



Newsletter of the Louisiana Academy of General Dentistry

Summer 2008

ORLANDO—AGD ANNUAL MEETING 2008



The Louisiana AGD was very excited about the National Academy of General Dentistry Annual Meeting in Orlando, Florida. The meeting was held July 16-20, 2008 at the Walt Disney World Dolphin Resort.

There were two keynote speakers that inspired and entertained us at the meeting. Thursday morning Captain Lovell, a NASA astronaut, intrigued the audience with his story of courage and leadership when he recounted

his experience commanding the almost doomed Apollo 13 spacecraft back down to earth from a perilous flight. The importance of working as a team and taking charge of a situation were stressed by Captain Lovell. His audience enthusiastically appreciated the efforts of this true American hero!

The second keynote speaker was Lou Holtz who, of course, was a football coach at Notre Dame, South Carolina, and is presently a sports commentator for ESPN. He spoke to the group on Saturday morning. Lou Holtz is an excellent speaker who excited us with his characteristic leadership skills and motivation qualities we all need in running a Dental practice.

Both men were gracious enough to hold book signings after their speeches. The AGD is very grateful to have these two men give their time and efforts to help us reach our goals.

Delegates in the Governance Session from the Louisiana AGD were Drs. John Portwood, DDS MAGD, Kay Jordan, DDS FAGD, and Tony Guilbeau, DDS MAGD. The delegates in this Session make and/or refine the rules and regulations for the AGD. This ensures our AGD maintains itself as one of the premier groups of organized Dentistry. It is also the only group to represent the interest of General Dentists exclusively.

Saving the best for last, I have great news! Your Louisiana AGD has won national recognition for its efforts in providing your continuing education courses. We won the prestigious "Award of Excellence in Continuing Education" in our category. This means we have been providing the best CE courses to you consistently in the past year. So, when you attend one of our courses in the future, you can be assured you are getting the best CE available. We appreciate the hard work of our Executive Director, Brenda Descant, and the LAGD Board!

It is also worth mentioning that our friends in Arkansas AGD won the "Constituent of the Year Award" in their category. We are proud of them as well, because this award depicts excellence in the many facets of the organization such as CE courses, membership, and advocacy. Congratulations Arkansas AGD!

The Pollicow's Patch

UPCOMING SEMINARS

October 10, 2008

"Core Concepts: Rotary Endodontics"

Speaker: Dr. William Henson

Place: Lafayette, La.

December 5, 2008

"Anterior Case Planning"

Speakers: Drs. Chiche,

Ratcliff and Brady

Place: New Orleans, La.

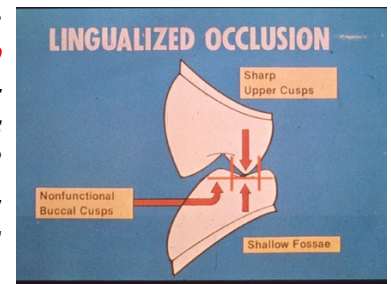


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Lingualized Occlusion

If I had to choose the one thing that's had the greatest effect on the success of the dentures and partial dentures I construct for my patients, it would be lingualized occlusion. From a functional standpoint, it goes without saying, that the occlusion you provide to a patient will always have the most profound effect on the success or failure of any prosthesis. If the occlusion is simple to arrange, simple to adjust and esthetically pleasing, what more could you ask for?

Just what is lingualized occlusion? In its simplest form, a sharp upper lingual cusp functions in a shallow fossa of a lower tooth. ***There is no function between the buccal cusps of either tooth.*** A longer and sharper lingual cusp produces better function. The open fossa of the lower tooth has wall inclinations of 10 to 12 degrees. The lingual cusp functions in an area 2 to 3 millimeters in diameter around the centric stop. Lingualizing the occlusion over the crest of the lower ridge seats both upper and lower prostheses and reduces tipping forces during function.



Lingualized occlusion can have a very natural look, particularly since my maxillary teeth of choice are Trubyte Bioform 33° porcelain posteriors. These teeth have the longest and sharpest lingual cusp of commonly available teeth on the market.

The mandibular teeth I use are Trubyte Bioform 20° porcelain posteriors. The occlusal surfaces are ground out to produce a shallow, open fossa of approximately 10 to 12 degrees. This allows the upper lingual cusp to function in an area 2 to 3 millimeters around the centric stop. ***There is no function between the buccal cusps of either tooth.***

You say you don't use porcelain teeth? That's okay, because the Trubyte Bioform teeth are available in an IPN material and there are a number of other manufacturers that produce teeth for lingualized occlusion set-ups. Ivoclar/Vivadent has the Ortholingual DCL and Vita has its new Lingiform Posterior, to name two. As with the Bioform teeth, I find that even these specially designed lingualized teeth have too much anatomy and cusp form on the lower posterior occlusal surfaces. The central fossae will need to be adjusted to produce a shallow, open and more functional occlusion as demonstrated in the following two pictures.

This laboratory view from the lingual side of an upper and lower set-up demonstrates how the upper lingual cusps are seated in the shallow open fossae of the lower teeth.





In this view, the surfaces of the first bicuspid have been reshaped to open their fossae and to reduce occlusal anatomy. The second bicuspid has yet to be reshaped.

In case you haven't noticed, all adjustments are done to the lower teeth only.



What does the laboratory do to set your case up in lingualized occlusion?

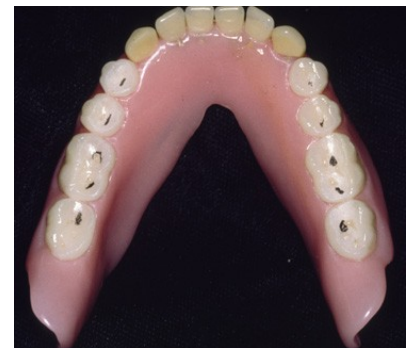
The maxillary posterior teeth are arranged with their lingual cusps on the occlusal plane.....with the exception of the disto-lingual cusp of the first molar and the lingual cusp of the second molar. These are raised off the plane to create a compensating curve. The necks of the teeth are canted inward slightly to likewise raise the buccal cusps off of the plane.



The lower posterior teeth are reshaped to create shallow, open fossae and to provide a centric stop for each of the five upper lingual cusps. Any lateral interferences between the buccal cusps are removed by reducing and reshaping the buccal cusps of the lower teeth.

What needs to be accomplished chair side?

At delivery, your job is to make sure that the five upper lingual cusps contact the lower posterior teeth somewhere along the central groove.....not always dead center.....variations anteriorly or posteriorly will occur depending on the patient's occlusal classification. *Adjust only the lower teeth.*



What about function?

Again, *adjust only the lower teeth.* Forget about BULL and those other rules for working and non-working function. Cover the lower posterior teeth with Kerr Occlusal Indicator Wax and have the patient chew several pieces of canned peach, or banana or seedless grapes. Remove any contacts outside of an area 2 to 3 millimeters around the centric stop and you're done.



Lingualized occlusion....simple and functional....what more could you ask for? *Maginnis the Dentist*

If you have any questions concerning Removable Prosthodontics or suggestions for future articles, send them to Dr. Scott Kogler at skogler@catel.net.



Dr. David Finley graduated from the Louisiana State University School of Dentistry in 1985 and promptly moved back to his hometown of Monroe, Louisiana to practice dentistry. Dr. Finley has maintained a private general dental practice in Monroe for 23 years with an emphasis on cosmetic smile creation and implant restoration. He has been an Academy of General Dentistry member since 1990. He joined the American Academy of Cosmetic Dentistry in 2000, passed the accreditation written exam in 2002, and achieved accreditation in 2005. He is also a Fellow of the International Academy of Dento-Facial Esthetics. Dr. Finley has completed advanced cosmetic continuums at LSU and LVI. He is married to a wonderful wife, Valerie, and they have five children ages 17 to 6. Dr. Finley enjoys coaching youth athletes baseball and football and guiding his children as they embark on their own journeys in life.

Tissue Management for Pontic Sites: An Often Overlooked Essential to Successful Tooth Replacement

Introduction

The replacement of a single missing front tooth is one of the most difficult esthetic dental procedures to perform successfully. It is difficult for most dental practitioners to achieve an excellent result with this type of procedure because we often overlook the soft tissue and its relationship with the teeth in our quest to replace the missing tooth. We must look at the whole picture, not just the replacement tooth. It is difficult to create a pleasing esthetic result if you ignore the soft tissues and the emergence profile from the tissue that nature intended a tooth to have.¹

History

The patient is a 24 year old cosmetology student with a history of orthodontics and a congenitally missing right maxillary lateral incisor replaced with a metal wing Maryland bridge. She was disappointed in the final result of the Maryland bridge which had a very low value compared to her natural teeth. The large metal wings were noticeable at the incisal edges of the abutment teeth. The pontic was short and appeared to hover over the gums with no real emergence profile. There was no root eminence apical to the pontic which exaggerated the falseness of the pontic.



Treatment Plan

Pretreatment records included complete medical and dental history, preoperative radiographs, 35 millimeter preoperative slide and print photographs, dental examination, periodontal probing and mounted diagnostic models. The treatment plan would involve a subethelial connective tissue pocket graft to augment the root eminence of tooth #7 and the fabrication of a "Eubank" bridge to replace the existing unesthetic Maryland bridge. A diagnostic wax up was done of the proposed ideal end result of tooth size, tooth shape, emergence profile and gingival contours. The wax up model was duplicated in stone and vacuform stents were fabricated. One stent would be used to create the temporary bridge and one stent was used as a guide when augmenting the facial of the pontic site.

Preparation

The patient was anesthetized with Xylocaine 2% with epinephrine 1:100,000. The old Maryland bridge was removed by sectioning the pontic from each wing with a carbide bur. Then each wing was removed by carefully sectioning each wing with a small carbide bur. Air abrasion was used to clean the lingual enamel of each abutment tooth. The split thickness pocket incision was made from the incisal at the pontic site undermining the tissue to create a pocket on the facial of the ridge in the location of the missing root eminence. A 10 millimeter long, 6 millimeter wide and 2 millimeter thick graft was harvested from the left palate. This graft was tucked into the pocket incision from the incisal and positioned within the pocket to replicate the root of a tooth and create a root eminence.² The graft was tacked in place with 5-0 gut sutures and primary closure was achieved with 5-0 gut sutures.





The donor site flap was tacked back in place with surgical glue.² The abutment teeth were prepared using the cingulum box and slot technique for retainers as taught by Dr. Jimmy Eubank. Once temporized, the patient was re-scheduled for 4 weeks later for final impressions.

Impression Appointment

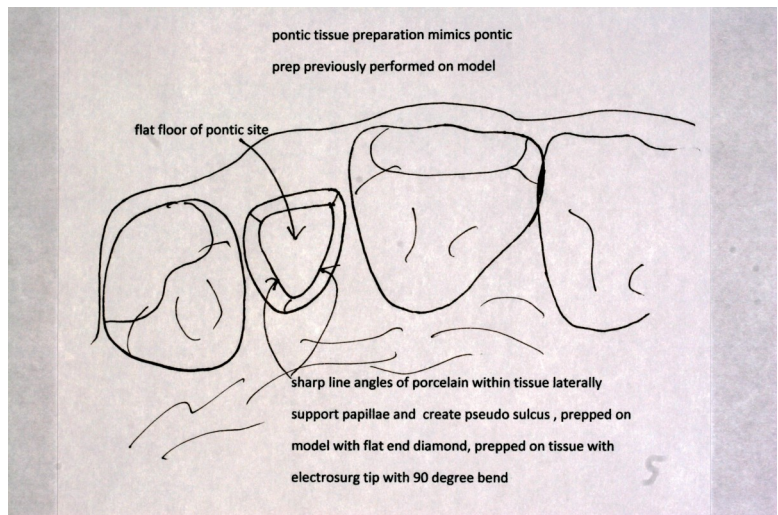
The patient was seen for impressions four weeks after the connective tissue graft was placed. The patient was anesthetized with 2% Xylocaine with epinephrine 1:100,000. The temporary bridge was removed and preps were cleaned with air abrasion to remove any residual flowable composite. Polyvinyl impressions were taken and the temporary bridge was recemented in place with flowable composite. The patient was scheduled for three weeks later to deliver the bridge. The impressions were poured in die stone. After the models are separated from the impressions, it is necessary to prep the pontic site on the stone model. This gives the laboratory an exact dimension of the tissue surface desired of the pontic tissue surface. The pontic site on the model is prepped with a flat end diamond bur to create a depression 2 millimeters deep into the stone. This depression's dimensions mimic that of the cross section of the root of the tooth being replaced. In addition, the depression has sharp internal line angles. This allows the laboratory to create a pontic with a flat tissue surface that has sharp line angles that support lateral papillae and facial and lingual gingiva.¹

Bridge Delivery and Pontic Tissue Preparation

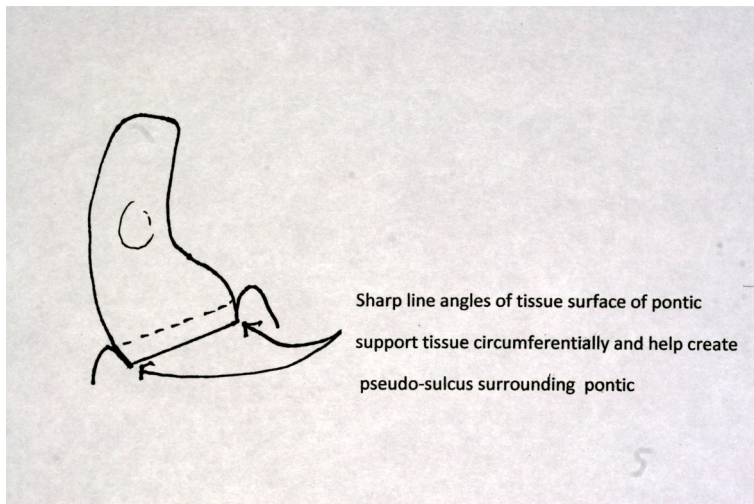


The patient was anesthetized and the temporary bridge was removed. Air abrasion was used to clean the box and slot preparations. A dry

erase marker was painted onto the gingival surface of the pontic and the bridge was tried in. The dry erase markings were transferred to the tissue of the pontic site. An electrosurgical tip bent at a 90 degree angle 2 millimeters from the tip was then used to sculpt away tissue marked by the marker. This was repeated until minimal tissue blanching was noted and the bridge retainers were fully seated in their preparations. This tissue removal mimics the pontic site that was previously created on the stone model.



Care must be taken to leave adequate tissue facial to the pontic site to create a probable sulcus and mesial and distal to create papillae. This facial tissue and papillae are then supported by the sharp line angles of the tissue surface of the pontic. The bridge was then cemented with a highly filled luting agent.





Follow-up Appointment



At the follow-up appointment, the gingival tissues were in excellent health. The emergence profile of the pontic resembled that of a natural tooth. There was a sulcus of greater than 1 millimeter in depth on the facial of the pontic. The mesial and distal papillae were well supported and exhibited no inflammation. The patient was extremely pleased with the natural look of her final restoration.



3 weeks post op



3 weeks post op



1 year post op
Tissue continues to
look extremely
healthy and natural

Summary

Lack of adequate tissue creates many esthetic failures in our attempts to replace missing anterior teeth. In many cases, when an anterior tooth has been missing for many years, it may be necessary to augment tissue in some fashion to achieve a better esthetic result. In this case, it was necessary to place a subepithelial connective tissue graft to replicate the root of the missing tooth. This helped create the natural and proper emergence profile that dramatically improved the end result.

References

1. Eubank, Jimmy; Morley, Jeff; et al: The Louisiana Academy of Continuing Dental Education. Louisiana State University School of Dentistry, Cosmetic Dental Continuum, Level 1, Sept.—Dec. 2001, Level II, June—July 2002.
2. Sato, Naoshi: Periodontal Surgery, A Clinical Atlas. Quintessence Publishing.



TWO GREAT DENTIST GO TO WASHINGTON DC

March 10-11, 2008 Drs. Scott Kogler and Tony Guilbeau traveled to Washington DC as part of an Academy of General Dentistry advocacy group. As part of the effort, Drs. Kogler and Guilbeau attended a class on day one to learn what advocacy is all about. They participated in simulated meetings with congressional members to be better able to handle any questions or concerns that could be thrown at them. On the second day, Dr. Kogler, his wife Melissa, and Dr. Guilbeau were taken by motor coach to the Capitol area. A photo was taken in front of the Capitol Building before breakfast in the Rayburn Office Building. Then their work began. They met with the staff members of Representative Charles Boustany, Senator Mary Landrieu, and Senator David Vitter. Although the group did not actually meet with the Congressmen/woman, their staff was very cordial and welcomed the group's ideas. The AGD was advocating various bills which help the underprivileged in our country. The AGD will be watching to see if these bills become law in the future.



Did You Know?

The Hindus in India were the first people to use a toothbrush around 4000 BC. They used the end of a fresh twig that had been frayed to brush their teeth.



Janet Steward Asks “Who’s Your Daddy?”

At the end of February, the Louisiana AGD had the pleasure of hosting Janet Steward who presented information on Practice Management. The meeting was held at the Marriott hotel on February 29, 2008. Mrs. Steward originally hails from South Africa and now makes her home in Colorado. She has consulted with numerous Dental practices in the country, including several in the Baton Rouge area. She has also co-authored the book

What do Dentist Really Want

with her husband Lawrence Steward, MBA. Mrs. Steward’s main focus was on “Style Analysis”, which determines what type of personality you and your team members have. Once this is determined, she expounds on the compatibility of each personality type.

In a dental practice, the dental team should work in harmony with each other. Finding out what personality type fits a team member has shown to be crucial in determining if this member will be compatible with the doctor and the other team members. If conflicts arise on an ongoing basis, it could be due to a clash of personality types. A change in the make-up of your staff may be necessary to regain the harmony and stability you once enjoyed. All in all, it was a fun course for our 40 meeting participants.

Our next meeting will be in Lafayette on Friday, October 10, 2008 at the Hampton Inn and Suites, so mark your calendars and log onto lagd.org for updates.



**Robert Melton, DDS MAGD is
Region 12’s First LLSR Recipient**

We are especially proud of Bob Melton, DDS MAGD here in Region 12 (AK, KS, LA, OK, and MS) who has been awarded the prestigious Lifelong Learning and Service Recognition Award. The LLSR Award can be earned only after a Mastership in the AGD is obtained and an additional 500 hours of credits is earned, including a combination of requirements. The requirements include certain CE courses, teaching and/or publication credit, volunteer service, and service to

organized Dentistry.

Dr. Melton practices in Oklahoma with 3 other General Dentists. Being the modest person he is, he told me he accidently discovered he had obtained the requirements necessary for the LLSR award. In addition to his dedication to organized Dentistry by being actively involved in the AGD, Dr. Melton has taken part in many volunteer mission trips, both domestically and internationally. He and his wife have traveled to Paraguay, Belize, Africa, and other far away places to provide care to the less fortunate.

Since he is our region 12’s first recipient, a special ceremony was held at our AGD meeting in Orlando, FL to present Dr. Melton with the LLSR award. Dr. Vinny Mayher, our national AGD President, personally came to our regional caucus to present him with the award. It couldn’t have gone to a nicer person!

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