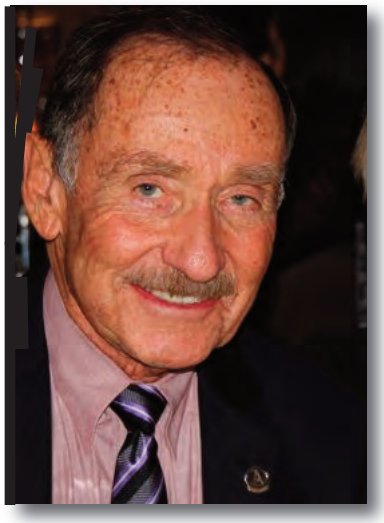
# GP NEWS

*The Publication for the General Practitioner*

Volume 40, Number 2 July, 2016


# Advocacy: The AGD and Dental Practice

## WE'RE WATCHING OUT FOR YOUR GENERAL PRACTICE



**Dr. Myron "Mike" Bromberg**
*Division Coordinator, Advocacy, AGD*
*Past President of the California AGD*
*AGD Representative to ADPAC*

The Academy of General Dentistry, long recognized for excellence in all aspects of continuing education with attainable goals of Fellowship and Mastership (FAGD and MAGD) has another focus as well. That focus, which is largely unnoticed by our membership, is **ADVOCACY**, representing the needs concerns and issues of the general dentist. A number of years ago it became clear that there were entities from within and out of the profession that were attempting to place limits on procedures that general dentists were capable of and licensed to perform as well as attempting to place unreasonable burdens on our ability to perform those and other procedures. It was obvious that [Advocacy for the AGD] had to become a priority, and the two advocacy councils took on new, important roles.

The first of these councils that we will discuss is the Council on Dental Practice, which deals with issues germane to the private practice of general dentistry. The council members are AGD representatives from different regions across the country and deal with a plethora of issues that our members have identified as a concern or problematic for general dentists. Most of the issues should be familiar to you.

**HIPAA, OSHA** and **ERISA**—The problems associated with those are always on the agenda.

**Evidence Based Dentistry**—This, with it's many definitions is a continuing issue. Some definitions are being used by certain carriers to limit or deny benefits to our patients.

**Sedation**—The lack of enough courses at this time, combined with some onerous state regulations make it almost prohibitive to deal with. There have been some positive results in this area.

**Workforce Issues**—including mid-level providers are always considered. Further, how to deal with the fact that many across the country view the dentist population as being in a shortage mode *(along with concomitant feelings by others that there is an oversupply of dentists)* as opposed to there just being a geographic maldistribution of dentists. Under this category, all classes of auxiliaries are analyzed and discussed with the AGD position in mind that all auxiliaries must be under the supervision of a dentist.

**Third Party Issues**—Always a major concern. Council members deal with complaints and disagreements from general dentists against some carriers, evaluation various types of plans, following

*(continued on page 4...ADVOCACY)*

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# ADVOCACY *(continued from page 1)*

emerging activities from dental insurance carriers, monitoring new trends and policies by carriers and meeting with them when the situation warrants.

**Discrimination**—Discrimination on the part of some carriers towards general dentists performing certain procedures is always on our radar. Helping our AGD members resolve third party issues is part of our charge as well. The myriad of problems associated with Medicaid, causes and solutions are debated with results communicated to the appropriate agencies.

The second council is the Council on Legislative and Governmental Affairs, which actively interacts with Congressional representatives with the goal of having new legislation introduced, influencing the outcome of pending legislation as well as dealing with and attempting to influence regulatory agencies. *The goal of all of this is to attempt to create optimal environments in which general dentists can treat their patients.* Communicating with our members on these issues is a priority for the council. State advocacy training is also a priority for the AGD. To that end, AGD holds state or regional conferences to teach interested AGD members how to influence their state legislators and how to best get their message across. There are a number of issues we are dealing with at the time of this writing. *To name a few:*

**Opt out or Opt in**—Dentists who prescribe **Part D covered drugs to Medicare beneficiaries** must opt in, opt out or opt in as a prescriber to Medicare. Otherwise, these drugs will not be paid for by Medicare. The enforcement date has been changed numerous times, due to complaints from the dental profession. As of now, the enforcement date is February 1, 2017. There is new bipartisan legislation (November 18, 2015) pending which would exempt dentists from this onerous requirement, but no action has taken place as of this writing. The AGD has been enormously active in promoting support for this bill which is **H.R. 4062**. AGD members have enthusiastically communicated with their legislators in support of this bill.

**Obamacare**—Another issue of concern is contained within the **Affordable Care Act**, which is a 2.3 percent tax on medical devices which has increased the prices on certain materials, supplies and equipment sold to dental practices. This unfair and onerous tax has been under attack and is unpopular with many entities. As a result, legislation calling for the delay and full repeal has been introduced in the House, **H. R. 160**, and Senate, **S. 149.** Further, in December 2015, Congress passed the Protecting Americans from Tax Hikes Act of 2015, which suspended the 2.3 percent tax for two years, 2016 and 2017, but unless the other pending bills are passed, will become law again in 2018. By the way, don't expect a refund or a lowering of the raised prices from your suppliers. I doubt that will happen.

**Antitrust Exemption**—A long-standing issue always being considered is the exemption carriers are afforded under the law known as the McCarran-Ferguson Act of 1945. This special exemption, not afforded to other businesses in the United States, is felt by many to have both interfered with the delivery of health care and negatively impacted patient care as well as leaving consumers susceptible to price fixing. Hope and help is on the horizon. Dentist-Congressman Paul Gosar from Arizona introduced **H.R. 494**, the Competitive Health Insurance Reform Act of 2015 *(hooray for Paul Gosar!)* which would restore the application of Federal antitrust laws to the business of health insurance. Essentially, this bill would repeal a section of the Act which exempted the insurance industry from the Sherman Act and the Clayton Act—acts that have the purpose of ensuring fair competition, in this case affecting only the health carriers. We are in full support of this issue, obviously.

**Student Debt**—Of course, another primary issue is, student loan refinancing and repayment. A major concern is that student debt is so large that some recent graduates may be forced into making career choices they would not make under other circumstances. Much time and discussion has been spent on this very important issue.

**The AGD in D.C.**—Throughout the year, often, whenever necessary or appropriate, AGD leaders go to Washington, D.C. and along with our lobbyists, meet with legislators and regulators on issues relating generally to dentistry, and specifically to general dentistry. Late Spring every year, AGD leaders throughout the country *also* meet in Washington to hear legislators and their representatives discuss legislative activities and then visit with legislators in their offices to express AGD's positions on these issues. AGD leaders met in Washington, D.C. in May and discussed these and other issues with Legislators and Regulators, expressing the AGD's point of view.

**Priorities**—In today's world, for general dentists, advocacy **must** be a priority. Excellent continuing education will always be a priority for the AGD.

As you can see, your dues money is being well spent and goes toward causes you would greatly favor. *But, what more can you do?* It should be clear that the broader the base of our membership, the more effective is our representation on your behalf. To that end, consider asking a general dentist colleague or two to join the Academy of General Dentistry.

***All of you will benefit...!*** ■

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**ABOUT THE AUTHOR:**

*Dr. Mike Bromberg is the Legislative Chairman and the Dental Care Co-Chairman for the California Academy of General Dentistry. He is a Past President of the California AGD, a Past President of the San Fernando Valley Dental Society, and a Past Trustee to the California Dental Assn. He is in solo private practice in Reseda, California.*

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# In This Issue of the "GP News"

*California* AGD *in* NEWPORT BEACH

# CAGD's Annual Meeting a Huge Success!

**Howard Chi, DMD, MAGD**, *CAGD President, Stockton*

The California Academy of General Dentistry Annual Meeting was a blast! We had two outstanding courses with two great presenters. Dr. Daniela Silva presented on "Current Views on Managing Traumatic Injuries to Children and Esthetics for the Pediatric Patient." And Dr. Mike Chen's hands-on course on "Bone Grafting of the Alveolar Ridge and Sinus." Both rooms of the course were filled to capacity with participants and special guests.

Among the guests were Dr. Maria Smith, the AGD's president-elect and Dr. Manuel Cordero, the AGD's vice president. They both attended Dr. Silva's course and had high remarks about her class. Other attendees were students from the FellowTrack program, where the CAGD once again opened their doors to our future leaders, who attended Dr. Silva's class for free. I certainly learned a few pearls. Now I routinely use a dycal applicator to help place resin filling material on pediatric preparations. Thank you, Dr. Silva, for that tip!

From dissecting pig jaws with a piezo unit and practicing a sinus lift on a raw egg, all of the participants in Dr. Chen's course came out learning a great deal, ready to perform grafting procedures on their patients. The enthusiasm from the participants could be felt all day, not even wanting to take a break!

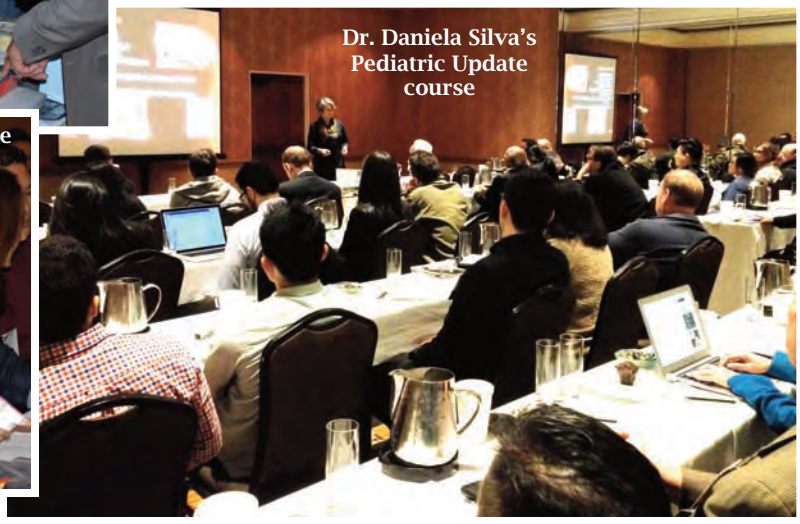
In addition to our Annual Meeting was our business meeting where the general membership voted in the new 2016 slate of officers and revised by-laws. Later that evening, the CAGD had their installation dinner where the new slate of officers were sworn in by Dr. Maria Smith. The evening was highlighted by recognizing three outstanding members of the CAGD.

Dr. Mike Chen's hands-on Bone Grafting course



Bone Grafting course

Bone Grafting course



Dr. Daniela Silva's Pediatric Update course

Dr. Cheryl Goldasich received the Dr. Virgil Brown Memorial Dentist of the Year Award for her tireless efforts with FellowTrack Students. Then, Dr. Bob Hubbert for his outstanding service as editor of the "GP News." He shared a heart-warming story about his father and a bit of history about how the typesetting and printing world has evolved. Finally, Lynn Peterson, our Executive Director for the past fifteen years, was recognized for her years of service before retiring. It was a special evening being able to see Lynn again and meet her sister and their mother.

The day was long and full of activities, learning and celebration. Although many of us were exhausted by the end of the night, we were all still smiling and energized after hosting another successful Annual Meeting. Many thanks also go out to our corporate vendors who supported our meeting. We could not do this without them.

Your 2016 CAGD Board looks forward to seeing all of you in the Fall for our next meeting. It will be held in San Francisco on Saturday, November 5th. ■

# Continuing Education ✶ Awards ✶ Installation








**I FOUND WHAT I WAS SEARCHING FOR IN CALIFORNIA AGD'S MASTERTRACK PROGRAM**

# See You at the Top...!

**Dr. Jared Adams**, *Alaska AGD, Secretary-Treasurer, Anchorage*

A meaningful and career-shaping connection was made between the Golden State and the last frontier in 2014 when I joined the California AGD's four-year MasterTrack program. I had come to a crossroads in terms of calculating the forthcoming year of desired CE courses, travel expenditures, time out of the practice and away from my family—the numbers and days were simply not adding up the way I had anticipated. I was in search of something that would combine high quality dental courses with reasonable tuition and a standardized format for an Alaskan dentist trying to maximize each out-of-state learning expedition.

Although I discovered several similar MasterTrack programs throughout the U.S. that offered coursework over five years, I found exactly what I was searching for with the California AGD MasterTrack program: two weekends per year (four days each), over four years at a price per hour unrivaled by the majority of individual courses I had taken or heard about. Less travel and more hands-on learning than I could find on my own was a huge draw, and I had no idea how much I would learn from my MasterTrack colleagues. Rather than risking mediocrity and a lone-ranger approach to life-long learning, I intentionally sought out a path to copy genius by tapping into a thriving community of dentists.

As we strive together to achieve a significant milestone with the AGD, a true mastermind develops while we learn from nationally recognized leaders through a complete series of hands-on courses, and in turn present and discuss our individual in-office practice of those disciplines. In addition to enriching your clinical skill set and advancing your ability to provide comprehensive dental care, you will enjoy the benefits of professional ties and positive friendships that emerge while socializing throughout the process. As dentists, we are called to remain students for life. Let's continue to excel in our profession and have a great time doing it. I highly encourage you to consider stepping out and stepping up to experience the value found in such a dynamic learning environment. *From the far north, see you at the top!* ■

*Dr. Jared Adams is a graduate of Loma Linda University School of Dentistry (Class of 2013) and is the Alaska AGD constituent Treasurer/Secretary. He has practiced in Alaska since 2013 with the Alaska Premier Dental Group.*

# THE PRESIDENT'S MESSAGE

**DR. HOWARD CHI**
*Stockton*

**THE AGD IS WORKING WITH CALIFORNIA'S DENTAL BOARD AND WITH FEDERAL LEGISLATORS TO PROVIDE RELIEF**

# Overwhelming Costs To Get a Dental Education in the USA

Student debt has become more challenging and prevalent in the past decade. The cost of a dental education has increased according to the American Dental Education Association survey in 2014. From this survey, the average dental school debt in 2014 was $247,227. Comparing this figure to the average dental school debt in 2009 it was $189,678 and in 2004 it was $135,721. And in looking at the overall graduating seniors from dental schools in 2014, 30% of these students had debt over $300,000*!* [1]

The outcome of this significant indebtness does affect the graduating dental students in their ability to practice dentistry. Alternative options such as moving out of state (for California graduates) to other states that have opportunities for them to find a job is a real consideration. This can also affect the opportunities for access to care because of the lack of practitioner willingness to accept these positions in the outlaying areas that have no dental coverage.

The AGD has advocated to congress to address these concerns. One area in particular is to provide more funding to the National Health Service Corps to allow opportunities for the recent dental graduates to participate and take advantage of loan forgiveness in exchange for dental services in underserved areas.

Currently, there are bills in the assembly and senate that are specific to loan forgiveness programs. AB 2048 National Health Service Corps State Loan Repayment Program authored by Assembly member Gray. This bill proposes a continuous fund of $1 million from the General Fund each year to the Office of Statewide Health Planning and Development for the purpose of providing state matching funds for the National Health Service Corps State Loan Repayment Program.

AB 2485 Dental Corps Loan Repayment Program authored by Assembly member Santiago is proposing a transfer of authority and renaming from the Office of Statewide Health Planning and Development account to the Dental Corps Loan Repayment Account. By making these changes, the Dental Corps Loan Repayment Program will have more visibility.

SB 1039 Establish Dental Corps Scholarship Program authored by Senator Hill. This bill is to establish a Dental Corps Scholarship Program to increase the supply of dentists serving in medically underserved areas.

If you want more details on these bills and their pending amendments, they can be found at **www.leginfo.ca.gov**

Nationally, the AGD is addressing these aforementioned concerns and also on the state level the CAGD is also actively involved. Our Watchdog Committee, chaired by Dr. Guy Acheson, has been actively attending Dental Board meetings, and informing the CAGD Board and their members on current events.

Our profession's future is at stake here. Our new colleagues could use as much of our assistance as possible. The days of graduating from a dental school and hanging your shingle on the door and become instantly successful are gone. The large debt these recent graduates have to carry will certainly burden anyone trying to make a living. ■

Howard Chi, DMD, MA, MAGD, *President*

1. "Student Debt." *Student Debt.* Academy of General Dentistry, n.d. Wed. 29 Apr. 2016.

# Thoughts on INSURANCE, OCCLUSION, OBSTRUCTIVE SLEEP APNEA

**Paul Schafer, DDS, MAGD**, *Novato*

**DR. SCHAFER**

The Northern California AGD was very fortunate to have Dr. William Dickerson lecture to dentists and students in San Francisco. Dr. Dickerson is perhaps best known as Founder and CEO of the Las Vegas Institute for Advanced Dental Studies (LVI Global) which has provided an educational forum for advancing our profession.

The first of four parts of his all-day presentation was "What Dental School Never Taught Us." He emphasized that it is not your school's fault that a subject may not have been covered. Each school can vary little from the curriculum that has been dictated to it. Each of the state boards have requirements that each graduate must be taught. There is just too much material to cover in a few short years. Your dental degree should be thought of as a license to a lifetime of learning. Dental schools are often isolated from the rest of the profession and this lack of outside influence creates intellectual inbreeding. We should be neither defensive nor angry when hearing new things. We are doing only what we were taught. Remember the saying, *"You don't know what you don't know."* Seek out knowledge and new techniques. Strive to make your practice exceptional.

### *Insurance Company Objectives vs. Dentists*

Dr. Dickerson discussed how dentists and insurance companies do not share the same objectives. Insurance companies want low fees which result in lower expenses and thus maximize their profits, and return to shareholder equity. These objectives result in low clinical standards, rather than excellence in care. For example in Hawaii, where over 96% have Delta Dental Insurance, the fees are the second lowest in the Unites States, just above Mississippi. Yet the cost of living index in Hawaii is the highest in the nation. The ADA survey shows that average income for dentists has been down in recent years, and has not kept pace with inflation in thirty-six of the last thirty-eight years. This may be why applications to schools of dentistry have dropped from 21,000 in 1974 to 9,000 last year. So dentists should practice "Value Added Dentistry" based on the wants of their patients, rather than have a conventional insurance-driven dental practice that often leads to burnout.

Insurance companies do not produce a product. They collect premiums from one group, eg., employers, and figure ways to keep from giving it to another group: dentists and their patients. With insurance in the 1960s, the annual maximum was $1,000. It is basically the same today. After inflation, that value would be $157. It should be $6,337 today! Dentists cannot provide excellence unless they charge for it. Then the dentist can purchase new technology and invest in continuing education which would provide better care for their patients. "Do not feel guilty about being successful. Patients want you to be successful, so do not be afraid of remodeling the office. If you have to have brain surgery, wouldn't you want the most successful brain surgeon?" The best thing for society is if all dentists were rich, so they can do more charity cases, and afford new technology, high quality treatment, and so on. Be a mouth doctor, not a tooth mechanic.

"People have money for what they want, whether they need it or not. It's our job to make them want what they need."
*—Harold Wirth, DDS*

### *Physiology and Occlusion*

In his second part, Dr. Dickerson then discussed the physiologic connection of dentistry and the rest of the body. He waded into "The Occlusal Debate," and noted that there are seven official definitions of Centric Relation in the USA. In dental school, they did not tell you that you CAN open bites. Heck, you do it with dentures all the time. As Janet Travel stated in the 60s, 90% of pain comes from the muscles. So we should be making the muscles happy. After treatment, the joint is less compressed. Why are we the only medical profession that wants to compress joints? LVI has a collection of 2,000 articles supporting the science behind neuromuscular dentistry. Some critics have said that reconstruction using neuromuscular dentistry is too aggressive, but with adhesive dentistry, we can be conservative and also be aesthetic.

Dr. Dickerson talked about "The Pure Hinge Theory." Many of us were taught that there is a 20 mm pure hinge when the jaw opens. A study in Milan, Italy showed that there is not a pure hinge, even in the first few millimeters of opening. So Passalt's pure hinge was made only by forcing the jaw posterior and rotating by hand. In fact, in Passalt's envelope of function there is a middle line that shows the "natural" opening of the mandible which shows there is no pure hinge, instead immediate translation as well as rotation. Therefore, you always function on the eminence, not on the pure hinge. If we were still in doubt, he had us feel it on ourselves that our condyle immediately begun to translate as we opened.

Yet some patients, even those without a condyle, can function. Some had a condylectomy, others may have been born with a condyle defect. He showed an example of a man without a condyle who is able to eat apples and raw carrots, and a woman who had a cancerous tumor removed, who can still chew even though she lacks both a ramus and condyle. The way many dentists were taught to adjust the bite with their patient lying flat in the chair is the worst possible method as it removes interferences. Patients need interferences to provide a home for the jaw. Do NOT have a person close and grind around to remove the contacting points as this removes all the needed interferences.

*(continued on the adjacent page)*

# OCCLUSION AND OBSTRUCTIVE SLEEP APNEA *(continued from the adjacent page)*

Dr. Dickerson recommended we start with the HIP Plane in establishing a plane of occlusion. The HIP Plane is made by the Hamular notch and Incisive Papilla. It will be level with the occlusal plane 95% of the time. The position of the head affects the bite. Posterior teeth hit if we move our head forward like a 95-year-old man driving. Sitting up straight with good posture, most hit on the front teeth. Posterior teeth separate as posture improves. When taking a bite, have your patient sit up straight with square shoulders and good posture. Have [her] wiggle [her] jaw, then let it float up into the maxilla like a helium balloon is floating up.

### *Airway and Development of Malocclusion*

Dr. Dickerson then discussed the importance of the airway and why malocclusion occurs. He noted that the the most important thing we put into our bodies is oxygen. Children are born with larger craniums in proportion to body size. The cranial cavity is 90% of full size by age twelve, but the lower face will grow significantly and is affected by the environment. The glenoid fossa is formed by use and newborns do not have a fossa. Babies should nurse, rather than use a bottle to develop proper arch formation and tongue posture. Nursing is needed to prevent constriction of the arch. If a pacifier is used, it should be the NUK invented by James F. Garry, DDS, who taught at LVI before he died and considered the airway expert in the world at the time.

Dr. Dickerson recommended "Rabbit-Proof Fence," a 2002 Australian film about three Aboriginal girls who are taken from their village and are kept in a settlement, but escape and make it back to their village by following the rabbit-proof fence. But what was discovered back then was that those in the camps developed malocclusion while their siblings in the villages did not, proving it's environmental. The foods and other environmental influences caused them to have allergies. Allergies can lead to mouth breathing in children. In a healthy child, the tongue touches the palate and counters the midline push from the buccinator muscle. When the tongue is not in the proper position, the arch is constricted. Anterior open bite is a result of hypertrophy of the adenoids.

If the tongue rests on top of the posterior teeth, eruption is prevented and the child needs to pull the jaw backward to get the posterior teeth to touch. This creates Class II, Division II with bicuspid drop-off *(what Dr. Terry Tanaka calls Two-step Occlusion).* Tiny nasal orifices indicate not using them due to mouth breathing. In some cases, a four-year-old develops bruxism. This can be done in an attempt to equalize eardrum pressure. Dickerson recommends a six-minute video about the dramatic consequences of airway obstruction in a young boy: "Finding Connor Deegan." *Link:* https:/www.youtube.com/ watch?v=Sk5 qsmRyVcE

### *Obstructive Sleep Apnea*

Dr. Dickerson concluded his lecture with information on obstructive sleep apnea. There are three stages of apnea. Snoring is the most common symptom, but not all people with OSA snore. There are many comorbidities of OSA, eg., 35% of those with apnea have HTN and 83% of those with HTN in spite of taking three meds have OSA. Children who snore need medical attention including a sleep study. Children should never snore. He recommends that we give all of our patients an Epworth Sleep Survey. Link: https://www.slhn.org/docs/pdf/neuro-epworth-sleepscale.pdf We can provide a Home OSA tester for our patients. It costs $3,500 from Great Lakes Orthodontics: http://www.greatlakesortho.com/commerce/detail/?nPID=2038 The UCR for the use of this device is $68 which covers the wear and tear and disposable wiring harness.

Dr. Dickerson closed by encouraging all of us to be mindful of this quote from Dr. Albert Schweitzer: *"The tragedy of life is what dies inside a man while he lives."* That we never give up hope for achieving our dreams. You can see many of the things he talked about in various five-minute entertaining LVI TV episodes on You Tube — https://www.youtube.com/user/LVITV/videos. You can also find out more on the LVI website —http://www.lviglobal.com/ ■

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**Paul Schafer, DDS, MAGD, FICOI** is in solo private practice in Novato and has served on the Northern California AGD Board since 1993.

**A LIGHT-HEARTED LOOK AT ORAL RINSES AND CARIES PREVENTION**

# *Dental Health and Red Wine Consumption*

**Dinu Gray, DDS**, *President, NCAGD / Mill Valley*

Well, in case you missed it dental colleagues, maybe we are finally going to get the public accolades we deserve for restoring smiles…*maybe.* Implant dentistry? Perhaps same-day milled restorations…*both, a possibility.* BUT what I'm thrilled about is the relationship we're going to build with our patients, *based on relatively new research that correlates dental health with red wine consumption…!*

In an article published in The Journal of Agricultural and Food Chemistry, published April 29, 2014, researchers found that certain compounds in red wine known as polyphenols can interfere with the activity of streptococcus mutans, having an anti- microbial effect. *Title of the original research paper:* "Red Wine and Oenological Extracts Display Antimicrobial Effects in an Oral Bacteria Biofilm Model."

M. Victoria Moreno-Arribas and her team studied red wine with or without alcohol and grape seed extract.

The possibilities are endless. Double-blind studies of mouth rinses of California wines versus French; Pinot versus Cabernet, you get the drift. Rx: Rinse with your favorite "Cab" 2 x day and drink one to two glasses per day to prevent dental caries. An added benefit is, of course, lowering the risk of heart disease. Let's leave that for the physicians to recommend.

Have red wine rinses in every operatory and possibly have patients take a swig prior to dental implant placement. Clorhexidine rinses? When was the last time patients complimented you on the choice of terroir, vintage or the bouquet of the rinse? Or, the perfect balance and tannins.

I suggest that this subject deserves further study and research. Yes, drink responsibly. Please, no letters to the editor regarding my misguided foray into alcohol consumption. I'm just looking into all our options for caries prevention, patient compliance and, of course, humor. ■

# Precise IMPLANT PLACEMENT WITH Guided SURGERY

JOHN DiPONZIANO
DDS, DICOI, MAGD
*Pleasanton*

*A confidence building modality*

It is an accepted fact that cone-beam computed tomography (CBCT) has become the method of choice for the treatment planning of dental implants.

Although tens of thousands of implants have been placed, throughout the world, using only periapical or panoramic radiographs, the peace of mind of knowing the exact bony topography, afforded with CBCT, is undeniable.

Going one step further—using CBCT technology to construct a precise surgical guide—provides an even greater stress-free experience for the clinician when placing implants.

The mesial-distal and facial-lingual positioning is provided with the surgical guide. But its biggest advantage is that it allows the osteotomy to be safely created without the fear of over-drilling and damaging vital structures.

How is this precision achieved?

The latest advances in virtual implant placement combine the CBCT data with the data from an optical scan of the mouth or stone model.

When joined in the software, a virtual guide can be developed, which is then exported to a 3-D printer for production into a plastic surgical guide. The implant osteotomies are created by guiding the implant drills using stainless steel sleeves embedded into the plastic guide. *(Figs. 1 and 2)*

These special implant drills have a shoulder built into them. When the shoulder reaches the top of the stainless steel sleeve, the osteotomy is created at the proper depth. *(Figs. 3 and 4)*

These guides have such a high degree of accuracy, that a previously fabricated provisional restoration can be attached to the implant at the day of placement, provided that the implant has sufficient initial stability. *(Figs. 5 and 6)*

In addition to the advantages that guided surgery provides for the clinician, the patient also benefits substantially, as well:

Guided surgery is typically much faster than free-handed implant placement. From a patient's perspective, the least amount of time spent in the dental chair, the better.

Post-op discomfort is also diminished since guided surgery is usually less traumatic. *(Fig. 7)*

The practice building potential of these points far outweigh the additional cost of the surgical guide.

All of the above factors produce a compelling case for using guided surgery for every implant placement. *(Fig. 8)*

This is especially true for the dentist new to implant surgery, who will find that his or her confidence will grow much faster using this modality. ■

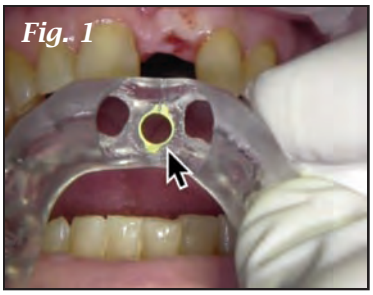
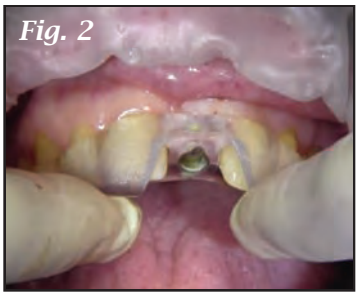


Fig. 1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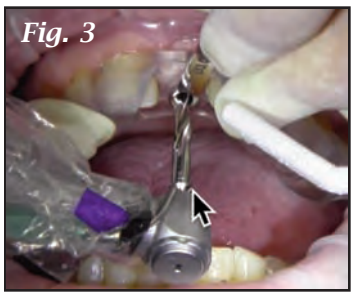
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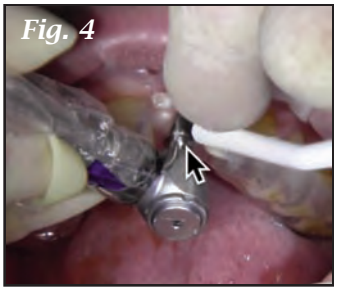
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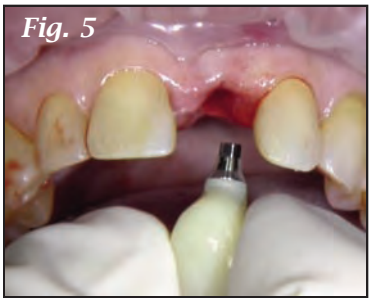
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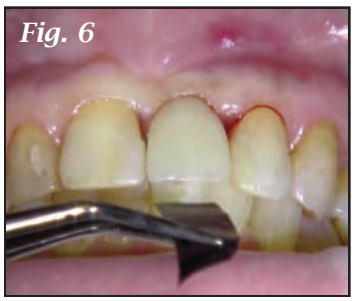
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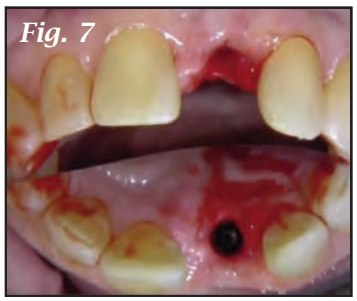
Fig. 7

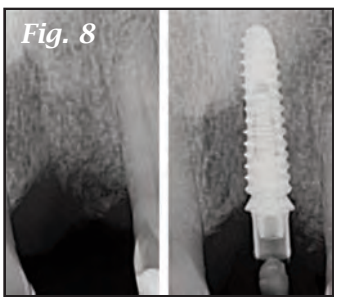
Fig. 8

# See the Truth, Remove the Obstacle and Move On!

**Michael Lew, DMD, MAGD,** *Novato*

**DR. MIKE LEW**
*CAGD Trustee*

***"When you play the Game of Thrones, you win or you die. There is no middle ground."***

*from "Game of Thrones"*
*by George R.R. Martin*

Fortunately for us in the AGD, our professional lives are not so desperate. But the show "Game of Thrones" can entertainingly illustrate traits of great leaders.

Tyrian Lannister is a dwarf. And in a world where dwarves are not well respected, he stands tall. He is rich and from the most wealthy and powerful family in his kingdom and could be destined for royalty, but he is a dwarf. He is well read, well educated and can give excellent council, but he is a dwarf. He is brave and can lead men, but he is a dwarf. He has amazing talents and would make an excellent king. But he is a dwarf. Early in the show we see that he is a drunk and a whoremonger. Instead of properly attending a family political function *(in medieval times family connections are huge),* we are introduced to him waking up in a pigsty. His antics and personality makes us suspect that he is his family's embarrassing "loser." Because he is a dwarf. I believe that his biggest challenge is not his physical size, but his self-image.

***"Never forget what you are, for surely the world will not. Make it your strength. Then it can never be your weakness. Armor yourself in it, and it will never be used to hurt you"*** says Tyrian. And he owns his status as a dwarf. But during the show we often quickly forget his physical size and we see what a hero he is. His quick wit escapes him from many impossible predicaments. His leadership inspires men to fight in battles. His ability to make wise decisions elevates him to the ruling council. He really is a giant of a man. As the show continues, he leaves his identity as a smaller man behind to rely on his talents

***"Let them see that their words can cut you, and you'll never be free of the mockery. If they want to give you a name, take it, make it your own. Then they can't hurt you with it anymore."***

Tyrian is a metaphor for us. We dentists are all multitalented. We each do have abilities that we can be proud of and achievements that can impress others. And we each have had events that make us small and embarrassed with ourselves. The unsuccessful denture, the failed root canal, the cracked restoration, the missed diagnosis. Or the failed relationship. The unsuccessful practice. The money shortages. Like Tyrian's journey, our road in dentistry is full of challenges. Like Tyrian, see the truth, remove the obstacle and be ready to move on.

***"Every man should lose a battle in his youth, so he does not lose a war when he is old."*** ■

# Watchdog REPORT

**Guy Acheson, DDS, MAGD,** *Rancho Cordova*

**DR. GUY ACHESON**
*Rancho Cordova*

I am writing this article in May, which is when the legislative sausage making is at its most furious pace. All of you need to be aware of very interesting pieces of legislation that are working their way through the system. They try to address things like dental student debt, mal-distribution of dentists, opioid abuse, the safety of pediatric anesthesia for dentistry, the underperforming DentiCal program, overuse of antibiotics, fee splitting in advertising, and further expanding the ways to obtain a California dental license. Some will pass, some will fail, and some just die in the process. If any of these items interest you, please use the very easy to navigate website **www.leginfo.legislature.ca.gov** to read the full bill and contact me or the legislator who is sponsoring the bill to learn more.

The dual problems of massive dental student debt and lack of dentists in many areas of California is getting attention through several loan repayment programs. AB2048 would make any dentist who is employed in any federally qualified health center eligible for the National Health Service Corps State Loan Repayment Program. AB2485 would transfer oversight of the Dental Corps Loan Repayment Program from the Dental Board of California to the Health Professions Education Foundation, which should provide more time and effort to advertise and recruit for this program. AB1039 would establish the intent to start a new program called the Dental Corps Scholarship Program. All of these programs provide money to repay student loans in exchange for working in federally designated underserved areas. Every little bit helps.

As of July 2016 all prescribers of controlled substances are required to be registered on the CURES database system. The CURES database lists all controlled substance prescriptions filled by a patient and who the prescriber was. Currently prescribers are only required to be registered on the site. They are not required to use it. Proposed legislation, SB482, will make it mandatory for a prescriber to look up a patient on the CURES system before writing a prescription for any controlled substance and to do this at least annually thereafter.

This type of legislative micro-management of the opioid abuse problem has unintended consequences. Dr. Nordland's article in the May 2016 CDA Journal, "The Pendulum Has Swung Too Far," speaks to my feelings and behavioral responses to recent restrictions on prescribing.

The cynical side of me can foresee the next step in CURES where one will have to obtain a security code for each patient lookup to record in the chart as proof that the prescriber actually did complete a CURES search.

I have fantasized about further legislative tinkering such as to create a pain scoring system to justify prescribing a class of pain meds. It could be something like every dental procedure and diagnosis has a pain score. A simple direct restoration would have a score of 1. A pulpitis treated with a pulpectomy has a score of 3. A simple extraction is 6. A partial bony extraction is 8. Add some modifiers for the patient's medical history; say 3 points for chronic pain, 2 points for daily psychotropic medications, 4 points for having a stressful job. Add up the points and see what medications qualify. Up to five points gets you over the counter meds. Reach eight points and you get prescription strength ibuprofen. Ten points gets you Tylenol #3. Fifteen points qualifies for hydrocodone. Eighteen points is oxycodone. Twenty points gets you mandatory pain management by a physician. Twenty-five points means call 911. Finally, some quantifiable objectivity to providing pain medication!

An excellent article on the complexities of pain management is, "Pain Specialists Are Vital in War on Opioid Abuse," by Dr. Shalini Shah in the Sacramento Bee, May 18, 2016, page 7-B. She says, "The factors behind the opioid epidemic are numerous, but there is misunderstanding about the impact of physician prescribing—or overprescribing—practices."

I have faith that education will provide the best medicine for opioid abuse. Give the providers good tools and they will make well-reasoned decisions taking into account each patient's unique situation. More rules leads to frustration, burnout, and avoidance.

AB2235 would require the DBC to review the safety of pediatric deep sedation and general anesthesia in California. This will be a huge undertaking because there is very little good quality data on how many anesthetics are administered and no central reporting system on adverse outcomes. It would also require the DBC to develop a written informed consent form to be used by all providers.

SB1098 would form a DentiCal Advisory Group to oversee the policies and priorities of the DentiCal program with the goal of increasing the utilization rate among children. Furthermore, it specifies that proposed decisions relating to the DentiCal program are based on the best available evidence. AB2207 would require MediCal programs to provide dental health screenings and refer patients with needs to DentiCal providers. It also would require extensive performance measures to be posted on the DentiCal website on a per year basis such as: the number of patients seen on a per-provider basis and the number of dental services rendered by every provider.

SB994 would require that individual dentists develop a written Antimicrobial Stewardship Policy and document that they are following their policy. Dentists would be required to submit a copy of their written plan when they renew their dental license. The DBC would be required to audit every dentist as to whether they are complying with their plan on a regular basis. Failure to have a written policy and to follow that policy would constitute unprofessional conduct. This bill looks like it will be withdrawn by its sponsor. *Whew!*

AB2744 would allow advertising programs (such as Groupon and other daily deal businesses) that involve dividing a pre-paid fee between the advertising agent and the advertising practitioner. There has been extensive debate in the ADA, CDA, and AGD houses of delegates whether this business model is a form of fee splitting. Existing law and the ADA Code of Ethics do not allow fee splitting.

*(continued on page 19...WATCHDOG)*

NEWS
Sacramento-Sierra
ACADEMY OF GENERAL DENTISTRY

**Samer Alassaad, DDS, FAGD**, *President*

**DR. SAMER ALASSAAD**
*Davis*

# Thousands of Friends

"Which rotary endo system do you use?" I asked my neighbor, Vahid, an AGD-member general dentist. "Come on over. I will show you what I can do with it," he answered.

"What do you think about this Invisalign case?" I asked Ashkan. "This would be a great case," he replied citing his reasons about what and what not to consider.

"Hey Guy, I am proposing this presentation idea." "That looks like a great idea. Let's make it happen" encouraged Guy, even though he had just recently met me.

This kind of genuine support is what makes being an AGD member so valuable. But to enjoy these benefits, we have to build relationships by attending AGD events. There are many opportunities at the local component level, the state constituent level, and the national level. These actually remind me of the friendships we made in dental school.

Welcome to the AGD, a [dental school] of 35,000 dentists helping each other succeed.

The Sacramento-Sierra Component of the AGD had an exciting time this year. We have held local study club meetings across our component, from Fresno to Sacramento, to Davis, and in Redding, connecting members locally. We have offered pertinent continuing education closer to their communities. We invited local speakers and have utilized the knowledge of our neighboring dentists. These smaller group meetings are a great opportunity for discussions among general dentists who share the same values and goals. ■

*Stay updated with event details at:* **www.ssagd.org**
*Contact us at:* terri@cagd.com

*In Davis, Dr. Guy Acheson presented* "Rescuing Endodontically Hopeless Teeth of a 12-year-old"

*In Redding, Dr. Michael Lew presented* "Surgical Extractions for the General Practitioner"

*In Sacramento, Dr. Quincy Gibbs presented* "Implant Abutments from a Single Tooth to a Full Arch" *(organized by Dr. Chirag Vaid)*

*In Fresno, Dr. Samer Alassaad presented* "Early Diagnosis and Treatment of Asymptomatic Enamel and Dentin Cracks"

*Delta Dental of California and the*
*California Academy of General Dentistry present*

# The Seven Keys To Sleep Success:

# Successfully Integrating Dental Sleep Medicine into Your Practice

*with* **Dr. Rob Veis**

*on* **Saturday, November 5, 2016**

*at the* **Hotel Nikko San Francisco**

## *Learning Objectives:*

- *Understanding sleep*
- *Understanding your role*
- *Working the dentist/physician team*
- *Making the diagnosis and collecting data*
- *Selecting, fitting and follow-up*
- *Getting paid — the medical model*
- *Getting the word out — marketing*

## *Course Description:*

In addition to CPAP, dental appliances are the preferred non-surgical treatment solutions to help patients with sleep apnea. The dentist plays a key role throughout the procedural levels of Sleep Medicine. The screening of existing and new patients, the diagnosis of condition and cause, and the presentation of individually viable treatment options. This lecture is designed to help you effectively integrate Dental Sleep Medicine into your practice and to treat patients at all levels.

Family-friendly Weekend ✳ Welcome Reception ✳ Enjoy All That San Francisco Has To Offer

Experience the Wine Country in Napa Valley ✳ Visit Alcatraz Island and Penitentiary

***Tuition:*** $129 *for* ***Delta Dental*** *and* ***AGD*** *members;* $229 *for non-members*

***Registration:*** *Online, go to* **www.caagd.org**

*or call* **877.408.0738**

***Sponsors:*** DELTA DENTAL® *and* California Academy of General Dentistry

Academy of General Dentistry™

PACE Program Approval for Continuing Education

*(more on next page)*

NO MORE "ONE SIZE FITS ALL"

# *Sleep Appliance Therapy: Where It Is and What It Needs To Be*

Every patient is unique. Each has their own "dental landscape"…and when you take into account the variety of appliances and the uniqueness of every patient, it becomes crystal clear that finding the ideal sleep appliance to treat your patient is not (and has never been) a matter of "one size fits all."

### *So how do you know which sleep appliance is the right one for any given patient?*

Almost all of us start by using one appliance. Whether your friend or colleague recommended it or you read about it in an article or you went to your first sleep course and that's the appliance they taught…chances are you start with one.

Even if you're lucky and that one appliance ends up being the perfect choice for most of your sleep patients, you'll still need to know how to take a proper construction bite and/or impression for the appliance in question. You'll also need to determine what your starting point is for *securing* the construction bite. And that's not all.

- One type of appliance may hold the upper and lower jaw firmly together. For someone who is a mouth breather, this can prove to be nothing short of torturous.
- If your appliance of choice is retained in the patient's mouth by grabbing the natural undercuts in the dentition…will your patient have enough back teeth to anchor the appliance?
- Is your patient a lateral bruxer? If so, any appliance that prevents lateral movement may be less than ideal. In fact, some sleep appliances will not survive the force of bruxing and will simply break.

### *To be successful in selecting the right sleep appliance, you need to know:*




**Materials, qualities, design and functional specifics of the different appliances.** Hard acrylic? Cad-Cam Appliance? Does it allow lateral movement? Is it easily adjustable for patient and/or doctor? How is it retained —— ball clasps and clasps? Is it lined with thermoplastic material? Can you adjust it and realign it easily?

**The VITAL, controlling parameters in relation to the patient.** As a dentist you should be looking at all possible levels of obstruction: nasal, oral and airway space. You will need to perform a full and complete dental sleep examination and a TMJ exam. Number of teeth in both arches? Signs of periodontal disease or decay? Broken fillings or crowns? Signs of lateral bruxism? What is the range of lateral movement? Range of movement from centric relation to the most protrusive position. Size of their tongue, arches, palate? Skeletal class l, ll, or lll?

**Whether combined therapy is a better approach.** I feel that one of the main reasons that appliances don't work at a higher success rate overall is that a combined therapy approach, while often needed, is seldom considered.

This approach may prove as simple as prescribing a sleep appliance with a nasal strip —— to encourage the patient to breath nasally and keep the air passage open. It may be as in-depth as employing a CPAP with an appliance of choice. For a patient whose nose is completely blocked, therapy may necessarily include nasal surgery to clear the airway…*before* adding an appliance.

Because *every* patient *is* different, here are some sample combination approaches for your consideration:

- There is a direct correlation between malocclusion and sleep apnea. Research will back me up on this. Those of you who are treating malocclusion patients, need to evaluate those patients for sleep apnea.
- If you're treating a patient for bruxism, TMJ or any condition somewhere within the spectrum of joint dysfunction —— pop/click, pain, etc., it's in your best interest to exercise caution when prescribing a splint/orthotic *without testing them for a sleep disorder.* Numerous articles and investigations confirm a definite link between bruxism and sleep apnea.
- For patients with a large tongue, mandibular advancement may not be enough. Sometimes tongue retention is a necessary concern for correcting what is wrong.

*(continued on page 28...see SLEEP)*

*Hands-on* Treatment and Prevention of Dento-Alveolar Injuries in Sports Dentistry

# FABRICATION OF PRESSURE THERMOFORMING APPLIANCES

**DR. RAY PADILLA**

*Faculty, UCLA School of Dentistry*

*World-renowned international lecturer*

*Co-founder, SportsDentistry.com*

*Multiple published articles on Facial Injuries and Prevention*

*Team Dentist: UCLA Athletics, Galaxy Major League Soccer and more!*

## ✶ Featuring **Dr. Ray Padilla**

## ✶ Friday, September 30, 2016 (8 a.m. till 3 p.m.)

**THIS WILL BE SDAGD'S ANNUAL MEETING**

### ✶ Topics to include:

- ✓ **Review treatments of all dental traumas including luxations, avulsions, contusions, and lacerations**
- ✓ **How to incorporate a preventive program for dental patients into your practice**
- ✓ **Comparing over-the-counter guards vs. custom pressure-formed mouthguards**
- ✓ **Diagnosis, design and fabrication of vacuum-formed vs. pressure-laminated**

### ✶ Where: **Patterson Dental Supply Education Center**

*4030 Sorrento Valley Boulevard, San Diego 92121*

✶ **Open to all team members with free parking**

✶ **Come prepared with specific questions**
*(plenty of time will be allowed for questions and answers)*

✶ **Four lecture hours plus three participation "CE" credits**

✶ **Continental breakfast and lunch for all attendees**

*Sponsored by:*

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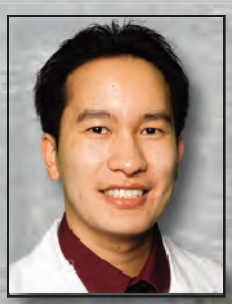

**DR. THANH TRAN**
*San Diego AGD President*

*Tuition:* *Before September 15th—*
*AGD Member @ $**199**, Non-Member @ $**249**, Staff.Military @ $**99***
***After** September 15th—*
*AGD Member @ $**249**, Non-Member @ $**299**, Staff.Military @ $**129***

*Registration via mail or fax or online:*

9936 Scripps Westview Way, #256, San Diego, CA 92131

*Online at:* **http://www.sdagd.org**
*Phone:* (858) 353-2182
*Fax:* **(760) 736-8261**
*Email:* **exec@sdagd.org**

Academy of General Dentistry
PACE Program Approval for Continuing Education

# Dental Board Recognizes the AGD Transcript for Earned Credit

**Eric Wong, DDS, MAGD,** *PACE Council Chair*

**DR. ERIC WONG**
*Sacramento*

Having the California Dental Board conditionally accept the AGD transcript—as proof that CE credits have been earned—is a great benefit for our members. Remember that the burden of proof that a dentist has taken the required CE units to maintain their licensure is the responsibility of the licentiate. On January 16, 2015 AGD's Board adopted AIRW15#16, requiring a course completion certificate in order for CE credit to be displayed on members AGD Licensing and Award Transcripts. The AGD has taken extraordinary measures to archive members continuing education certificates in the event any of its members were to be audited by the Dental Board. This would assist our members in that all submitted certificates are archived by the AGD. Not only is this a convenient benefit for our members, the AGD has researched the requirements to maintain licensure specifically for each state. By viewing the Licensure Transcript, you can easily track your progress and to plan accordingly to take the required CE courses before your next licensure renewal.

At the AGD website on the Education and Events menu "Manage My CE," our California requirements can be found, and as part of the fifty hours of CE necessary for each renewal period are: CPR, two hours of California Infection Control, two hours of the California Dental Practice Act. A maximum of ten of the fifty hours may come from practice management courses that primarily benefit the licensee.

Submission of this transcript to your licensing board does not guarantee that you will not be audited, nor that all of the CE records will be accepted by the board. Your licensing board has the final say in evaluations of your CE records. Please maintain all your original course documentation.

I was proud and honored to represent the AGD at the California Dental Board Meetings in March to request that our AGD Transcript be considered after conditional acceptance. This request was honored, and it was placed on the agenda for a vote in May. The California Dental Board voted to accept the AGD Transcript as conditional proof of CE. Mr. Nick Femyer from AGD Chicago was most instrumental in identifying the need for this member benefit. California is the currently the latest and the thirty-fourth state constituent to reach this agreement with their respective licensing board. ■

## WATCHDOG REPORT *(continued from page 14)*

This law would declare that this type of advertising is not fee splitting.

AB2331 would legislatively authorize the American Board of Dental Examiners (AMEX) exam to be used to qualify for a dental license in California. Currently the Western Regional Dental Exam (WREB) is the only authorized testing program. The AMEX is used by almost all the other states. If the AMEX is authorized it would allow virtually every dental school graduate in the country to apply for a California license. This would be a huge step towards national portability of dental licensure.

There is much more. I thought these were the juiciest bits. ■

*Contact me by e-mail if you would like at:*
drguyacheson@gmail.com

*Look for this PACE logo on all of the course advertising for proper credit with the AGD and the California Dental Board*

Academy of General Dentistry™
PACE
Program Approval for Continuing Education

*Approved PACE Program Provider FAGD/MAGD Credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement 6-1-2016 to 5-31-2022.*

# *Comparing the Efficacy of Platelet-Rich Plasma and Platelet-Rich Fibrin*

**Muna Soltan, DDS, FAGD, DICOI**, *Napa*

**DR. MUNA SOLTAN**
*Napa*

Blood plasma is the liquid component of blood in which the blood cells are suspended. It makes up about 60% of total blood volume. It is composed of mostly water (90% by volume), and contains dissolved proteins, glucose, clotting factors, mineral ions, hormones, and carbon dioxide. Plasma is the supernatant fluid obtained when anti-coagulated blood has been centrifuged. Blood serum is blood plasma without fibrinogen or other clotting factors. Serum is clearer than plasma because it contains fewer proteins.

**Platelet-Rich Plasma (PRP)** The preparation protocol requires collection of blood with the addition of an anticoagulant agent (0.5 ml citrate solution). The blood is centrifuged in two steps to concentrate the platelets. After the initial centrifuge, the whole plasma above the buffy coat is collected, separating platelets from red blood cells and leukocytes. After the second centrifuging, the platelet concentrate is collected and coagulated using calcium chloride and bovine thrombin. This method is used to add concentrated growth factors released from the platelets. The growth factors enhance the natural blood clot in wound healing and stimulate bone regeneration.

**Platelet-Rich Fibrin (PRF)** is a blood product achieved by centrifuging whole blood that was collected in a tube without an anti-coagulant agent. After centrifuging, three layers are formed. The top layer is a straw-colored acellular serum and is removed. The middle layer containing the fibrin clot is the PRF and is collected by using tissue forceps. The bottom layer containing red blood cells (hematocrit) is discarded.

### The Function of Platelets

Platelets are small structures—2-3 µm in diameter. In a normal state, platelets circulate in the blood without interaction with each other or other cells. If tissue injury occurs, platelets rapidly change from a non-adhesive to an adhesive state. They also stimulate other platelets to come to the site and aggregate to form an effective plug to seal the injured vessel and lead to thrombosis (clotting).

### Fibrin Clot

Fibrinogen is a major soluble plasma protein that is responsible for the formation of the clot. This fibrin clot contains long strands of tough insoluble protein that are laid down, and are bound to, the platelets. Factor XIII completes the cross-linking of fibrin so that it hardens, forming an overlying mesh that completes the clot. A natural human blood clot consists of 95% red blood cells (RBCs), 5% platelets, less than 1% white blood cells (WBCs), and numerous amounts of fibrin strands.

Platelet-Rich Fibrin (PRF) offers better clinical results than the Platelet-Rich Plasma (PRP) for the following reasons:

1. The fibrin clot reaction is already initiated in vitro in the centrifuged tube. When the PRF is placed in vivo, the fibrin clot provides an autologous scaffold to which the cells can attach to form new bone.

2. PRF is significantly better in promoting soft tissue healing and is also faster in the regeneration of bone, compared to PRP. This could be attributed to simpler preparation and handling protocols of PRF over PRP, and the ability of PRF to release growth factors in a controlled way due to the presence of the monocytes and other white cells that are involved in healing.

3. The process of PRF is simpler and more predictable because a clot is formed after centrifuging, and the end result is a more stable product, as opposed to the handling of the unclotted PRP.

4. The special texture of PRF provides structural properties. It can be used clinically in its amorphous form. In addition, a membranous form can be made by slight compression of the gel between two sterile plates. This membrane can be used to cover and protect a large tissue graft.

5. PRF has a higher number of platelet concentrations than the PRP

6. PRF releases autologous growth factors gradually, and expresses a stronger and more durable effect on the proliferation and differentiation of osteoblasts than PRP. Also, the presence of white blood cells—especially monocytes—in the plug, provide a constant release of growth factors necessary for regeneration and healing.

All of the above features support the conclusion that the PRF is the blood product best able to enhance the healing of soft and hard tissue, compared to other autogenous blood products available to the clinician. ■

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# CAD • CAM CORNER

Steve Lockwood, DMD, MAGD

**DR. STEVE LOCKWOOD**
*La Jolla*

## What are the ideal characteristics of a crown?

This very question requires an objective perspective on what is actually and realistically available in dentistry today. Is the ideal crown the least expensive crown you can order from a dental lab? Perhaps it is somewhere between the strongest and most esthetic crown available. Is the ideal crown lathed from a monolithic block, cast gold or artistically stacked porcelain? We can't forget to ask which is the most biocompatible crown and whether it is best to have an adhesive or cohesive luting agent.

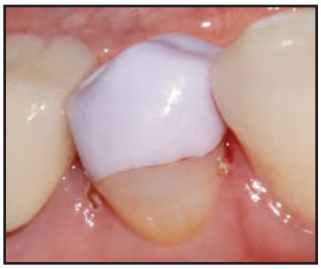
In our pursuit of excellent dentistry we have all seen crowns fail. If you have practiced long enough you might be *fortunate* to see your own crown failures. This is where we can learn why a restoration failed. Sure there are many reasons crowns fail such as recurrent decay from poor oral hygiene, occlusal interference/grinding, inadvertent porcelain fracture, inadvertent wear through gold, or complete fracturing off at the gumline. There things we just can't control, but we may be able to mitigate some previous reasons for failure. Discussing the ideal characteristics of a crown **does assume** an accurate impression, accurate bite registration, optimal margination, excellent luting, biocompatible function/occlusion, and cleansibility for the patient. As professional artists, we are responsible for creating functional and esthetic biomimicry. We cannot delegate this duty to our staff or a lab technician.

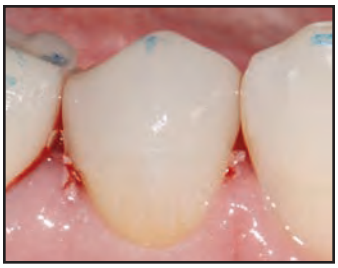
Below are clinical features describing an ideal crown:

1. Strong enough material to withstand all biomechanical forces
2. Biomimicry of contours, anatomy, shade, translucency
3. Moderate radiolucency/opacity for radiographic diangnosis
4. Luting ease and clean-up
5. Supragingival margination
6. Minimal pulpal trauma
7. Easy to adjust, finish and polish
8. Biocompatible with endodontic access and repair (bondable to resin)
9. Minimal to no temporization (patient-management)

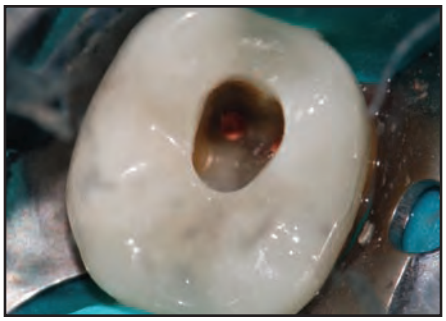
Cuspal coverage of a vital tooth increases the demand for conservative preparations reducing pulpal trauma. Keeping margins supragingival allows for better cleansibility, less trauma to the periodontium, and use of remaining enamel for very strong adhesion with shade-correcting resins. Supragingival margins also allow a thorough finishing and polishing of margins. The ideal crown should allow radiographic visibility of all core and endodontic materials, as well as viewing of excess interproximal luting agents. In the event a crowned tooth subsequently requires endodontic therapy, the crown material should allow conservative access prep void of false-positive readings while using an apex locater. Moreover, the crown material should allow for a seamless composite seal to maintain the strength and esthetics of the original crown.

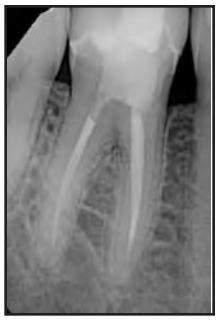
The following images are of CAD/CAM monolithic lithium disilicate crowns. The images will serve to illustrate the features for my understanding of an ideal crown. It must be stated that this is not the standard of care of dentistry today. There are many clinically acceptable crowns in the marketplace, but very few can achieve all of the nine clinical characteristics listed.

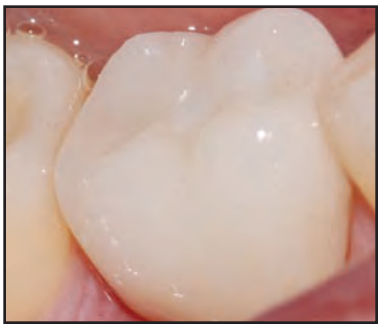




*The two images above illustrate conservative cuspal coverage with supragingival margins on #28. The pre-sintered state of lithium disilicate allows for margin and IP contact verification prior to oven crystallization. Crown material has high translucency and is adhered with neutral dual-cured resin.*







*This series of three images (#30) show endodontic access through a lithium disilicate crown and subsequent resin/GI core and hybrid composite. Note the radiographic viewing of all dental materials and remaining tooth structure.*

*Gold, PFM or zirconium crowns have limited radiographic diagnostic viewing.*

In conclusion, the journey we are all on to pursue excellent clinical dentistry for our patients is ever-changing. Today there are many choices for dental materials especially for cuspal coverage. Years ago I seated my first all-porcelain crown, but even this "porcelain" has evolved. Eventually, I learned about lithium disilicate and its many clinical benefits. Ask your lab technician if they can mill a bondable lithium disilicate crown. If you like the results you may want to consider digital impressions and e-mail the scans to your lab. In the meantime, keep an ear to the ground regarding in-office fabrication of your own lithium disilicate crowns and see if this technology fits into your practice or business model. Then you may discover the patient satisfaction of receiving a final crown restoration the same day. ■

News
SOUTHERN CALIFORNIA
ACADEMY OF GENERAL DENTISTRY

**Ricardo Suarez, DDS**, *President, West Covina*

DR. RICARDO SUAREZ

*If you would like further information about any of our upcoming courses, please visit our newly-designed website at* **scagd.com**

As the chime from my phone fills the silence in my ears, I slowly awaken to the start of yet another work week. I begrudgingly get out of bed and stop to check for any messages from the office or staff regarding emergencies or illnesses. Good, there are none! So far the day is starting off just right. No one calling-in sick and no office emergencies, especially after a long weekend. What more could I ask for? My favorite surprise is when the server is frozen, or the phone lines are down. Talk about putting out fires.

This week is payroll, my favorite 'hat.' Wow, that's a pretty penny to cover. I sit back and wonder if I'm overly generous with my wages and benefits. Then the email requests to use some PTO from the staff come in. "You want how much time"? I think to myself that I need to review my office manual, or at least update it. How many years has it been since that happened?

Being a business owner in employee-friendly California is quite a fine line to straddle. I wish that I felt more comfortable knowing what I can and can't do to reward and to reprimand both good and bad behavior. Examples: frequently calling-in sick, or being late to work, or being late back from lunch.

Oh yeah, I almost forgot to calculate the 401-K employer match and health benefits so that the almighty IRS has those figures in the W-2s, since now all this information is required by law. Just one more thing to do and one more thing that I can't afford to get wrong.

I just hope I'm saving enough money to eventually retire gracefully. I need to find a great financial planner to review my investment choices.

Thank goodness the day was busy. No major hic-cups, and all the patients left happily and made their copays.

As the years go by it seems as if patients and their dentistry is a reprieve from what's really difficult: the management side of running a dental practice. It's a love/hate relationship, but one I would never change.

Oh, how I love the business of dentistry! ■

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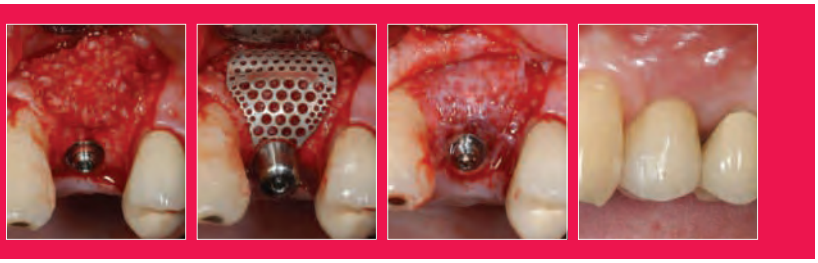

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TECHNIQUES AND PRODUCTS IN THE CONSTRUCTION OF AN

# Implant-Supported Hybrid Fixed Denture

**Sako Ohanesian, DDS, MAGD**, *Anaheim Hills*

DR. SAKO OHANESIAN

In early 2008, a forty-five-year-old female came to our office to replace her old, unaesthetic full upper denture. She had become edentulous on her upper jaw at a very young age *[Figure 1].* We fabricated a new full upper denture that satisfied her need at that time by changing the size, shape and color of teeth, following basic guidelines of a full upper denture *[Figure 2].*

In early 2013, she decided to restore her upper jaw with an implant-supported hybrid fixed denture. Due to the need for extensive bilateral sinus grafts and a deficient maxillary ridge, she was referred to Loma Linda University, School of Dentistry to perform the surgical procedures.

Based on her records from the University to reconstruct her maxilla, Infuse bone graft (rhBMP-2/ACS) by Medtronic and Puros cortical particulate allograft by Zimmer Co. and Bio-Oss by Geistlich, along with titanium mesh were used to augment the deficient ridge vertically and horizontally—both posteriorly and anteriorily and for the bilateral sinus graft under IV sedation.

After those augmentations and a healing period, eight Dentium implants were placed on her maxilla *[Figure 3].* Four Dentium implants were also placed on her posterior mandible—two on each side *[Figure 6].* After the integration of the implants, the patient returned to continue with the restorations.

Two preliminary impressions were taken of the upper and lower jaws using Counterfit quick-set silicone by Clinician's choice to fabricate acrylic custom trays. All healing caps were removed and open tray impression copings were placed and hand-tightened *[Figures 4 and 5].* Affinis (Coltene/Whaldent) regular body and Colorise (Zhermack) rigid heavy body were used to capture an accurate impression. A verification jig was used in the patient's mouth *[Figures 7 and 8]* and sections were glued together using Primopattern LC gel made by Primotec and verified on the cast sent by the lab to make sure of the accuracy of the impressions taken *[Figure 9].* Then centric relation and vertical dimensions were recorded using basic denture fabrication techniques.

At the following visit, we tried in the upper teeth set in wax and made some corrections and it was sent back to the lab to complete the case.

At the delivery appointment, we removed all the healing caps. For her fixed hybrid denture, abutments were placed and torqued to 30 N/cm, all eight screws were torqued to 10 N/cm and the holes were sealed by cotton pellets and tooth colored flowable composite *[Figure 13].* Holes on the pink part of the denture were sealed with PermaFlow pink by Ultradent *[Figure 11].* Lower screw retained implant crowns were torqued to 30 N/cm and the holes were sealed with cotton pellets and flowable composite (Beautifill F00) by Shofu *[Figure 12].*

*(continued on the adjacent page)*

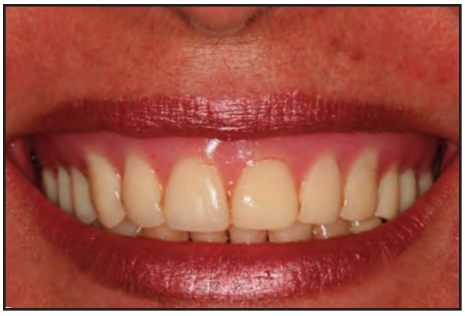


***Figure 1:*** **Patient's old denture (2008)**

***Figure 2:*** **Patient's new denture (2008)**

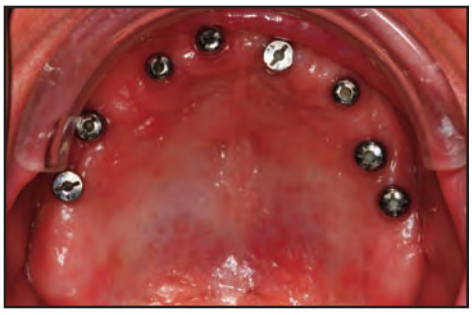


***Figure 3:*** **Healing caps**

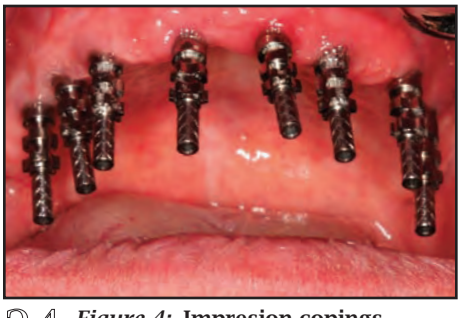


***Figure 4:*** **Impresion copings**

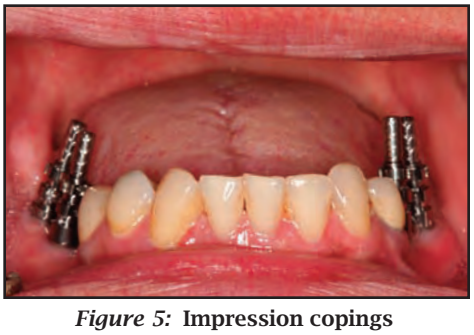


***Figure 5:*** **Impression copings**

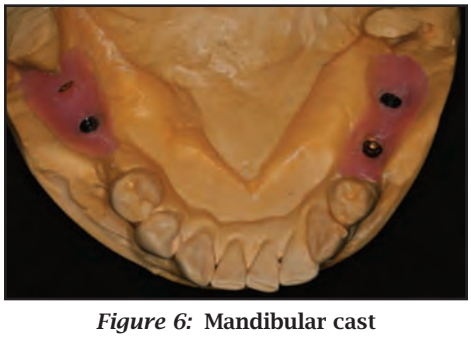


***Figure 6:*** **Mandibular cast**

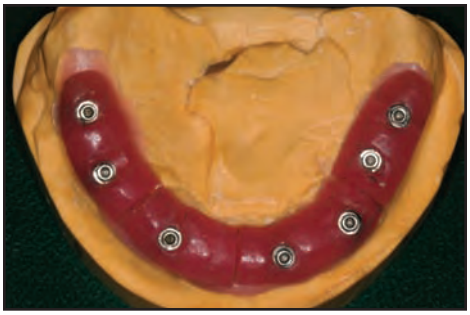


*Figure 7:* **Verification jig**

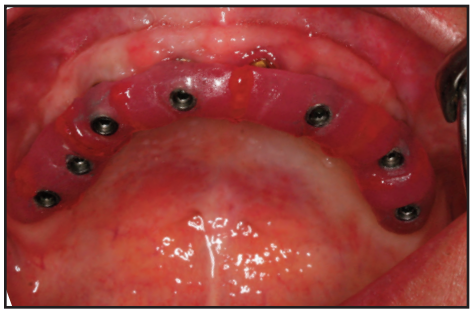


*Figure 8:* **Verification jig in the patient's mouth**

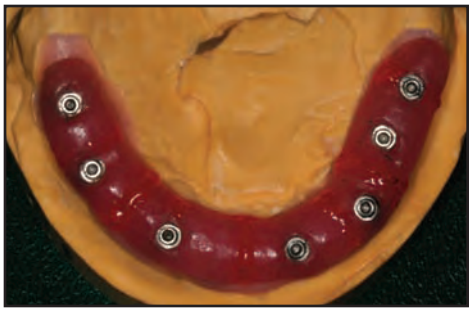


*Figure 9:* **Verification jig on the cast**

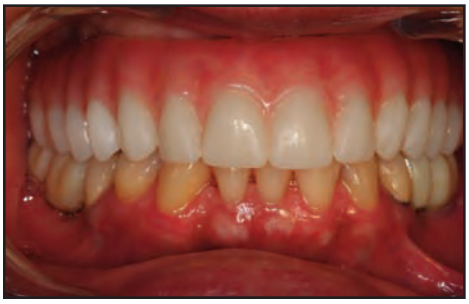


*Figure 10:* **Fixed upper hybrid denture**

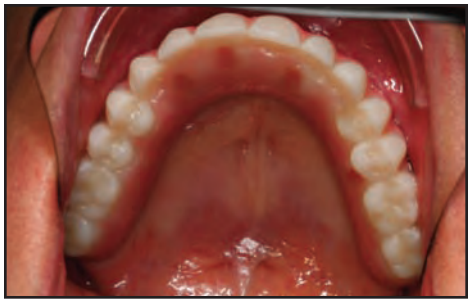


*Figure 11:* **Fixed upper hybrid denture**

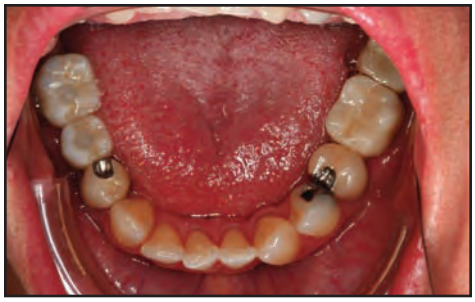


*Figure 12:* **Mandibular posterior implant restorations**

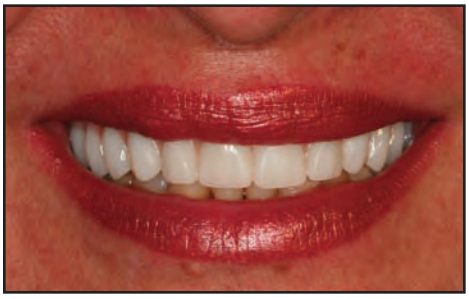


*Figure 13:* **Fixed upper hybrid denture**

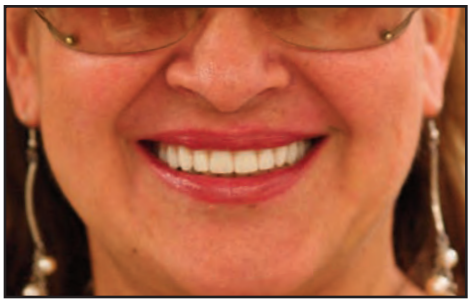


*Figure 14:* **Fixed upper hybrid denture**

*Figure 15:* **Fixed upper hybrid denture**

Instructions on how to keep the restorations clean using woven and tape floss, interdental brushes, theWaterpik, etc. were provided to patient. The patient was scheduled to come in every three months for cleanings.

I thank Creative dental lab in Scottsdale, Arizona and Marco Rocha, the Dentium company representative for their assistance with this case. ■

*Dr. Ohanesian is in solo private practice in Anaheim Hills and participated in the California AGD's MasterTrack program.*

# Dr. Mark Yamamoto Recognized for His Work

Dr. Chi

CAGD President Dr. Howard Chi presents Dr. Yamamoto with an award recognizing his years of service to the CAGD

Terri Wong, CAGD's Executive Director, works closely with Dr. Yamamoto ensuring that course providers follow AGD's PACE approval guidelines

CAGD President, Dr. Howard Chi, presented Dr. Mark Yamamoto with an Award of Recognition at the recent CAGD Board Meeting in Anaheim.

Mark Yamamoto, DDS, MAGD has been reviewing all local PACE applications for the CAGD for decades. He couldn't recall how long he's been at it. I looked it up—*he's been doing it since 1988...!* It's an endless job, with applications of seventy-plus pages coming in every month. Dr. Yamamoto has traveled to Chicago to be calibrated with other PACE application reviewers in the U.S.

Dr. Yamamoto has been in private practice since 1972, and he received his MAGD in 1996. He is currently teaching part-time at the USC School of Dentistry as a Clinical Assistant Professor in the Operative Department. He is also an expert witness for TMJ injury cases, and has spoken on the topic of TMJ Therapy for many years.

The CAGD is very thankful to have Dr. Yamamoto as our state's PACE Application Reviewer. He has reviewed hundreds of applications over the past twenty-eight years, and says he does it to give back to the profession and to the AGD.

We truly appreciate his hard work on the CAGD's behalf. ■

Academy of General Dentistry
PACE
Program Approval for Continuing Education

# Northern California
## ACADEMY OF GENERAL DENTISTRY

**Dinu Gray, DDS**, *President, Mill Valley*

DR. DINU GRAY

The NCAGD continues to expand and refine the "Pearls and Bullets "continuing education seminars, as well as our full-day courses.

So far this year we have co-sponsored a DOCS three-day sedation certification course, as well as seminars presented by Dr. Jeff Brucia and Dr. Ray Bertolotti.

Going forward, we have set courses on dental liability issues and dental management, as well as a meeting with Delta Dental executives.

We strive to bring speakers and topics of interest at very reasonable costs, at times subsidised by sponsors.

Bringing the speakers together with our members, and dentists in general, poses challenges that deal with an appropriate geographic location, days of the week, time and subject matter. We appreciate feedback. We strive to vary our seminars.

Please check our website at NCAGD.COM for upcoming events. ■

# University of Southern California

DENNIS SOURVANOS
*Los Angeles*

The FellowTrack Club at USC gives student members the unique opportunity of becoming familiar with organized dentistry at a very early point in their dental career. Some students join because they are looking for a dental community. Others see this as an endeavor that will bring alumni networking and help with job placement. Regardless of initial motives, all involved quickly learn that participating in FellowTrack events is a great way to become lifelong learners.

The core mission of our chapter is to promote an innovative culture of growth for dental students while accumulating credits toward the highly prestigious "Fellowship" designation. Great efforts are made by our faculty sponsor (Dr. Cheryl Goldasich) to support students by cultivating their interests, representing their educational needs, and inspiring them as future general dentists. This is reflected through participation in CE courses, leadership opportunities, educational guidance, career planning, and one-on-one expert advice. These experiences provide a foundation that will develop fundamental ideals towards their professional endeavors.

The FellowTrack club has become well known to all USC dental students for the variety of topics explored during Lunch and Learn seminars. Student members have been able to participate in several CE seminars, allowing them to capitalize on the advantages of the FellowTrack organization. Led by USC Ostrow faculty, these seminars introduce alternative approaches while supplementing skillsets taught in the dental school curriculum. Both Lunch and Learn seminars and off campus CE courses over the past year have included the following topics: life after dental school, the basics of dental photography, alternative bone grafting, managing traumatic dental injuries in children, stent guided dental implant placement (and hands-on placement workshop), oral pathology diagnosis, and dental forensics.

**Dental Photography** *by* Dr. Drew Eggebraten

The presentation made by Assistant Professor Dr. Eggebraten inspired and captivated audience members. He shared his knowledge on the basics of photography, and the parameters needed to capture the esthetics of dentistry. He introduced advanced techniques and explained how to utilize the photography equipment available to students on the clinic floor. All participants were given the opportunity to enroll in a hands-on session where they could apply methods learned from the course.

**Stent Guided Implant Placement** *by* Dr. Kamyar Nouri

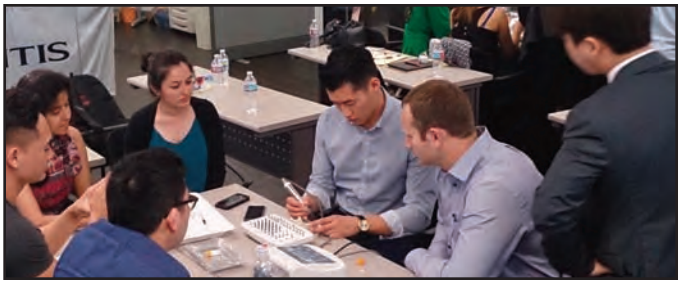
The Spring 2016 term featured our annual two-part Implant Placement seminar and Hands-on Implant Placement course led by Assistant Professor Dr. Nouri. He presented case studies and shared his clinical experiences with using implant placement systems. He explained the importance of stent guided placement, brought a great value to proper surgical preparation, and stressed due diligence with patient care.

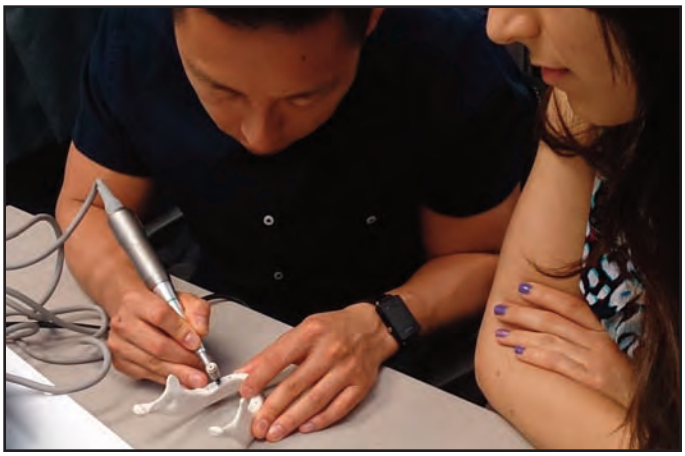
**Introductory Implant Placement** *by* Dr. Stephen Kallaos

The hands-on implant placement course was sponsored by Dentis Implants and was held at the Global Dental Implant Academy in La Palma. Over twenty students participated in the course. Dr. Kallaos explained the fundamentals of biomechanics and bone biology, the rationale of diagnosis and treatment planning, taught a step-by-step implant placement technique, basic implant restorations, and the management of post-surgical complications.

It is important to reflect that the AGD community of USC is led by very willing and capable mentors. Our organization provides a forum where a student is inducted into the "academy." This provides a home where one is embraced as a scholar, a place where their imagination is nurtured. *Our purpose is to cultivate flickers of insight and sparks of inspiration.* ■

**Dennis Sourvanos**, *President, AGD FellowTrack at USC*



*FellowTrack South*

# University of California at Los Angeles

**Allyson Taylor**, *President, UCLA FellowTrack*

ALLYSON TAYLOR
*Moorestown, New Jersey*

This past Spring quarter, the AGD student chapter at UCLA put on a well-received educational and practical "Lunch and Learn" event for fellow students. Dr. Marc Hayashi spoke about "Life After Dental School" to a crowd of interested students over a tasty lunch provided by the UCLA AGD. Dr. Hayashi graduated from the University of Pennsylvania School of Dental Medicine in 2009 and completed general LAC+USC as well as at the practice residencies at Sepulveda Veterans Administration before becoming a full-time faculty member at UCLA. Because of his experiences as a relatively recent graduate, Dr. Hayashi was able to connect with students and provide a vivid picture of what it's like "on the outside" right after you graduate from school. Dr. Hayashi made the presentation very personal and practical, sharing information about his background and the path his career took. He spoke about practicalities not often discussed in the dental school curriculum, such as the need for good disability insurance and the benefits of starting a photo portfolio of your work while in dental school. Another interesting part of his presentation was his discussion of real-life ethical challenges he faced as a young dentist and how he navigated these challenges, counseling students to never compromise on their ethics. Dr. Hayashi effused an enthusiasm that showed students that while dentistry can be a challenging profession, it is ultimately extremely rewarding as well. The Lunch and Learn had an excellent turnout, with over sixty dental students from all four years attending. Students rated the event very highly in their feedback.

Looking toward the Summer quarter, the UCLA AGD is hoping to put on further CE events as well as expand the types of events we host. One idea that we are currently working on is a shadowing experience for FellowTrack members with some of our clinical faculty members in their private practices. We believe an experience like this can be educational for students as well as help students and faculty get to know one another better.


With new events and by continuing our CE lectures, we are hoping to recruit even more students to the UCLA FellowTrack in the upcoming year. ■

## SLEEP APPLIANCE THERAPY *(continued from page 17)*

In many cases, the expectation that you might get *everything* done with a single appliance approach —— or that one size fits all —— is foundational to why we experience a 50% success rate as opposed to a 90% success rate.

The goal, simply stated, is to open the airway and keep it open. Weigh appliance characteristics and patient parameters. Get as close as possible to the appliance —— or combination —— that will work best for your patient.

### *What does the future hold?*

- New designs, new low level oxygen delivery/mechanisms for treating OSA, new forms of combined sleep therapies
- The application of microchips in what I term "patient accountability therapy"—— making sure that our appliances *are actually being used.* Definite game changer.
- Active, early prevention. Most sleep appliances today are essentially band-aids. They manage the problem of OSA but they don't prevent it. We need to address the entire spectrum of causal factors in the range of sleep disorders.

**Last Word:** Confidence in the here and now of sleep appliance therapy is a function of first embracing the fact that selecting the right appliance for your patients is never a case of one size fits all. Match the materials and technological componentry to the existing dental landscape of each individual patient…and then explore the third variable —— the possibility that combined therapy may just be the ideal "fitting" solution. ■

### *About Dr. Veis...*

He began practice in 1984 as a solo general dentist and has been a part of both solo and group practices since then. A graduate of the USC School of Dentistry, he taught for twelve years at the University of Southern California as a Clinical Professor in Restorative Dentistry. He is an internationally-renowned lecturer *(at locations including UNLV, Columbia University, Loma Linda University and NYU)* on the topics of Dental Sleep Medicine, Orthodontics for the General Practice and Appliance Therapy. Dr. Veis has served on the faculty of the Las Vegas Institute of Advanced Dental Studies. He is the co-author of "The Principles of Appliance Therapy for Adults and Children" *(considered one of the definitive texts on the subject).* Dr. Veis has lectured extensively for the Academy of General Dentistry-sponsored mastership program.

FellowTrack North ✳ *Arthur A. Dugoni School of Dentistry*

# University of the Pacific

**McKay Butler**, *AGD FellowTrack Program President*

**McKAY BUTLER**
*Hurricane, Utah*

*We thank the California Academy of General Dentistry for providing the platform for the many ways in which we have been able to learn and grow as students.*

The University of the Pacific Chapter of the Academy of General Dentistry had an amazing and productive year. Our goal was to provide as many opportunities as possible for students to develop themselves both clinically and professionally in areas they would not otherwise learn while in school. Many of these events provided CE credit for the students who are pursuing the AGD FellowTrack Program.

*Presentations were as follows:*

**Immediate Placement and Provisionalization of Implants Using the Natural Tooth**
*Presenter:* Robert Margeas, DDS, FAGD

**Anterior Restorations—Considerations for Creating Great Esthetics**
*Presenter:* Paresh Shah, DMD

**Essential Tools for the Successful Dentist**
*Presenters:* JoAnne Tanner, MBA; Julia Goldman, JD; Guy E. Acheson, DDS, MAGD; Carson Henderson, CPA

**Minimally-Invasive Aesthetic Techniques**
*Presenter:* Michael Miyasaki, DDS

We also incorporated opportunities for the personal development of our students, bringing in well-rounded speakers with a wide range of expertise in the educational and business sides of dentistry.

*Presentations were as follows:*

**Eagleston Financial: Achieving Financial Success**
*Presenter:* John Eagleston, MBA

**Insight into AEGD and GPR Programs: Which Is Right for Me?**
*Presenters:* Jesse Manton, DDS; Laura Steward, DDS

**Second Annual "The Real World: Life after Dugoni"**
*Presenters:* Panel of ten recent "Dugoni" dental graduates ■

FellowTrack North

# University of California at San Francisco

**Ralph Hoffman, DMD, MAGD**, *UCSF FellowTrack Coordinator*

The CAGD FellowTrack program hosted a seminar for the dental students of UCSF and UOP including recent graduates. The presentation was entitled **Essential Tools for the Successful Dentist** and was held at the UCSF Millberry Union. The six-hour course presented relevant and vital information for the practical management of a dental practice. The early session featured practice management, dental accounting and dental law. The speakers were JoAnne Tanner, MBA; Carson Henderson, CPA from Thomas, Wirig, and Doll; and Julia Goldman, Esq., from the Goldman Law Firm. The afternoon featured our own Dr. Guy Acheson, covering clinical photography and included hands-on experience.

The UCSF Student Union provided an excellent meeting site with easy access for all the students in San Francisco. A great lunch was catered by AG Ferrari. In addition to introducing the students and young dentists to a lot of very useful information not covered in the dental school curricula, the program generated eight new student AGD members!

*This full-day course was sponsored by:*
**Patterson Dental ✳ Fremont Bank ✳ Fleming Insurance ✳ The Lending Club**

Both the California AGD and the benefitting students are *very grateful* for their support. ■

# The California AGD Welcomes New Members

*January 1, 2016 thru April 25, 2016*

**Dr. Waseem Alpatty**
*El Cajon*
**Dr. Marichris Ancheta**
*San Diego*
**Dr. Moller Awad**
*Huntington Beach*
**Dr. Reynaldo P. Barbon**
*La Crescenta*
**Dr. Omran Bishbish**
*Redlands*
**Dr. Brett C. Brazeal**
*Corona del Mar*
**Dr. Andrew Castillo**
*Rohnert Park*
**Dr. Elizabeth M. Chavez Matias**
*San Francisco*
**Dr. Nicole Chen**
*Danville*
**Dr. Silverina O. Chua**
*Chino*
**Dr. Megan E. Clarke**
*La Mesa*
**Dr. Ethan T. Do**
*San Francisco*
**Dr. Jennifer I. Dole**
*Novato*
**Dr. Rasha Dubuni**
*Covina*
**Dr. Amr M. Enaya**
*Elk Grove*
**Dr. Arnel T. Eugenio**
*Cerritos*
**Dr. Kevin Fang**
*Arcadia*
**Dr. Shahnaz L. Formoli**
*Sacramento*
**Dr. Crystal Garcia**
*West Covina*
**Dr. Jymie Graham**
*Los Angeles*
**Dr. Swati Gulinai**
*Los Angeles*
**Dr. Gretchen L. Gurion**
*Chino Hills*
**Dr. Mahmoud Hamad**
*East Boca Raton, Florida*
**Dr. Naji F. Hamoui**
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**Dr. Jared Hawthorne**
*Pomona*
**Dr. David B. Hernandez**
*Covina*
**Dr. Kevin W. Ho**
*San Francisco*
**Dr. Mahak Jain**
*Kearney, Nebraska*
**Dr. Laine A. Janzen**
*Claremont*
**Dr. Melanie Jenkins**
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**Dr. Vibha Jhawar**
*Sacramento*
**Dr. Sheri Jones**
*Rancho Cucamonga*
**Dr. Petr Kadera**
*North Highlands*
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**Dr. Juste Karvelyte**
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**Dr. Jonathan Kim**
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*Baldwin Park*
**Dr. Vishal V. Kulkarni**
*Los Angeles*
**Dr. Chang-Fen Wynee Lee**
*San Francisco*
**Dr. Bernadette Leoncio**
*El Monte*
**Dr. Yelizaveta O. Luchkovska**
*San Francisco*
**Dr. Asya G. Marsh**
*(no city listed)*
**Dr. Christina P. Mason**
*Clayton*
**Dr. Nathan R. McDonald**
*Upland*
**Dr. Naimatul M. Mirza**
*Chino*
**Dr. Raees Mohammed**
*San Carlos*
**Dr. Jose E. Molina**
*Visalia*
**Dr. Maria Naanaa**
*San Francisco*
**Dr. Raman E. Nazari**
*San Jose*
**Dr. Kelly E. Nelson**
*Bellevue, Washington*
**Dr. Austin R. Owen**
*Loma Linda*
**Dr. Akshaya Pallod**
*San Francisco*
**Dr. Tatyana Pihur**
*San Francisco*
**Dr. Srijana Pokhrel**
*San Mateo*
**Dr. Kyle D. Poulsen**
*Loma Linda*
**Dr. Ian N. Prins**
*Concord*
**Dr. Tyler J. Quinn**
*San Diego*
**Dr. Lina Raffo**
*Upland*
**Dr. Mina Raffo**
*El Cajon*
**Dr. Meenu P. Rai**
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**Dr. Alexander Reimann**
*San Bernardino*
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*Newport Beach*
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**The AGD is for general dentists.**
**It empowers your voice and celebrates continuing education.**

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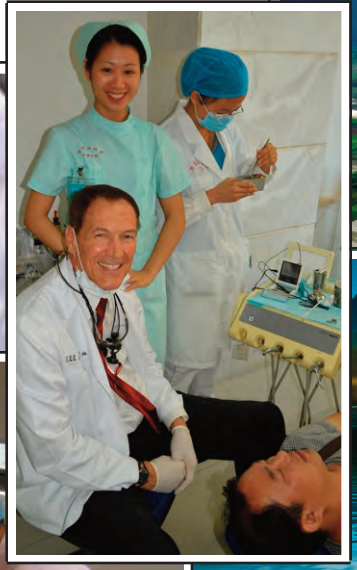
**"PEARLS AND BULLETS"** FEATURING A CLINICIAN'S PERSPECTIVE ON

# *Fixed Prosthetics ◆ Guided Bone Regeneration ◆ Success in Dentistry*

## *as well as a* Humanitarian Trip *to* Guilin, China

◆ **Dr. Bruce Bosler** ◆ **Dr. Michael Lew**

◆ **October 14th-25th, 2016**




◆ *Four and one-half days in the new dental clinic at the Guilin School of Stomatology; three days in the Zhangjiajie National Forest in Hunan Province*

◆ *Three one-hour lectures will be given on three separate days after clinic participation at the dental school (3 CE units).*

◆ *Participants will be introduced to indications and strategies for altering the alveolar environment for improved periodontal and implant success*

◆ *Tips for facilitating easier crown and bridge procedures*

◆ *Five strategies to become a successful dentist*

◆ *The Guilin School of Stomatology, located in Guilin, welcomes participants to use the clinic to treat the indigent farmers, disabled children and students from the area. They also invite us to lecture to staff for an hour after each day in the clinic. The clinic staff and dental students bend over backwards to help make our mission productive and enjoyable.*

◆ *The city of Guilin is in southern China and is known for its dramatic sceneries. The vertical Karst Mountains grow right in the middle of the city. You will experience some of the most beautiful and memorable sights you can imagine bike riding in the countryside and floating down the Yulong River on bamboo rafts.*

◆ *The cost of $2660 covers airfare, transfers, hotel, breakfast, two banquets and sightseeing*

◆ *Contact the organizer, Dr. Bruce Bosler, if you are interested in joining this wonderful opportunity at* **boslerdds@msn.com**

*Dr. Bosler received his DDS from Case Western Reserve Dental School. He received his Masters from the Academy of General Dentistry after completing the CAGD MasterTrack Program in 2014. He practices in Vacaville, California.*

Academy of General Dentistry™

PACE Program Approval for Continuing Education

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*Dr. Lew received his DMD from the School of Dental Medicine at the University of Pennsylvania. He received his Masters from the Academy of General Dentistry after completing the CAGD MasterTrack program in 2007. He practices in Vacaville, California.*

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*The broader the base of our membership, the more effective is our representation on your behalf.*