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**First Quarter 2014    Issue No. 30**

In The Know is published four times a year by National Distribution & Contracting, Inc.
Practice culture affects a team’s ability to be passionate about dentistry and be motivational with patients. The right team, when excited about a practice’s vision, has endless potential.

Synergy creates a productive, fun environment, and patients respond by accepting necessary and elective treatment. Clarity is the first step toward a successful practice culture. The thriving practices we work with have leaders who are clear about their values and vision for their practices and communicate this consistently to their teams.

Team members who are on the same page and enthusiastic about the services and products their practice offers are more effective at patient education. As they see the positive results from patients’ experiences with recommended services and products, they gain confidence to further promote and support the doctor’s advice regarding products or services.

If one of a practice’s values is to create an environment in which patients ask for a beautiful smile, promoting the benefits of teeth whitening is a part of that culture. Try the following four simple tips to highlight the significance of a beautiful smile and promote whitening services and products in your practice:

**Tip 1:** Use smile quotations, poems, and statistics about the importance of smiles in your practice and as part of patient giveaways. Put them on statements, use them as screen savers, or have them run as part of a digital photo frame picture sequence in your operatory.

Life is like a mirror; we get the best results when we smile at it. 63% of people say they look best in photos when they show their teeth.

**Tip 2:** Office décor that is supportive of health, longevity, a beautiful smile, and a quality life subtly reinforces the message that a beautiful smile matters. Hang photos of fabulous smiles and families enjoying a healthy lifestyle in the reception area, the patient bathroom, and the operatory.
**Tip 3:** Inspire your patients to consider whitening with two easy steps:

1. As part of the cosmetic evaluation portion of the new patient experience, record a shade to have as a baseline. Use this evaluation to introduce the benefits of tooth whitening and the results you see in patients who have chosen this treatment.

   Have shade guides in each operatory. Match the shade as closely as possible. Record the shade in a designated spot in your patient chart system. Take an intraoral camera photo of the patient’s smile with the shade guide. Show the patient where he or she falls on the shade spectrum. Educate the patient about changing tooth color due to nutrition and aging.

2. Annually, record his or her shade and compare to the baseline. To encourage the desire to whiten, discuss the shade and any changes with the patient.

**Tip 4:** Create tasteful displays of whitening products on shelves in the operatory, on retail display shelves in the reception area, and at the checkout counter. Present-type packaging is attractive and complete, easy to purchase, and no work for the gift giver. Use social media such as Facebook to promote gift certificates for teeth whitening. You might say something such as, “Teeth whitening is a great gift for a new grad.” Include a picture of the beautifully wrapped package. Get started now by brainstorming the benefits of teeth whitening at a team meeting. Discuss your personal philosophy on whitening and the services and products your practice offers. Review the tips presented in this article with your team.

What could you do in your practice to illustrate the importance of a beautiful smile? Bring in a sales rep to ensure the team is educated about the products and services you provide. Make sure your entire team has personally experienced the benefits of whitening, especially the doctor. When time, money, and energy are spent on developing team members, they gain an understanding of the life-changing benefits dentistry can offer. When a team embraces its practice culture, productivity and profitability will soar.

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Jody Catalanello and Linda Valencia are co-owners of Mosaic Management Group, which provides coaching and consulting to dental practices. They are also founding partners of International Institute for HealthCare Businesses, a company dedicated to educating practice leaders about the fundamental impact the proper organizational culture has on a team and its patients.

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Original print date Oct 2013, Volume 103, Issue 8
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Management of the
INCISAL EDGE

The key to functional and esthetic success in anterior restorations

Leonard A. Hess, DDS

A ccording to Peter Dawson, DDS, founder of The Dawson Academy, “Determination of precisely correct incisal edges is the second most important decision a dentist must make regarding occlusion (centric relation is the first in importance).” The position of the incisal edges influences the esthetics of a patient’s smile, phonetic comfort, lip comfort, envelope of function, anterior guidance, posterior disclusion, and tooth contour. Therefore, it is critical to understand the rational for prosthodontic incisal edge placement.

An excellent example of this rationale is the functional esthetic matrix as described by Dr. Dawson (Figure 1). The matrix is composed of the following six factors:

1. **Lingual Centric Stop** – This is an ideal holding contact contoured for the anterior teeth with the mandible in centric relation.

2. **Gingival Half of the Labial Surface** – This tooth surface continues as an extension of the alveolar process, thus allowing a smooth and unaltered emergence profile.

3. **Horizontal Position of the Incisal Edge** – Minor variations in this position can greatly affect patient comfort and tooth stability. A slight change in the horizontal position can change the perceived length of the incisors (Figure 2).

4. **Vertical Incisal Position** – The terminal position of the incisal plane is determined by combining the horizontal with the vertical position.

5. **Lingual Contour** – This contour establishes the anterior guidance, which must be in harmony with the envelope of function. This area starts with the centric relation contact point and ends with the incisal edge position, and is the starting and ending point of the functional envelope.

6. **Cingulum Contour** – This area from the gingiva to the centric stop should be smooth and care should be taken not to overcontour.

**Planning for Functional Success**

Managing complicated restorative situations can often be overwhelming. When a complex situation arises, it is often helpful to divide the problems of the case into manageable components. Predictable success is usually the product of a consistent methodology in the diagnosis and planning.
stages. It also allows patient and dentist participation in the exploratory process and will aid in both parties commitment to the outcome.

Data collected before prosthodontic restoration should include a complete medical and mental history, preoperative photographs, necessary radiographs, periodontal examination, diagnostic impressions, face-bow record, bite registration in centric relation and maximum intercuspation, and a complete maxillofacial exam with emphasis on the temporomandibular joint (TMJ) condition. Although the topic is beyond the scope of this article, the restorative philosophy of this author is based upon working in centric relation. When cases involve anterior reconstruction, often problems have arisen due to some form of instability in the patient’s occlusion. Therefore, effort is put forth to determine the health of the joints and to begin the restorative phase with the joints in centric relation. If stability is to be regained through the proposed treatment, stability must also be evident in the joints to allow long-term success.

Emphasis must be placed on pretreatment photographs obtained in the planning stages. This author uses at 21-photo series on most patients. With regards to the incisal edge position, five photographic shots are critical to the process: 1:3 full smile, 1:3 rest position, 1:3 “e” position, 1:3 full smile tip down, and 1:3 lateral 90° smile.

**Factors Related to Position of the Incisal Edges**

**Anterior Envelope of Function and Anterior Guidance**

The envelope of function determines the incisal edge position that then dictates the anterior guidance. The combination of the lingual contours and the position and inclination of the maxillary anterior teeth influence whether the relationship of the anterior guidance and envelope of function is harmonious. Improper positioning of the incisal edges can allow proper anterior guidance yet still interfere with the envelope of function.

**Neutral Zone**

The neutral zone is the perioral complex composed of the soft tissues and muscles surrounding the mouth and the opposite pressure exerted by the tongue. Prosthodontic errors that violate the neutral zone can be very uncomfortable for a patient and start a chain reaction of compensations. Lip closure paths and muscle-induced function against the teeth must be considered.

**Phonetics**

The interaction of the lower lip against the incisal edges is critical for many proper speech sounds. Misplacement of the incisal edge can create speech difficulties and minor impediments.

**Determining the Length of the Incisors**

**Vertical Incisal Edge Position**

The maxillary incisors are often the starting point for smile rehabilitation. Diagnostic planning of this aspect should be precise, as it influences symmetry, proportion, and functional parameters of the adjacent anterior teeth. The final restored length will be influenced by a variety of individual factors. These include the lower lip position during smiling, the lip positions at rest, the lip positions in repose, upper lip characteristics, soft tissue characteristics, the envelope of function, and facial proportion.

Depending on the preparation style or restorative product used, the length will set the foundation for the width-to-length ratio. An accepted ratio for width to length is approximately 80%. This also lays the foundation for establishment of the anterior golden proportion. Ideally, the width of the lateral incisor would be assigned a value of 1.0, the canine a value of 0.6, and central incisor a value of 1.6. This is an apparent measurement and should only be relied upon when viewing from the direct anterior. The canine’s value of 0.6 from the anterior is dictated from the facial line angles and height of contour. When viewed laterally, the canine would have a value much greater than 0.6.

Determining the correct length can be very difficult in patients who present with a worn dentition. The length can only be estimated from known references and collected data. The patient must then test the result during the provisional phase. Studies of crown length have shown that unworn central incisors average 11.69 mm in length and worn centrals average 10.67 mm in length.

The rest position is accomplished by having patients close their lips with relaxed facial muscles, and then slightly open their lips as if to breathe through their mouth. In this position, Vig and Brundo determined that men and women show average of 1.91 and 3.4 mm of central incisor, respectively. These amounts will decrease with advancing age as the soft tissues are more affected by gravity.

The “e” position is a repose position created by the lips and musculature when having the patient say the long “e” sound. It is similar to a smile position, but simulates the position of the soft tissue in a more functioning position. Ideally, the incisal edge of the central incisor will fall between 50% and 70% of the distance between the upper and lower lip.

This author has found that a good starting point for the central incisor length is 10.5 to 11.0 mm. The “e” and rest positions are then used to determine the approximate vertical position to place the incisal edge. In many cases involving tooth wear, the patient will want longer looking teeth. Simply adding length to the incisal to achieve 10.5 to 11.0 mm will often result in encroachment on the envelope of function and the neutral zone.

To create predictable success, the laboratory and ceramist must also be a vital part of the process.
Phonetically, the position of the incisal edge is important when considering the lower lip. The lower lip must interact with the incisal edge in a natural, effortless fashion. This is evident during the pronunciation of words beginning in the letters “v” and “f.” The incisal edge contact should occur in the moist or inner vermillion border of the lip and not the cutaneous or dry portion. This error can often be seen in restorations that are too long incisally.11

**Horizontal Position of the Incisal Edge**

Establishing the proper horizontal incisal edge position may be one of the most important yet most commonly overlooked factors in anterior reconstruction. This position must accommodate the patient’s envelope of function and neutral zone. A position too far to the facial can lead to interference as the lower lip closes to seal against the upper lip. A facialization error can also affect the function of the upper lip, causing the lip to “work around” the incisal edge. Many times the patient will complain of muscle fatigue and “a not quite right feeling” during function.

A lingualization error of the incisal edge can lead to an antero-posterior constriction in the patient’s envelope of function. This would occur as the edges interfere with the lower incisors’ arc of closure.4,12 Similarity exists between the horizontal and vertical incisal edge positions in terms of phonetic issues. A horizontal discrepancy can also interfere with the production of “f” and “v” sounds.

In addition, the horizontal edge position must accommodate production of “s” sounds. These are created by squeezing air between the upper and lower incisors. Difficulty in creating this sound can be very frustrating for the patient.1,13 This author has found it to be a more common error with the edge position to the facial, and is usually caused by the preparation design error of failing to reduce anterior teeth in three planes. When the middle and incisal thirds are under-reduced, the lab technician has no choice but to fabricate an overcontoured restoration. Reduction stents can be produced from the diagnostic wax-up to aid in proper reduction depths.

**Communicating with the Dental Ceramist**

To create predictable success, the laboratory and ceramist must also be a vital part of the process. The technician needs to have a working mastery of functional smile design. Only then can the doctor and technician communicate effectively.

The position of the incisal edges influences the esthetics of a patient’s smile, phonetic comfort, lip comfort, envelope of function, anterior guidance, posterior discision, and tooth contour.

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allows a 3D transfer of the maxilla (this includes the incisal edges) and TMJ to the articulator. The face-bow also allows recording of the condylar axis of rotation. This is absolutely necessary when using an open bite record such as in centric relation.¹

**INCISAL EDGE POSITION ERRORS**

**Facial Position**
As previously mentioned, when the incisal edge is restored too far to the facial, the patient may complain of teeth feeling too long, dry, or in the way of the upper lip. The lower lip may feel overworked or that it must overextend forward to meet the incisal edge when articulating “f” and “v” sounds. Evidence may be found in these cases that the edges are interacting with the dry or cutaneous portion of the lower lip. In addition, the patient may have trouble producing “s” sounds as the mandible strains to get close to the malpositioned incisal edges. In short, this author has found that a facial error produces complaints mostly regarding patients’ feel and phonetic function.

**Lingual Position**
Errors of lingual position will often be evident from problems associated with restoration failure. With these errors, the edges will hit first in the patient’s arc of closure. Chipping of porcelain and debonding of the restorations are commonly seen in these cases. Problems with provisional restorations breaking or coming off can be an early warning sign that contour changes are needed. Issues with provisionals should not be viewed as an aggravation, but rather as a chance to refine positions and correct problems before they become set in porcelain. Be cautious when patients complain of feeling their teeth hitting wrong even when it only occasionally happens. The patient’s lower lip may also be overworking to the lingual to interact with the lingualized edges. Difficulty may also be encountered during pronunciation of “s” sounds because teeth nip each other in this malposition.

Properly contoured and patient tested provisional restorations are the only way to test the correctness of the incisal edge position. Patients often try to rush the process and want to limit the time in provisionals. Proper patient education and production of high quality temporaries will ease this process and provide the necessary information.

**Case 1**
A patient presented with advanced breakdown of her anterior teeth (Figure 3). She had posterior centric relation interference, resulting in advanced lingual wear of the maxillary anterior teeth and incisal edges of the mandibular teeth. In addition, a nocturnal bruxing habit caused advanced maxillary incisal edge wear. With so much instability present, it was critical to place the incisal edges in an esthetic and functionally correct position. The patient’s rest position photo (Figure 4) showed...
zero tooth display. The “e” position photo (Figure 5) revealed the incisors to be at a 45% position. Both photos confirmed the loss of tooth structure to wear and showed that 1.0 to 1.5 mm of length could be added vertically at the incisal edge. The tip down photo (Figure 6) and the 90° photo (Figure 7) both show the horizontal edge position to be acceptable (a trajectory of the edge towards the inner border of the lower lip).

The treatment for this patient included equilibration of the occlusion to eliminate the centric relation to maximum intercuspation slide. Treatment included recontouring and creating incisal edge composite restorations for the mandibular incisal edges; lithium disilicate crowns were prepared for teeth No. 6 through No. 11. Based on the four functional photos, 1.5 mm of length was added vertically in the current horizontal plane of the maxillary incisors. These incisal changes were tested and confirmed in the provisional restorations, and then transferred to the definitive restorations. The postoperative result and functional photos are seen in Figure 8 through Figure 11.

**Case 2**

A patient who lost tooth No. 10 due to localized severe periodontal disease presented to the dental office (Figure 12). Once periodontal treatment was completed, the patient desired to have tooth No. 10 replaced with an implant and also considered cosmetic improvement to her remaining maxillary anterior teeth.

The patient’s rest position photo (Figure 13) revealed excessive tooth display of 4.5 mm. The “e” position photo (Figure 14) showed the incisors at the 75% position. Both photos confirmed that shortening the maxillary anterior teeth would make the centrals less dominant and allow better proportion and a more balanced smile. Both the tip down and 90° photos (Figure 15) confirmed that the incisal edges were too far to the facial. Excessive length and a facial bias resulted in the maxillary incisors functioning against the cutaneous portion of the lower lip.

The patient was equilibrated to eliminate a centric relation/maximum intercuspation slide, and teeth No. 6 through No. 11 were restored with lithium disilicate crowns and veneers. The definite treatment shortened the maxillary centrals by 1.2 mm and lingualized the incisal edges. Better symmetry and proportion resulted in an enhanced looking smile. This eliminated what the patient described as her “Bugs Bunny” teeth. The postoperative results and functional photos are seen in Figure 16 through Figure 20.

**Conclusion**

Patients often present with esthetic issues that occur as a result of functional deficiencies. Restoring the incisal edge into a correct position will not only create a better looking smile, but a functional smile as well. Thinking
about the 3D matrix of anterior teeth will allow restorations in the functional zone to be predictable for the patient and the dentist. ~ITK

References

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- See more at: http://www.dentalaegis.com/id/2013/10/management-incisal-edge#sthash.C1u03rxJ.dpuf


Think of it as “Dental Doppler”
Early caries detection means less excavation.
QUESTION:
What do you advise if a patient of record refuses to fill out a medical history form? We had one yesterday who said, “I’m not filling that out.” I noted it in the chart and told the patient that I documented the refusal in the chart.

ANSWER FROM JAN KELLER
Jan Keller & Associates, consultantontheego.com
This is one where the doctor needs to make a decision – can he treat someone without knowing their medical history?

Considerations:

• Does the patient understand the importance and link between their medical health and dental health?

• Did you offer to work in “private” with the patient to complete the form and have them sign it?

As health-care providers, we need to understand why patients might refuse to sign a form. For instance, is it because they have trouble seeing? Reading? Comprehending? Are they afraid to make a mistake? Are they unable to write or spell, which could be a source of embarrassment to them?

Having a child who is dyslexic, I know it can cause stress when having to complete a form, especially if they feel they will be judged on their spelling and writing. Also, my mother has macular degeneration, and completing forms is impossible for her. For years I have attended appointments with my parents to assist them in completing forms and signing on the correct line.

On a related note, this is an opportune time to discuss the link between medical and dental health, and an opportunity to educate patients about its importance. As you know, patients do not feel it’s important for their dentist to know about their medical history, so we need to start asking direct and leading questions, such as:

1. When was the last time you visited your doctor, urgent care, or any other health-care provider? (This question often makes them think a little more about their last visit.)

2. What medications, vitamins, or supplements are you currently taking? (If they are returning patients, review their medication list with them.)

3. What is your family history of periodontal disease, diabetes, heart disease, cancer, etc. (This is helpful as a risk assessment.)

4. Have you had any hospitalizations since your last visit? (Give them the exact date they last visited your practice.)

5. Are you taking any new medications? Are you using any eye drops? Vitamins? Dermatology meds? Fish oil or herbal supplements?

6. Are there any changes in the dosage of your medications?

7. Do you have a need for antibiotics before your dental treatment?

8. Is there any reason we cannot take dental X-rays today? Pregnancy? Recent medical X-rays?

Taking the time to understand why a patient might not want to complete the forms, as well as making an effort to inform them of the importance of their medical health to their dental health, is vital to providing the best possible dental care to all of your patients, all of the time.

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I am going to give you some tips to control patient gagging. Many times when we are about to take an impression, we are stopped when a patient goes through an episode of hyperactive gagging. Virtually all dentists will experience this phenomenon sometime in their careers. Patients who appeared during the examination to be able to tolerate dental procedures with ease were not always so easy to work on. When least expected during a routine impression, a patient will become extremely hyperactive and begin to gag. This generally ends up in aborting the appointment. My mentor taught me an easy way to determine who these patients are. His method was to place a slightly oversized metal tray into the patient's mouth at the examination and move the tray back toward the palate while applying pressure. The patient who would be able to tolerate impressions would have little to no response. Other patients would begin to increase their breathing rhythm and begin to hyperactively gag. This simple test allows us to know our patients' needs better and to treat them accordingly.

Here are some methods that I have utilized to reduce gagging reactions during dental procedures. The gag reflex is generally thought to be controlled by the hypothalamus of the brain. We also know that other reactions are controllable by the hypothalamus. Place a Q-tip with salt on the tip of the patient’s tongue. We are now stimulating taste sensors. This taste will also be reflected in the same part of the brain as the reflex, so we are giving the hypothalamus a second signal. The next plan of action is to give the patient a lollipop made with tetracaine 1%. This is the same medical topical anesthetic utilized after tonsillectomies or for sore throats. We suggest a 1% concentration and have the patient suck the lollipop until it begins to coat both the hard and soft palates. The third method of defense would be to use extreme cold in the form of a chemical ice. We have the patient massage their hands with a chemical ice bag. We also know that extreme cold sensations are also signaled in the hypothalamus. These are three different methods to send additional signals to the hypothalamus to decrease the gag reflex due to getting bogged down, like being caught in a traffic jam.

The next suggestion is to ask the patient to move their ankle and calf of the leg slightly off of the chair and hold it, not allowing it to touch the chair. Flexing muscles will also distract the patient by sending additional signals to the brain, thereby creating a traffic jam. We have used the following tactics to reduce patient anxiety. A patient who is listening to music while watching TV will be distracted and more relaxed, which diminishes the reflex. Dental chairs are now available with heat and vibrating modes. The patient controls the dental chair with their own remote control that provides

By Joseph J. Massad, DDS

The gag reflex is generally thought to be controlled by the hypothalamus of the brain.
pleasing vibration during the procedure. It is impossible and impractical to put every patient to sleep. We need the patient’s cooperation to get a good functional impression. Nitrous oxide is a good way to calm the patient and their reactions to sensations during dental procedures. The last line of defense would be to utilize an antianxiety elixir.

Generally, the patient will be asked to come in with a driver and not eat breakfast. Morning appointments are very effective especially for the anxious patient, and – combined with giving the patient an appropriate amount of antianxiety elixir – will decrease the patient’s anxiety and improve the dental experience.

I’m hoping that these tricks will assist you as they have assisted me. If you would like references, please do not hesitate to email me and I would be happy to send you references for the distraction techniques and antianxiety methods to decrease patient gagging. I hope my pleasure in dentistry will also be yours.

~ITK

Dr. Joe Massad may be reached by phone at (918) 749-5600 or by e-mail at office@joemassad.com.

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