique feature in providing a reference for the range of skeletal vertical normality for an individual patient and can serve as an invaluable guide to treatment decisions.

We as Neuromuscular clinicians providing orthodontic treatments acknowledge that the major reasons for orthodontic case failure are lack of vertical development, and lack of adequate arch development. These are 2 of several critical keys to success in Neuromusclar orthodontic treatments. It has been my clinical experience treating advanced TMD adult patients for 14 years with Neuromuscular protocols, that a common thread amongst these patients is that a majority have had orthodontic treatments already. I am of the distinct opinion that the nature of conventional orthodontic protocols is a significant culprit in creating a TMD pain patient in time as the adaptive capacity of these patients is overwhelmed with chronic pathology in the multiple areas as mentioned above. I am further of the distinct opinion that chief among the reasons for this are unwanted, and undetected intrusive orthodontic movements leading to among other things compressed and pathologic TM joints.

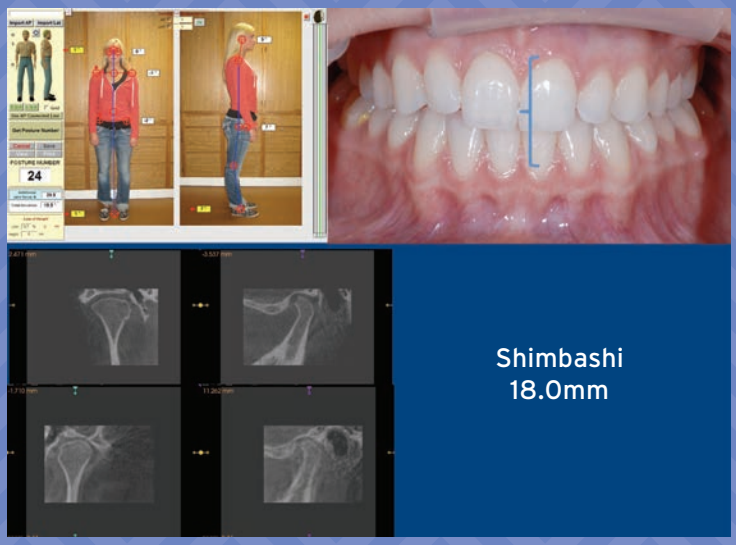
Let's look at how conventional orthodontic treatments done without a Neuromuscular approach create compromised outcomes.

First case:

- Female early 20's
- Orthodontically treated twice
- Disabling migraines with multiple hospitalizations in acute, intractable pain. Migraine medications do not work.
- Patient has headaches 3-4 times per week with severe migraines almost weekly
- No other systemic, lifestyle contributory risk factors now in phase one orthotic therapy for 2.5 months
- No migraines for 6 weeks, minor very mild headaches only once per week
- No hospitalizations for pain management
- Will be treated orthodontically for third time

Second case:

- Female late 30's
- Orthodontically treated twice for esthetic concerns
- Chronic neck pain
- Chronic joint pain, radiating facially
- Chronic joint noises and pain on eating
- Low grade headaches
- Meds Cymbalta for depression/anxiety



Shimbashi
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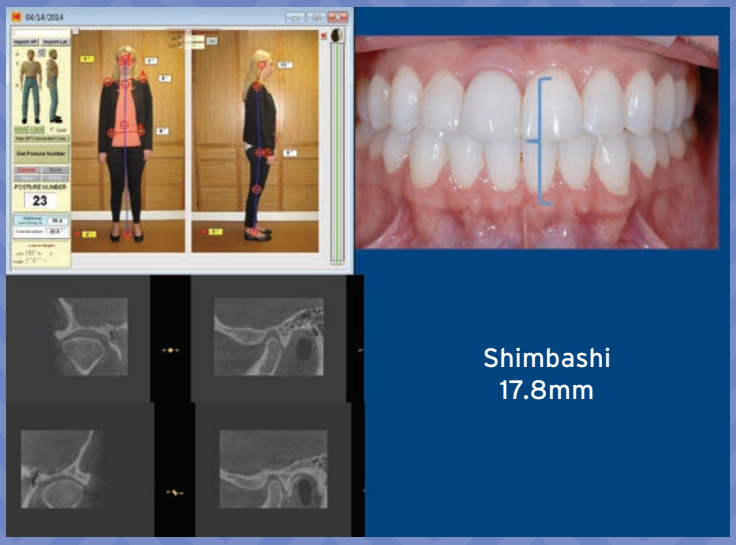
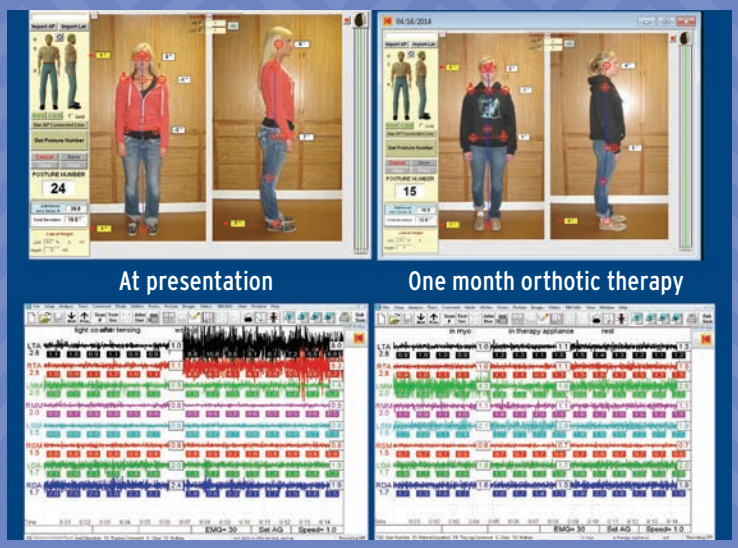
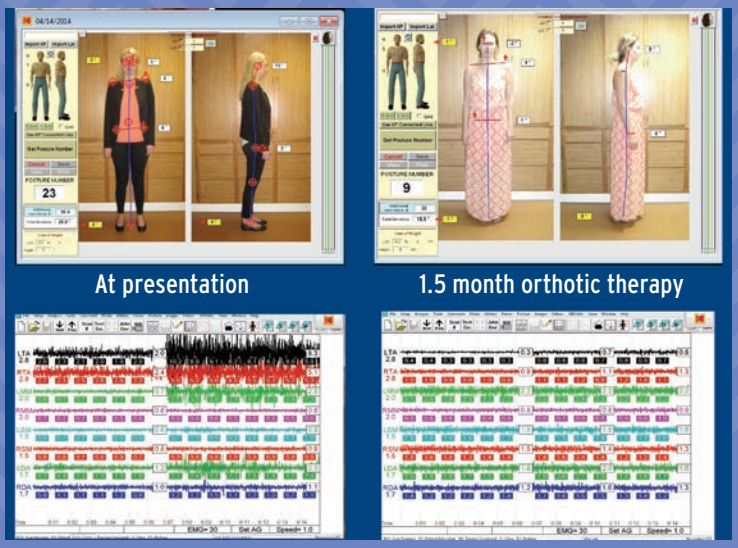


Shimbashi
17.8mm



At presentation | One month orthotic therapy



At presentation | 1.5 month orthotic therapy

I offer two examples of patients seeking help for significant pain and headaches. Both have had multiple rounds of conventional orthodontics, and are now in disabling pain which affects all areas of life. Note the corrupt posture at presentation, the higher the number on Posture Pro the more damaged the postural presentation , and note the unstable and hypertonic muscles in MIP. The TM joints on both patients are highly compressed, distalized, and painful yet the appearance of the occlusion looks "normal" as viewed in the intraoral views. This demonstrates the "intrusive" problem inherent in conventional orthodontics. Notice how both the muscles and posture are correcting while these patients are in orthotic therapy. They both are also reporting significant reduction of pain complaints. This sets the stage for corrective orthodontics when the system becomes stable and pain-free.

Tim Gross, DMD:

Physiologic Orthodontics: So much more than straight teeth.

- Teeth will intercuspate maximally.
- Mandibular posture will compensate for maximal intercuspation.
- Compensatory mandibular posture leads to muscle strain.
- Masticatory muscle strain leads to craniocervical postural change.
- Postural stability and occlusal stability are codependent.

The science and mechanics of moving teeth is abundantly researched and published.

There are new technologies emerging to enhance tooth movement efficiency. But now emphasis on the physiology of the entire person must be integrated into the diagnosis, treatment plan and application.

The typical patient comes to the office and says, "I wanted straight teeth. I don't like the way my teeth look. Can you fix my smile?"

General dentists and orthodontists oblige with clear aligners or brackets and wires and make the teeth quite pleasing in appearance. With skill, the anterior teeth can be moved to follow the lipline, teeth are straight, midlines are aligned and contacts are tight. Voila! Another successful orthodontic result, or is it? Orthodontic tooth movement has evolved beyond making teeth straight for the sole purpose of cosmetics.

For physiologic orthodontics, it is all about the bite. In other words, it is about correcting malocclusions. But before proceeding, the definition of malocclusion must be clarified. It is interesting that a web search for the definition of malocclusion came up with eight incorrect definitions before the ninth one correctly defined it. According to About.com, "Malocclusion is a discrepancy in the way the upper jaw and lower jaw meet, or more simply, how they bite together." Well put, About.com. Well put. Correctly, there is no mention of teeth. The misunderstanding by most people, general dentists as well as dental specialists included, is that the bite is the way in which the teeth come together, when it is actually the way that the upper and lower jaws meet. The reality is this: there are people with terribly misaligned teeth that have a good bite and people with perfectly straight teeth that have a bad bite. So if not the teeth, then what determines the bite? The answer is simple: everything. Posture, airway, habits, development, genetics, trauma, nutrition, teeth alignment and tooth loss are all possible determinants of the bite. To correct the bite is to correct whatever caused the malocclusion.

Physiologic orthodontics corrects the occlusion, i.e. the relationship of the upper and lower jaws, before even a single orthodontic bracket is ever bonded to a tooth. Airway patency is first addressed. An anatomical functional orthotic is bonded to the teeth to correct vertical, anterior-posterior, lateral, yaw, pitch and roll discrepancies of the bite. Temporomandibular joint decompression is objectively confirmed radiographically. Postural issues are corrected. The optimal physiologic relationship of the mandible to maxilla is refined with coronoplasty of the orthosis. Then, after occlusal stabilization is complete with comfortable teeth, muscles, joints, tendons and ligaments of the oral and craniocervical complex, orthodontic tooth movement is initiated. Orthodontic treatment begins only after physiologic stability is achieved. In summary, first the final position of the occlusion is determined, and then the teeth are moved to that position.

Physiologic based functional orthodontics has trumped conventional cosmetic based orthodontics. Architect Louis Sullivan said, "Form follows function." That axiom can be applied to orthodontics by stating, "Cosmetics follow physiologic function." Moreover, the application of physiologic orthodontic principles will yield a cosmetic result that is comfortable and maintains long term stability. Primum non nocere (First, do no harm.)

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Mark's Raves & Faves
2014 Materials Update

It's a remarkable time in dentistry where we know enough to be able to identify so much more than traditional dental school training addresses. Of course this is wholly appropriate as dental schools are there to teach us the framework, but not all the subtleties that this amazing profession encompasses. We know that the vast majority of bites are sub-optimal, but we don't know which bites are creating destruction of tissue and systems or impacting airway, so the only appropriate response on the part of the conscientious doctor would be to treat every patient as if they have an issue unless or until it is proven otherwise and so there starts our first opportunity to use advanced technology to provide better care for our patients. I want to walk through a case and highlight some of the materials I would reach for today.

As a new patient, there is a very intuitive and simple tool that provide the patient a quick and simple appreciation of the interconnections between their bite and body. With the **T-Scan occlusal tracking system** the patient can see real time readout of the various contact timing and force loads in their bite.

With this understanding of their system, my patient opts to move forward to determine if optimizing their bite will help with the sleepiness and head and neck pain they have been dealing with – so I reach for accurate impression and bite registration material. Typically I would have used Kettenbach's monophase or perhaps the Panasil final impression material – but now I have an option that stands toe to toe in **Ivoclar's** newly improved **Virtual XD.** This has similar wetting and great color contrast to make reading those margins a snap. Of course any time you take impressions, a bite registration goes with it and I would use the Futar D Fast – dimensionally stable and the lab can easily trim it with a handpiece to ensure excellent mounting of the models.

As this patient has more than one issue, we will discuss the significant wear and tear and chronic bruxism and how that is not only treatable, but it is *predictably and easily* treatable. Fortunately I was effective with explaining their issues and they are eager to correct them so they

opt for upper and lower fixed orthotics to balance out the functional issues and sort out the aesthetic details. The bis-acryl I would place would be **Kettenbach's Visalys** and because we are working hard to ensure we have a well laid out road map, I would use **Ivoclar's Empress Direct Color** to make the upper anteriors polychromatic and dial in those aesthetic goals.

Once we have established excellent objective (EMG data) AND subjective (patient comfort) indicators to move forward, we would embark on the actual drill-n-fill part of the process. The day of jumping in on an involved case and just putting a bunch of crowns in the mouth is long gone – as I have no doubt that I can arrive at a significantly better end point if we invest a little more time thinking at the beginning of the case. However, at some point it is time to actually do the dentistry and the patients ALWAYS slip into a sympathetic dominant stress mediated status. This is the last thing I want to do as I am working to heal my

patient, so I remove the possibility by employing **NuCalm** – a relaxation technology that is akin to plug and play meditation. It is a powerful tool to shift back to the para-sympathetic dominant and more hormonally balanced and stress-free state of being for our patient.

Unfortunately we all see cases that went neglected too long or for some other reason the pulp is at risk. In the tool box of every restorative dentist should be **Theracal from Bisco.** This is a light curable liner for both direct and indirect pulp capping and you apply it thinly and light cure and it will adhere to the dentin and bridge the exposure and release Ca ions for a year. Then over the top of that you would apply your SE or Universal adhesive. I typically would opt for a selective etch approach where the enamel is etched with **Bisco's HV Etchant** with BAC and the dentin is etched by way of the organic primers in the adhesive (most likely **Bisco's Allbond Universal** or **Ivoclar's Adhese Universal** in that awesome click pen).

In direct restorative situations there is an exciting new material out from **Ivoclar** that has just recently been launched and includes a new kind of photo-initiator, **Ivocerin**, allowing **Evoceram BulkFill** to be placed and bulk cured up to 4mm and has great working time and properties. As a matter of fact, **Ivoclar** has just released several new products that show great promise including the **Telio CS** desensitizer and **Adhese Universal** and the **Virtual XD** mentioned earlier.

Dentistry is a challenge to say the least- between the multitude of hats a dentist has to wear to the clinical expertise that can and should be gained at world class hands-on and live patient training opportunities, dentistry presents many frustrations to the practitioner. Hopefully some of these materials will simplify your clinical protocols so that you can focus on the comfort of your patients and providing the highest quality of care.

Upcoming Core III Course Dates

January 22-24, 2015
June 4-6, 2015
November 19-21, 2015

www.lviglobal.com/CoreIII

Sherry Blair

THE Patient Centered RECIPE

I love chocolate chip cookies! Who can resist that amazing aroma of freshly baked, hot out of the oven; melt in your mouth cookies. As a matter of fact I think it's time to go grab my grandma's recipe and whip up a batch right now. And what exactly will that recipe tell me? A recipe is a set of instructions for making or preparing something. And what is the first thing I will do when I have my recipe in front of me? I will check to make sure I have all the ingredients. Do I have flour, sugar, eggs, baking powder, etc.? Why would the recipe for the success of our dental practice be any different?

If I compare the ingredients of my cookie recipe to the recipe of success for the practice, I am going to make sure I have my 2 1/2 cups of communication, 1 1/2 cups of sound financial presentation, 2 effective handoffs, 3 cups effective scheduling, and 2 tablespoons of meetings. It's not until I know I have all the proper ingredients that I can put it in the bowl and mix it up to create our four patient experiences: The New Patient Experience, The Existing Patient Experience, The Restorative Patient Experience, and The Emergency Patient Experience. I must also know who the cook is, or which team member is responsible for each of these patient experiences and do we all have the same recipe?

A good first step is to simply evaluate your ingredients:

☑ *Patient Communication* - we routinely role play utilizing our communication tools. We identify our patients communication style (DISC) and are able to communicate with them in the best way for that patient. We co-diagnose with our patients by asking the right questions which allows our patient to come up with their own problem BEFORE we give them a solution rather than giving them a solution to a problem they don't believe they have (which sometimes appears as selling). Our Doctor never enters an operatory unless there is a photo of the patient's mouth on the screen in front of the patient because we understand that a picture is worth a thousand words.

☑ *Sound financial presentation* - Each team member understands their role in the financial presentation and knows that the presentation starts with what is discussed in the "back" and that the financial form itself is simply the last step in this presentation. All team members understand not only the business of collections but that the number one reason that a patient will become angry is that you were not clear on their financial obligation. Therefore no patient will be scheduled for restorative treatment without a written, signed, financial agreement so that the trust and relationship will remain intact.

☑ *Handoffs - transfer of power* - The Doctor receives a formal handoff every time they walk into an operatory from either the assistant (restorative or emergency patient experience)

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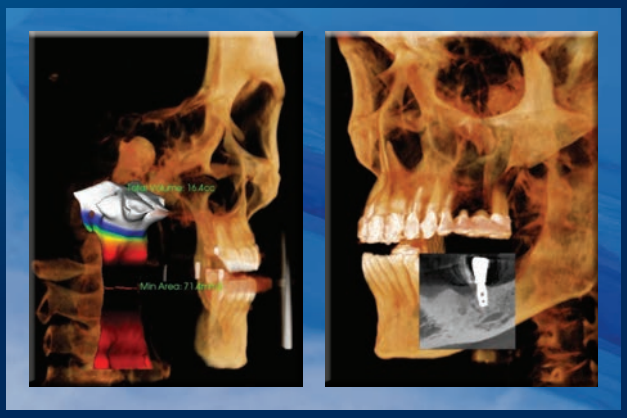

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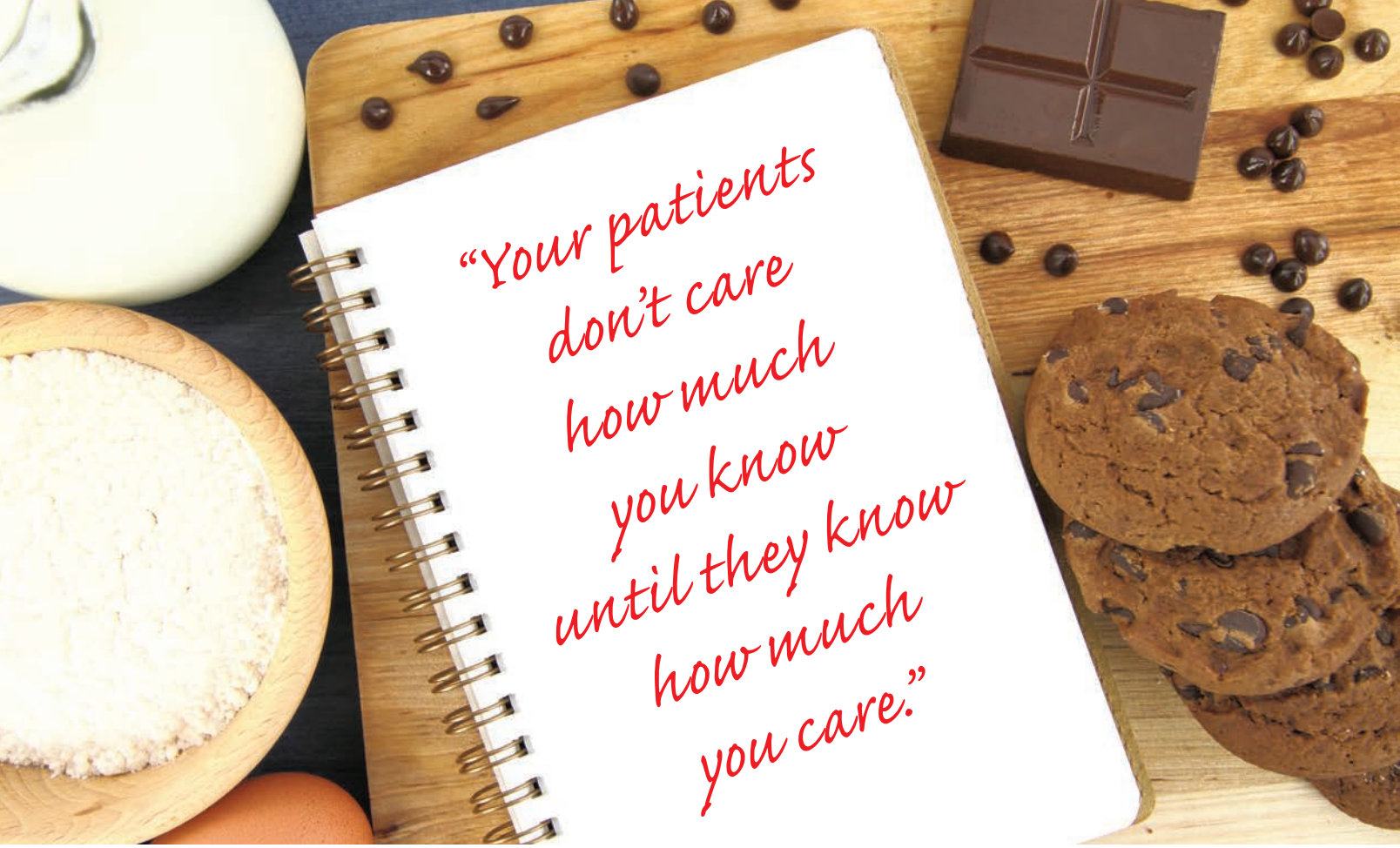

or the hygienist (existing patient experience). This is a moment of truth where trust is built because now the patient knows that the left hand knows what the right hand said and did. When applicable the clinical team member will handoff to the administrator. We understand that this is part of a process of treatment acceptance.

☑ *Scheduling -* We run on time 99-100% of the time knowing that we will chip away at the relationship if we do not respect a patient's time. We have a pre-blocked schedule that not only allows us to meet our daily production goal, but we also meet that goal stress free. We all understand and honor the blocks.

☑ *Team meetings -* We block a weekly business meeting where we utilize an agenda and an action plan to make our meeting productive. We never view this meeting as a waste of time. We conduct a Patient Care Meeting (as opposed to a morning huddle where we do "the reading of the schedule") utilizing patient prep worksheets (checklist) so that we know the patients past history, that we are prepared for today, and the patients next step. However, more importantly than those three items, we know something personal about each patient, their likes and dislikes, because your patients don't care how much you know until they know how much you care.

Now that you know that you have all the ingredients you can put it in the bowl and mix it up to create the checklist for the four patient experiences and you are ready to put it in the oven. The most important thing when baking is consistency. You can't bake it at 350° for 15 minutes one time and then the next time 425° for 20 minutes. You have to bake it at the same temperature for the same amount of time each and every time. Consistency is related to success and they can't just hang out every once and a while!

If you have come up short with your ingredients and want a new recipe, go to the right kitchen. The perfect recipe is presented at the Patient Centered Systems Course at the Las Vegas Institute for Advanced Dentistry or in your own kitchen for customizing the recipe through in-office training. Call today and inquire and get to baking up some success!

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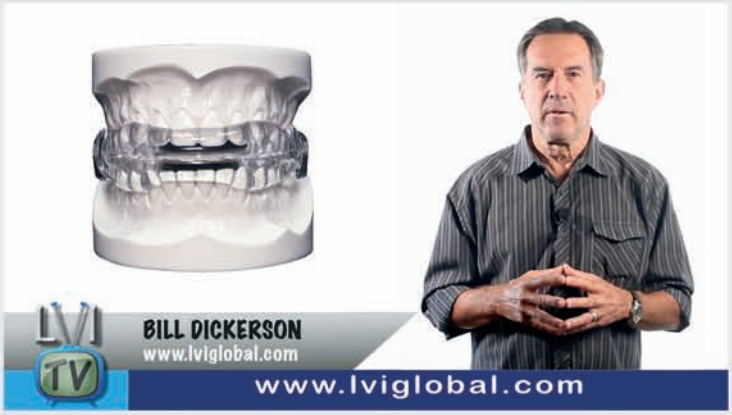

Episode 28: New Sleep Apnea Appliance

Episode 29: Is wine good for your teeth?

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How The Mid Brain Hijacks Dental Procedures

Jim Poole, MBA

The acute stress response is designed to keep us alive. The problem is, it is also killing us. Technological advancements allow us to live more comfortably today, but our survival instinct has remained unchanged for thousands of years. Stressors like work pressures, family illness, relationship conflicts, financial struggles, even traffic congestion can trigger an acute stress response. Our primordial midbrain reacts to all triggers without discrimination as if our lives were in danger. As a business owner doing complex procedures on moving targets, leading a team of professionals, and serving the needs of all types of people, you have your share of stress. On top of that, many of your patients experience an acute stress response and are literally trying to survive in your chair. This makes your profession one of the most difficult in the world. Your quality of life depends on your ability to develop healthy stress management techniques and coping strategies. What can you do about it?

When someone experiences a stressful event (real or perceived), the amygdala sends a distress signal to the hypothalamus, triggering the unconscious neurobiological motivational system known as the "fight-or-flight" response. The hypothalamic-pituitary-adrenal axis (HPA axis) triggers a series of hormonal signals to keep the sympathetic nervous system in a state of hyper-alertness. The hypothalamus releases corticotrophin-releasing factor (CRF), which signals the anterior pituitary gland, to release adrenocorticotropic hormone (ACTH). This hormone travels to the adrenal glands, prompting them to release cortisol (the stress hormone). As epinephrine circulates through the body, it brings on a number of physiological changes, including accelerated heart rate which pushes blood to the muscles, heart, and other vital organs. Respiratory rate quickens and sight, hearing, and other senses become sharper. Meanwhile, epinephrine triggers the release of glucose to provide energy to muscles. All of these changes happen so quickly that people are not aware of them. In fact, the process is so efficient that it occurs in milliseconds – before the neocortex knows what is happening.

For dentists, this midbrain hijack manifests in patients as gagging, excessive salivary flow, aggressive tongue movement, flinching, clutching, burning through local anesthetic, irrational social behaviors, and confusion. A stressed patient is not able to cognitively process information and is likely to have little or no memory of any dialog during and after the procedure. The cortisol flood also exaggerates the inflammation response, which leads to excessive bleeding and complicates the healing process. The hardest thing to understand is that your patients, during an active stress response, are not in control of their actions – they are crippled by their survival instinct and neural circuitry.

Why does the dental chair trigger such a primal response? The answer is simple. We are animals and we must protect our mouths to survive. For humans, our mouth is our source for food, communication, and intimacy. It is not natural for any animal to lie on its back and open its mouth for treatment with sharp instruments. This is why for many people, the mere thought of going to a dentist elicits a "fight-or-flight" response.

Every workday you are faced with challenges most other professionals never encounter, or even think about. Your working environment is compromised by the human survival instinct. The anxious patient behaviors you have to deal with everyday are human adaptations to a situation that the central nervous system considers unsafe. Managing your patient's stress response and psychological vulnerability can be exhausting.

What if you could use a clinical solution that naturally interrupts the stress response, puts you in a state of deep relaxation, allows your body to rejuvenate and re-tool, and builds your resilience to stressful situations? What if you could help your family and friends better manage their personal stress? What if your team could get relief from stress and perform better at your practice? What if you could convert your patients from resistant to relaxed in less than five minutes?

This neuroscience technology is available today and is being used by the U.S. military, top research universities, oncologists, cardiologists, psychotherapists, professional athletes, top executives, and dentists. Dentists in the U.S., Canada, UK, Europe, Russia, and Australia are currently benefiting from this technology called NuCalm.®

NuCalm is a clinical solution that safely and effectively neutralizes the stress response at the midbrain and guides you to a state of deep relaxation. Your thoughts remain active, but your body idles in parasympathetic nervous system dominance. Parasympathetic nervous system dominance is the only time your body can recover – cellular waste is removed, autonomic nervous system balance is restored, neuromuscular tension is resolved, biological clocks are tuned, and mental focus is improved.

NuCalm is a clinical solution that safely and effectively neutralizes the stress response at the midbrain and guides you to a state of deep relaxation.

NuCalm mimics your body's own process for "winding down" and preparing for sleep. Your body experiences a natural slow down every time you go to sleep. This process typically occurs when you are in the comfort and safety of your own home. The power of NuCalm is that it can produce this same physiological experience in an uncomfortable environment, where your midbrain perceives a threat and triggers the stress response.

NuCalm turns off the stress response at its source in the midbrain. By redirecting your brain's communication pathways, NuCalm pivots you out of hypervigilance and suspends you in deep relaxation. The NuCalm dietary supplements and the Cranial-Electrotherapy Stimulation (CES) device work synergistically to turn off the "fight-or-flight" chemical response. The all-natural ingredients of the proprietary formulation include inhibitory neurotransmitters Gamma-Aminobutyric Acid (GABA) and L-Theanine. The CES catalyzes the absorption and efficacy of the amino acids to ensure rapid and predictable relaxation. The NuCalm neuroacoustic software embedded in soothing music entrains brainwave function from beta or high beta down to the alpha/theta range. The neuroacoustic software utilizes binaural beat physics and frequency-following-response to systematically cycle brainwave function between 12Hz and 4Hz.

Dentistry is a noble and rewarding profession. It is also extremely stressful. You now have a choice to replace the primordial midbrain hijack with the NuCalm "relaxation hijack" that will protect you from the challenge of being human.

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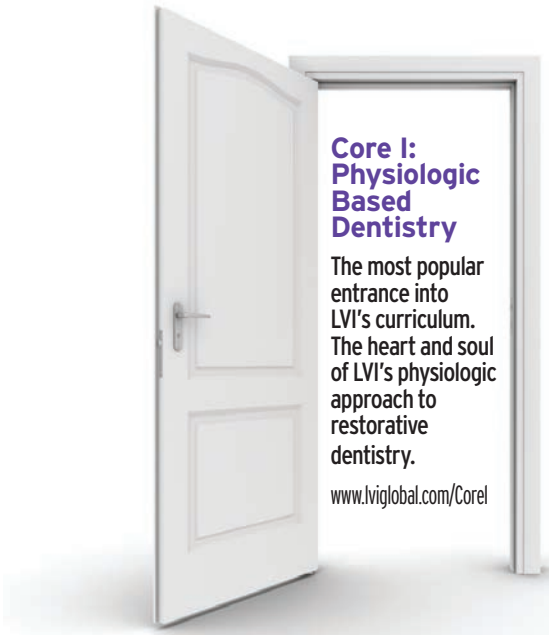

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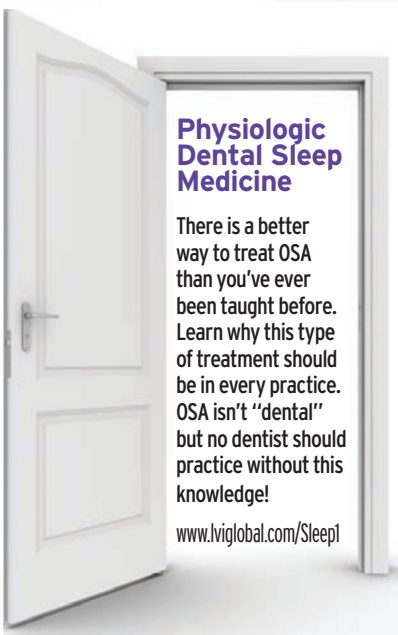

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Leo J. Malin, DDS

Your Perception Is Your Reality.

What is your perception of Implants and what is the reality?

Many of you who are reading this article may not have heard of me while others may have been to a course or read an article I have written in the past. One thing I can declare is that Implants are my passion and more specifically sharing how to successfully and predictably place and restore implants is my professional purpose. I also want to acknowledge that I realize implants are not a passion for every dentist. I realize to be successful you must decide how you want to run your practice and how you want to spend your time. More times than not, implants get overlooked or are referred out. And believe me I get it! As a matter of fact, I would have done the same thing 15 years ago, but many things have changed. So before you outsource your implants, let's take a look at a few things that have changed.

The Market… Look at some of these stats from AAID & Millennium Research Group (MRG)

- 15 million people in the US have C&B replacing missing teeth.
- 3 million people in US have implants placed annually and that is growing by 500,000 a year.
- Only 10% of all US dentists place implants.
- US Dental Implant market will be worth $4.2 Billion in 2015 and will grow at 10% per year.
- Everyday 10,000 people reach the age of 65.

In summary the Implant market is growing significantly. In addition, people are now more educated than ever with the Internet and the 100's of millions of dollars spent on implant advertising. Simply put, patients are demanding implants more than ever before. But I want to talk specifically about the market now in a micro manner, specifically your patients. I hear these two comments at least 5 -10 times a month when I talk to general dentists when discussing dental implants: 1) I only see a couple of implant cases a month and 2) My specialist does great and I don't need/want to do implants. Do you find yourself saying either one of these two things? If you are like 90% of the general dental providers you probably are. I would like to take a moment and dive into these self-perceptions in a bit more detail.

Part of the human condition is to more clearly recognize things we are familiar with. You notice this when you buy something new or buy a certain brand. You now start to notice that brand more frequently in the general population. The same applies with a new learned skill we have acquired and have CONFIDENCE in. You all can reflect back on a newly acquired skill you obtained and were confident with. I can assure you this is what happens with Implantology. Sure you see some of the obvious cases, but with the new technologies and training protocols, I can assure you the average practice will see 10-15 potential implant cases per month. It seems impossible, but asks the general dentists that have started training on implants and have developed clinical CONFIDENCE, and you will discover they see that many cases!

I have a great relationship with some specialists and a not so great relationship with others. Why is that? The one who likes me and what I am doing does not see me as a threat. As a matter of fact they encourage me to do implants and are willing to share and help educate me. They understand that the more I do, the more I will refer to them. I will open my eyes to more cases. I will learn to understand that of all the implant cases out there, I will be CONFIDENT doing 40%-60% of those cases and refer out the rest to them (as well as all those difficult 3rd molar extractions). They have an abundance mentality in the dental marketplace and encourage education and growth. On the other hand, the specialists that don't care for me, see me as a threat and "Playing is his/her sandbox" or taking away business. Actually, I find these are the people that go out and lecture and show the absolute most difficult cases, show screw ups with implants and all the potential legal nightmares that can result. They show how hard implant cases are and how much trouble you can get into by starting to place implants. I have actually had doctors approach me that fear talking to their specialist about starting implant therapy in their practice. Many times we hear that "My implants are 99% successful" after you watch them show how difficult Implants are to place. What does that mean? What is the definition of success? The implant does not fall out in a year, two years or ten years? Does it take esthetics into account, success restoring the implant or tissue health for that matter?

There is no question we need these specialists! I think many times people feel I am a cowboy and teaching dentists to do things they should not be doing when they are simply looking from afar. This could not be any further from the truth. Things have changed from our dental school days when we spent a few hours or a few days learning about implants in a book and then told to just refer them out. From a high level, let's just look at all the varying types of implant clinical cases. With today's technology and processes there is definitely a place for the dentist to be involved with implants. The facts are, today's technology can make certain cases VERY easy. These cases are predictable and profitable. Sure there will always be complex and compromised cases and everything in between, but the key is to know what to do, what to refer out and understand what you want to develop your implant practice into in the future. (See graphic at bottom of page)

Again, I want to reiterate that implants and teaching implants are my passion and implants may not be your passion. However, during your tenure in dentistry you may not have loved something, but when you learned more about the proper tools and protocols, that procedure was actually not that bad, but actually enjoyable once you had the CONFIDENCE with the afore mentioned. Implants can be that for you too when you have the proper training, tools and knowledge of what to accept and refer out, the cases you do accept will be very straight forward, profitable and your patients will appreciate the service you gave them. Even with just doing the basic implant cases, it can make a sizable contribution to your practice cash flow. And remember, your patients chose you and if possible entrust you with their care, they do not generally like to be referred out unless absolutely necessary. The Implant market is growing and is a great way to grow your practice. Come along for the journey and see why implants are my passion, and for many of you likely would be too if some of the confusion and misinformation was cleared up. I can only encourage you to grant your self some practice freedom and get involved in the benefits of implant dentistry for you, your patients and your clinical practice.

Upcoming Implant Course Dates

Surgery Session 1	Surgery Session 2	Surgery Session 3	Restorations
January 7-9, 2015	October 6-8, 2014	October 9-11, 2014	February 22-24, 2015
May 6-8, 2015	April 15-17, 2015	April 18-20, 2015	July 24-26, 2015
August 12-14, 2015	October 15-17, 2015	October 18-20, 2015	
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John Krasowski, DDS

Framing The Smile Utilizing **Botox**

Is there a place for Botox in dentistry? Yes or No? However simple the answer may be, the opinions are certainly numerous. If the answer is no, then the discussion should end. If yes, the next logical questions are… should there be limits to the use of Botox by a dentist? Can a dentist use Botox for both aesthetic applications and therapeutic treatments such as in the treatment of TMJ disorders? The truth is… Botox was designed to treat muscle related anomalies such as spastic muscle conditions. It was only later recognized that Botox was a way to delay the formation of fine lines and furrows on or about the face. If dynamic facial lines (repetitive lines from facial expressions) exist, then Botox is an effective means to relax those lines and allow for secondary healing of the skin. The profession of dentistry has experienced numerous occasions over many decades where new techniques and material use was deemed inappropriate or beyond the scope of dentistry. However, as a demand for a new technique or material grew; the tipping point was reached and considered acceptable. Think about the use of alcohol or ether to dull the unpleasant sensations of dentistry. The use of mercury (a known potent neuro-toxin) as a component in amalgam fillings, saving teeth with endodontic treatment, the use of an acid to etch dentin in vital teeth, the placement of dental implants to replace teeth. All of these treatments were revolutionary at one time; only to become universally acceptable dental treatments.

The point is, what other medical profession is more intimate with the function and structure of the muscles of mastication and how they are related to the teeth? How the vital structures of the cranial complex and oral cavity are cautiously breached daily with needles, drills, scalpels, and lasers. It only seems natural that a dentist has access to both the therapeutic use of Botox and its aesthetic paradigm. What other medical profession has their clients returning every 4-6 months for dental cleanings and therapy year after year? Botox treatment and its inclusion in dentistry is the perfect complement to our profession.

Botox, also known as Botulinum Toxin A, is a prescription medication that received FDA approval in 1989 for the treatment of muscle related pathologies. It was more than ten years later that Botulinum Toxin A was granted use for the relaxation of muscles that contribute to the wrinkling of skin in the glabellar area. This later became universally known as “Botox”. It was only recently, in 2011, that Botox was FDA approved for the treatment of chronic migraines.

The mechanism of action for Botox, in its most basic description, is injected into muscle tissue where it diffuses into the muscle nerve complex inhibiting the release of acetylcholine necessary for the completion of a muscle contraction. Botox is not a toxin, but rather an active molecule which is a highly refined protein. The Botox medication contains absolutely no Botulinum bacteria.

"The science is pure and measurable, not opinion."

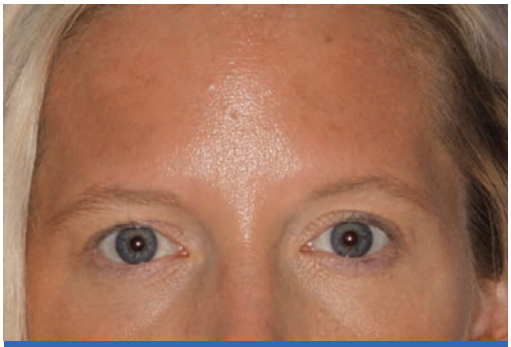
The use of Botox for Therapeutic treatment of migraines and the symptoms associated with TMD (bruxing and clenching) is growing in the dental profession. As a neuromuscular trained dentist using sound physiologic principles one should pause and realize that the Botox treatment is only dealing with symptoms and not the etiology of these symptoms. It has been established at the Las Vegas Institute that bruxing can be controlled 100 percent of the time, and clenching 90 percent of the time. This is accomplished with the use of ultra-low frequency Myo-monitor TENS and a physiologic neuromuscular orthotic. The fact is, the LVI trained neuromuscular dentist is having significantly high success rates when controlling the destructive forces of a pathologic occlusion. The science is pure and measurable, not opinion. As more and more dentists recognize the growing success of physiologically based neuromuscular dental care in the treatment of TMD and its symptoms, fewer dentists will be compelled to use Botox for these "therapeutic" dental related procedures. It could be argued that Botox may be used in the acute cases of TMD, but, it should be recognized that it takes 24-36 hours for Botox to initiate its mechanism of action with full action in 30 days. The patient of an LVI trained neuromuscular dentist can already be experiencing the long term non-medicated benefits of proper phase one orthotic treatment.

The awareness of therapeutic Botox treatments for migraines and TMD among the general public creates a unique opportunity for the well trained dentist to explain the process for treating and actually healing the pathology that exists.

Botox for cosmetic treatment in dentistry is also growing in popularity. It is this application of Botox in which the dentist should be most active. The ability of a dentist to have a long term relationship with his or her clients allows for a unique opportunity to share this aesthetic procedure with them. A dentist has an intuitive sense of beauty and its relationship to the smile and face. The use of Aesthetic Botox to soften dynamic facial lines of the forehead, glabellar area and eyes is in the wheelhouse of dentistry. As more and more dentists seek new and innovative treatments to add to their menu of services, Botox should definitely be among them.

The learning curve for Botox use in the dental office is a surprisingly small step. Dentists, on average, give over a thousand intraoral injections yearly. Many times these injections are in the proximity of significant anatomic structures that could have adverse results. Botox injections are similar. With proper basic understanding of facial anatomy and technique the dentist can be providing this service almost immediately. There are many nuances in the application of Botox treatment that a provider develops over time. The chance of an unintended treatment outcome is rare and avoidable with proper training. With any new dental procedure look to LVI with its extensive curriculum to provide the education that provides you the knowledge for this appreciated and exciting service.

Before



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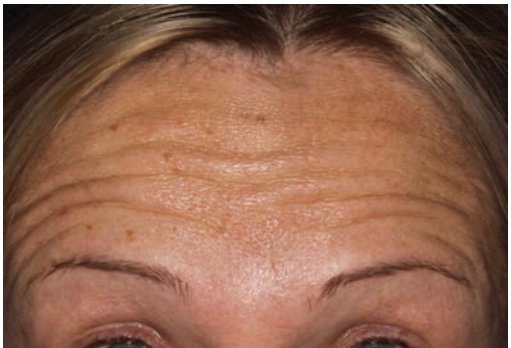

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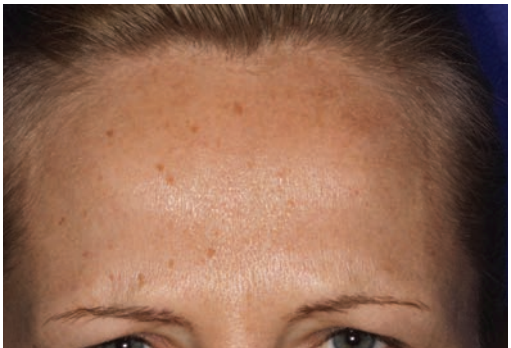


After






RUSSIAN ROULETTE & SLEEP APNEA

What do they have in common?

Anne-Maree Cole, BDSc, LVIM, MICCMO
Featured Instructor, LVI Physiologic Sleep Programs

Sleep medicine is an extremely young discipline; in fact less than 50 years old. When the complexity of the sleep apnea syndrome was first described, its focus was directed towards obese, sleepy individuals. Since those early days, unfortunately, the obesity epidemic has produced a rising pool from which to draw. Severe sleep apnoeics need urgent treatment. Of that there is no doubt yet they represent but the tip of the iceberg. An avalanche is developing and that avalanche is full of the yet-to-be-diagnosed mild and moderate sleep apnoeics– people for whom CPAP could be perceived as overkill by themselves and their primary care physicians and as such they risk remaining untreated and vulnerable.

The words we use have power. They have the power to properly represent, to diminish or to amplify. Grading sleep apnea as mild, moderate or severe awards a subjective connotation to an objective diagnosis. The word mild implies a lack of necessity and certainly a lack of urgency. Where would we be today if cancer was graded as mild, moderate and severe? "Mrs. Jones, you have cancer but it is only mild." Instead Mrs. Jones is told that she has cancer, period. She is given a grading, the lower the better. Better because she has the opportunity to do something about it. A lower grade affords the prospect of being able to treat it early, to prevent its spread and ultimately an untimely demise.

Can the same be done with sleep apnea? "Mrs. Jones, you have sleep apnea. The good news is that it is Grade 1, which means we can do something about it. We can manage the condition to prevent the health, cognitive and lifestyle consequences, which insidiously manifest themselves over time. We can keep you well." Too often both the patient and their health care provider, through an incomplete understanding of the cause and consequences misinterpret a mild sleep apnea diagnosis as something that can be postponed and that intervention is optional.

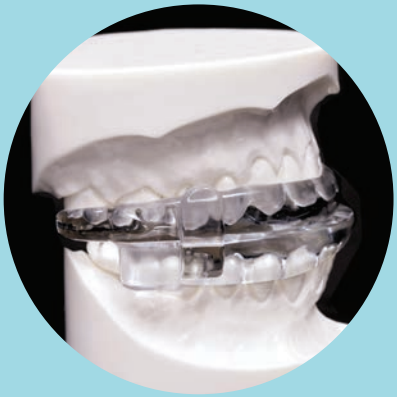
Unfortunately the physiology does not read the rulebook, it just responds. And it is the continued physiologic intervention to the repetitive fluctuations in blood gases and airway compromise that lead to an up-regulation of the sympathetic nervous system into the state of chronic stressful responsiveness that underlies the pathophysiology of sleep disordered breathing. Even primary snoring has health consequences. Don't play Russian roulette with your patients. They deserve better.

As dentists with an understanding of the physiology of the head, neck and airway and all associated structures, we are in a prime position to optimise the physiology before we put the patient in the cast – the sleep appliance. It is vital, for optimum health outcomes, that we not only provide a patent airway but in doing so, turn down the sympathetic nervous system. We have to support the jaw and airway to prevent the patient from having to do it for themself.

The Physiologic Approach to Treating OSA Course Dates

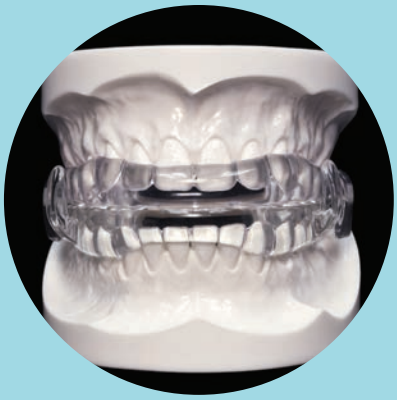
OSA I	OSA II
March 21-23, 2015	March 25-27, 2015

www.lviglobal.com/sleep1



New Mandibular Advancement Device for Treating OSA

MicrO_2



William G. Dickerson, DDS, FAACD, LVIM

By now every dentist should be aware of the need to be able to diagnose and treat Obstructive Sleep Apnea (OSA). Treating OSA is not that simple. For it to be done properly and insuring the best results, without making the patient worse, or preventing post issues like temporal mandibular disorder or dysfunction, it has to be done physiologically. There is only one place in dentistry that teaches this approach and of course it's at LVI.

But now there is a new appliance that is completely designed around the physiologic approach, requiring less forward titration to open the airway while also preventing the unintended closing of the airway which can be seen in many mandibular advancement devices. The MicrO_2 is a patented device made by Micro Dental Laboratories in Dublin, CA after 18 months of research, prototypes (of which I was the guinea pig on many of them), studies and beta testing. I have now been wearing one for the last 15 months and even though I don't suffer from OSA, I find I sleep better so I don't leave home without it. And instead of having moving parts that can break or create areas of weakness, the titration is done with alternate appliances (you get 2 maxillary and 2 mandibular appliances).

The top ten advantages of the MicrO_2 appliance are:

1. **Airway preserving fins**
2. **Lingualess – more room for tongue so less forward position necessary**
3. **Lightweight**
4. **No moving parts**
5. **Smaller than normal sleep appliances (less obtrusive)**
6. **Comfortable so better compliance**
7. **Stronger**
8. **Milled, not powder / liquid made, so always a good fit**
9. **Back up appliances in each order**
10. **If a remake is necessary, since milled, no new impression is necessary and no need to send anything but a request to them to have a new one made.**

I believe you will find this device superior to any sleep appliance you've ever used. Here are some considerations for you when using the appliance.

1. This is not a functioning appliance so does not need to be, nor should be, as tight as a daytime orthotic. They don't eat with it so it's not important that it be a tight fit. In order to get the thickness necessary for the strength (3mm between the thinnest separation of the arches unless the LVI Golden Vertical is more than that) the appliances don't drop down or come loose. It would be my advice NOT to ask for ball clasps. I have been wearing the various beta forms of the appliance for over 15 months and find it incredibly comfortable and retention not a problem.
2. If the bite is taken at the physiologic position as taught in LVI's Physiologic Approach to Dental Sleep Medicine, then very little titration will be needed if at all. We are finding that very few find they have to use the titrated appliances. You still will want to get them and it would be best to have one extra for the maxillary arch at 1.5mm titration and one extra for the mandibular arch at 2.5mm. That way you can titrate 1.5mm, 2.5mm or using both, 4mm. It also provides you an extra backup for both arches in case one breaks so they can use it while you are having Micro make a new one to replace the broken one.
3. If someone is obese and or has a small arch, then more titration may be needed. In that case, make the extra maxillary arch 2mm and the extra lower arch 3.5mm. That way you can titrate the case from the original bite 2mm, 3.5mm or 5.5mm.
4. I would keep the backup appliances at your office so you can control the titration and have the backup for them in case they lose the case with all of them in it.
5. If you have not taken the "Physiologic Approach to Dental Sleep Medicine," and use a standard George Gauge, then there is no reason to do a 70% advancement. Since there is no lingual flange to the appliance, much less forward advancement is necessary. Understand that this bite is a pathologic bite that may result in TMD symptoms such as a sore jaw, inability to get teeth together in the morning, headaches or worse. If you want to learn how to prevent that and achieve better results with your appliance, I would suggest you take the Physiologic Approach to Dental Sleep Medicine at LVI.
6. If not using the "physiologic approach," too far of a forward advancement may make it difficult for the patient to open because of the vertical fin. If this occurs, it is an indication that you have advanced the mandible too far. There is no reason to advance it that far.
7. The vertical fin is a very important feature that prevents closing of the airway as the patient opens. It would be advisable NOT to ask for a tapered fin as seen in other appliances.
8. If using the "physiologic approach," after a month of wear, attempt to titrate back towards the physiologic bite position. Do this in a step by step process. This should be achievable as the tissue of the throat heals. This should not be done if using an arbitrary pathologic bite like the George Gauge.

Upcoming OSA Course Dates

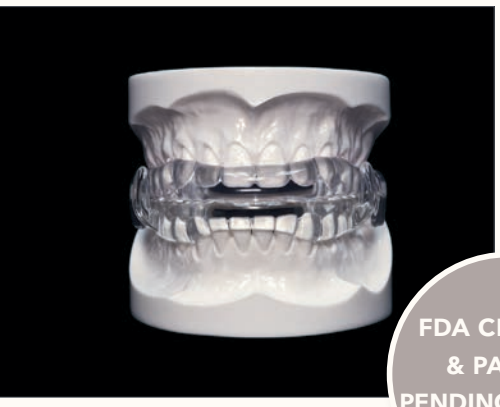
OSA I
March 21-23, 2015

OSA II
March 25-27, 2015

If you are not treating Sleep Apnea in your practice... you should be, but only if you treat them "physiologically." And if you are treating sleep apnea, you should try out this new appliance on your patients for all of the reasons listed above. I think they will love you for it.

NEW

MicrO$_2$™ SLEEP DEVICE. MORE SLEEP. LESS HASSLE.



FDA CLEARED & PATENT PENDING DESIGN

Digital simplicity and precision make the new MicrO$_2$ OSA device the comfortable choice for dentists and patients.

ADVANTAGES

DIGITAL SIMPLICITY

SMALL YET DURABLE

EASY TO ADJUST

PRECISE AND PREDICTABLE

ONE-PIECE, LINGUAL-FREE DESIGN

NO MOVING PARTS

BIOCOMPATIBLE

How effective are CPAP or Sleep Devices if patients do not wear them? Or if it is difficult for patients and dentists to use or adjust the device? With the goal of answering these questions, and more, the new MicrO$_2$ Sleep Device offers:

Digital Simplicity. The first CAD/CAM milled OSA device, MicrO$_2$ is precise, predictable, and easy to use.

Comfortable Profile. The only OSA device made from control-cured PMMA, MicrO$_2$ is compact without compromising durability or retention.

Easy Adjustment. Featuring an adjustment method similar to changing aligners, MicrO$_2$ has a one-piece construction with no moving parts.

Lingual-Free Splint. MicrO$_2$ offers a lingual-free design that is intended to offer the patient maximum tongue space.

Expert Design. The MicrO$_2$ Sleep Device design is based on the clinical expertise of leaders in the field of Dental Sleep Medicine.

Contact MicroDental today at 800.933.6838 to learn more about how the MicrO$_2$ Sleep Device might fit into your practice.

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Williams Dental Lab offers the unique combination of **exceptional technical skills** and **superb customer service.** I have trusted Bob Clark to create my own neuromuscular full mouth restorations, as well as my family members' and all my dental guests. Whether I request an orthotic or a full mouth restoration, the answer is always, **'Yes, we can do it.'** That makes it easier for me to provide exceptional service. What more can a clinician want from a dental lab?"

– PRABU RAMAN, DDS, LVIM

Dr. Raman pictured with wife, Woonmi
Dentistry by Williams Dental Lab

DR. PRABU RAMAN: Past President of the International Association for Comprehensive Aesthetics • Council on Dental Education & Licensure – American Dental Association • House of Delegates - American Dental Association Board of Trustees - Missouri Dental Association • Kansas City, Missouri 64155

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