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THE NOSE KNOWS

THE AIRWAY & NASAL BREATHING ISSUE

NITRIC OXIDE & MOUTH BREATHING

DEVELOPING THE MAXILLA

THE BENEFITS OF LIP TAPING

ACTUAL PATIENTS

20
YEARS OF SMILE STORIES
by
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EDITOR'S NOTE

Breathe

Hi Readers!

I can hardly wait for you to read this issue of VISIONS!! Physiologic Dentistry considers the body as a whole. We are not just focused on the teeth and gums but how every system relates to one another. The reality is that nasal breathing completely influences our state of health. From how our arches and face form to the oxygenation of our brains and organs, nasal breathing plays a key role in all of these systems.

As dentists we need to know and understand the physiology. We need to stop pathology from starting as well as stopping it from progressing in our patients.

I encourage you to read all the interesting articles I've gathered for you and then decide what you need to learn more about and come to LVI to enhance your skills and knowledge.

We CAN make a difference in our patient's health and life span! How cool is that?

From a child's allergies to an adult with chronic rhinitis ... do you know how to comprehensively treat them? Do you know how to treat common OMD's and when to do Myofunctional Therapy? Do you have skills to intervene early in the development of children's arches? Do you know what to do with the common mouth breather?

These are just a few questions you should ask yourself. If any of your answers were "no"... make 2017 the year to learn about it!

I know after reading this issue you will want to know more!

Heidi Dickerson, DDS, LVIM, FIAPA
hdickerson@lviglobal.com

nosefacts

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Marketing Physiologic Dentistry

William G. Dickerson, DDS, FAACD, LVIM, FIACA

I had a discussion with a very good Physiologic Dentist on why it is so difficult getting people to move forward with Physiologic Based Treatment. His comment was that he doesn't do a physiologic computer workup unless the people are committed to have an orthotic. This is the reason many people are not doing as many physiologic cases as others. They say that they don't have patients that want this treatment but it's because they are not getting the patients to "own" their problem and they are not going to "own" their problem unless you have measurable, documented evidence to show them WHY it's related to their bite.

So you tell someone that their headaches MIGHT be related to their bite and they need an orthotic. That's it? You expect your patients to not only believe you, but to understand how that's even possible? If you showed them the EMG's of their muscles in their existing bite and they saw where exactly their headaches were coming from, they would be sold. If you were able to show them the EMG difference of where their bite should be compared to where their bite is and the percentage difference, it would be compelling and convincing. If you could show them on the picture of a head with big red circles where the muscles are contracting, it would be dramatic... and then show them how they turn to little green dots when you move them to the physiologic position they would become hopeful.

People need to see the PROOF of why their pain may be related to their bite and it's not only arrogant to think they will just believe you, it's naive and ridiculous. Why would they? They have never heard from any TV show or medical doctor that their migraines may be due to their bite... and now you... a dentist... who has a vested interest in them getting this orthotic, is telling them that their bite is the problem.

So many Physiologic Dentists are not doing the number of cases they should because they expect the patients to just believe them without giving them the documentable evidence that would SHOW them the measurable data to prove why they are having the chronic pain.

SO, HERE ARE MY SUGGESTIONS

1. Use the M-Scan for a quick evaluation to see if they might be a candidate for physiologic workup. This can even be done in the hygiene operatory on recare visits like taking their blood pressure. If the EMG's are high, ask them if they are having headaches or other symptoms. Show them the difference between their rest score and their CO score. Let them know what the EMG's should be. Then ask them if they would like a detailed computer analysis of their bite.
2. Do a complete workup on anyone with symptoms even if they are not committed to an orthotic. Seeing the data may in fact convince them that it might be the issue. No longer is it necessary to do a long workup to evaluate someone. A complete computer workup with the BioPAK can be done in less than seven minutes.
3. Make an AAG before the workup appointment so you can show them the difference in their EMG's of where they should be.
4. Give yourself enough time to analyze the results... showing them the difference between the bites and the other evaluation data you gather in the short workup that is diagnostic to show pathology.
5. Make sure you are up to speed on all the advances and changes in Physiologic Based Dentistry. How impressed would your patients be when you talk to them about their cervical and postural issues you learn in PAT... about their turbinate problems that you notice on the CBT... about their airway or tongue posture issues?

Understand that you can't be a Physiologic Based Dentist unless you think like a Physiologic Based Dentist. Would you want to go to a MD that doesn't evaluate your total health? It's your OBLIGATION to diagnose the complete condition of your patient's oral health and that includes any pathology that is due to the bite or bite related issues like OSA and FHP.

Guess what I'm saying is... be the best that you can be! Be A PHYSICIAN OF THE MOUTH!

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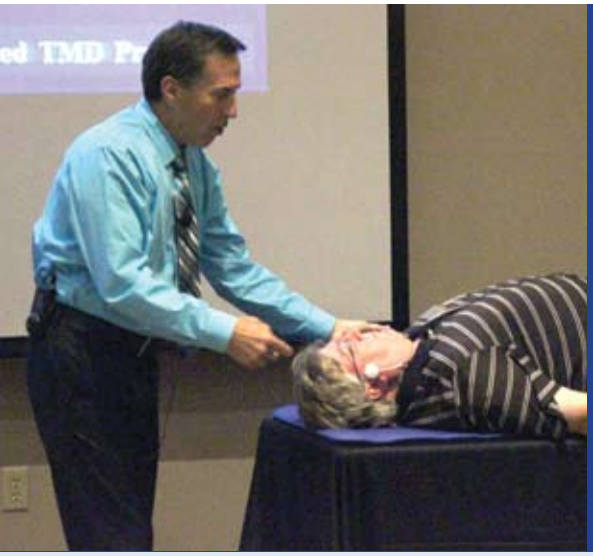

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Dr. Sahag Mahserdjian • Dr. Anne-Maree Cole
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SEPTEMBER 17-19, 2017

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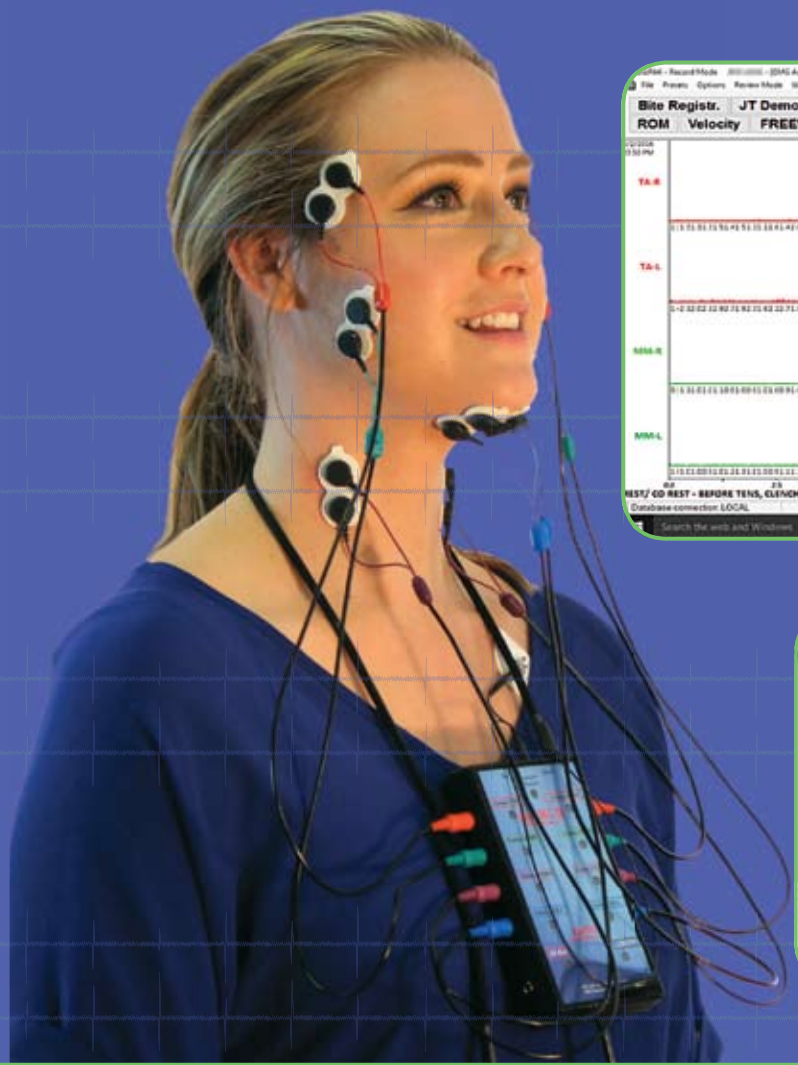

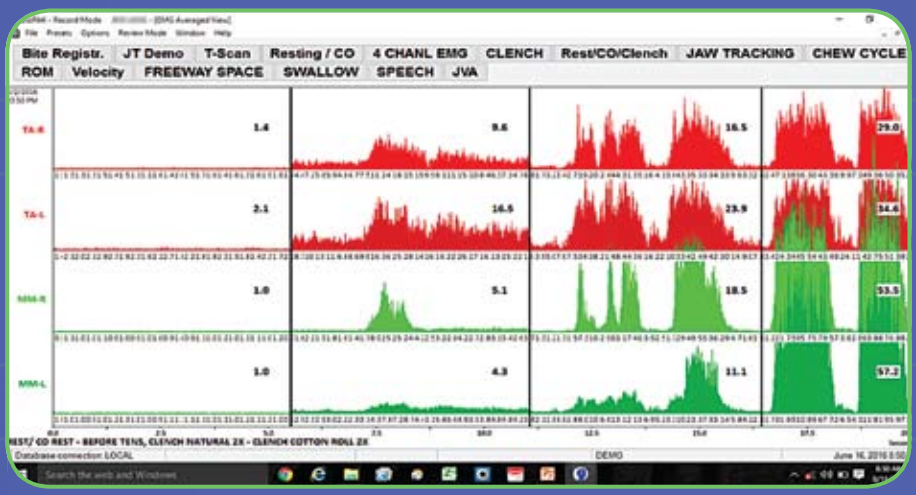

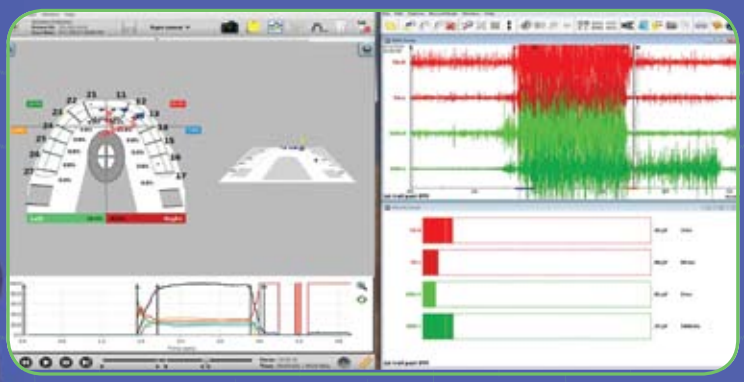

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Hamada Makarita, DDS, MAGD, MICOI, LVIM, FAACD

AND EMBEZZLEMENT IN THE DENTAL OFFICE-PART 2

You are not immune

In the last issue of LVI Visions I listed examples of only a few of the ways a team member can commit fraud or embezzle, let us discuss ways to prevent this from ever happening in your office.

SEE THINGS DIFFERENTLY!

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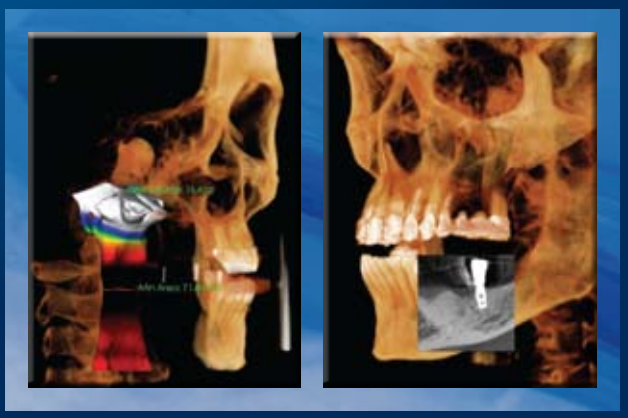

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Pearls for Fraud Prevention

NEVER BLINDLY TRUST YOUR EMPLOYEES
Trust must be earned and even so, you must show them that you are aware of everything and there is a verification and reconciliation process that occurs.

ALWAYS PERFORM A BACKGROUND CHECK
This is a minimal cost and can save you a lot of aggravation in the future. Contact previous employers for references.

BANK DEPOSITS
Reconcile the deposits on the deposit slip with the end of day report. Make sure all credits to ledgers are in fact on the deposit slip.

Have two people review the deposit slip and both should sign or initial it.

CREDIT CARD CHARGES AND ACCOUNTS
Review the credit card statements for unusual activity and charges.

Review the credit card banking statements with transaction numbers and ask about any credits and review on ledger to make sure it is a legitimate credit to a patient account.

Verify that purchases for the office were in fact received.

Make sure payments to credit card companies have been posted. Remember, you can write a check to MasterCard and someone can use that check to pay their own MasterCard bill.

GUARD CHECKS
Make sure the checks are in chronological order and on the bank statements make sure a check number out of sequence was not used.

Routinely flip through the checks to make sure a check at the back of the checkbook is not missing.

REVIEW SUPPLY AND MATERIAL ORDERS
Check the supply bill and ask to see the order sheet and some random items. Often the supply bills do not itemize what was ordered. It is just a balance amount and order numbers.

Ask for the packing slip of each order and keep in a folder. Open the boxes randomly yourself.

REMOTE SERVER ACCESS
Make sure server access is securely monitored and restricted.

Never allow anyone to delete or modify anything from your systems without your knowledge and consent.

DENTAL SOFTWARE AUDIT TRAIL
The audit trail will show all entries and deletions under every team member's login credentials.

Routinely review the audit trail in your dental software and make sure the team knows you do this. It is better to prevent embezzlement than having to catch someone doing it.

Hire a professional with your software system such as a trainer to routinely review the audit trail report.

AUTOMATE PAYROLL AND RETIREMENT ACCOUNTS

Make sure the payroll is automated with a payroll company that offers direct deposit so checks do not have to be written. It is a minimal cost and they handle all the necessary tax withholdings.

Retirement account contributions should also be automated and withdrawn automatically by your payroll service provider.

SOFTWARE PRIVILEGES

Many dentists do not spend enough time or thought into what privileges certain members are allowed in the dental software. There is a lot of sensitive information that does not need to be divulged regarding practice numbers etc. There are certain tasks or modules that should only be accessible to the dentist. By limiting and restricting certain tasks on the computer, the doctor limits the chances of fraud and embezzlement. Some of the restrictions that should be applied and delegated to only the doctor are as follows:

- No deletion of claims
- No printing of prescriptions
- No deletion of prescriptions
- No deletion or editing of payments
- No editing of insurance payments
- No deletion of insurance payments
- No access to practice analysis and financial information
- No ability to edit or delete passwords
- No ability to edit fees
- No ability to edit or add dental codes

Every individual doctor must decide what permissions he or she is comfortable with and not all employees have to be the same. You may assign certain things to one person and not to another. Although it is sometimes inconvenient to be called to the front to put in your password to perform a certain task, it is far less traumatic and devastating than being a victim of embezzlement and fraud.

I would like to make one point clear; that is, the majority of the team members are honest and the intention of this article is not to have you assume your team members are committing fraud. Instead, the purpose of this article is to make you aware that it could in fact happen and has probably happened to you at one point in your career. The longer you have been in practice, the more likely it has happened. One needs to be aware of what is happening in his or her office at all times. It is not enough to say you are too busy practicing what you love, as overseeing your practice is a necessary part of the job. You should trust but you must verify all the other aspects of the practice. You must work on your practice as much as you work in your practice.

nosefacts

The floor of the nasal cavity is also the roof of the mouth.

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Heidi Dickerson, DDS, LVIM, FIAPA

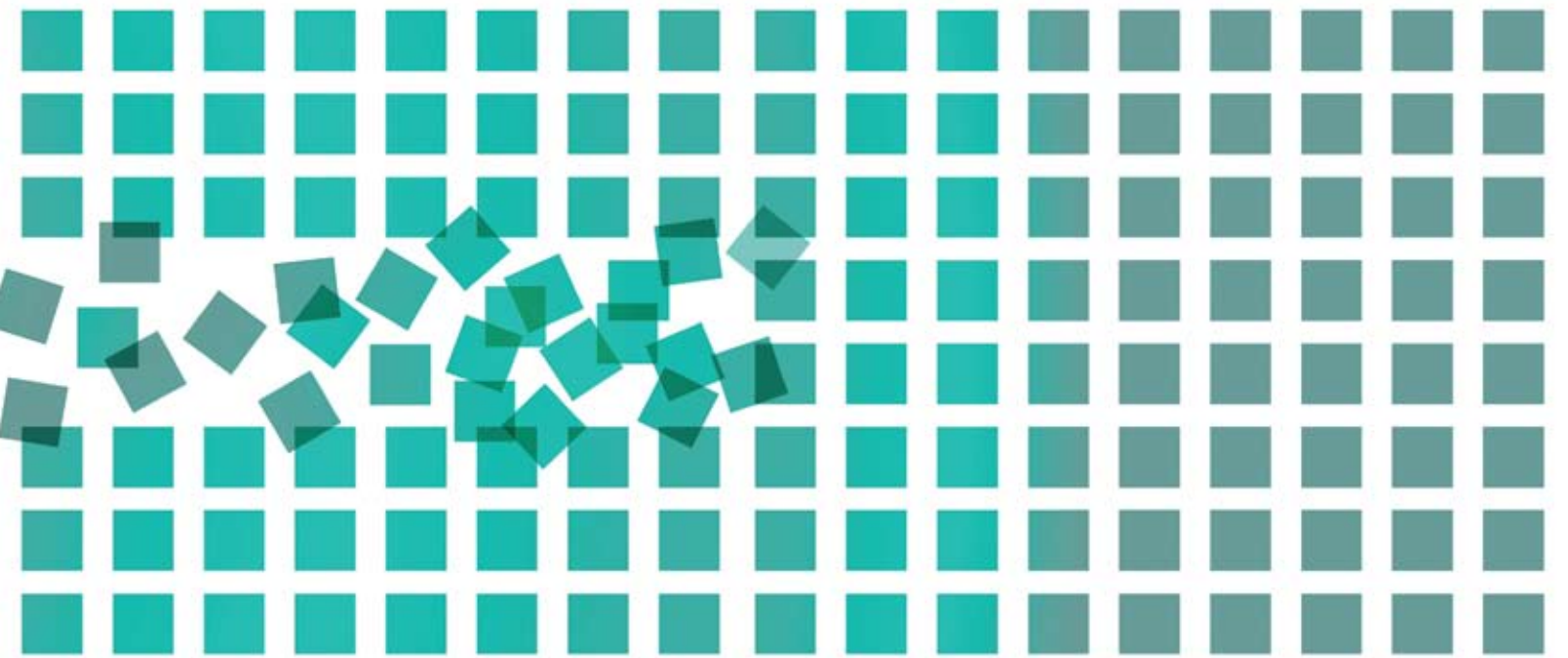
Nitric Oxide & Mouth Breathing

PHYSIOLOGY YOU WANT TO UNDERSTAND

In 1998, The Nobel Peace Prize was awarded jointly to Robert F. Furchgott, Louis J. Ignarro and Ferid Murad. The title of the Nobel Prize was **"Nitric Oxide as a Unique Signaling Molecule in the Cardiovascular System."** Today, it is recognized that **NO** is a widespread signaling molecule in all organs of the body, not only the cardiovascular system.

Their contributions to the understanding of this gas and its effect on the human body are of major importance in our understanding of the regulation or our bodily systems and of ultimate health.

Enzymes have been found in the nose and in the paranasal sinuses that produce Nitric Oxide. Nitric Oxide levels in the sinuses are even much higher than what is produced in the nose. These findings show that the main site for Nitric Oxide production is the paranasal sinuses. [Lundberg JO, Farkas-Szallasi T, Weitzberg E, Rinder J, Lidholm J, Anggaard A, Hokfelt T, Lundberg JM, Alving K. High nitric oxide production in human paranasal sinuses. Nat Med1995;1:370–373.]



There is a link between low NO levels and many diseases.

What does Nitric Oxide do?

NO plays a role in every organ of your body! Here are a few things it does:

- As a vasodilator it decreases blood pressure and improves blood flow to the organs
- Anti-inflammatory action in the arteries
- Prevents blood clotting and obstructions in the arteries
- Immune defense: destruction of viruses and parasitic organisms
- Plays a role in respiration
- Enables erectile function
- Enhances memory and learning
- Protects the skin from harmful ionizing radiation
- Promotes a healthy digestive tract by regulating the secretion of digestive hormones and enzymes
- Hormonal effects: influences secretion of hormones from several glands
- Regulates bladder function
- Acts as a signaling molecule to maintain normal bodily functions
- Regulation of binding/ release of O2 to hemoglobin

There is a link between low NO levels and many diseases. Here are a few of the diseases associated with low Nitric Oxide: high blood pressure, heart disease, heart attack, stroke, digestive tract issues such as Irritable Bowel Syndrome, Alzheimer's disease, dementia, erectile dysfunction, and bladder issues.

Some ways to increase Nitric Oxide are eating foods high in it, exercising and BREATHING THROUGH YOUR NOSE! If you ask most people if they are a nose or a mouth breather, the majority will answer that they breathe through their nose. However, this is not true. Observe those around you... a large percentage of the population are mouth breathers. It is imperative that we recognize this sign in our patients and help them to become nasal breathers.

Breathing through your nose is one of the most beneficial things you can do for the overall health of your body and for your longevity.

Let me simplify why mouth breathing is bad. First and foremost breathing should be very passive and with little effort. We should not hear or notice someone breathing. Breathing heavy causes blood vessels to constrict. This is one reason why mouth breathers are tired a lot of the time. There is less delivery of O2 in mouth breathing. Normal breathing is approximately 4-6 liters/minute and 10-12 breaths per minute. Oxygen saturation would be around 95-98%. If you have a breathing problem you may breathe 10-15 liters/min, you may even take more breaths, but you do not have any more Oxygen.

Carbon Dioxide is key for how Oxygen gets released from red blood cells into our tissues and our organs. When you breathe heavy you lose CO2, which results in O2 sticking to the hemoglobin and not getting released. Basically the heavier you are breathing the less that Oxygen is getting released.

With this heavy breathing also comes a vasoconstrictive effect and up to a 50% restriction of our blood flow up to our brain. You can see that chronic hyperventilation is not a healthy situation to be in.

Each hemoglobin molecule carries four Oxygen molecules. And since we know that Oxygen is released by the presence of Carbon Dioxide you can understand that the harder you breathe the less Carbon Dioxide there is, so less Oxygen is released. You may have blood that has a high Oxygen level, but the Oxygen to the organs would be less because it is not being released by the hemoglobin. This is the problem with most mouth breathers.

When we breathe through our nose, nasal resistance increases by approximately 200% and helps in the release of Oxygen. Mouth breathing does not let our bodies take advantage of the sinuses production of Nitric Oxide.

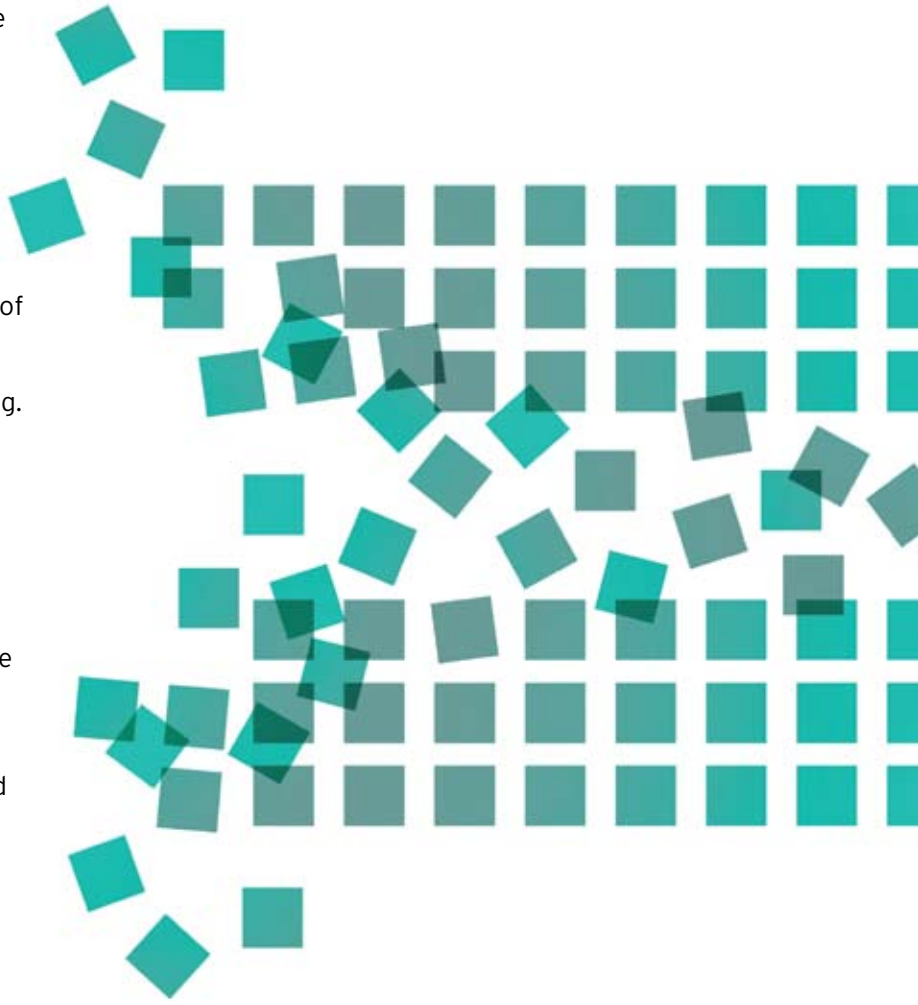
Close to 80% of the population breathes wrong. They may breathe through their mouths, or have shallow breathing, they may not breathe with their diaphragm, and they might breathe heavy and you will notice them breathing or hear them.

The only organ that helps us get ready to breathe correctly is our nose. When we breathe through our mouths it can lead to chronic hyperventilation, reduced blood circulation, lowering of Carbon Dioxide levels, and vasoconstriction of our airways! The continued mouth breathing will have detrimental effects on our overall health such as sleep apnea, high blood pressure, heart disease, asthma, allergies...and more.

Our bodies need supreme oxygenation...this is not happening for our brain, heart, and organs when we are mouth breathers.

If you can keep in mind the function of each of our organs then it becomes quite simple. We use our mouth to eat and talk and we use our nose to smell and breathe! A primary focus we should have for the well-being of all our patients is to help them become nasal breathers through life.

Close to 80% of the population breathes wrong.



nosefacts

The nose is made up of five muscles: dilator naris anterior, dilator naris posterior, depressor septi, nasalis and procerus.

OMD

Orofacial Myofunctional Disorders (OMD) and Myofunctional Therapy

COURSE DIRECTOR:
Heidi Dickerson, DDS, LVIM, FIAPA

FEATURED LECTURER:
Jill Taylor, RDH, BS

PREREQUISITE: None

TUITION:
Doctor: $1995
Team/Hygienist: $995

CE CREDITS: 15

AGD CODE: 180

DECEMBER 4-5, 2017

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COURSE DESCRIPTION

When the tongue is not acting properly during speech, swallow, or at rest... it can cause all sorts of problems from newborns to adults.

From issues with OSA, TMD, pain, restorative/ortho relapses, speech, sucking, posture, and swallowing... to name a few, the tongue plays a huge role.

The muscles of the face, mouth, and throat must be in balance to work together in harmony.

This course is designed to enhance your Physiologic Based Practice by uncovering the secrets of the most powerful muscle we work with...THE TONGUE!

LEARNING OBJECTIVES

- Identify, diagnose and treat the most common OMD's in your practice.
- Utilize knowledge of how faces develop to create beautiful faces.
- Stop patients from practicing Oral Habits.
- Classify Tongue tie and Lip ties and identify when and how to surgically remove them.
- Discuss Posture as it relates to OSA, TMD, and OMD.
- Treat a patient starting Monday morning utilizing Hands on Myofunctional Therapy Exercises.
- Review of Tongue anatomy and what you need to remember.
- Tongue health: What can your tongue tell you about the state of your health?
- Identify warning signs from birth to puberty and learn how to direct the growth of your children.
- Discuss how OSA and TMD relate to OMD.
- Discuss what screening tools to use the very next day back in your practice.

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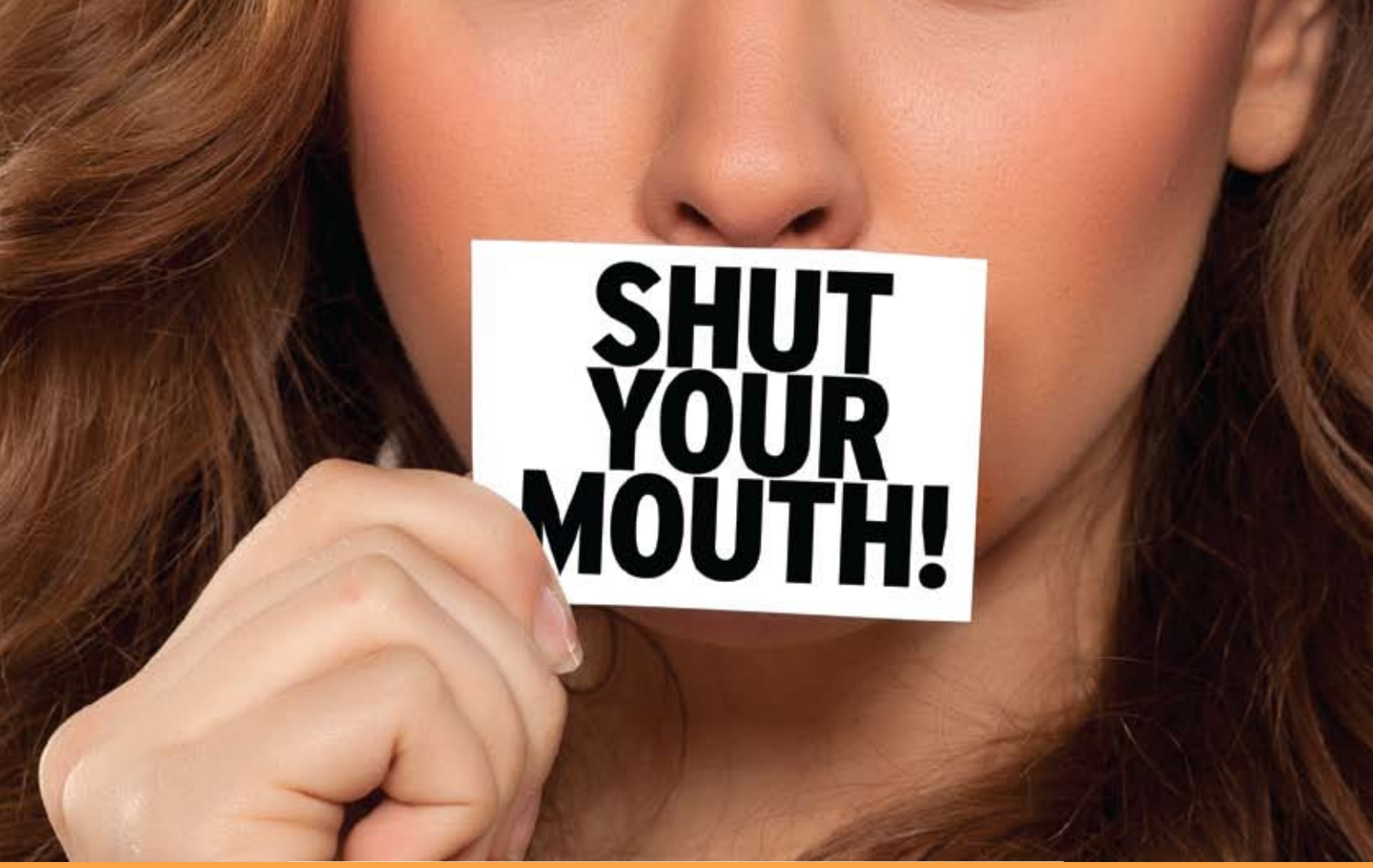


THE BENEFITS OF LIP TAPING

Heidi Dickerson, DDS, LVIM, FIAPA

It seems crazy to think you should physically tape your lips closed when you are asleep, doesn't it? Well, the reality is... it is a pretty smart thing to do! Let me explain why.

Lip taping MAKES US breathe through our nasal cavity. This is very important in order to utilize the benefits of Nitric Oxide that is produced in our paranasal sinuses. When Nitric Oxide is inhaled into the lungs it supercharges our lung's ability to absorb Oxygen by 10-25%.

Breathing through your nose will also make you healthier. Nitric Oxide kills bacteria and viruses. That fact combined with the role of our nasal mucous, helps us to get rid of bad germs that cause infections, such as sinus and ear infections, to name a few.

Breathing through our noses elicits a Parasympathetic Response. Our heart rates will be lower, as will our blood pressure!

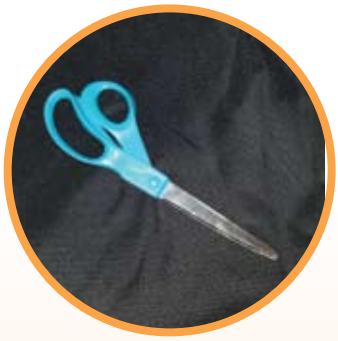
Mouth breathing causes chronic hyperventilation which throws off our Oxygen/Carbon Dioxide balance, leading to Oxygen starvation. Our brains and organs are directly affected by this imbalance. I don't know about you, but I want all the Oxygen I can get to every part of my body!

For overall health, well-being and for better sleep quality, you and your patients should try lip taping. It's an inexpensive and easy thing to do that has optimum benefits for your body!

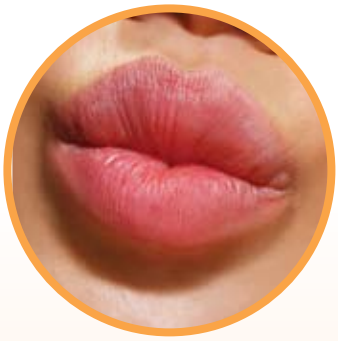
HOW TO LIP TAPE

What you will need

1 Inch Micropore Surgical Tape: Hypoallergenic



Scissors



Lips

What to do

Get ready for bed: wash your face, brush and floss your teeth.

Cut a strip of tape long enough to cover your lips horizontally.

Fold the tape over on both ends to make it easy to rip it off if necessary.

PAT your lips dry.

Relax your lips, (do not purse them, or it may be a little uncomfortable). Place the tape on your lips, from corner to corner, horizontally.

For Beginners: start with using the tape vertically, as pictured.

Nighty-night!

If you tear off the tape in your sleep... contact your dentist. He/She can help you figure out what is stopping you from being able to consistently breathe through your nose. Perhaps you have allergies, a deviated septum, reactive turbinates, large adenoids/tonsils, or other airway issues that need to be addressed prior to beginning a lip tape protocol.

Timothy Gross, DMD

The Big 3 and Me

Part One

In the Physiologic Orthodontics class at the Las Vegas Institute, we focus heavily on the "Big 3." Orthodontic treatment and post treatment orthodontic stability necessitate management and correction of the "Big 3." So, what is the "Big 3?"

1

Nasal Breathing

2

No Tongue Habits

3

Lip Seal

Corruption of the "Big 3" is the root cause of nearly all malocclusions. That's right. Class I, Class II, and Class III malocclusions, crowding, deficient midfaces, cross bites, impacted teeth, high palatal arches, deep bites, open bites (and the list goes on) can all be explained by Enlow in his textbook, "The Essentials of Facial Growth." That textbook is paramount for understanding normal facial growth and development and should be required reading for every dentist and dental specialist. Malocclusions, so predominant in our society, cannot be explained by genetics alone. Our phenotype, i.e. our genome in addition to environmental influences, is the result of corruption of the "Big 3."

The inability to breathe nasally, habitual mouth breathing, and/or tongue habits lead to altered facial growth patterns which in turn lead to observable dental and orthognathic malocclusions. Orthodontic treatment is utilized to correct these malocclusions, but the underlying pathophysiology must be addressed in order to achieve an optimal physiologic occlusion, balanced facial growth and facial beauty.

Sleep apnea, temporomandibular dysfunction and malocclusion may all be related to the inadequate horizontal growth of the maxilla when the "Big 3" are violated. A more vertical growth pattern occurs whereby the midface is radiographically and clinically deficient and the mandibular growth pattern is resultantly more vertical than horizontal. The clinical appearance of the lower face is a steep mandibular plane angle and a short retruded mandible or even a Class III appearance if the midface is significantly deficient. The underdeveloped midface appears retruded with depressed cheekbones, excess sclera display, a prominent nose with a dorsal hump and a thin upper lip and a gummy smile. A long face with open mouth habitus and strained lip seal is the classic appearance of excess vertical facial growth.

According to Dr. John Mew, maxillary dental crowding is not the result of large teeth or small arches; rather it is the result of lack of forward growth of the nasomaxillary complex. The result is an underdeveloped, retrognathic and less aesthetic facial profile.

Occlusion is the relationship of the upper jaw to the lower jaw. But what if the upper jaw is deficient? What if the lower jaw is deficient? Can we really correct the dental occlusion without correcting those deficiencies? Sure, we can make the teeth straight and make the upper and lower teeth couple nicely. Unfortunately, the result is a skeletal and physiologic malocclusion with straight teeth, at the expense of the airway, the temporomandibular joints and facial aesthetics.

A Case Study... Me

As a 48 year old male, I had multiple issues: a retruded lower jaw and an unaesthetic gummy smile with retroclined upper anterior teeth. I had considered, but did not pursue, orthognathic surgery, osseous crown elongation and gingivectomy with porcelain veneers and a surgical lip tack procedure, all to improve my smile and facial appearance. When I smiled, I did it cautiously to prevent the display of my gummy smile.

My medical and dental history I fear are, at least in part, all too common. I grew up in a rural area outside of Pittsburgh, Pennsylvania in the 1970's when the steel mills were spewing their plumes of smoke from the factories. I grew up on a pine tree nursery and had poorly controlled environmental allergies, which is no wonder considering the acres of grass, trees and polluted air by which I was surrounded every day of my young life. For 13 years, I endured up to two allergy shots per week (allergy immunotherapy) in an effort to control my allergies. My environmental allergies were so profound, I missed several days of school per year due to severe congestion, facial swelling and uncontrolled episodes of sneezing. At the peak of pollen season in the spring and fall, I was a chronic mouth breather and had difficulty sleeping due to a lack of nasal patency. I was referred twice as a teenager by my primary care physician to otolaryngologists for removal of tonsils and adenoids to improve my airway. Both times the physicians refused on the grounds that there were not enough actual tonsil infections in a one year period.

You have the opportunity to recognize, diagnose and treat the root cause of airway disorders and dramatically improve the quality and the duration of your patients' lives.

To this day, I have enlarged palatine tonsils with large crypts that trap food which becomes foul-smelling tonsiloliths (tonsil stones) which I irrigate to remove daily. A broken nose in middle school only further compromised my nasal patency. After that, retraction orthodontics with headgear likely exacerbated the multitude of airway problems and did not correct the gummy smile and worsened the retroclined incisor appearance. Early into adulthood, chronic sinusitis became a complication that led up to three yearly sinus infections bad enough to cause missed work. By the age of 40, excessive daytime sleepiness and a sudden onset of nocturnal gastroesophageal reflux led to a diagnosis of mild to moderate Obstructive Sleep Apnea following a home sleep study. Remarkably, I self-referred for the sleep study after my primary care physician addressed the reflux by prescribing a proton pump inhibitor and suggested my somnolence was the result of a busy practice and having two small children at home.

Misguided, mistreated and misdiagnosed, my health was on a slow downward spiral. It was a descent that took 40 years to manifest, all as the result of early childhood airway problems. Management of symptoms only resulted in the development of different and more serious consequences. We all have patients that are chronic mouth breathers, have allergic shiners under their eyes, have inadequate nasal patency and have sleep disorders. Through the outline of my personal experience above, you don't need a crystal ball to know what is going to happen next. You have the opportunity to recognize, diagnose and treat the root cause of airway disorders and dramatically improve the quality and the duration of your patients' lives. In part two I will detail how to prevent and treat deficient midfaces that lead to sleep disorders, TMD and malocclusion. These are the foundational principles taught in the Physiologic Orthodontics series at LVI.

nosefacts

Anything that the human nose cannot smell is LETHAL to humans. For example, human noses cannot smell natural gas, carbon monoxide and carbon dioxide.

ORTHO

Beginners Orthodontics
Physiologic Orthodontics

INSTRUCTORS


Dr. S. David Buck


Dr. Tim Gross

PREREQUISITES: NONE
LENGTH OF COURSE: 3 DAYS
CE CREDITS: 22
AGD CODE: 370
TUITION:
DOCTOR: $3,495
TEAM: $795

COURSE DESCRIPTION

This is an introductory course for dentists and their teams who have performed minimal to no orthodontic treatment in their office. Through both didactic and hands-on instruction, this course is designed to teach participants how to introduce and implement comprehensive physiologic orthodontic treatment in their practice.

COURSE OBJECTIVES

- Recognize and diagnose patients that can benefit from occlusal rehabilitation through comprehensive orthodontic treatment.
- Recommend and administer basic comprehensive orthodontic treatment in their office.
- Utilize T.E.N.S. to stabilize occlusion before, during and after orthodontic treatment to achieve an optimal physiologic occlusion.
- Complete a hands-on bracket placement exercise.

F20

Full Face Orthodontics "F20"
Physiologic Orthodontics

INSTRUCTORS


Dr. S. David Buck


Dr. Tim Gross

PREREQUISITES: NONE
LENGTH OF COURSE: 3 DAYS
CE CREDITS: 21
AGD CODE: 370
TUITION:
DOCTOR: $3,695
TEAM: $795

July 21-23, 2017

COURSE DESCRIPTION

This second level orthodontic course is designed to teach epigenetic facial development utilizing orthodontic appliances. By controlling the direction of orofacial growth, dramatic improvements in airway, function and aesthetics are achieved. Conventional retraction orthodontics in nearly all cases is contraindicated with protraction mechanics becoming established as the standard of care for orthodontic treatment. Whereas it was previously thought not possible, patients of any age can benefit from the orthopedic concepts taught in this course.

COURSE OBJECTIVES

- Overcome craniofacial deficiency by harnessing growth and remodeling
- Utilize new cutting edge diagnostic protocols
- Discuss the significant limitations of conventional retractive orthodontic mechanics
- Discuss how jaw surgery, reverse pull facemasks and sagittal appliances all fail to three dimensionally stimulate growth of the nasomaxillary complex
- Discuss what all aspects of a beautiful face look like.

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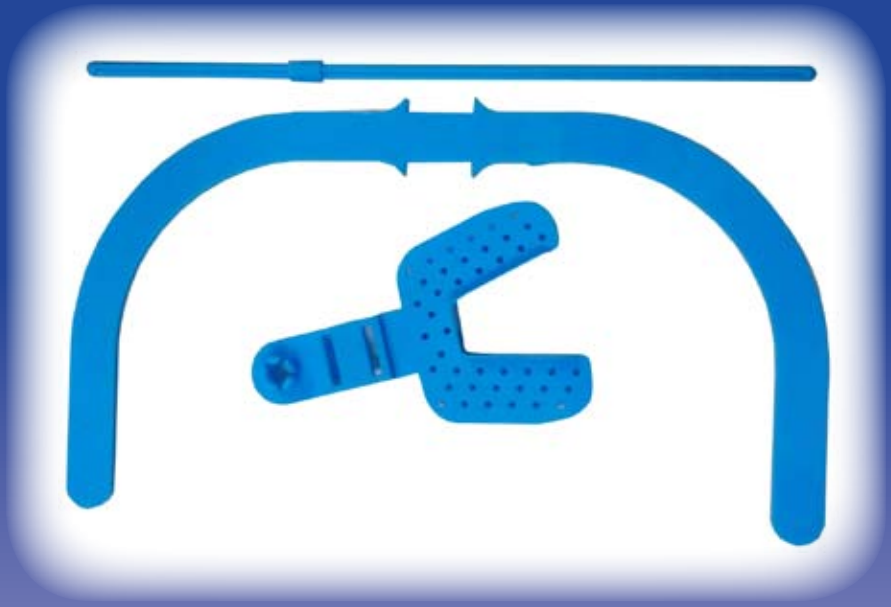

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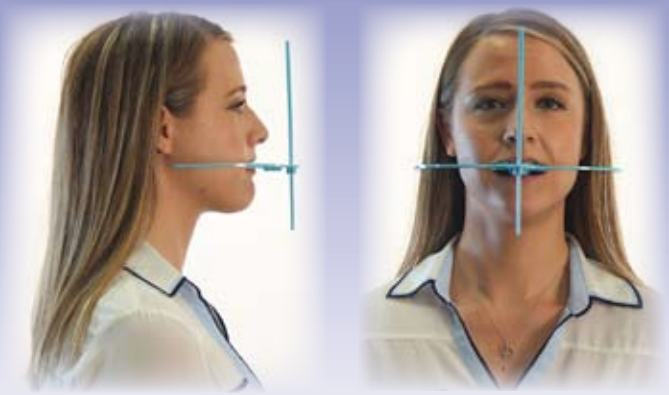

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John Pawlowicz, DMD, LVIF, MICCMO

The ProSomnus® MicrO2® Sleep & Snore Device

What would you do?

When the wife of your best friend comes to you for help with her husband who snores like a freight train, causing her to sleep in another bedroom.

What would you do?

When another friend confides in you that her husband stops breathing for a short period of time in between his snoring episodes, only to awaken in the morning feeling even more tired than when he went to bed.

What would you do?

When a father approaches you and says, "I'm not wearing my CPAP and I am becoming non-compliant with my Obstructive Sleep Apnea (OSA) therapy. I know I am at risk of having a heart attack."

These types of scenarios occur more often than not in our profession today. "What would you do?" weighs in the back of your mind, because our friends, patients and maybe our family members are coming to us looking for answers to their issues pertaining to sleep disordered breathing.

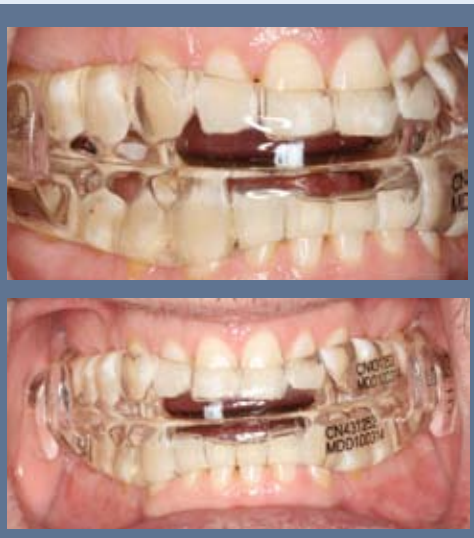
The fact is that many dental and medical providers are not staying current in the newest therapy for snoring and treatments for non-compliant CPAP wear. A doctor, when challenged, may prescribe a patient oral appliance therapy (OAT) in the form of a sleep appliance whose invention is from the bygone days of dentistry. Or they may refer their snoring/OSA patient out to a medical specialist who treats sleep disordered breathing. Focusing here on the appliances of OAT: there is a major problem with the designs of the older styles, as well as many current appliances, in that they can cause the patient's issues

of snoring or OSA to worsen. It wasn't long ago the options for oral appliance therapy (OAT) available to dentists as sleep appliances impinged greatly in their tongue space. Meaning, they were manufactured with hardware that made them big, bulky, difficult to titrate and thus extremely uncomfortable to wear. Additionally, the bulkiness of those older appliances causes an impingement on tongue space thus developing a battle between the tongue which is attempting to find a proper resting posture and the oral appliance. This struggle can cause the tongue to retreat most of the time to the posterior palatal area of the mouth (where the uvula resides) producing a full or partial obstruction of the airway space. This forced tongue position exacerbates a patient's snoring and/or stoppage of breathing.

Furthermore, the bulky types of sleep appliances can and do create pain in the Temporal Mandibular Joint (TMJ) and difficulty in putting one's teeth back together after removal of the appliance in the morning. It has been reported the patient's teeth don't easily go back to normal until well into their day, meaning after lunch or late into the afternoon for some. This is due to the dentist's lack of understanding and education in taking a proper measurement of the jaw placement for the building of the sleep device. This is the most critical measurement when fabricating an appliance for a snoring or non-compliant CPAP patient. It has to be fitted to the proper muscle physiology or in other words, to have harmony of the jaw muscles and the tongue in order to assure patient comfort and an open airway while wearing the device during sleep.

Even to this day, many dentists are still prescribing these older types of appliances due to an unwillingness to learn the newest way to record muscle measurements, or a lack of knowledge in computerized teeth and bite registration techniques, and the low medical/dental monetary insurance reimbursement. Also, if the dentist chooses not to treat the snoring, or non-compliant CPAP patient, and makes a referral to a medical sleep specialist; many times the patient falls through the cracks of alternative treatment, or the medical billing bureaucracy; never to return back to the referring dentist's practice.

Now you have a small glimpse into how important it is to have the proper oral appliance for treating our snoring and noncompliant CPAP wearers, coupled with the appropriate knowledge, skill, and training. In the past, I was one of the dentists that was stuck in the camp of having to utilize those big, bulky, difficult to titrate, and cumbersome night time oral appliances. I had no other options because our menu was so limited. Now my treatment and therapy has all changed due to the forward thinking of a company named ProSomnus® Sleep Technologies, and the Las Vegas Institute (LVI) which is the Premier State of the Art Live Patient Education and Training Facility. The terrific partnership of these two companies has brought the treatment and therapy of snoring and non-compliant CPAP patients into the modern age of dentistry. To reference the ProSomnus® Sleep Technologies press release dated October 3, 2016, "ProSomnus, developer of the MicrO_2® Sleep and Snore Device concentrated resources on partnering with dentists to treat the rapidly growing number of patients with Obstructive Sleep Apnea. Obstructive Sleep Apnea (OSA) is a Sleep Breathing Disorder affecting an estimated 20 million adults in the United States. OSA has been linked with an increased risk of stroke, cardiovascular problems, motor vehicle



MicrO_2 SLEEP APPLIANCE

Even to this day, many dentists are still prescribing these older types of appliances due to an unwillingness to learn the newest way to record muscle measurements...

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Because of its sleek design and predictable fit, it has solved the tongue space issue found in older devices.

accidents, depression, memory loss, and snoring."
Len Liptak, CEO of ProSomnus Sleep Technologies commented, "ProSomnus invents and manufactures devices that enable dentists to treat more patients who are suffering from OSA. Tens of millions of adults have undiagnosed OSA, millions of adults have abandoned CPAP and dentists can help."

This new MicrO_2 device has revolutionized the way that I look at my snoring and non-compliant CPAP patients. Because of its sleek design and predictable fit, it has solved the tongue space issue found in older devices. In fact, due to its advanced CAD-CAM design it is able to be made smaller and stronger then it's bulkier and cumbersome counterparts and without teeth-moving ball clasps. The company touts the MicrO_2 as being "more biocompatible and more precise than predicate intraoral sleep apnea devices, allowing dentists to get patients into therapy faster, and with greater comfort and convenience." I fully believe this statement to be true as evidence of my patients' immediate feedback on the difference between their old sleep appliance and their new MicrO_2 appliance. They comment on the ease of use and their increased tongue space and comfort while dosing off to sleep.

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They experience very little tooth movement and it causes little to no intercuspation changes. The device is easier to titrate for both the patient and the doctor due to four individual CAD-CAM designed appliances, as opposed to the hardware and mechanical screw adjustments of the older appliance choices. In short, the MicrO$_2$ series of arch forms are designed to match the advancement positions that are prescribed by the dentist.

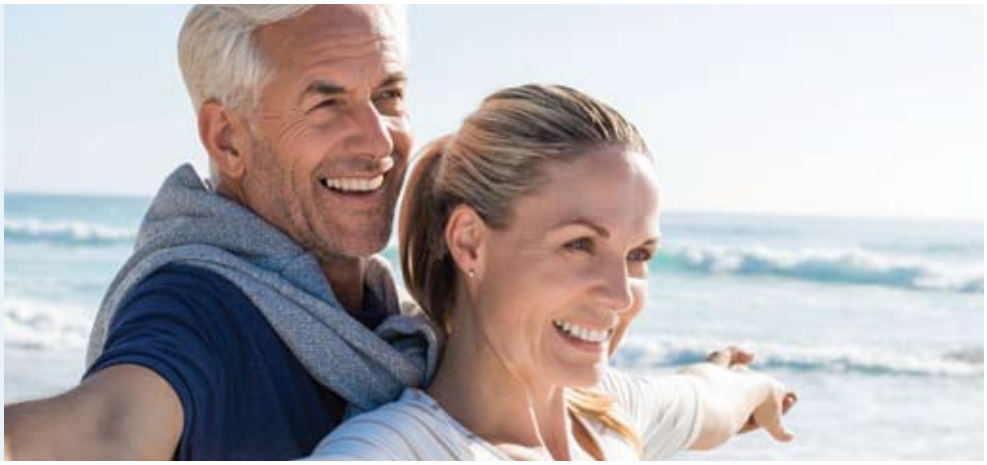
Over the course of approximately the last four years, beginning as a beta test doctor, I have moved exclusively to the MicrO$_2$. Patient-reported and clinically measured outcomes of this device has my friends, patients and family all wearing this new ground breaking device to treat snoring and aid in the opening of airway space for non-compliant CPAP wear with great success. I would encourage you to investigate the educational opportunities at LVI with the OSA I and OSA II courses to learn about diagnosing and treating Sleep Disordered Breathing and to begin experiencing the results of the MicrO$_2$.

Physiologic Approach to Treating OSA Level I
September 17-19, 2017

Physiologic Approach to Treating OSA Level II
September 20-22, 2017

nosefacts

The Maori people in New Zealand press noses as a greeting.



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OSA I

The Physiologic Approach to Treating OSA

INSTRUCTORS:
Dr. Bill Dickerson
Dr. Anne-Maree Cole
Dr. Sahag Mahseredjian
Dr. John Pawlowicz

PREREQUISITE: None

TUITION:
Doctor: $3,695
Team: $795

CE CREDITS: 14

LENGTH OF COURSE:
3 Days

September 17-19, 2017

FOR MORE INFORMATION OR TO REGISTER
www.lviglobal.com
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888.584.3237

COURSE DESCRIPTION

Hundreds of millions of people of all ages around the world suffer from deadly obstructive sleep apnea. Obstructive Sleep Apnea (OSA) has been linked to Cardiovascular Disease, Cerebrovascular Insult, Endocrine Disorders and Obesity. Our medical colleagues are asking for our help, NOW! OSA is considered a disease of craniofacial anatomy so the ONUS is on dentists to identify and help manage OSA sufferers.

ARE YOU PREPARED TO START SAVING LIVES?

This course presents an excellent introduction to evidence-based Dental Sleep Medicine and is designed to prepare dentists and their teams to confidently identify, refer and help co-manage patients with snoring and deadly obstructive sleep apnea. Participants will have the opportunity to learn about the relationships between sleep breathing disorders, Physiologic Dentistry and health. They can discover how to get started, immediately expanding their diagnostic acumen and scope of practice.

The goal of this course is designed for all participating dentists to become Dental Sleep Physicians. The possibility of knowing what to do about OSA when you return to your office on Monday morning should encourage you to experience this course!

COURSE OBJECTIVES

- How to take a physiologic sleep bite
- Discuss sleep and breathing physiology; normal and pathologic
- Discuss the anatomy and physiology of airway and its relationship to OSA & TMD
- Integrate OSA signs and symptoms into routine dental diagnostics
- Identify and differentiate OSA sufferers versus snorers with 99% accuracy
- Discuss why The Physiologic Approach is important
- Perform OSA Consultation examination/palpation
- Select what is needed in snoring and OSA appliances
- Utilize Combination Therapy - Jointly treating both TMD & OSA at the same time
- Develop the skills to make OSA more practical, efficient and profitable

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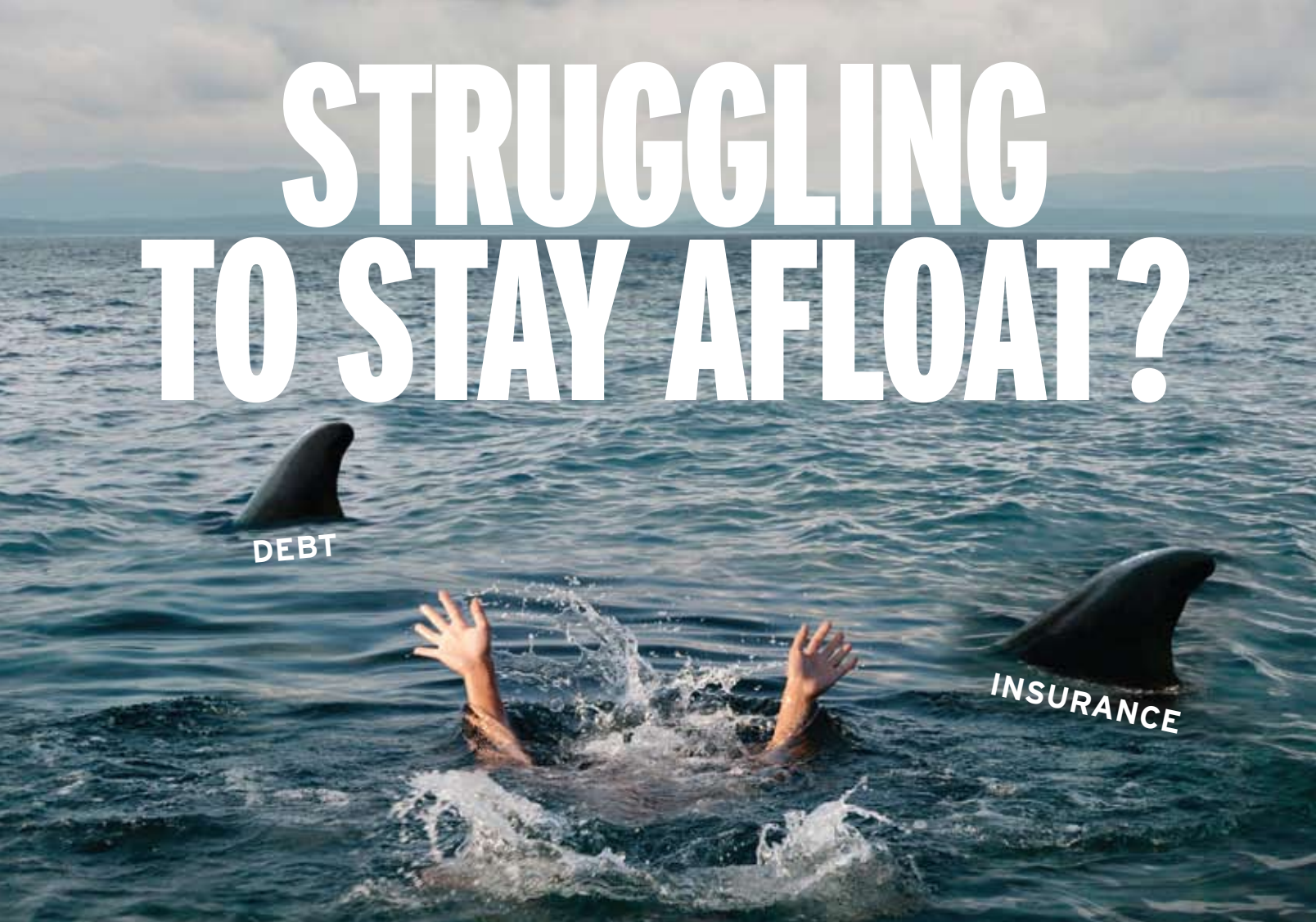

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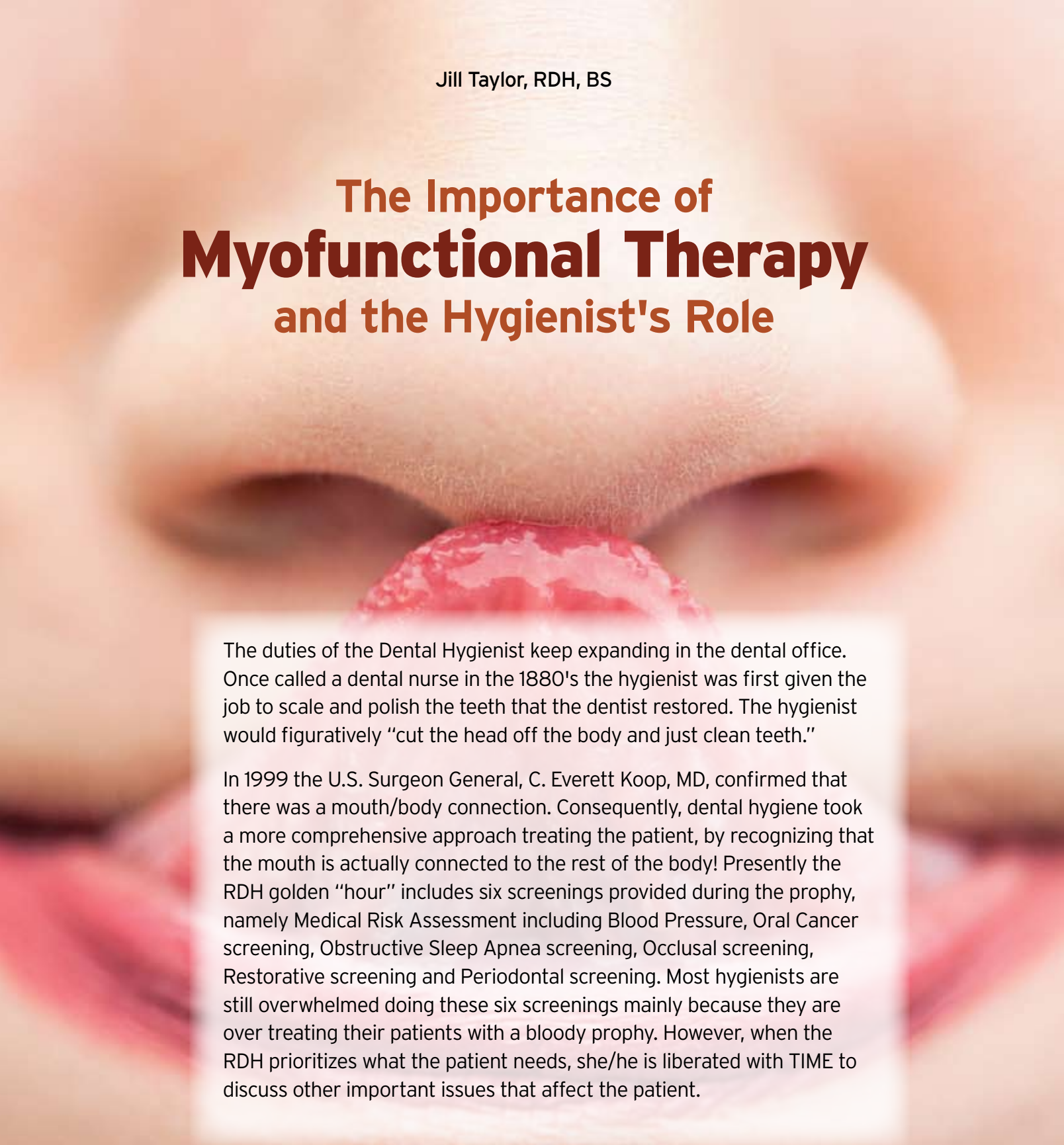
Jill Taylor, RDH, BS

The Importance of Myofunctional Therapy and the Hygienist's Role



The duties of the Dental Hygienist keep expanding in the dental office. Once called a dental nurse in the 1880's the hygienist was first given the job to scale and polish the teeth that the dentist restored. The hygienist would figuratively "cut the head off the body and just clean teeth."

In 1999 the U.S. Surgeon General, C. Everett Koop, MD, confirmed that there was a mouth/body connection. Consequently, dental hygiene took a more comprehensive approach treating the patient, by recognizing that the mouth is actually connected to the rest of the body! Presently the RDH golden "hour" includes six screenings provided during the prophy, namely Medical Risk Assessment including Blood Pressure, Oral Cancer screening, Obstructive Sleep Apnea screening, Occlusal screening, Restorative screening and Periodontal screening. Most hygienists are still overwhelmed doing these six screenings mainly because they are over treating their patients with a bloody prophy. However, when the RDH prioritizes what the patient needs, she/he is liberated with TIME to discuss other important issues that affect the patient.

One area that is expanding in our knowledge base is to evaluate Orofacial Myofunctional Disorders (OMD) as part of our screenings. The field of orofacial myology is giving the hygienist an extra revenue stream in production. Practicing as a Myofunctional Therapist can even spice up the career veteran's options if a disability has occurred with the RDH hands, neck or back. "Orofacial myology is the study of the normal and abnormal patterns of use of the mouth and face and their relationships with dentition, speech and vegetative functions."[1] Orofacial Myofunctional Therapy (OMT) is used to help to re-pattern the orofacial muscles used in chewing, correct swallowing, promote the proper oral rest posture, and promote nasal breathing. Believe it or not, the things that the RDH is looking for in the other exams "crossover" to the OMD screening.

So what is myofunctional all about? Dr. Alfred Rodgers, DDS, is attributed to starting Orofacial Myofunctional Therapy in Orthodontics in the early 1900's and is considered the "father of myofunctional therapy." He started this work because orthodontists found that their work was being undone by improperly functioning oral muscles. Dr. James Garry (1925-2004) did extensive studies into the effects of upper airway obstruction on orofacial development and understood the Neuromuscular ramifications as well. Many offices are now including Obstructive Sleep Apnea questionnaires such as Epworth, STOP BANG, and BEARS in their offices that will help screen some of the habits that point towards OMD already. "Sleep disorders have been estimated to affect 50-70 million Americans and have been linked to increase risk for hypertension, diabetes, obesity, depression, heart attack and stroke."[2] Chances are if the patient has OSA, they probably are a mouth breather or have a low lip competence.

Signs and symptoms that the RDH should be looking for during her screening exams that might indicate that an Orofacial Myofunctional Disorder may be present include: pharyngeal obstructions that promote mouth breathing (large tonsils and adenoids), nasal incompetency, improper rest postures of the lips and tongue (low forward tongue posture), predominate mouth breathing, tongue thrusting, lip incompetency, lip or tongue tie, snoring, high OSA scores on Friedman, Tonsil Grading, long face syndrome, difficulty swallowing pills, forward head posture, tongue, finger, or object sucking, bruxism, TMJ disorders, drooling, narrow dental arches, scalloped tongue, open bite, retruded bite, cross bite and excessive overjet. (Phew!) Luckily, these all cross over with the other screenings, but we have to be aware of what the symptoms are linked to!

By catching OMD early and providing treatment at the proper time, the adolescent patient will have less risk of future OSA and systemic disease later in life.

Orofacial myology is the study of the normal and abnormal patterns of use of the mouth and face and their relationships with dentition, speech and vegetative functions.

When is the proper time to start myofunctional therapy? The time is now! 60-70% of facial growth is complete by age seven. The most successful time to treat any jaw discrepancies is from the ages of 4-6 when the most rapid growth occurs. The first step in a solid myofunctional treatment plan is to first eliminate any non-nutritive oral habits such as thumb sucking or nail biting. Parental support and involvement is key at this age. If a child is already in ortho, myofunctional therapy can still be a benefit to helping finish the case faster, especially if there is an existing issue such as a tongue thrust or low tongue posture. Once the noxious oral habit is eliminated, the therapist can begin myotherapy exercises with the patient. These exercises are targeted to strengthen the tongue, buccinators, and lips, help re-train the proper swallow/chew pattern, promote proper rest position, and encourage nasal breathing. Exercises start out easy and get more difficult as the weeks progress. Typical treatment plans are 12 months in length. If a tongue or lip tie is released, there are certain exercises that should be performed before and after the procedure to ensure success, and then the therapy moves on to the facial muscles.

OMT is not only for children. Adults can benefit from Orofacial Myofunctional Therapy as well, especially if there is an OSA overlap. CPAP can sometimes be titrated back when the patient learns proper tongue placement while sleeping or better lip competency. OSA and sleep disordered breathing causes intermittent hypoxia and oxidative stress which in turn can affect the TMJ and muscles of mastication. OMT can help address this along with treatment of the sleep apnea. In addition,

adult orthodontics is becoming more accepted especially with maxillary remodeling and expansion; myofunctional therapy will encourage the speed and successful outcome of these cases.

The dental patient will benefit from not only the current six screenings that our hygienists and dentists perform, but the inclusion of accessing myofunctional disorders as well. By catching OMD early and providing treatment at the proper time, the adolescent patient will have less risk of future OSA and systemic disease later in life. Accessing our adult patients for OMD, will provide our patients with a higher level of care that ensures dental and overall systemic health.

Sources:
1. Hanson ML, Mason RM. Orofacial Myology International Perspectives.2003 Springfield 2nd edition, pg. 3: Charles C. Thomas

2. Commitee On Sleep Medicine and Research. Sleep Disorders and Sleep Deprivation: and Unmet Public Health Problem. Washington, DC: The National Academies of Sciences, 2006.

Orofacial Myofunctional Disorders Course
December 4-5, 2017

nosefacts

Our nose contributes to how we perceive taste.

Anne-Maree Cole, B.D.Sc, MScMed, LVIM

The academic literature is replete with acknowledgement that when it comes to growth and development, form follows function. The structure and how we develop is not a blue print of our genetic code but an intangible expression of that template and its unique interaction with how we function, our internal environment. Humans are born obligate nasal breathers enabling the highly orchestrated muscular action of breastfeeding, whilst continuing to breathe. This soft tissue signaling initiates the stimulus for optimum jaw development, out from under the cranium.

It is an interesting interplay that function develops the structure and the structure supports the function. The complex nature of the relationships between the head, neck, jaw, face and airway mean that even small transitions away from expected soft tissue signaling can mark the beginning of a divergence from normal genetically encoded growth and development. Prolonged compromised adaptation away from physiologic norms results in maladaptation. This failure to develop the nasomaxillary complex, jaws, face, posture and airway results in the potential for lifelong physiological and structural stress, illness and disease, not the least of which is sleep disordered breathing.

As clinicians, we have a very serious role to play in the prevention of these anomalies. Crooked teeth are the least of our worries. We have to recognize, educate, train, and intercept early, very early.

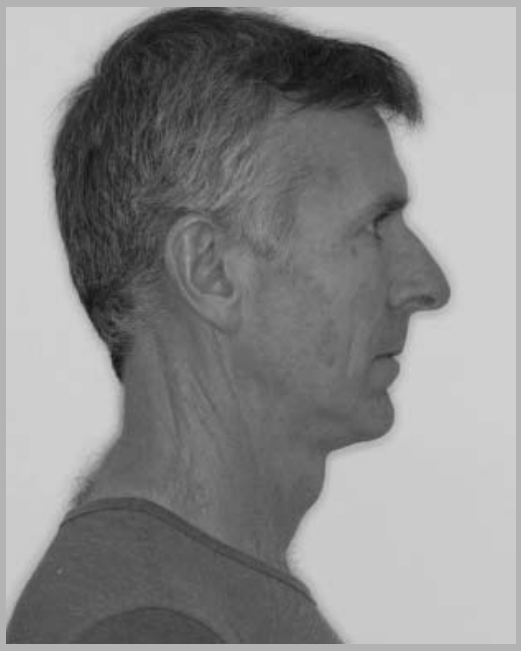
But when is it too late? Most would argue that you cannot grow bone and develop arches in adults. The problem with that presumption is that the concept of growth is associated with changes in height. We get to a point where we stop 'growing'. But if that were true, we would never heal following a fracture as an adult. Are we not 'growing bone' in that healing process? The difference between a fracture and the normal homeostatic state is the trauma. Given appropriate stimulus, the body is quite capable of laying down new bone at any and every age.

Semantics aside, regardless of whether it is called bone growth or remodeling, orthopedic orthodontic tools exist today to develop jaws to an optimal size, shape and position, at any age. To create jaws with more than enough room to house all the permanent teeth, bringing them out from under the cranium where they belong, leaving an airway less susceptible to collapse during sleep.

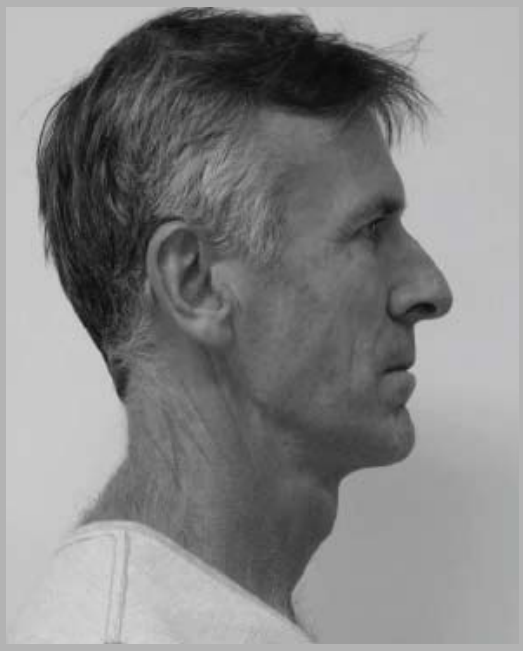
The tools used, create a 'micro-trauma', and this along with a change in function stimulate the body to respond and lay down new bone, not linearly, but 3-dimensionally. It is a physiological process, not a mechanical one. It steps away from traditional orthodontic, mechanically based thinking to an understanding of physiology and working alongside physiology to create organic change. It is a major paradigm shift and may well hold the key to true health and longevity.

This case is 10 months into treatment. The patient is a dentist with obstructive sleep apnea. Through the processes of Jaw Development Orthodontics™, we are stimulating new bone to form, bringing the jaws out from under the cranium, where they belong and in doing so, optimizing the airway to reduce the impact from sleep disordered breathing.

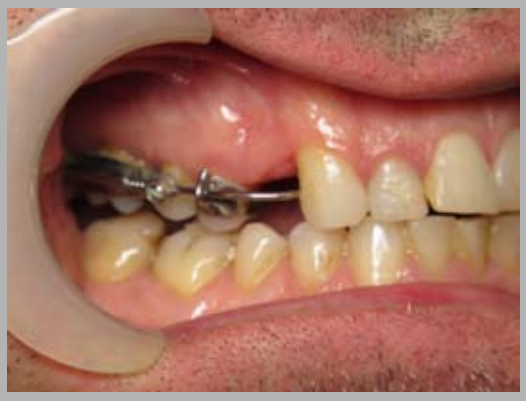
BEFORE TREATMENT

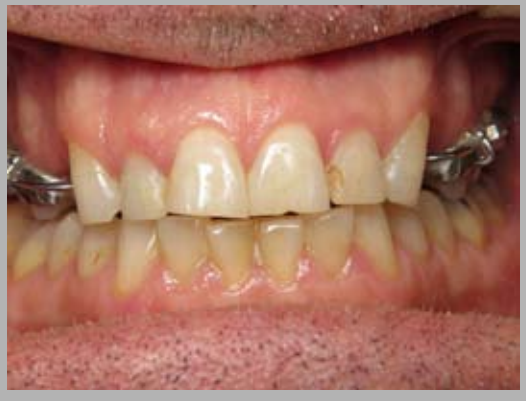


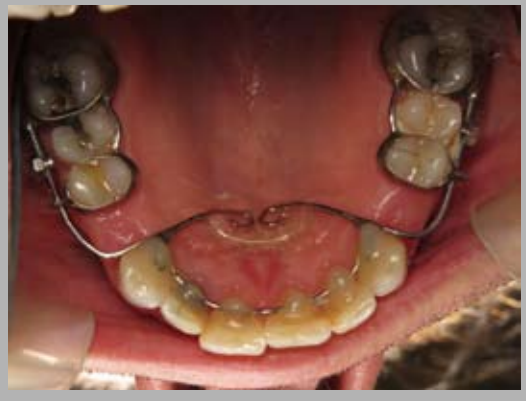
10 MONTHS INTO TREATMENT



When you develop the jaw you develop the airway. When you fail to develop the jaw you contribute to the development and/or perpetuation of sleep apnea.







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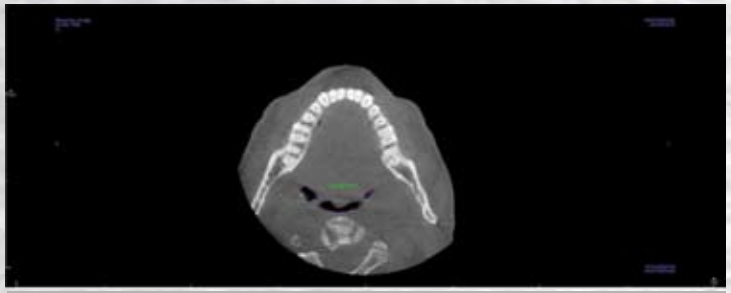
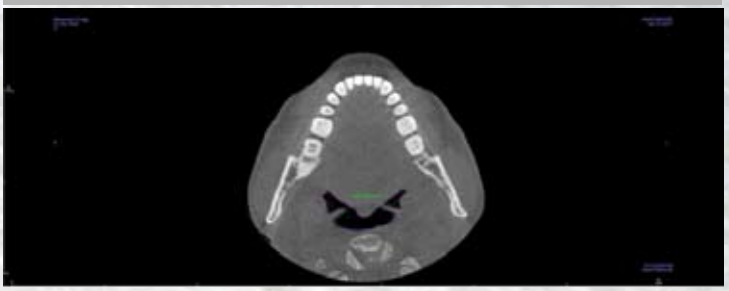


Minimum Airway Area: 216.69mm²

10 MONTHS INTO TREATMENT



Minimum Airway Area: 509.80mm²

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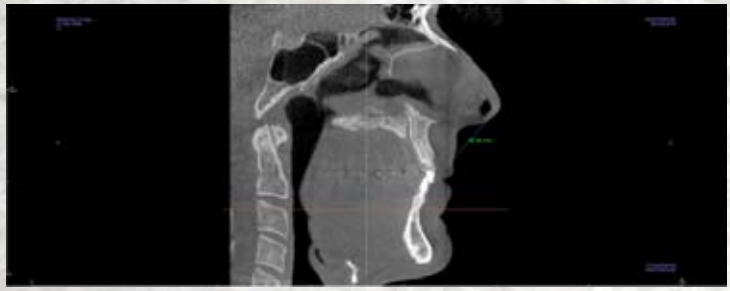
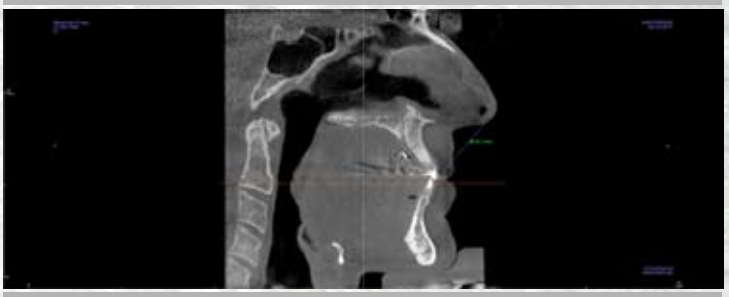


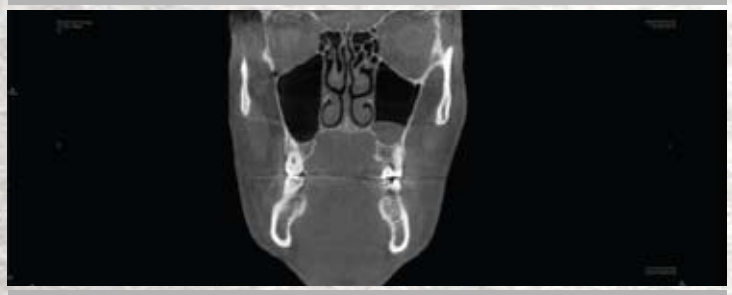
Indicator Line Measurement: 55.35mm

10 MONTHS INTO TREATMENT



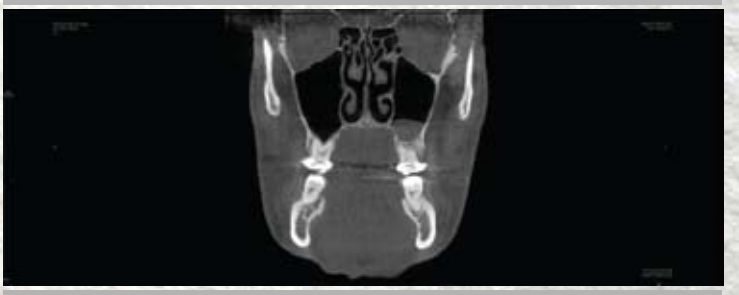
Indicator Line Measurement: 49.51mm

BEFORE TREATMENT



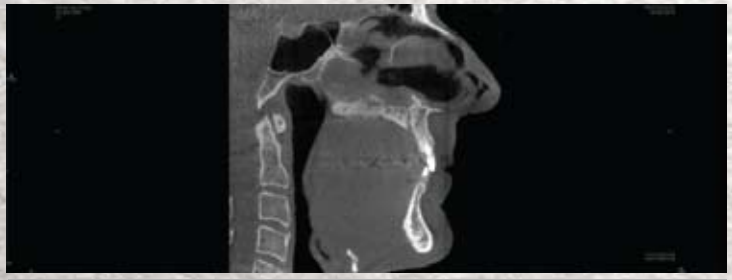
Enlarged turbinates prior to treatment

10 MONTHS INTO TREATMENT



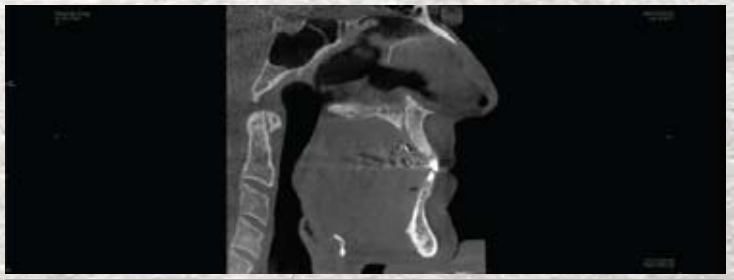
Improved nasal airway / no surgical intervention

BEFORE TREATMENT



Sagittal view

10 MONTHS INTO TREATMENT



Note improved cervical lordosis and position of hyoid

The Jaw Development Orthodontics™ techniques illustrated here are now being taught at LVI, the premium institute for Physiologic Based Dentistry. If it is being done... it is probably possible!

nosefacts

During sneezing irritants are expelled at a speed of 100 miles per hour.

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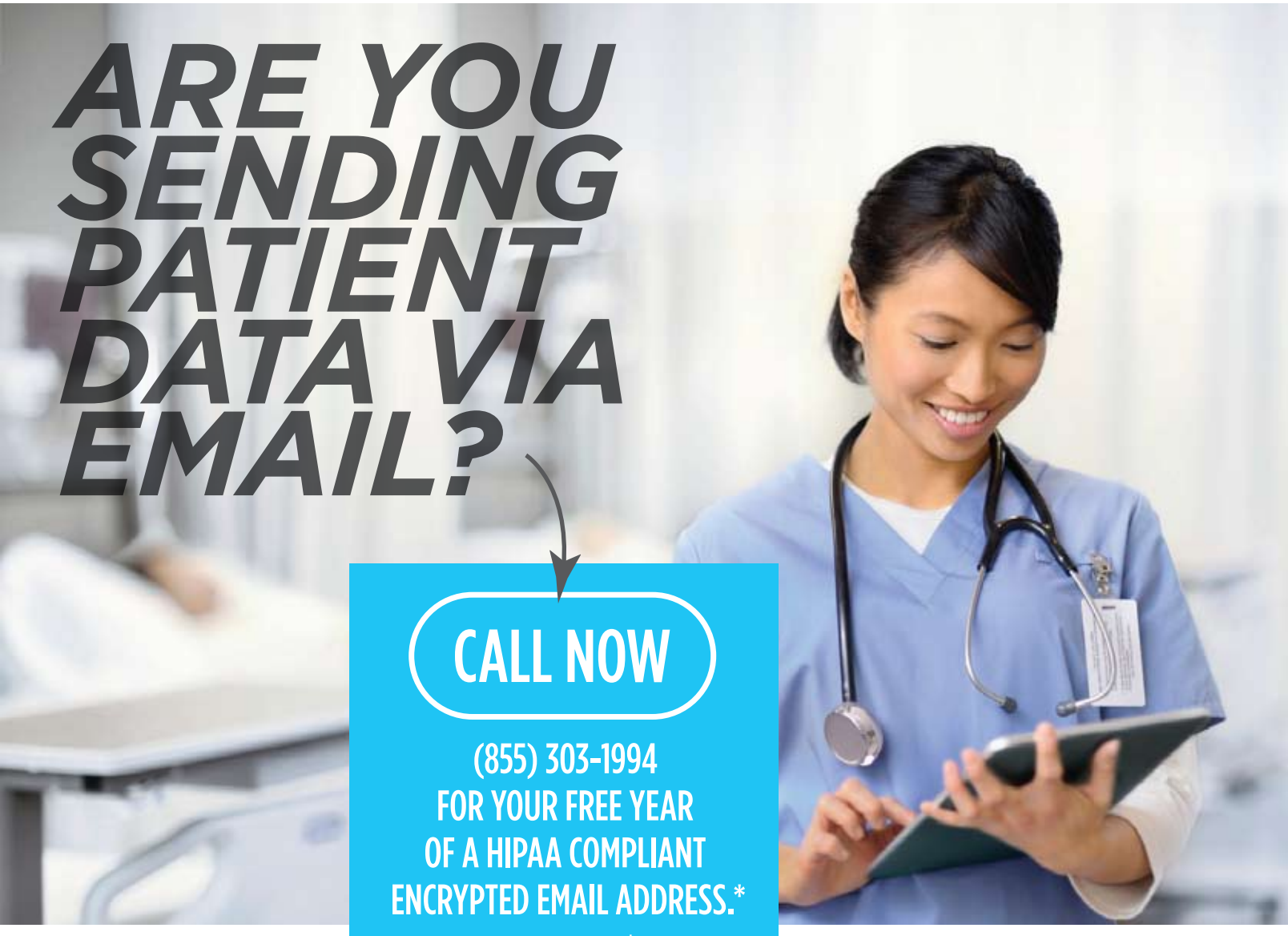

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Sherry Blair

Make it more than Just a Cleaning

You can watch any team member that has been trained around philosophies and systems cringe when they hear a patient say "well, it's just a cleaning." However, dentistry in general has trained our patients to think that way. Therefore, because you are a Comprehensive Physiological Dental Practice, you might want to consider retraining your patients. Want to know where to start? Implement a clinical system around your comprehensive philosophy and take the time to create value with your patients around that system.

All comprehensive practices will do six screenings for their patients. Define them, educate your patients as to why you do them, do them in the order you introduced them, educate the patients about the findings of those screenings in the order you did them, and then (existing patients) hand off to your Doctor the information from the screenings in the same order. Voila, you now have a system.

A systems approach will eliminate generalized solutions, seat-of-the-pants operations, employee discretion and everything else left to chance.

Screening # 1 - Risk Assessment
Stop with the "medical history" stuff that was brought into dentistry a hundred years ago with the simple information that kept us from killing our patients. Science has shown us so much more about the mouth/body connection. Change your mind set when approaching their health questions; what is this patient at risk for? Create value around this screening by letting them know that their mouth is a window to their entire health.

Screening # 2 - Head and Neck Oral Cancer
All doctors and hygienists were taught to perform head and neck and oral cancer exams in school. Then we advance to the busy every day, real life dental practice where it gets shortened to the intra oral cancer screening. When did that become okay? PLEASE let your patients know why you do this screening for them! One person every hour dies from oral cancer in the United States. It is our job to educate the public with this statistic.

Screening # 3 - Airway
Oxygen is pretty important for our bodies. 80% of sleep apnea goes undiagnosed and death rate triples for sleep apnea sufferers.

Screening # 4 - Occlusal
Please don't confuse your patients with all of your Physiologic knowledge until the proper time. Simply let them know we will be checking to see if the joint, muscles and teeth are all working in harmony together.

Screening # 5- Restorative
Educate your patients about the fact that we will be checking for active decay and broken down dentistry and by the way those usually go hand and hand.

Screening # 6 - Periodontal
80% of the population has some kind of periodontal disease and this disease is linked to heart disease, diabetes, low birth weight babies, cancer and the list goes on and on.

The entire team must memorize all six screenings in the correct order because it is the foundation of being a comprehensive practice. And in order to set your practice apart from any other practice we will first introduce these screenings during the New Patient phone call. "Mr. Patient, Dr. Jones loves to spend time getting to know her patients and she is very comprehensive. In addition to your cleaning and x-rays she will be doing six screenings for you at your new patient experience and off we go identifying those screenings and creating value around why we do them."

These screenings are always done by the Doctor at the new patient experience and by the hygienist at each and every continuing care visit. Let's adopt the medical model when it comes to repetition concerning exams and screenings. I don't care how many times I go to a physician, they always do the same thing, take my blood pressure, get my weight and do the blood test. Why are we any different? We always do our six screens each and every visit.

By the way, has every member (yes, you too Doctors) been through these screenings? Do we have consistency and continuity with each and every screening? I can't even begin to tell you how we will chip away at the trust of our patients if we are all doing the screenings in a different way. So first and foremost train your team why and how we are doing theses screenings. They have to first see and feel the value in something before they can pass that value along to the patients with passion.

In addition to clinical systems you will want to consider your business systems. In order for your clinical systems to work you must have proper stress free scheduling, know how to present financials dealing with insurance objections, mastering the correct communication, and on and on. Michael Gerber said, "Organize around business functions, not people. Build systems within each business function. Let systems run the business and people run the systems. People come and go but the systems remain constant" (E-Myth Revisited). Do whatever it takes to get your team trained on business systems or don't expect your clinical systems to work.

Oh and by the way we will clean your teeth too.

Patient Centered Systems
September 17-19, 2017

nosefacts

Anosmia is the inability to smell.

BUYING AN LVI PRACTICE

Paul Peterson, DDS, LVIF

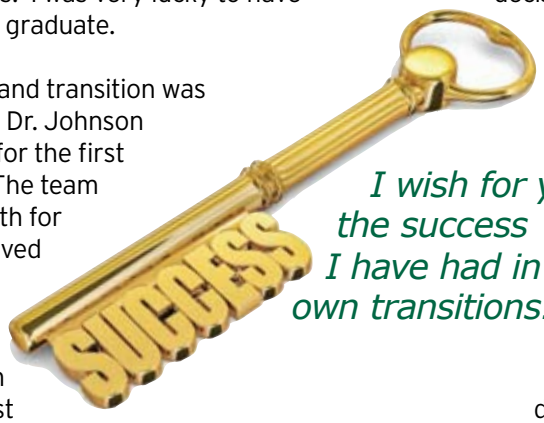
In the Spring 2016 issue of Visions, Dr. Kent Johnson, discussed his experience selling two practices, the second time to Dr. Paul Peterson in Park City, Utah. This is Dr. Peterson's perspective on buying an LVI practice, his journey with LVI, and the role of Practice Transition Partners in guiding the practice purchase.

I have purchased two practices in my life. Once from my father in a community where I was born and raised and the second time from former LVI Instructor, Dr. Kent Johnson, in February 2015. My father, a dentist, had spent years talking about me while I was going through school (in the hopes I would join him in 2004), and then had nine months to prep his patients as I planned to take over in 2008. I was the fortunate recipient of a well-primed patient base and a father to son transition with the first practice. I also inherited my mother as an office manager for the first two years and an extraordinarily great back office manager/chairside assistant who everyone loved, and who had been with my father for nearly 20 years. I saw very few patients leave the practice over the first few years. I was very lucky to have this situation as a new graduate.

The second purchase and transition was dramatically different. Dr. Johnson was only in the office for the first few days I was there. The team that he had worked with for many years had dissolved prior to my coming in. I had no chairside, a hygienist that most patients had only seen once and a receptionist that had been with him for a little over a year. I tell you all this to emphasize my next point. I had very similar patient retention. Why?? I believe that there are three main reasons. First, Dr. Johnson told his patient base that he hand-selected me. Second, the patients understood that I embraced the same approach to dentistry that they appreciated so much in Dr. Johnson. Third, patients could appreciate a passion for excellence as they questioned me or discussed treatment options. (I imagine having purchased and run a practice before also helped). I was truly surprised by how many times I heard, "If he picked you, then I trust you."

When it came time to sell my original practice, it was a daunting task. My father had built it, I had transformed it (including a new office build out), and I feared my patients, employees, and especially my parents weren't going to be happy with me. I had worked with a practice consultant for 2-3 years and he also managed practice sales. I had what I thought was a great relationship and friendship with him. I thought this was the obvious best choice and would make the process much easier. Boy was I disappointed. He was MIA as soon as I had a signed contract with him. If not for Rob Stanbery at Practice Transition Partners being on the other end of the deal helping me, it never would have closed. Rob really went the extra mile, even helping me find potential financing. After seeing how hard he worked on behalf of Dr. Johnson, I decided to use him in the future if need be!

In the end, I am so glad to have made the decision to take LVI courses and purchase an LVI practice. I enjoy my fee-for-service, Physiologic Based, cosmetic, TMD and OSA practice so much more than my previous general practice. The skills I have obtained at LVI have made my practice soar.



I wish for you the success I have had in my own transitions!

My advice to other doctors considering buying an LVI practice is to focus on lifestyle, don't compromise and let your practice overrun your life, or bite off more cost than you can chew. You have to know that you can keep up with what was being done if you expect to match the same practice production. Follow your intuition based on who you are and your confidence in taking over. If you are new in practice or in your LVI journey and you feel you'd benefit from a transition period, then ask for it. But don't be afraid of walking in one day as the last doc walks out if you think you are ready for that. I did that twice and it worked out great. Be far enough along in the journey with LVI that you have decided this is how you want to practice and the skills & knowledge to back it up. Use an amazing Practice Transitions Partner, like Rob Stanberry, whose expertise is in buying & selling dental practices. I wish for you the success I have had in my own transitions!

nosefacts

Mucous helps warm the air that comes into your nose and also adds water to it so the lungs do not get dried out. Mucus traps bacteria and dirt trying to get in!

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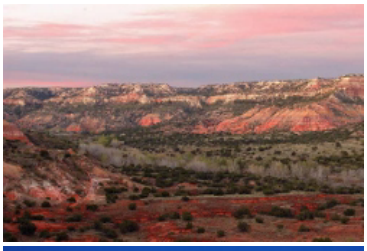
CAPITOL HILL, SEATTLE SOLD!

Fantastic opportunity to purchase busy general dental practice in an urban village setting. Affluent, high-density neighborhood, five well-equipped operatories and strong net income.

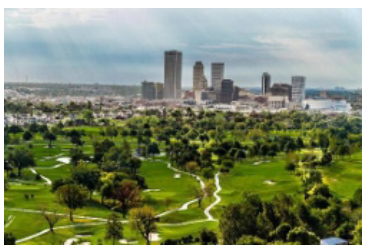


TEXAS PANHANDLE

Very well-established, advanced dental practice in a fantastic location with state-of-the-art equipment. This profitable practice is recognized for its high level of service, excellent reputation and includes four well-equipped operatories in an elegant and inviting setting.

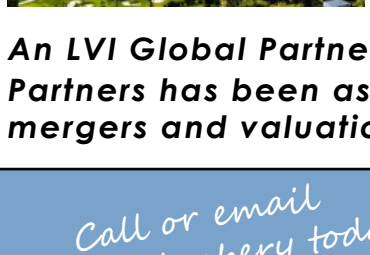
UPTOWN HOUSTON, TEXAS Sale Pending

Stunning, seven-operatory practice completely updated with a contemporary buildout and state-of-the-art equipment in 2011. In addition to general dentistry, this highly-successful practice offers cosmetic, neuromuscular and TMJ densitry.



NORTHWEST HOUSTON, TEXAS Sale Pending

Long-established, advanced dental practice in a very prestigious location, with state-of-the-art equipment and consistently strong collections. The practice includes four very well-equipped operatories in a stylish and modern setting, and specializes in surgery and implants.



TULSA, OKLAHOMA SOLD!

The consistent comment about this four-operatory (three equipped) practice, is that it doesn't seem like a dental office, but more like a spa – quiet, comfortable and relaxing. The latest technology combined with patients seeking the best care, has this practice growing steadily.

UPCOMING LISTING - HOUSTON, TEXAS

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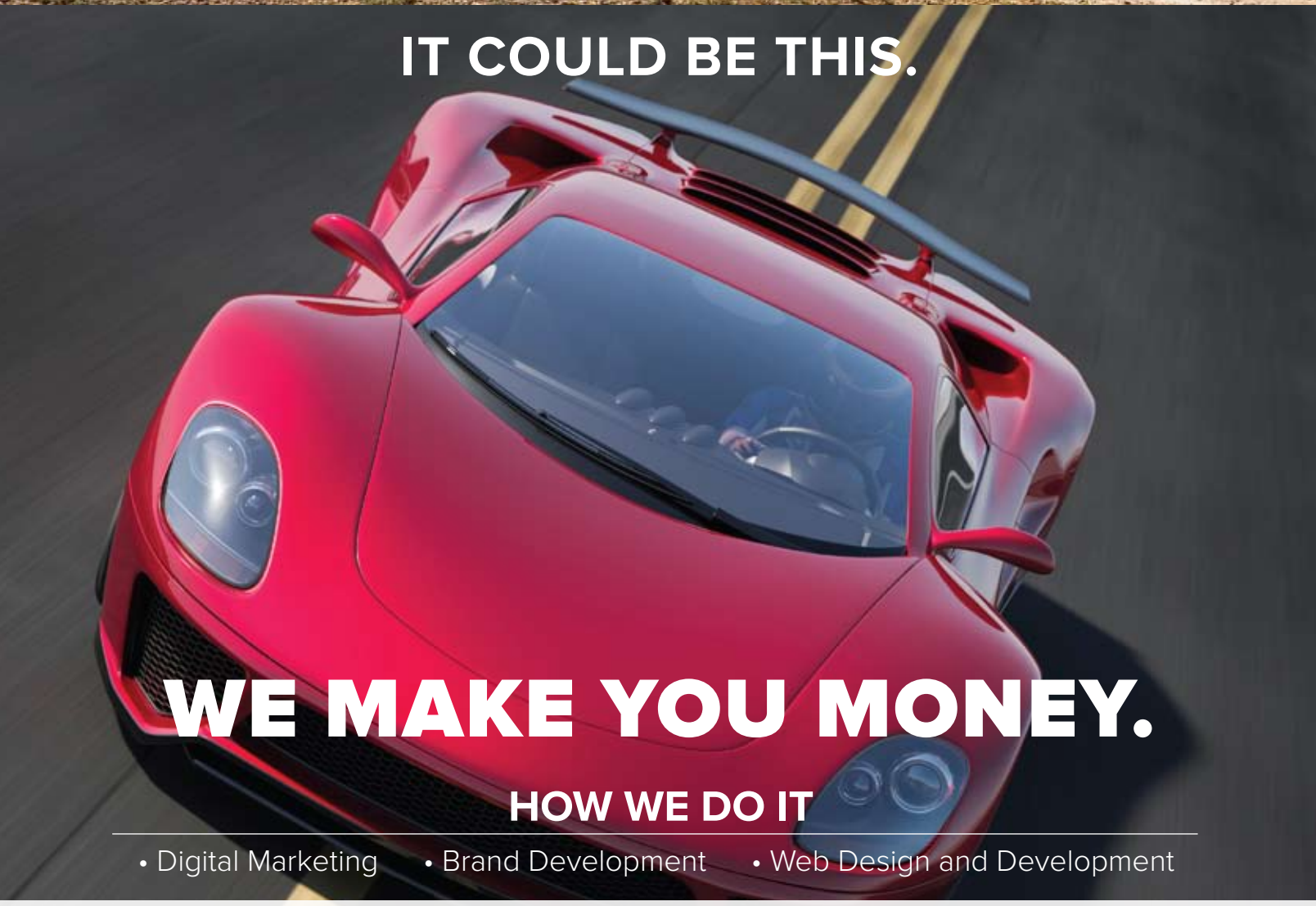
IT COULD BE THIS.



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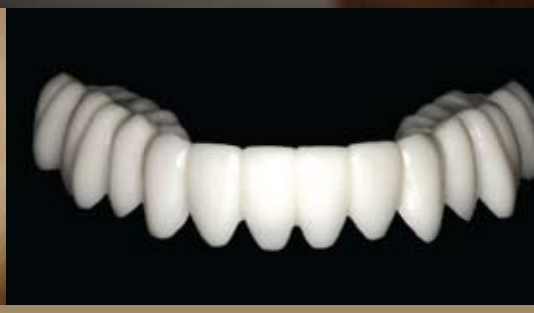

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