Winter 2016-2017

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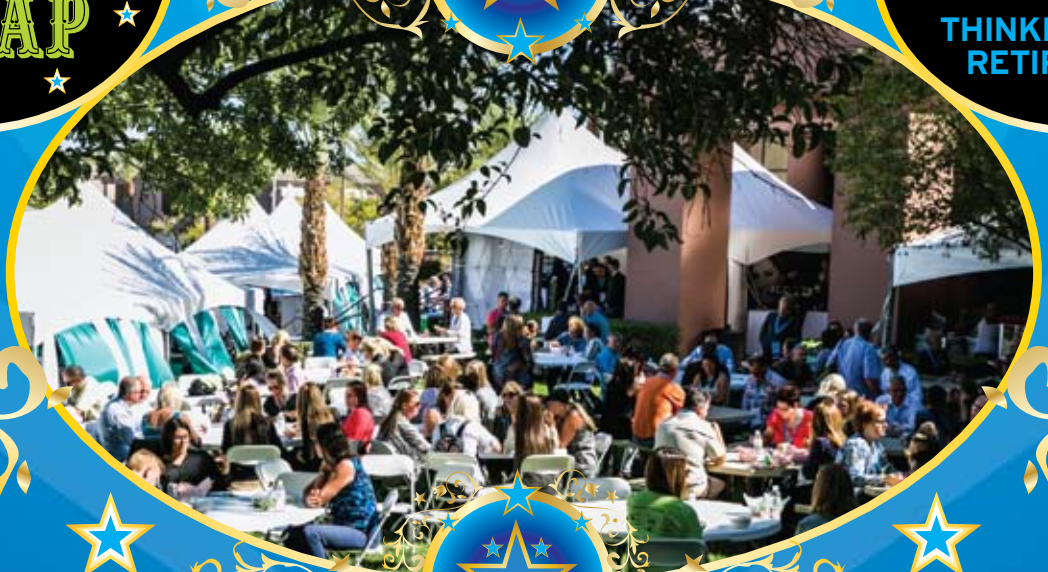
# LVI Visions

*Changing Dentistry. Changing Lives.*

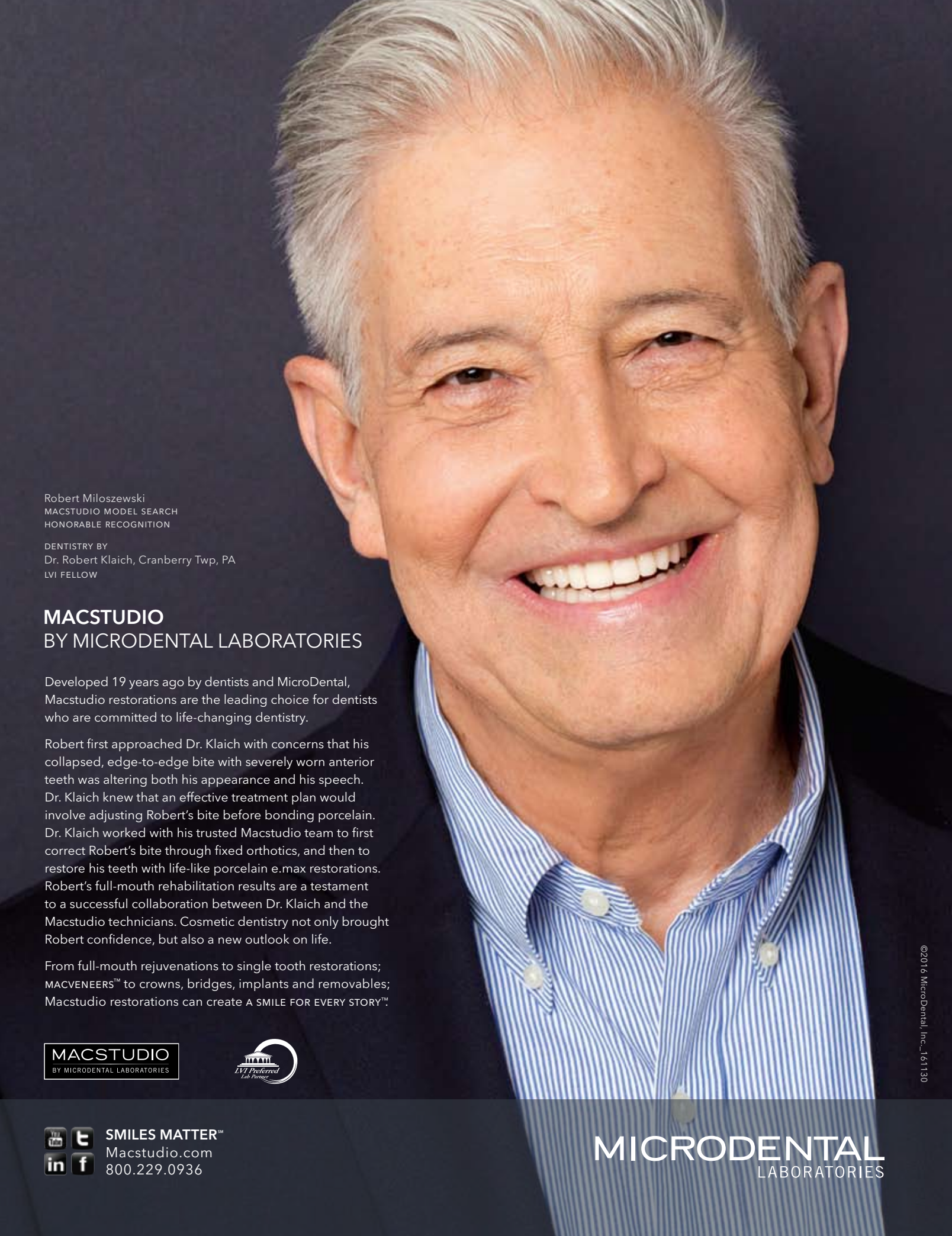
## 2016 IAPA RECAP



**DENTISTRY IS A MARATHON!**

**SNOTTY NOSED KIDS**
YOU THINK THEY LOOK BAD NOW!

**THINKING ABOUT RETIREMENT?**



Robert Miloszewski
MACSTUDIO MODEL SEARCH
HONORABLE RECOGNITION

DENTISTRY BY
Dr. Robert Klaich, Cranberry Twp, PA
LVI FELLOW

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# Where has this year gone?

It has FLOWN BY! No one can say it wasn't an exciting year: professionally, with new and improved materials and procedures coming out all of the time… and personally, lots of exciting adventures. We certainly can't say 2016 has been boring!

Well, this year's IAPA meeting was one for the books! Hundreds of docs and team members flooded LVI's campus for three full days of learning and fun. Our key note speakers were tremendous… and the breakout lectures were full of pearls and new information for all those in attendance.

Admittedly, my favorite parts of these meetings are the social outings where all the docs, teams, and family members let their hair down to have some fun! These times are when we truly laugh and get to know each other… these memories are always dear to my heart.

I hope you enjoy this issue of VISIONS. I have collected articles from many of our IAPA speakers focusing on the topics they presented this year. These articles are AMAZING!

***I hope to see you all in October for the next IAPA!***

ENJOY….

Heidi Dickerson, DDS, LVIM, FIAPA
hdickerson@lviglobal.com
Editor in Chief

# *Imitation is the sincerest form of flattery that mediocrity can pay to greatness.*

OSCAR WILDE


**LVI IS THE INDUSTRY LEADER IN PHYSIOLOGIC BASED DENTISTRY.**
**WE STARTED THIS REVOLUTION 20 YEARS AGO.**
**NO ONE HAS TAKEN MORE PHYSIOLOGIC BITES AND SEEN MORE ADVANCED TMD CASES.**
**EDUCATION IS OUR ONLY BUSINESS, NOT JUST A SIDELINE.**
**ACCEPT NO IMITATIONS.**

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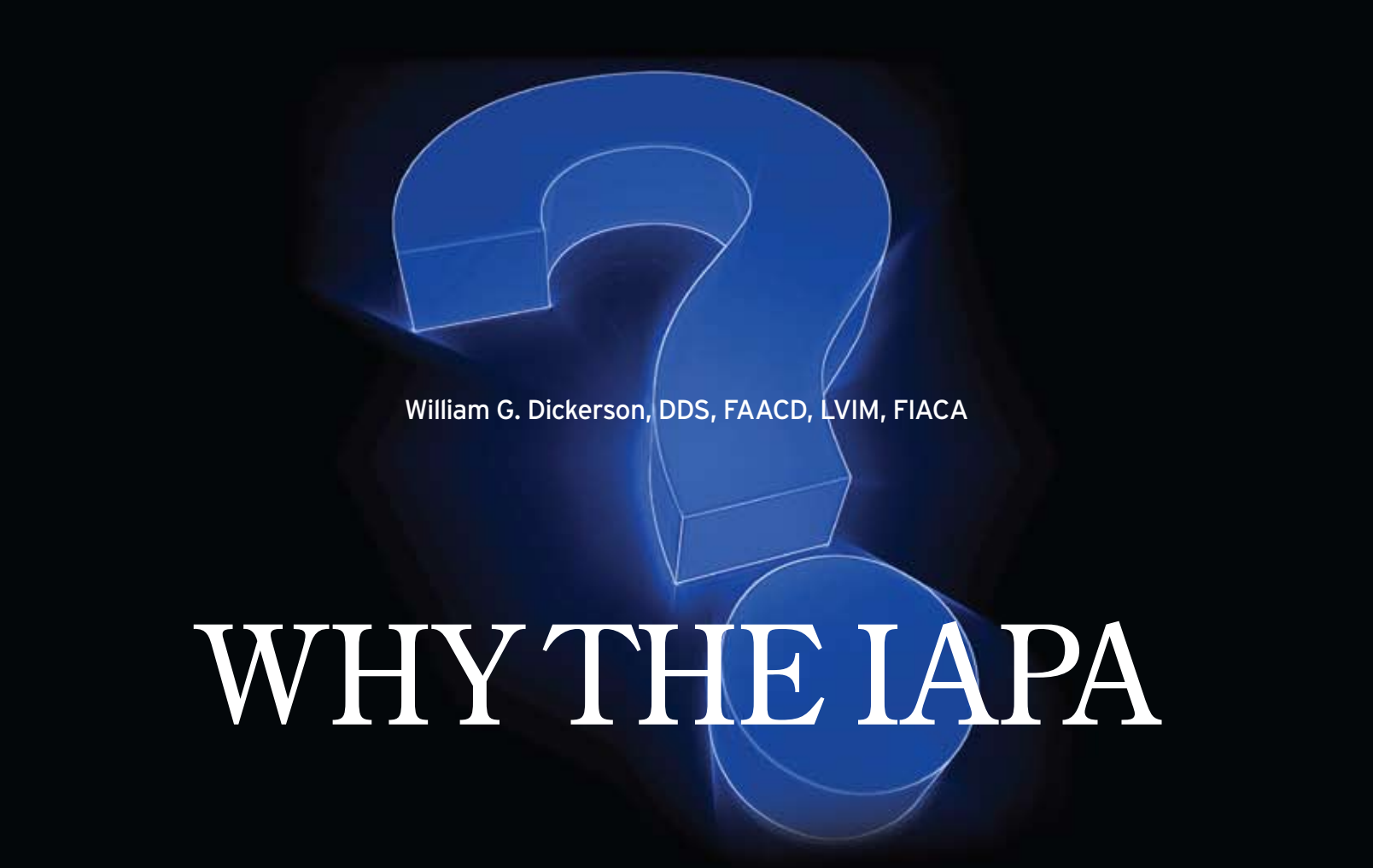

William G. Dickerson, DDS, FAACD, LVIM, FIACA

# WHY THE IAPA

**The IAPA was launched in 2005 because many organizations in dentistry were philosophically exclusive with a closed door policy about progressive, cutting edge information. One in particular that previously had been the cutting edge organization had not only fallen to a level of mediocrity but to a position of protecting the status quo like so many others and was intentionally preventing podium time to any differing philosophy, going to extremes to eliminate any physiologically based science and techniques from being presented at their annual meeting. There needed to be a new organization that would not only pioneer the profession but allow a good solid debate of controversial issues, allowing both sides to present their case which would propagate the growth and advancement of the profession.**

Because of the demand for an organization like this, with only six months preparation, more than 600 people gathered for the first meeting in San Diego in the summer of 2005. The evolution of the organization progressed through the years and it has become the voice of the physiologically based science of dentistry. Now in its thirteenth year, it has led the way in fighting the professional ignorance, insurance company backed advocates and special interest groups with vested interests in stifling any growth of this logical and evidenced based field of dentistry. And because of the IAPA, thousands of dentists have been able to help tens of thousands of their patients improve and even save their lives. It will celebrate its thirteenth annual meeting this October on the LVI Campus with over 800 attendees expected to gather for another amazing event with the Octoberfest theme.

It has also become the most positive, upbeat and inspiring meeting in dentistry as well as just a lot of fun. The energy and excitement at these meetings is infectious and carries over to the dentist's practices when they get home. "The use it on Monday" information is practical and eye opening, giving many the direction and avenues they need to pursue to improve their practices and treatment for their patients. This year was a revolutionary year with the dramatic changes in Physiologic Based Dentistry, like the TAG bite and evolutionary equipment advances as well as important SBD treatment. Everyone left knowing that doing the best for your patients is not only the right thing to do, it's the only thing to do. Because of all this, while other organizations are losing members and attendance at their annual meetings during these economic times, the IAPA remains strong.

This positive attitude is carried through on the IAPA forum where valuable information is shared on a daily if not hourly basis, since there are members from all over the world. The support for each other is palpable, unlike most animus and hostile dental forums that litter the internet. Many will ask questions while a patient is in a chair and will receive a response within minutes. Along with the addition of the IAPA buying club, free subscription to Vision's magazine, reduced rate for the annual meeting, free IAPA educational webinars, reduction in educational courses at LVI, industry discounts and the quarterly newsletter, members are placed on the website for patients looking for IAPA dentists and allowed to use the IAPA logo for promotional purposes.

But for the freedom for ANYONE to practice dentistry that THEY feel is best for their patients, the IAPA has become THE VOICE for that freedom. There is a concerted effort by various interest groups to dictate how we as dentists must practice so we do what they think is best or by abiding by the dictates of insurance procedures for example. The IAPA strongly believes in the fact that you are educated doctors, who can review the available information out there and make your own decisions as what is the best treatment for your patients. Just look at some of the things the IAPA does to protect your right to decide how YOU practice:

**1: IAPA fights against the threat and assault on progressive dentistry by creating a strong and powerful voice that only a large membership can do.**

**2: IAPA sends representatives to critical meetings to protect your rights representing a large membership.**

**3: IAPA sends letters to government bodies, dental organizations and industry leaders supporting your rights representing a large membership.**

**4: IAPA supports those that need help with technical advice and direction in legal or board related matters.**

**5: IAPA initiates TMD Alliance responses to help protect your rights.**

**6: IAPA initiates letter writing campaigns to support your rights.**

**7: IAPA facilitates articles that support NM dentistry representing a large organization that improves the chance of publication.**

**8: IAPA has a team of employees behind all this that work incredibly hard to organize these efforts. None of this could be done without these employees efforts.**

**9: IAPA has the network to monitor and report on practice restrictive movements happening in various board and ruling dental associations.**

10: IAPA is available for advice on local issues of concern.

11: IAPA is able to provide world-wide information on movements among restrictive groups that could affect you later.

12: IAPA promotes Physiologic Based Dentistry research to be published.

13: IAPA places on the Internet through their website, letters to editors that a publication might refuse to print making it show up higher on searches with the SEO of the IAPA.

14: IAPA meeting makes possible an interactive discussion on Physiologic Based Dentistry which provides a better chance for ideas than a newsletter or email.

15: IAPA meeting provides up to date information on developments which lessens your chance of coming under attack by uninformed people that are in authority positions.

16: IAPA is like an Army and with a larger trained and active force opposing forces will be hesitant to attack versus if it is only YOU!

17: IAPA meeting provides enough yearly CE hours in one meeting that qualifies for re-licensure for most licensing bodies.

18. The IAPA forum is not only a valuable learning tool, but a source of support from like-minded dentists with a family atmosphere.

19. The printed version of VISIONS as well as many other benefits that are way more valuable than the annual membership fee.

20. And most importantly... it gives you a sense that you are involved and participating in the efforts to save dentistry from those that would like to take our individual practice freedoms away and supporting the growth of the organization that is the voice of Physiologically Based Dentistry.

***Can you imagine what would happen if there was no IAPA?***

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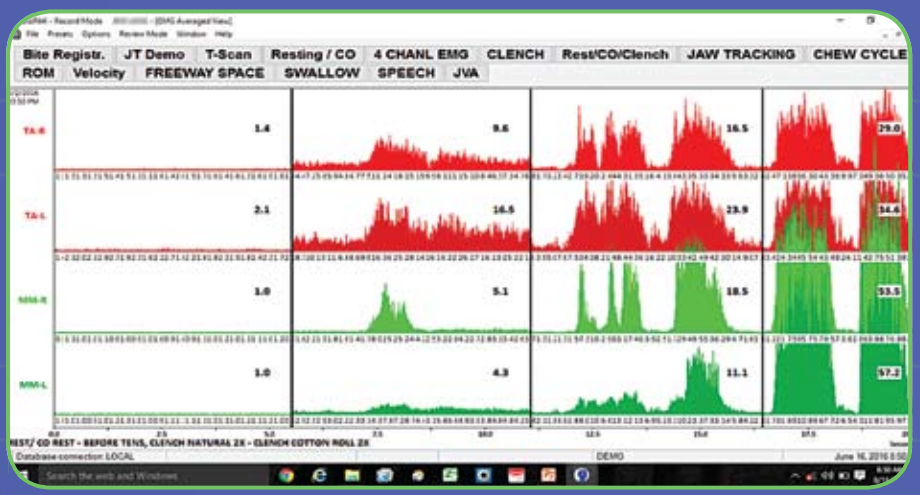


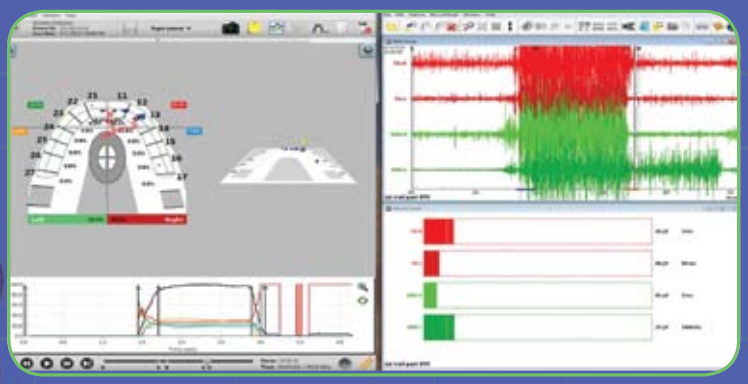

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FRAUD AND EMBEZZLEMENT
IN THE DENTAL OFFICE

# You are not immune

PART ONE OF A
TWO PART SERIES

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

It is a sad reality that in our dental profession, a high percentage of dental offices will experience some sort of fraud or embezzlement and much of it is completely undetected. In my opinion, it is not detected for three main reasons. One, the dentist is very busy focusing on patient care and doesn't have the time to oversee or police every aspect of his or her practice. Secondly, we love and trust our employees, which is why we employ them. We often think of our team as extended family. We tell ourselves, "No way this would happen to me" or "My team would never do anything like that." Lastly, despite our best efforts, we don't know how or where to look so that we may safeguard our sensitive information and finances.

## THE MINDSET OF AN EMBEZZLER

Many that commit fraud or embezzle, justify their actions and may not even think it is a crime. It may start out with only a few dollars, or taking something small from the office such as supplies; however, embezzlement and fraud usually escalate when confidence sets in.

Let us explore some possible scenarios to understand the mindset of an embezzler.

## EXAMPLE 1

Let's look at Susan, a front desk employee who collects money. Susan is working hard and doing a good job; however, times are tough and bills need to be paid. This person sees what the doctor's fees are and that the doctor is living a good life, therefore won't "miss" a cash payment, or won't notice the use of the practice credit card to pay a phone bill. After all, the dentist charges so much and Sally feels she works just as hard, with the same hours, so she deserves it.

Now at first, Susan might justify her actions by thinking to herself "it is just a loan and I will pay it back." Worse, perhaps Susan doesn't feel a need to pay it back, as the doctor "should have paid me for that snow day" or something of that sort, and now feels they are even. If Susan gets away with it, the next thing that happens is she will feel it is easier to repeat such behavior. As Susan gains confidence, she starts getting more creative, perhaps sending in false claims for work on her friends or family that the doctor never actually did and deletes the claim from the computer after they are produced. After all, it's not the doctor's money, it's the insurance company's money and they rip everyone off and make too much money so it's ok... you get the point!

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Happier business

Happier you

# It's a Win. Win. Win.

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## EXAMPLE 2

Another front desk staff member, Karen, is angry at the doctor because she feels she earned another paid week of vacation or a bonus and the doctor denied her request. Well Karen knows that the office reimburses patients' credit card accounts when there can be an overpayment between the patients' portion and what the insurance paid, resulting in a credit on their account. All she has to do is go to the credit card machine and input the credit card number and credit them what is owed. Karen comes up with the idea that she can credit her own credit card the same way. She convinces herself that nobody will detect it because it won't be a huge amount, and she will make it an odd amount to make it believable, perhaps 127 dollars or so. If she gets caught, well she can say that she was trying to pay the office for the bleaching gel she used and it was not supposed to be a credit. Karen also knows that the credit card statement does not have names or credit card numbers on it so how will it ever be traced to her? These monthly statements only show long transaction numbers listed on them with a credit or debit amount. Karen now decides she will do it weekly and it will be a different amount each time as to not draw suspicion.

## EXAMPLE 3

Let's talk about Jane, the trusted dental assistant who does not deal directly with finances. Jane is the person responsible for ordering supplies in the office. She does such a good job and the office always has what is needed. As we know the supply catalogues have many nice things in them that we could use at home such as Band Aids, expensive vitamins, analgesics, etc... It might not feel like a big deal to order 50 dollars' worth of items here and there, as Jane is the one who is responsible for opening the packages and stocking the shelves. After all, Jane is helping the doctor and she feels she is doing him or her a favor, because all of these items are an expense to the office and the doctor can write them off. Other staff members may also just take a few things off the shelves for home. The scenario just described is a more "innocent" scenario.

## EXAMPLE 4

Then there is Steve, another assistant who is a little more risky. Steve, knowing that the doctor's DEA is on file with the supply company, in the middle of his normal order for the office, decides to order a bottle of 100 Tylenol with codeine. After all, if Steve is questioned about it, he can always say it was an error, or that bottle never came. However, if Steve did get away with it, perhaps he will try to order Percocet next time. A lot of money can be made by selling narcotics on the street. Steve thinks it's no big deal and he will stop as soon as he catches up on his overdue rent and car payment. Once that is paid and since it was so easy and undetected, Steve might feel he needs a new car. If the doctor's DEA is not on file with the supply company, he can still order instruments and small equipment and sell them on eBay. Again, you get the point... this starts to escalate.

## EXAMPLE 5

Any member of the team who knows the doctor's DEA number and a person's phone number and address can call in a narcotic prescription in many states. The prescription can be for a friend, or for his or herself. In many instances it can be a fictitious name altogether. These pills can be sold or abused by the team member or the person receiving the prescription. The doctor is responsible for safeguarding your DEA number and prescription pads, and it is only the doctor who should print or call in prescriptions.

## EXAMPLE 6

A team member, Leigh, who collects checks or cash, decides to keep a check for herself, then credits the ledger of the patient so the patient never receives a bill, since their payment would have been credited. This check or cash is never actually deposited in the bank account, instead, this check is endorsed over to the team member or even someone else altogether and the doctors signature is forged. The check is then cashed. This is usually only possible if the checks are written to the doctor and not the name of a business. A bank will not sign over a check written in the name of a business to an individual. It must be deposited only.

Unfortunately, the above examples are real and happen to dentists' every day. I can tell you this, because every one of these happened to me personally and on a large scale. I have shown you all possible scenarios and in part two we will discuss how to prevent them from happening to you. So before then think about the scenarios mentioned and if they could possibly be happening in your office.

**"Steve thinks it's no big deal and he will stop as soon as he catches up on his overdue rent and car payment. Once that is paid and since it was so easy and undetected, Steve might feel he needs a new car."**

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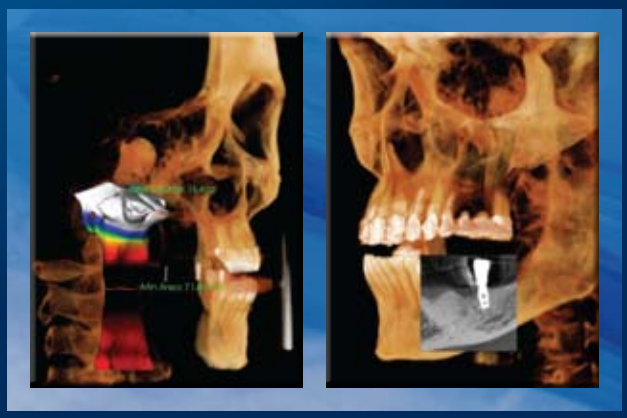

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# SNOTTY NOSED KIDS
## YOU THINK THEY LOOK BAD NOW!

Heidi Dickerson, DDS, LVIM, FIAPA

**Most people think the way they look as an adult is due to their genetic makeup. The reality is our genes play only part of this role and our environment plays the other part.**

**Our body is so adaptive it will do whatever it takes to survive. What do we need for survival? Well, warm shelter, food, water, and oxygen.**

**Consider the RULE OF 3:**
**You can survive for 3 HOURS WITHOUT SHELTER in a harsh environment (unless that environment is icy water)**

**You can survive for 3 DAYS WITHOUT WATER (if sheltered from a harsh environment)**

**You can survive for 3 WEEKS WITHOUT FOOD (if you have water and shelter)**

**However,**

**You can ONLY survive for 3 MINUTES WITHOUT AIR (Oxygen)**

**These numbers should show you the importance of Oxygen's role in our bodies!**

Consider when you have a cold...how do you feel? Tired, fatigued, no energy...LOUSY! When you are sick and you can't breathe through your nose, you open your mouth and drop your tongue so that you establish a secondary airway. Breathing through our mouths is not what nature intended. Our noses were meant to breathe through, our mouths were meant to eat and talk with. We should not be mouth breathers!

What's the big deal? Let's look at Harvold's Experiments on Monkeys (In 1918, Egil P. Harvold, D.D.S, Ph.D, L.L.D; Brutta S. Tomer, D.D.S; Karin Vagervik, D.D.S; and George Chierci, D.D.S, examined the relationship between mouth breathing and dental malocclusion). He plugged their noses with silicone nose plugs to make them mouth breathers and they all developed malocclusions and had incorrect facial development.

After only one year of oral respiration the researchers noticed the monkeys with the blocked noses kept their mouths open, their tongues were low in their mouths, their arches didn't develop normally, and they developed an increase in facial height, steeper mandibular plane angles, larger gonial angles, and malocclusions.

This experiment demonstrated that breathing through one's mouth can physically alter the structure of one's face. **Form Follows Function!**

How does that relate to the snotty nosed child? If a child has allergies, they will become stuffed up. If they cannot breathe through their noses... they will do what it TAKES TO SURVIVE, so they will drop their tongues low in the mouth, open their mouths and breathe. Chronic allergies will develop chronic mouth breathers! Just like Harvold's monkeys, a human will develop the same facial and dental issues.

The correct place for the tongue is resting on the palate. In rest and in swallow it is important that 2/3rds of our tongue be resting on the palate as the tongue is our NATURAL PALATAL EXPANDER! If the tongue stays up on the roof of the mouth, then the maxilla and mid-face will develop normally. If not...we will not be able to develop to our full genetic potential!

Today, LONG FACE SYNDROME has become epidemic. REMEMBER...just because something is prevalent, does not make it NORMAL! Long Face syndrome is a condition characterized by a face that is longer and usually more narrow than normal. Individuals affected by it tend to have enlarged tonsils/adenoids, suffer from asthma, have allergies...all things that will clog their noses and make them breathe through their mouths.

When we can't breathe through our nose for a long period of time, we will keep our tongue posture low in the mouth to keep the airway open, also causing an incorrect swallow and tongue rest posture. Malformation of the dental arches and malocclusion are sure to follow!

The unbalanced muscle forces relating to the upper arch will create a heightened palate, and the low tongue posture will increase the length of the lower jaw.

**Some symptoms of mouth breathing include:**

- Headaches
- Gingivitis and gum disease
- Cracked/dry lips
- Sore throat and cold symptoms
- High narrow palate
- Bags under the eyes (venus pooling)
- Bad breath and higher risk for cavities
- Nocturnal salivation
- Laziness and anxiety
- Tires easily with exercise
- Poor concentration
- Forward head posture
- Nightmares
- Bed wetting
- Less growth hormone released
- Digestive disturbances-gas, upset stomach, acid reflux
- ADHD
- Poor sleep: Obstructive Sleep Apnea, Sleep Breathing Disorders

Can a snotty nosed kid develop normally? YES! IF you diagnose them early, find the cause, get rid of the source, retrain the tongue/ muscles (myofunctional therapy), develop the mid-face, utilize their growth potential, and create physiologic stability!

Our goal should be that every patient we treat becomes a nasal breather. If we can help our patient's achieve that, they will be healthier throughout their lifetimes.

Stay tuned: in future LVI VISIONS I will be going into more depth regarding the importance of nasal breathing!

Thinking ahead. Focused on life.

MORITA

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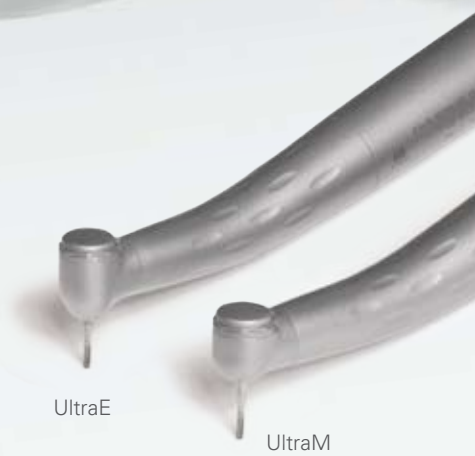


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Joseph T. Hickey, MD

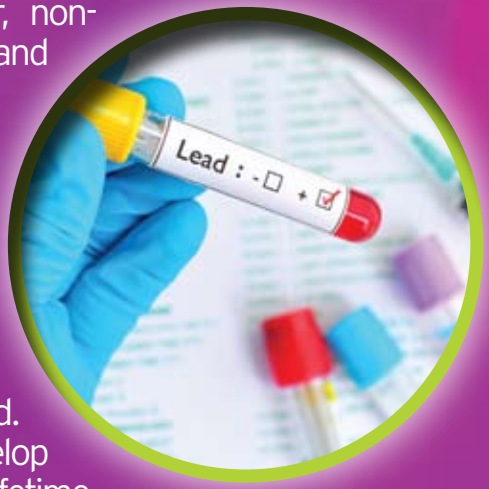
# Environmental Toxins

## *& Their Relationship to*

# SKIN CANCER

We hear it all of the time, stay out of the SUN, put your sunscreen on, and wear a hat, long sleeve shirt and pants that cover you while out walking the beach.

When I walk the beach where I live in Hilton Head Island, SC, I observe that people are following this advice. They are lathered in sunscreen, and yet, skin cancer, non-melanoma basal and squamous, and melanoma cases are increasing.




Each year in the United States, there are more than five million new cases of melanoma skin cancers. Each year, there are more new cases of skin cancer than cancers of the breast, prostate, lung and colon combined. One in five Americans will develop skin cancer throughout their lifetime. Why is our prevention advice not working?

> "We need 20 minutes of sunlight per day to stimulate and enhance our immune function."

As usual, we do not discuss or even acknowledge the true mechanism for developing skin cancer. We will do that here but first, one more statistic. Organ transplant patients are 100 times more likely to develop squamous cell cancers than the average person. Now that is a clue. Organ transplant patients require immune suppressive drugs to prevent organ rejection. When you suppress the immune system, you are going to get cancer.

How about ENHANCING your immune system to PREVENT skin cancer? Oh my goodness, what a concept! It is probably more effective for prevention than taking a bath in sunscreen, and it is easy to do. We will get to that shortly.

The sun and our exposure to it has not changed in the last 50 years. There may come a time when because of our disregard for our environment, the ozone falls apart and we will all fry. But, that has not happened yet. We need sunlight. Actually, we need 20 minutes of sunlight per day to stimulate and enhance our immune function. Sunlight enhances and activates Vitamin D3, which in turn, instructs our dendritic lymphocytes to repair us and defend from cancer and infection. Eliminate sunlight and we lose that immune enhancement. There are also several studies that have confirmed that sun exposure can actually prevent skin cancer. Occurrence has been found to decrease with greater sun exposure, and can be increased with the use of sunscreens.

Finally, melanoma is more common in people who work indoors than in those who work outdoors. And melanoma is more common in non-sun exposed areas of the skin, than on sun exposed areas. Why all of this confusion and misinformation?

Sunlight is necessary as we stated for enhancement of immune function through stimulation of Vitamin D3. However, ultra violet light, especially UVA is carcinogenic, but your skin is designed by the good Lord to repair that damage so you can make clean, healthy, new skin. Your skin expects to have DNA damage from sunlight. If your repair mechanism works, you don't get skin cancer and you reap the benefits of sunlight.

It is what is in your skin and what is not in your skin that causes cancer. Don't blame the sun. Your skin has a gene which produces an enzyme that repairs all skin DNA damage. It is your DNA repair shop called P53 and it can repair all the UVA damage and produce healthy skin. P53 depends on zinc for its function. Environmental toxins; mercury, lead, arsenic, nickel and cadmium, get into your skin and displace zinc from your P53, rendering it useless in the DNA repair process. The sun has not changed, but each year, there is more exposure from our environment. Coal burning factories release tons of mercury and arsenic into the air. We leaded gasoline for over 60 years. Our body is designed to pull minerals out of the food from our soil for our function. Analyze the soil and you will know what is in your skin. When you disable your P53, you age your skin prematurely and develop cancer. We will probably not succeed in cleaning up the environment any time soon, but you can clean up your skin and other organs of carcinogenic metals by removing them with chelation therapy. Both intravenous and oral chelation can remove the troublesome metals from you and replace them with the appropriate mineral. Then your skin and organs can protect themselves.

It is also what is not in your skin that can lead to cancer. When UVA damages your DNA, it becomes a free radical. Free radicals need to be neutralized to prevent cellular damage. This support is easy to achieve. Vitamin C is essential; it helps run the whole repair process. You need plenty of it, a minimum of 4000-6000 mg a day. N-acetyl cysteine (NAC) 600 mg twice a day helps promote glutathione, which in turn, protects DNA and cellular function. Chlorella and Resveratrol reduce skin aging and thinning by reducing matrix metalloproteinase (MMP) activity. These protein digestive enzymes; collagenase, elastase and hyaluronidase, excessively, thin your skin by breaking down collagen and elastin. Chlorella and Resveratrol reduce this enzyme activity.

There is more here than just the SUN. Be your own health advocate. Clear the toxic carcinogenic metals from your skin with chelation therapy, and place the correct mineral and antioxidants in your skin and organs to prevent cancer. Then, if you still want to use sunscreen, use it after 20 minutes of sunlight.


# DENTISTRY IS A MARATHON

## *How to Stay* FIRED UP, PUMPED UP & INSPIRED

**Matt Jones** went from being a three-time cancer conqueror, to surviving a bone marrow transplant, to relearning how to walk, to completing seven marathons on seven continents. He inspired everyone as a Keynote speaker at the 2016 IAPA Conference.

**Dentistry, like a marathon, can be an endurance event.** Ralph Waldo Emerson said, "Nothing great was ever achieved without enthusiasm." You have the opportunity to make a difference and impact the lives of others everyday. In order to be your best, you need to stay energized to cross the finish line. In this article, you will learn how you can remain fired up, pumped up, and inspired through developing your "Marathon Mentality." This is defined as the mindset to push through the walls of negativity, setbacks, and obstacles to cross your finish line and achieve your victory.

On September 11, 2002, my life forever changed. At the age of 23, I was told by my doctor, "You have cancer." After spreading to the fluid in my brain, I slipped into an unconscious state. Doctors did not think I would survive. Against all odds, I recovered and had a successful bone marrow transplant. Due to brain damage, I had to relearn how to walk, and have now completed seven marathons on seven continents. Yes, that includes Antarctica!

One of the most important lessons I learned is you can't always control your circumstances but you always have control over your choices. Too often we give away our power by focusing on the circumstances we can't control versus the choices within our control. Here are three choices that helped me that you can use to stay fired up, pumped up, and inspired in the marathon of dentistry as well as life. By making these three choices you will develop your "Marathon Mentality."

## 1 VISUALIZE YOUR VICTORY

When it comes to your victory, it's not the outside stuff that matters but the inside stuff that counts. It is easy to get discouraged in life. To stay fired up, pumped up, and inspired it is essential to be clear on the victory you want to achieve. Once you can see it, believe it's possible, then you can do it. Lying in my hospital bed I visualized myself crossing the finish line of a marathon. The key is to focus on the victory you are striving to achieve instead of focusing on all the challenges. In life what you focus on, is what you get back. There is timeless truth that says, "Where there is no vision, the people perish." What is one victory you are committed to achieve?

## 2 TAKE ACTION

How do you run a marathon? One step at a time. In order to fulfill the vision you are visualizing, you must take action every single day. It does not matter how small it is. The key is to do something everyday that moves you closer to your vision. This builds momentum. Think back to science class and inertia. Objects at rest tend to stay at rest, while objects in motion stay in motion. Remember, it is not enough to stare up the steps, you have step up the stairs.

One of the things I share in my talks and book is the "Massive Action Principle." Simply stated, the smallest actions produce the biggest results. For example, at two hundred eleven degrees Fahrenheit water is hot. You increase that by one degree to two hundred twelve degrees Fahrenheit, it becomes steam and can power a locomotive engine. As you think about the victory you want to achieve, what is one action step that will take you close to fulfilling it?

## 3 ELEVATE YOUR ATTITUDE

In order to complete a marathon I had to believe it was possible. Daily I had to check the negative self-talk and the self-defeating inner dialogue. You can't listen to the little voice that says its impossible. The biggest challenge you will face in dentistry or life is the negative self-talk, self-defeating inner dialogue, and your limiting beliefs. Daily you have to floss your mind to rid it of the negativity plaque that builds up. One way is through positive-talk or affirmations. My all time favorite affirmation is, "I'm too blessed to be stressed." Once you have the attitude that your vision is possible, you will take the necessary action to achieve it.

*"Nothing great was ever achieved without enthusiasm."*

Dentistry, like a marathon, can be an endurance event. It can be a roller coaster with ups, downs, and surprising turns. Crossing the finish line in each one of my marathons around the world, were some of the greatest victories in my life. Through developing your "Marathon Mentality" by making the choice to "Visualize Your Victory, Take Action, and Elevate Your Attitude" you will be able to stay fired up, pumped up, and inspired to cross your finish line.


EDITORS' CHOICE
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# How I Stopped my Baby's Night Terrors

Nancy Gill, DDS, LVIF

I crack open a blurry eye and look over at the alarm clock. It's 2 am. I roll over and look at my husband and ask, "Whose turn is it this time?" We stare anxiously at the baby monitor, watching and listening as our 18 month old daughter, Ceci, experiences a night terror in her room down the hall. This is her third night terror of the night. Her first terror was at 9 pm, so luckily we weren't attempting sleep of our own yet, but the terrors at 11 pm and 2 am abruptly ended what sleep we were able to manage.

From the time our daughter was 18 months, the night terrors started and persisted. Everyone kept saying it was going to get better, but it didn't. If you have never experienced a night terror, imagine your child's mind and body have been hijacked and there's nothing you can do about it. She is having the worst nightmare imaginable, but she won't wake up from it (hence the name night terror). She kicks, hits, screams, and doesn't recognize your voice. The sound of your voice or the touch of your hand makes it intensify tenfold. There is nothing you can do to help her. The best you can do is make sure she doesn't hurt herself and wait for it to pass, which can take as long as 15 agonizing minutes (which feels like an hour at 2 am). It's scary, emotional and frustrating because it's painful to see your child so upset, you're afraid they'll hurt themselves, and all you want to do is sleep. This happened to our family on a weekly basis for an entire year. I wished I could take this away from her easily or take her place as every parent would.

Because of LVI's teaching philosophy of airway, Sleep Breathing Disorders (SBD), and OMD (Orofacial Myofuntional Disorders) in children, I knew this wasn't normal. I started my own analysis. First, I looked at the back of her throat and noticed large tonsils. When she was sleeping, I also noticed mouth breathing and a lack of nasal breathing. I made an appointment with an ENT that we referred to in my practice. He agreed that the enlarged tonsils (Class III) and the enlarged adenoids (Class IV) could definitely be causing the problem. He prescribed oral steroids and antibiotics to see if it worked to reduce them. If it did, we can assume that the tonsils and adenoids were causing a sleep interference, as steroids are capable of reducing the tonsils and inflammation.

We couldn't believe it but it worked! We had three weeks of the most peaceful sleep we have all ever experienced. We had literally forgotten what it was like to sleep for eight uninterrupted hours. After the medication was finished, though, it all came crashing back. She went back to having three to four terrors per night. To top it off, the helpful ENT who agreed with us about the tonsils and adenoids retired.

# How many of these children can WE help?

Now what? A possible next step was to have Ceci's tonsils and adenoids removed. Having our toddler undergo surgery didn't give us a warm and fuzzy feeling, but knowing how important sleep is, we were willing to consider it.

I made an appointment with a new ENT. Let's just say, things did not go well. She was extremely dismissive, and I was so upset that all I can remember from our appointment was her saying: "So wait a minute...the only thing that is going on with your child is that she has night terrors?" This was something that affected our lives...every...single...day!

Next, we reached out to a children's sleep physician – it took three months to get an appointment with him. In the meantime, as luck would have it, LVI hosted an event in Denver and I went to brush up on my skills. During lunch, I mentioned my issues to Dr. Heidi Dickerson and she said, "While you're waiting for this appointment, why don't you try eliminating dairy for a solid month and just see what happens?" She said that something is causing those tonsils and adenoids to swell and if it doesn't seem to be environmental, it may be food related. She also mentioned allergy testing after this one month non-dairy trial.

Made sense! Elimination of dairy sounded easy after all we had been through. It was a long, Memorial Day weekend which was a great opportunity to change Ceci's diet. How did it go? The first day of that vacation was the last time Ceci drank cow's milk, because after one final terror early in the trip, she hasn't had a single one since. Amazing!

Although Ceci's night terrors were gone, we kept our appointment with the sleep physician to inquire about her mouth breathing. We discussed our history, and he didn't agree that the tonsils and adenoids could cause the night terrors. OK, so what did he think? He thought it was restless leg syndrome, which by the way, can be an indication of SBD as we LVI docs know. He suggested increasing her iron intake to help with the restless leg, but, "You should still do a sleep study in December to be on the safe side." Well, it was August. Because there are SO many kids out there that have sleep issues they are booked out for four months! I thought: How many of these children can WE help?

So where do we go from here? Ceci still mouth breathes at night, although her tonsils have remained at a Class I-II with the elimination of dairy. We have an appointment to do allergy testing and make sure there isn't an environmental component or any other foods, and we're looking forward to our official sleep test in December. For now, at least we have our lives and our sanity back! We started Oral Myofunctional Therapy exercises with her to help her with her lip seal at night and will lip tape as soon as we confirm nasal breathing is adequate.

**How did the medical community miss this? We saw a total of four physicians: our pediatrician, two different ENTs, and a children's sleep specialist. We went through so many emotions. Our pediatrician said it would 'pass when she gets older. ' The first ENT was in agreeance, but then retired. The second ENT was dismissive and didn't see it as a problem. And the sleep physician was reaching, and although empathetic, didn't give us anything but an appointment in December that we are still waiting on!**

So what is the moral of the story? Ask the questions to your patients. Before knowing what I know now, I would have accepted that this was a phase and continued on with our disrupted lives. As you continue your educational journey, I encourage you to break away from the norm and be something different. Your patients will thank you for it. I know we are forever grateful for the LVI education I have received. It made me look outside of the box and consider the question "why?"

*Can you imagine that of all the doctors it was me, a dentist who stopped my daughter's night terrors!*

# OMD

# Orofacial Myofunctional Disorders (OMD) and Myofunctional Therapy


COURSE DIRECTOR
Dr. 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

**JANUARY 26-27, 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.

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- 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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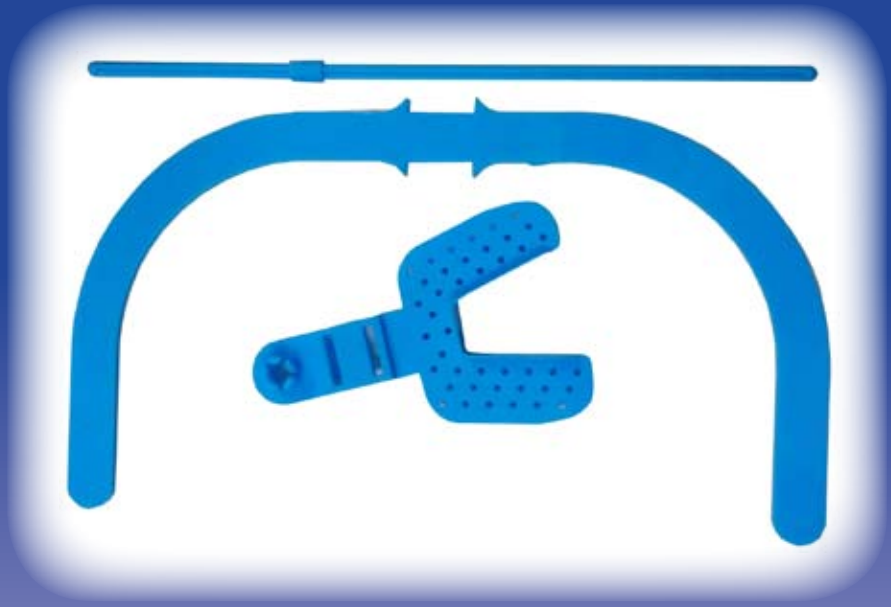

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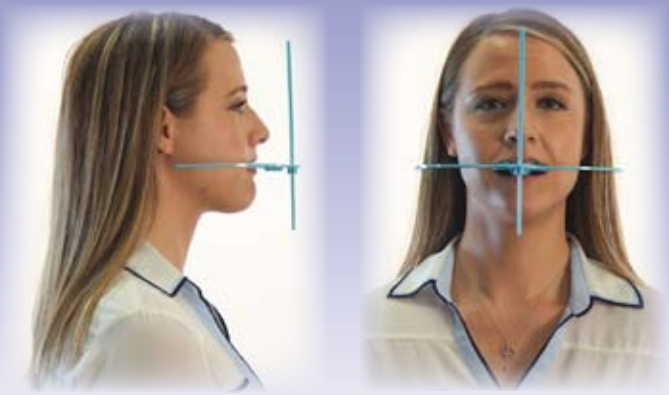

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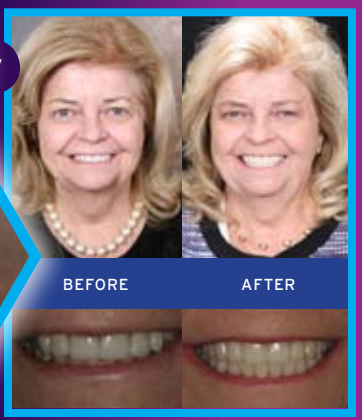
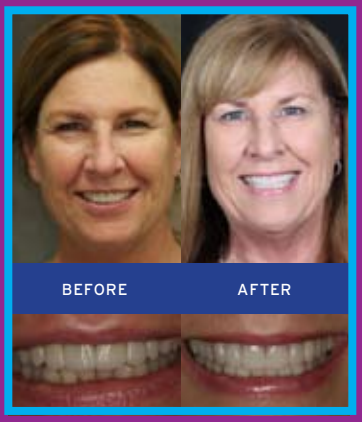
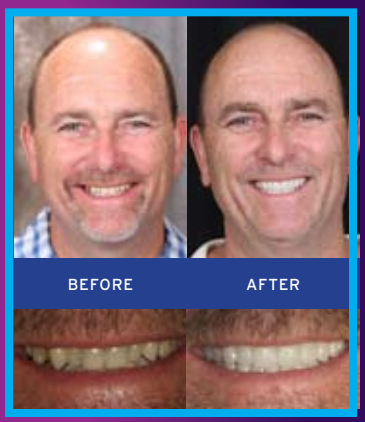
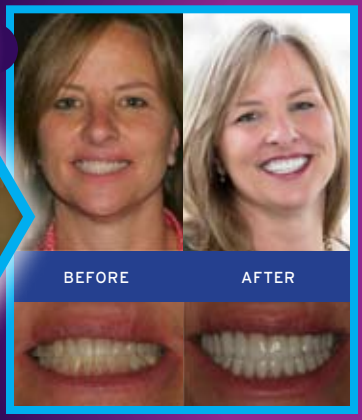
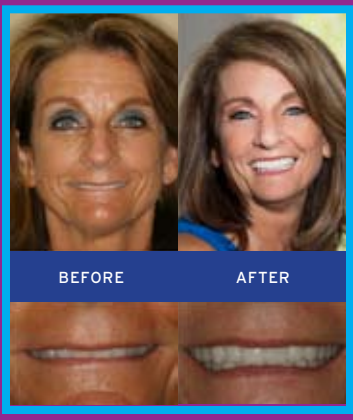


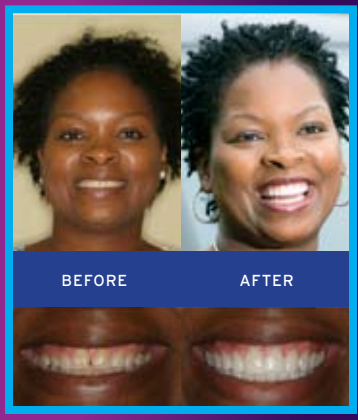




## Dr. Gordon Rye



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BEFORE AFTER

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BEFORE AFTER

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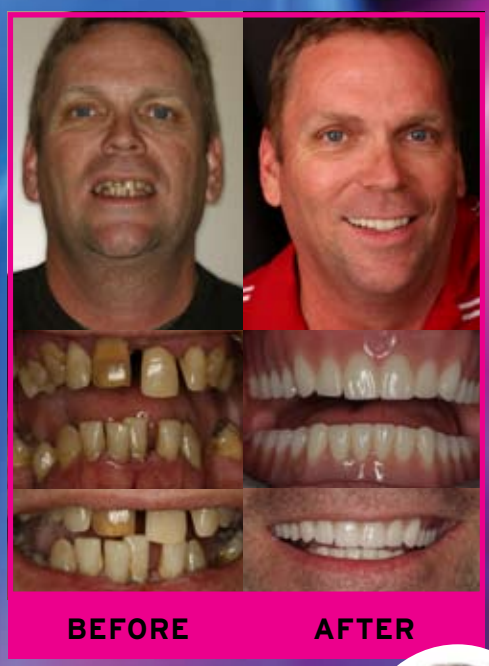
Dr. Nicol Cook


**Glamour Portrait Shots**
Dr. Nicol Cook

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# SPOTLIGHT

## 2016 TEAM Best in Practice Awards

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# *Born Beautiful* It is Never Too Late

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

Eleven years ago, our daughter met a young boy. At the age of 14, one assumes that these relationships will be transient so I tried not to look too closely at his smile which structurally had certainly gone awry. But the years went by and the whole family grew to love Casey and it became apparent that he was going to stay around, so I had to have a closer look at that smile. (**Figure 1)**

**Figure 1 Before**

When Casey smiled, you saw the gums above the upper molars, but you could not see the molars. He had a vertical maxillary excess that was much worse in the posterior. He had a triangular arch form vertically, transversely and sagittally. The teeth were rotated and lingually inclined. He had a Class III anterior relationship and an anterior open bite. He was congenitally missing seven permanent teeth - 3 wisdom teeth, 2 lower second molars and 2 lower second premolars. The lower Es were retained, he had a tongue tie, and inter-molar distance at the first molars was 31mm (normal 38mm). Facially, he had a dished-out profile due to the lack of midface development. His airway at the narrowest point was 144mm$^2$.

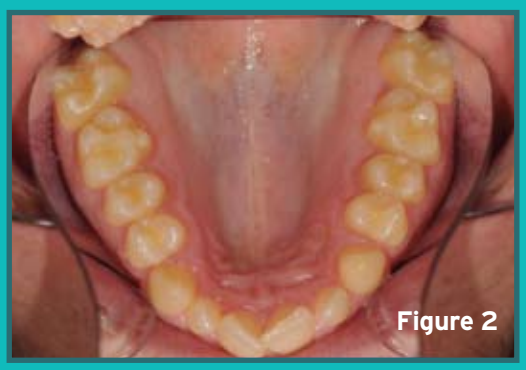


Figure 2

Figure 3

Figure 4

Casey was a life-long sleep walker. Sleep walking is a parasomnia triggered by arousals in NREM sleep. Was something contributing to this sleep disturbance? Why did his midface fail to develop? How much of a role did the tongue tie play? It did not take long to find another significant contributor- two giant healthy tonsils blocking his airway. **(Figures 2,3,4)**

Where do you even start with a case like this? Surgically, we had his airway unobstructed and his tongue tie released but Casey was no longer a child. By now he was 22 and the foundation needed to be corrected. I love doing porcelain veneers but porcelain veneers on his corrupted foundation would potentially draw even more unwanted attention. Fortuitously, I was introduced to the techniques of Controlled arch Braces and Anterior Growth Guidance Appliances by the developer of these techniques, Dr. Steve Galella. **(Figure 5)**

**Until the day we die, we never lose the capacity to "grow" bone.**

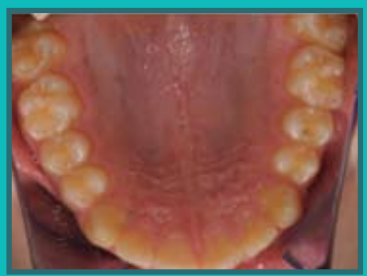
These methods work physiologically with nature to stimulate the body to lay down bone. Aberrant function is the cause. The solution lies in corrected function and tools that direct the stimulus appropriately. Until the day we die, we never lose the capacity to "grow" bone. If we couldn't grow bone at any age, we would never heal following a fracture or surgery. The problem is that people equate growth with a change in vertical height but growth is 3-dimensional, not linear, physiologic not mechanical. What we need to "grow" bone is an appropriate stimulus, trauma or micro-trauma. The orthodontic techniques mentioned above, along with well-directed oral function and nasal breathing provide that stimulus.

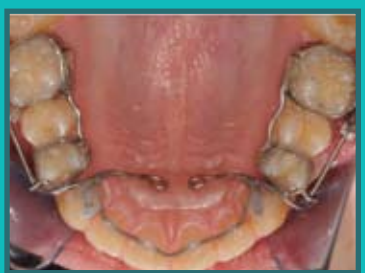
The cranio-facial system is a complex system. The parts that make up that system are heterogenous, independent yet interdependent and there are flows of information between the parts. What makes it complex is that it adapts or more correctly mal-adapts. Changes in the soft tissue signalling away from physiologic norms through aberrant function change the trajectory of growth. These epigenetic influences can markedly alter the expression of the genetic template such that the phenotype (how we turn out) varies significantly from the genetic blueprint.

Continued on Page 42

**Typical Result**
**Phase 1**
**Early Arch Redevelopment**

Anterior Growth Guidance Appliance
4 months treatment
Anne-Maree Cole





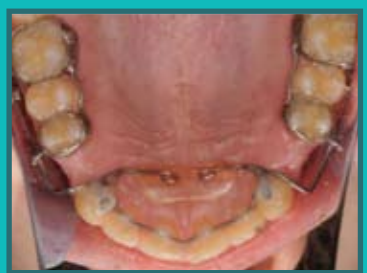


Figure 5

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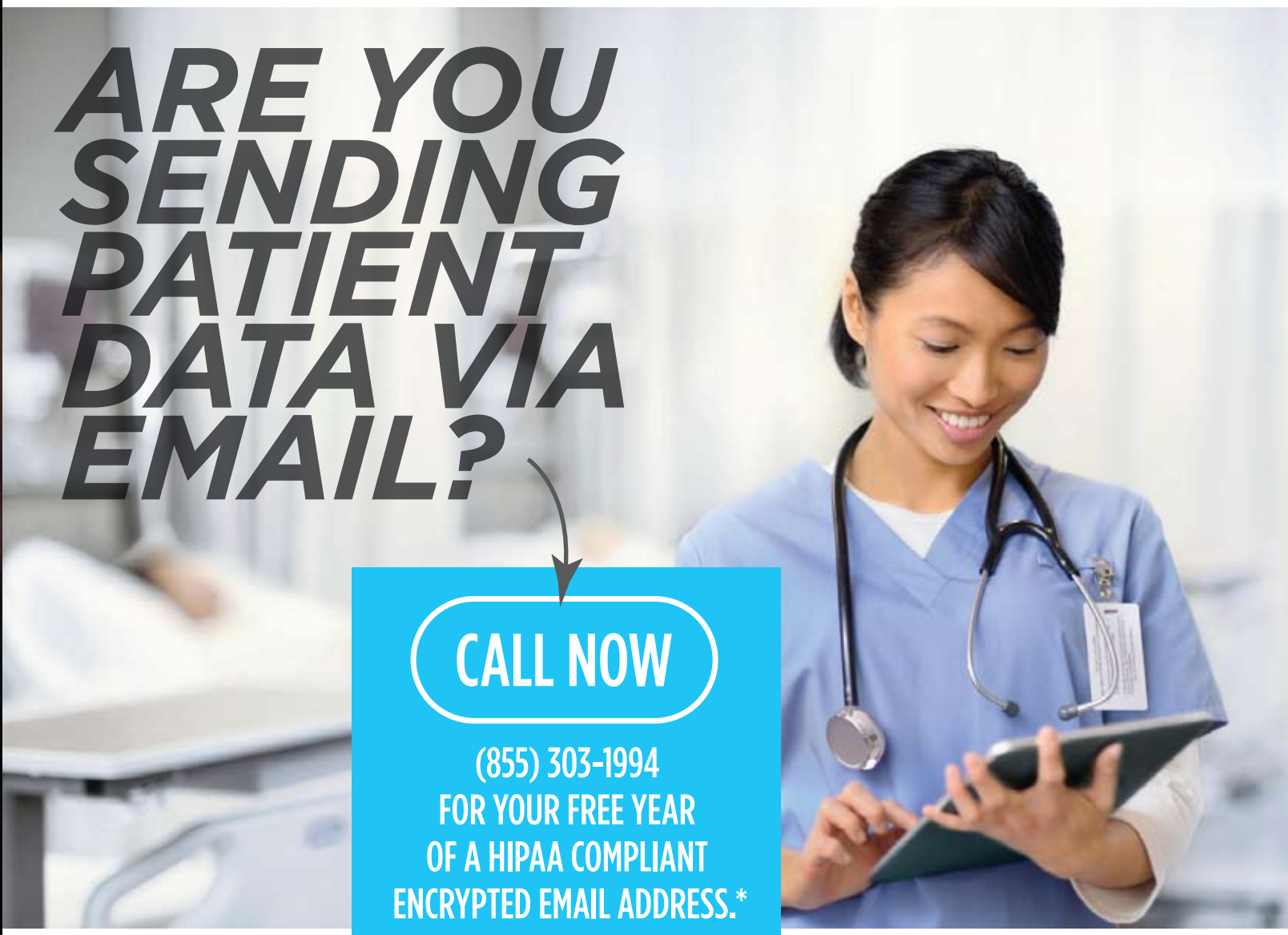

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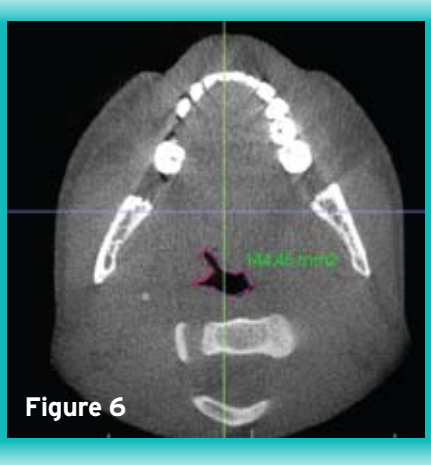


Figure 6

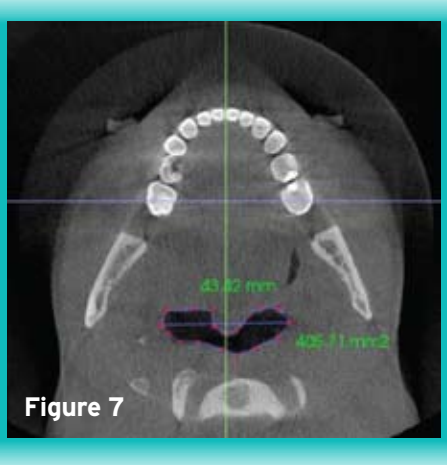


Figure 7

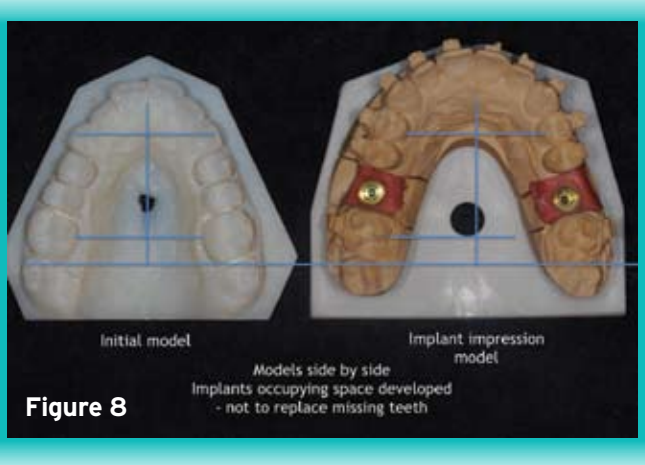


Figure 8

Continued From Page 39

Sleep-disordered breathing is largely an outcome of deficient cranio-facial anatomy. This is well recognized in the medical field. It is an epigenetic outcome that starts from birth through dysfunctional habits such as mouth breathing, low tongue posture, lack of lip seal, bottle vs breastfeeding, tongue and lip ties, failure to correct the infantile swallow, allergies, and failure to chew fibrous tough food, all of which stimulate the bone to grow to its genetic potential. Nasal breathing, a lip seal and a proper tongue posture on the roof of the mouth at rest and in function are essential to proper jaw development. With jaws developing to their genetic potential, there is more than enough room to house the 32 teeth our genetic blueprint dictates.

What is interesting though is that unless there is a genetic syndrome at play, the genes for a perfect jaw remain. If we understand the biology of growth and use tools that stimulate the expression of bone in an environment of corrected function (nasal breathing, lip seal and correct tongue posture on the roof of the mouth at rest and in function) we can redirect the direction of growth in a child and remodel the existing jaw structure in adults. Too much orthodontic thinking is about the mechanics and not enough about the physiology. Tools that work with nature rather than mechanics which oppose it are essential to achieving physiologic outcomes which optimize the airway through redeveloping jaws of the correct size, shape and position. **(Figure 6, 7)** Significant arch redevelopment is possible with the controlled arch technique. Space can be closed through protraction of the posterior teeth or the addition of implants. Note the space developed in **(Figure 8)** was occupied by the addition of molar implants. The sagittal development achieved corrects for the position of the maxilla being -7mm posterior to the anterior arc on the Sassouni Plus analysis. **(Figure 9)**

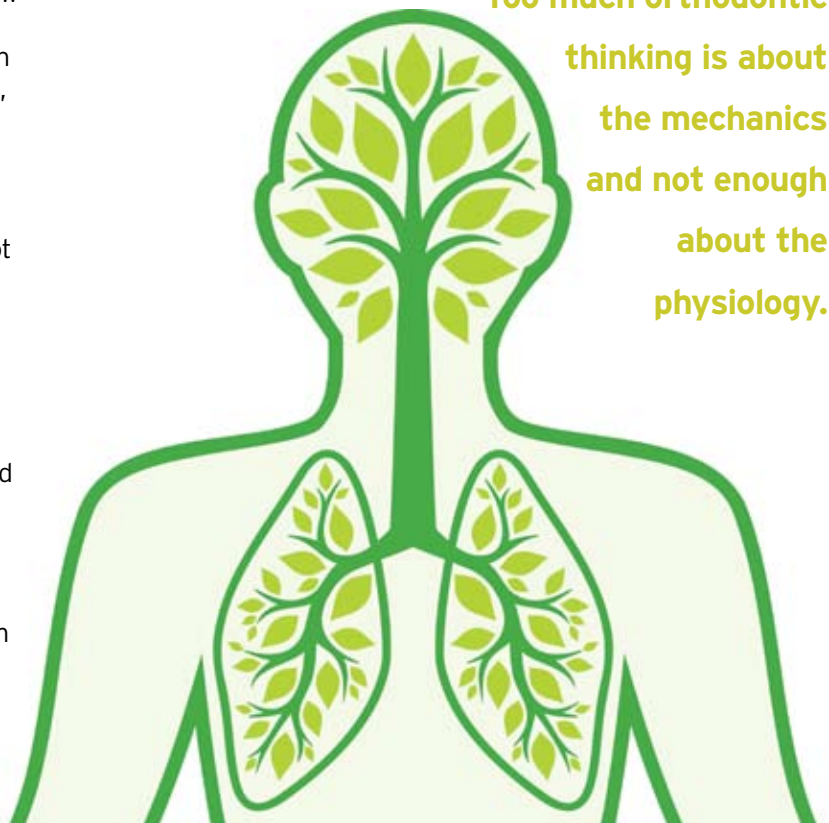
ADVANCED ADDITIONS

| Angle,Ratio or Distance | Norm | Actual |
|---|---|---|
| Upper Incisor to Palatal Plane | 110 - 113° | 110° |
| Upper Incisor to Optic Plane | 110 - 113° | 109° |
| B Perpendicular Distance | 6 to 9mm | 7mm |
| Premaxilla Length | 12-15mm | 18mm |
| Dental Alveolar Comp. | 32.5mm | 36mm |
| Position of Maxilla to Anterior Arc | -2 to 2mm | -7mm |
| Skel Vert (menton to age adj arcs) | -1 to 1mm | 9mm |

**Figure 9**

Dentists and orthodontists must recognize that extraction and retraction orthodontics adversely impact facial appearance, but also the greater evil of compromising the airway, potentially contributing to obstructive sleep apnea and temporo-mandibular disorders, OSA and TMD.

**Too much orthodontic thinking is about the mechanics and not enough about the physiology.**



Happily, eleven years after Casey came into our lives, he married our beautiful daughter, Megan. At the wedding he smiled a beautiful smile with a big broad arch and a face that was no longer dished out. He was unequivocally handsome. His minimal airway changed from 144mm$^2$ to 405mm$^2$. The sleep walking has taken a sabbatical. We did eventually place some minimal prep porcelain veneers but not until we had corrected the foundation with orthopedic orthodontic tools that worked alongside nature to develop the jaws out from under the cranium where they belong. The purpose is health. The added side benefit is a good looking face! **(Figure 10)**

Figure 10 After

As Walt Disney once said: "It is kind of fun to do the impossible." But there is a bigger message here. Something has gone awry big time. OSA and TMD have reached epidemic proportions. We have to understand it, find it, fix it and most of all prevent it. I concur most whole-heartedly with Dr. Bill Hang's 2014 Cranio editorial. The time has come to look at old problems with new eyes. If it is being done, it is probably possible. These paradigm shifting orthodontic concepts and techniques are now being taught at LVI.

**For references visit www.lviglobal.com/contributor-bios**

# OSHA/CDC CORNER

# Managing Exposure Incidents


## Nan Dreves, RDH, MBA


Do you know what to do in the event of an incident or accident with a contaminated instrument or needle? Proper post-protocol is outlined by the OSHA Bloodborne Pathogen Standard and Center for Disease Control (CDC), but it is often confusing, especially because these injuries are infrequent. These exposure incidents include contamination with not just visible blood, but saliva in dental procedures.

**EXPOSURE INCIDENTS ARE DEFINED AS:**

- Puncture or cut with contaminated item (e.g. instrument, needle)
- Blood or saliva splashing on mucous membranes (e.g. nose, mouth, eyes)
- Abraded/chapped/non-intact skin splashed with saliva or blood

**WHEN ANY OF THESE INCIDENTS OCCUR HERE ARE THE STEPS TO TAKE:**

**1.** First aid to the injured area by washing skin with soap and water, flushing mucous membranes with water. DO NOT SQUEEZE WOUND.

**2.** Report to your office's designated person.

**3.** Complete incident report form* (from your required written Exposure Control Plan).

**4.** Call the health care provider or facility that will provide post-exposure management to explain the incident. This call needs to occur ASAP. They will advise the necessity for medical evaluation.

- This evaluation includes a blood test for Hepatitis B, C and HIV determining the employee's "baseline" at the time of the exposure. Employee may refuse post-treatment, and will be required to sign a statement attesting they have been advised of the risks of exposure to Hepatitis B, C, and HIV.
- Obtain worker's compensation information of the practice (needed for the evaluation of employee).
- Counseling may also be provided to the exposed employee.

**5.** If you know the patient whose contaminated item was involved in the incident, they are asked to have their blood tested for Bloodborne diseases. This is NOT mandatory and if they refuse, no statement needs to be signed. They are called the "source patient" and when explaining what happened, assure them they are NOT at risk for transmission, but the testing would be helpful to allay any concerns for the employee. All results are kept confidential.

- If the patient is a child, you would talk with the parent or guardian.
- Payment of the tests for the patient are not under OSHA's authority. I highly recommend the practice offer to pay for these tests to maintain good patient relations and provide encouragement (you can request that it be filed with their insurance.)
- If the patient is known to be HIV-positive or has AIDS the health care provider may recommend the employee take antiretroviral drugs to help fight off an infection.

**6.** If the patient is unknown, the health care provider will determine the extent of additional follow up testing for the employee. These tests are often one month after the baseline, then at 3, 6, and 12 months.

**7.** More information for facilities or you: CDC Post-Exposure Prophylaxis (PEP) Hotline: 1-888-448-4911.

**8.** Finally, a review of the incident and implementation of any changes to avoid its reoccurrence should occur.

Most of these incidents are accidental and may be prevented, but others, such as a patient moving during an anesthetic procedure, cannot. Good reminders include taking your time when completing dental procedures, wear appropriate personal protective equipment, and recap needles appropriately.

*Includes date/time of exposure, details of procedure being performed, type and amount of fluid/material present, severity of wound, exposure source/exposed person details.

# *Thinking about Retirement?*

## READ THIS FIRST

Dan Jenkins, DDS, LVIF, CDE-AADEJ

Frequently I receive an email from a fellow "experienced" dentist asking for advice on retiring. Sometimes it might be just for a recommendation for a dental practice broker. Most of the time it involves how to find someone to take over their practice and how to structure any relationship after the sale. What I notice most of the time is they do not ask IF they should retire – their minds seem to be made up.

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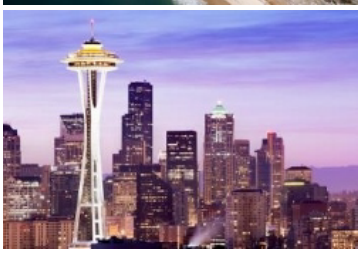
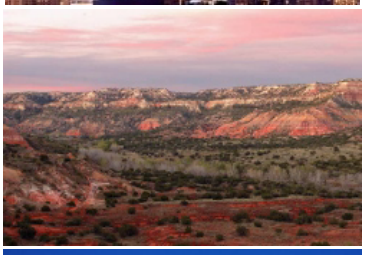


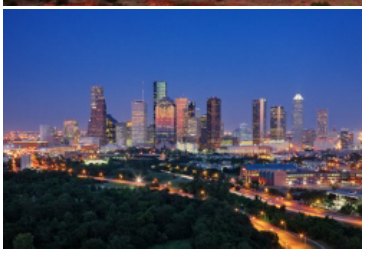
### CAPITOL HILL, SEATTLE SOLD!

Fantastic opportunity to purchase busy general dental practice in an urban village setting. Very desirable, affluent and high-density neighborhood, with easy access to the practice. The practice includes five well-equipped operatories in a comfortable setting, a stellar hygienist and strong net income.



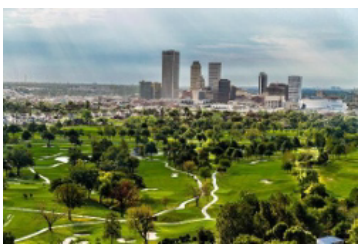
### TEXAS PANHANDLE

Very well-established, advanced dental practice in a fantastic location, with state-of-the-art equipment and rapidly-increasing collections. The practice has long enjoyed a reputation for excellence, and many specialists and their families have been patients. This very profitable practice includes four well-equipped operatories in an elegant and inviting setting.



### UPTOWN HOUSTON, TEXAS

Stunning seven-operatory practice, completely updated with a contemporary buildout and state-of-the-art equipment in 2011. Practice features modern amenities such as personal overhead flat-screens in each operatory, digital x-rays, and intraoral cameras. In addition to general dentistry, this highly-successful practice offers cosmetic, neuromuscular and TMJ densitry.



### NORTHWEST HOUSTON, TEXAS

Long-established, advanced dental practice in a very prestigious location, with state-of-the-art equipment and consistently strong collections. Enjoy a loyal, kind and committed team with long-term patient loyalty. 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.

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Before making the jump to retire you should keep in mind a story I read many years ago about an active dentist meeting an old friend at a convention who had retired a few years earlier. He spoke of his great life of financial stability, retirement home in Florida, apartment in his home town to visit his grandkids, and – then he paused and said, "But, I still miss the practice." He missed the social interaction with his patients and his team. I'm sure there are things about practicing dentistry that each dentist is stressed by. But, if you have been practicing for 40 plus years there must be something you like that you will miss if you cease to practice. You should figure out what it is and see if you can eliminate that stressor, even if it means downsizing or changing your practice model. If you could have a practice that you enjoyed every single aspect of, how long would you practice? Probably until they pry the hand-piece out of your cold rigamortised hand!

If you still are determined to retire or partially retire I have some ideas for you which I have shared with my friends in the past. If you are interested in bringing in an associate you will want one that has a similar philosophy as yours. For example, it could become very confusing for your patients if you provide porcelain inlays and onlays and the new dentist is opposed to this. The new dentist may feel they should be either resin fillings or crowns – and tells the patients that the work needs to be redone! Thus, your potential buyer associate should consider obtaining the similar training as yourself. For instance, if you are a Physiologic Based Dentist and your new dentist is of a different philosophy – Bio-Psycho-Social or CR – you will not agree on treatment either to be done or what has already been done.

What I suggest is to find a dentist who, as an associate, is already investing in your similar philosophy. I suggest meeting the potential buyers at a training course. Obviously, if they are there they are interested. You could audit the course and let it be known that you are seeking an associate for future buy-out and you will most likely have a lot of company during breaks and in the evenings! You also will have to decide how far along in the education journey you would want your associate to be. If you are considering a Physiologic Based associate, (my recommendation), you might meet them at CORE I at the Las Vegas Institute at the beginning of their journey.

If you wish to be able to practice what you want after the sale you can have an agreement to practice in an area your buyer does not – such as treating Sleep Disorders, Implants, Dentures, or Physiologic Orthodontics. Some dentists do not like doing some of these things and if you have the training and experience you could have your niche.

Another issue that may come up in the sale of your practice is the value of it if you have some high end expensive equipment. If you have Lasers (hard and soft tissue), TekScan, CBCT, CAD-CAM, EMG and TENSing equipment, as well as implant and orthodontic supplies, you will find they are of no interest to a buyer who does not have the training to use them. You may have to sell them separately to someone else. This will lower the sale price of your practice.

Often I hear the statistic that only 3% of dentists are able to retire at the same level of living before retiring. Many LVI practices are at the top of the market when sold...what a different story. Before you retire, plan ahead, use proven brokers such as Practice Transition Partners who can match you with a perfect candidate. With a plan...retirement can be just what you hoped for.

**"If you could have a practice that you enjoyed every single aspect of, how long would you practice?"**


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