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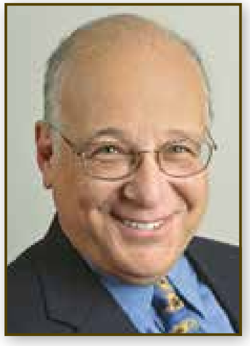

Editorial

Thank you, Dr. Archer-Festa

This issue of the Journal features an article that I have been seeking for the past four years, because it addresses an impasse that Clear Aligner practitioners often face:

"Is it safe, and is it prudent, to perform orthodontic treatment on patients whose dentitions display severely compromised periodontal support?"

We know, of course, that periodontitis must be resolved successfully before undertaking either restorative or orthodontic procedures; but, after resolution of active periodontal disease, when the remaining periodontium is now healthy but reduced, can we undertake Clear Aligner Treatment?

I am happy to report that this edition's Feature Article tackles this question, with an extensively researched contribution to our knowledge base.

Dr. Archer-Festa is a practicing dentist, an educator, and an associate professor at New York City College of Technology, Department of Dental Hygiene.

After studying her article, I feel certain that readers will join me in thanking her for providing scientifically sound guidelines to this common clinical challenge.

Dr. Jeffrey Galler
Editor

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Case Reports

Using Clear Aligner Therapy to Create Restorative Space in Order to Replace a Missing Maxillary Lateral Incisor

by Jason Alvarez, DDS

Dr. Jason Alvarez is a general dentist who was born and raised in New Orleans and completed his undergraduate studies at Louisiana State University in Baton Rouge, La. He received his DDS from LSU School of Dentistry in 2012. Dr. Alvarez currently practices in his hometown, and enjoys treating patients with Clear Aligner Therapy and seeing the wonderful results. His wife is a hygienist, and they both take pleasure in making new friends with patients and providing benevolent care to everyone that sets foot in the door. He feels very blessed to be practicing dentistry, and he enjoys the unique music, culture, festivals, and food that the Big Easy has to offer, and cheers on the Saints and LSU Tigers every chance he gets.

A 35-year-old Hispanic male presented to our clinic; his primary concern was a missing lateral incisor at site #10. Time and economics had complicated the situation.

He stated that he had had tooth #10 extracted at another dental office years ago, and that he was always unhappy with the space, but never was able to seek treatment to have it fixed. In the interim, the mesial-distal (M/D) space in site #10 had collapsed, and the alveolar bone had been resorbed and "caved in" to such an extent that implant placement would not be an option without an advanced and expensive grafting procedure (**Figures 1a-d**).

The patient's medical history was noncontributory. Our clinical exam revealed 2-4 mm probing depths anteriorly and posteriorly, missing lower first molars, lower anterior crowding, severely crowded maxillary premolars, minimal restorative treatment, and a healthy TMJ. Tooth #7 had an M/D width of approximately 7.5 mm, while the M/D width at site #10 was only 6 mm.

An interdisciplinary plan

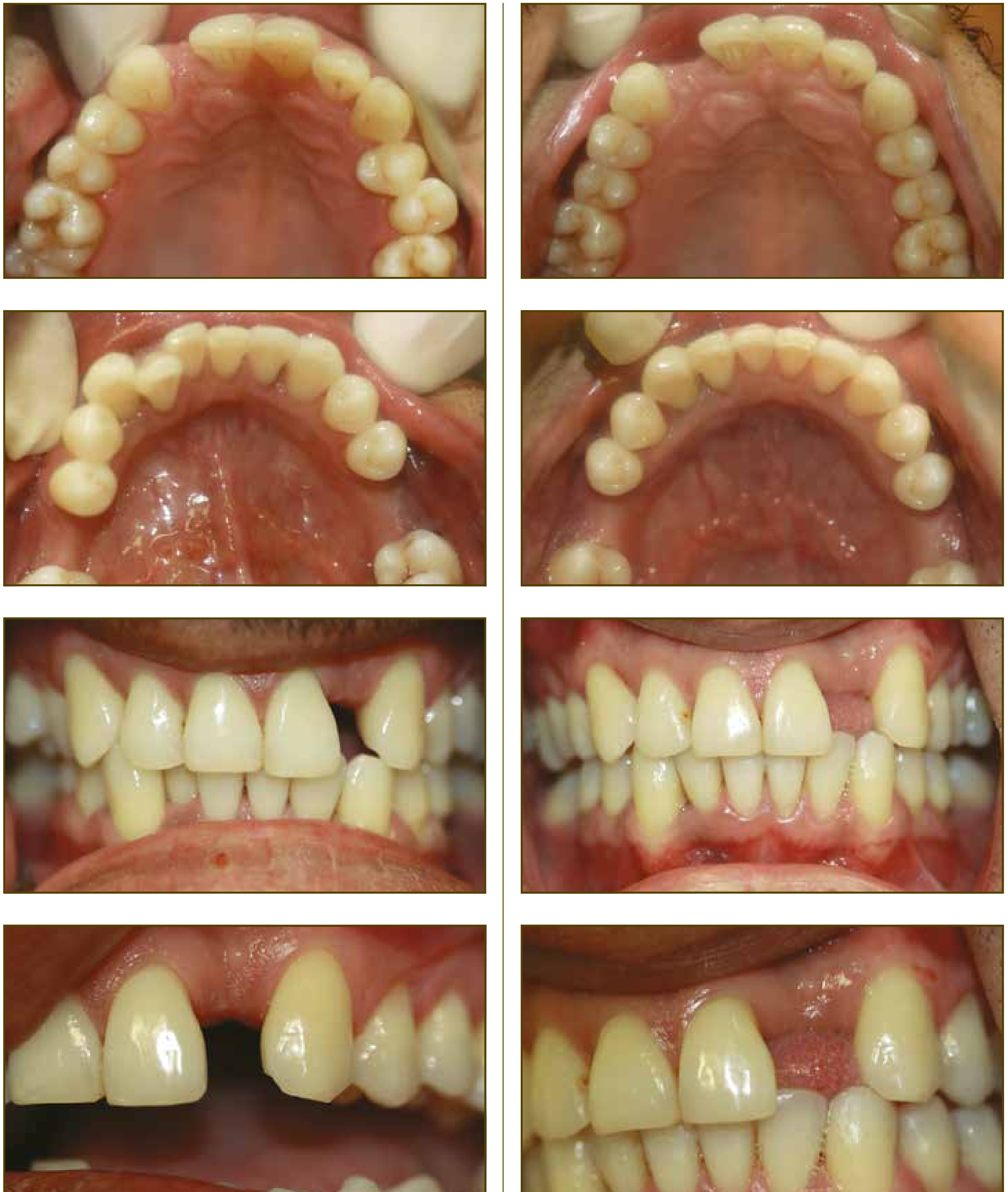
The missing maxillary lateral incisor presented a series of challenges for us to manage. We knew that in order to achieve an optimal esthetic and functional result, we needed to establish an interdisciplinary approach that would allow us to formulate a treatment plan to satisfy the patient's expectations.

We made study models and took clinical photographs of his dentition. Using these, we showed him the limited space he had at site #10, and explained that he was unlikely to be happy with the results of any immediate treatment, owing to the resulting tooth size discrepancy.

We then discussed in detail the range of treatment options that we could offer him, including both referral to an oral surgeon, who would review the feasibility of extensive bone grafting and implant placement; or, realigning his teeth with Invisalign Clear Aligner Treatment, followed by either a bridge, or a removable appliance to replace the missing tooth #10. We wanted to discern what the patient was willing to consider.

Our patient had been eager to find a quick solution to his problem, but once he understood that the restorative space in site #10 was compromised, he began to think that Clear Aligner Therapy was a pretty good fit for him. The use of CAT could not only enlarge the space to help create a more ideal tooth size for him; it could also provide a surrogate tooth to fill the visible gap during the entire process.

The patient was hesitant to undergo implant surgery because his wife had previously had a bad experience with an oral surgeon. We reassured him that he could decide on the final restoration once we had created the space for him.



Figures 1a-d: pre-op presentation.

Figures 2a-d: after Clear Aligner Treatment.

Preparations for treatment

The patient signed consent to start Invisalign, and we took our photos and PVS impressions to send to Align Technology. In our ClinCheck, we requested to level and align all teeth except the mandibular and maxillary molars.

The movement involved in the posterior crossbite (teeth #2 and #32) would require the use of aligners as well as more advanced orthodontic techniques. Since these movements were too challenging to achieve with aligners alone, we did not program them into the ClinCheck, and, instead, decided to let those teeth remain in crossbite.

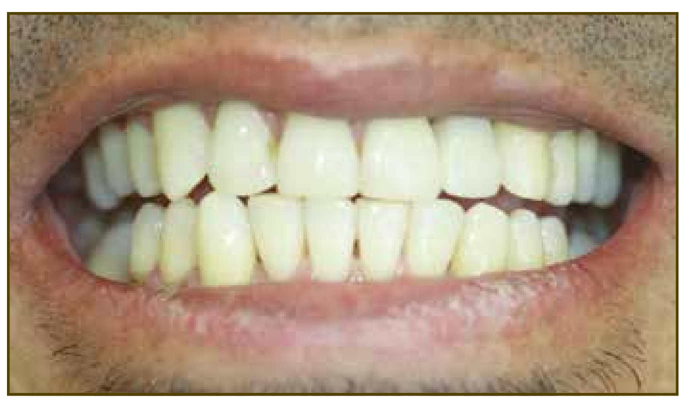
Power Ridges were placed to assist in the proclination and expansion of tooth #23. We performed approximately 0.3 mm of InterProximal Reduction (IPR) between maxillary premolars and adjacent teeth to help prevent collisions. No IPR was performed on the lower arch. We proposed allowing pontic spaces in site #10 throughout treatment to permit a temporary solution to the patient's chief complaint.

Placing the pontic

By about the eighth set of aligners, we had achieved sufficient expansion of the maxillary arch, so that we had enough room for a #10 pontic. Therefore, we created a "retention dimple" in the lingual aspect of site #10 in the aligner using dimple pliers, and filled the pontic site with conventional composite resin, shade B1. We delivered approximately 3 sets of aligners at each periodic orthodontic visit, and each time, we filled the upper trays to create the pontic in site #10 using this method. The patient was very satisfied that he could walk out of the clinic after each visit with a visible replacement tooth while he wore his trays during the day.

The aligner therapy proceeded smoothly, and the patient was very compliant during the course of treatment. We supplied the patient with Chewies and instructed him in their use to help seat the aligners completely. After completion of the Invisalign treatment, we placed a composite pad fixed lingual wire retainer (Specialty Appliances) across teeth #22 through #27 (**Figures 2a-d**).

The patient wore his last aligner with pontic for a period of 2 months before deciding on his final restoration. During this time, he received a consult with an oral surgeon, who proposed a grafting procedure and an implant placed in site #10. The patient did not want to undergo the surgery at this point in his life because of the costs and the extended healing period he



Figures 3a-b: after placement of Maryland bridge.

would have to endure. Instead, he elected to receive a Maryland bridge made of IPS e.max lithium disilicate to replace tooth #10 for the time being.

(A Maryland bridge is a variety of resin-retained bridge in which the pontic is bonded to a framework that extends to either side, forming "wings." The wings are then bonded to the lingual sides of the adjacent teeth using composite resin cement. This type of restoration is notably low in cost and invasiveness.)

Minimal preparation was needed, since the abutment teeth already expressed the necessary surface area for proper bonding thanks to the natural concavities of the lingual surfaces of teeth #9 and #11. This allowed for a minimally invasive final restoration, which produced esthetic results (**Figures 3a-b**).

The patient was very happy to finally have his missing tooth replaced with one of natural-looking size and shape. ■

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Lily: Straightened Out Without Extractions

by Drew Fairweather, DMD

Lily, a 36-year-old clinical researcher, arrived at our office in need of some orthodontic work, but worried about needing extractions in order to align her teeth and beautify her smile.

Chief complaint

She told us, "I would like to straighten my teeth without extractions, and to replace my missing lower right tooth. Two orthodontists have already told me that I'll need 2 or 4 extractions."

Dr. Drew W. Fairweather has been practicing dentistry for 30 years and now practices at Better Image Dentistry in Bridgewater, N.J. He earned his dental degree from the Fairleigh Dickinson University School of Dentistry. He is a Fellow of the International Academy of Implant Dentistry and an alumnus of the Dawson Academy. His professional memberships include the Seattle Study Club, and he serves as president of the Philadelphia chapter of Reingage, a study club for Invisalign.

Dr. Fairweather has specific training in reconstructive and cosmetic dentistry, implant restoration, endodontics, and more. He was named a Top Dentist in 2016 by peer vote in *New Jersey Monthly.*

Because active participation in the community doesn't stop at providing excellent dentistry, the practice participates in the Agape House for Women and Children and the Somerset County Food Bank. Dr. Fairweather and his wife Judy have five beautiful children and three grandchildren, and in his spare time, he enjoys skiing and travelling with his family.

Further discussion revealed that Lily's initial interest was in replacing the missing tooth #19; she'd come to us because our repertoire includes implants. We assured her that we could place the implant she wanted, but explained that aligning her teeth had to come first. .

Diagnosis

Our examination revealed Class II molar relationships and an extremely traumatic anterior tooth relationship. Tooth #10 was in crossbite, and tooth #6 was located far outside the arch. Lily had severe maxillary and mandibular crowding, with omega-shaped arches. She also presented with a fairly flat facial profile. Her maxillary midline was displaced approximately 3 mm to the right.

This traumatic and unstable occlusion, if left uncorrected, would certainly have led to more instability and shifting, and further uneven tooth wear. The position of tooth #10 presented a likelihood of further wear and perhaps even fracture of the opposing tooth #23.

Treatment goals

We chose Clear Aligner Therapy using Invisalign for Lily's treatment. Our goals included:

- Expansion of premolars to increase arch length
- Buccal root torque and rotation of the maxillary anterior segment, followed by relative, and then true extrusion

Treatment details

We submitted the case to Align, resulting in a ClinCheck that totaled 33 sets of aligners. Lily was aware that the likely treatment duration would be 1½ to 2 years.

By using horizontal bevel attachments on the premolars as well as on teeth #14 and #15, we obtained excellent anchorage both for leveling the plane of occlusion of correct the extrusion of #14, and for assisting with the dramatic movements of the maxillary and mandibular incisors. We were able to attain sufficient space by performing IPR of 0.5 mm on the maxillary anterior teeth, and we were able to avoid "round tripping."

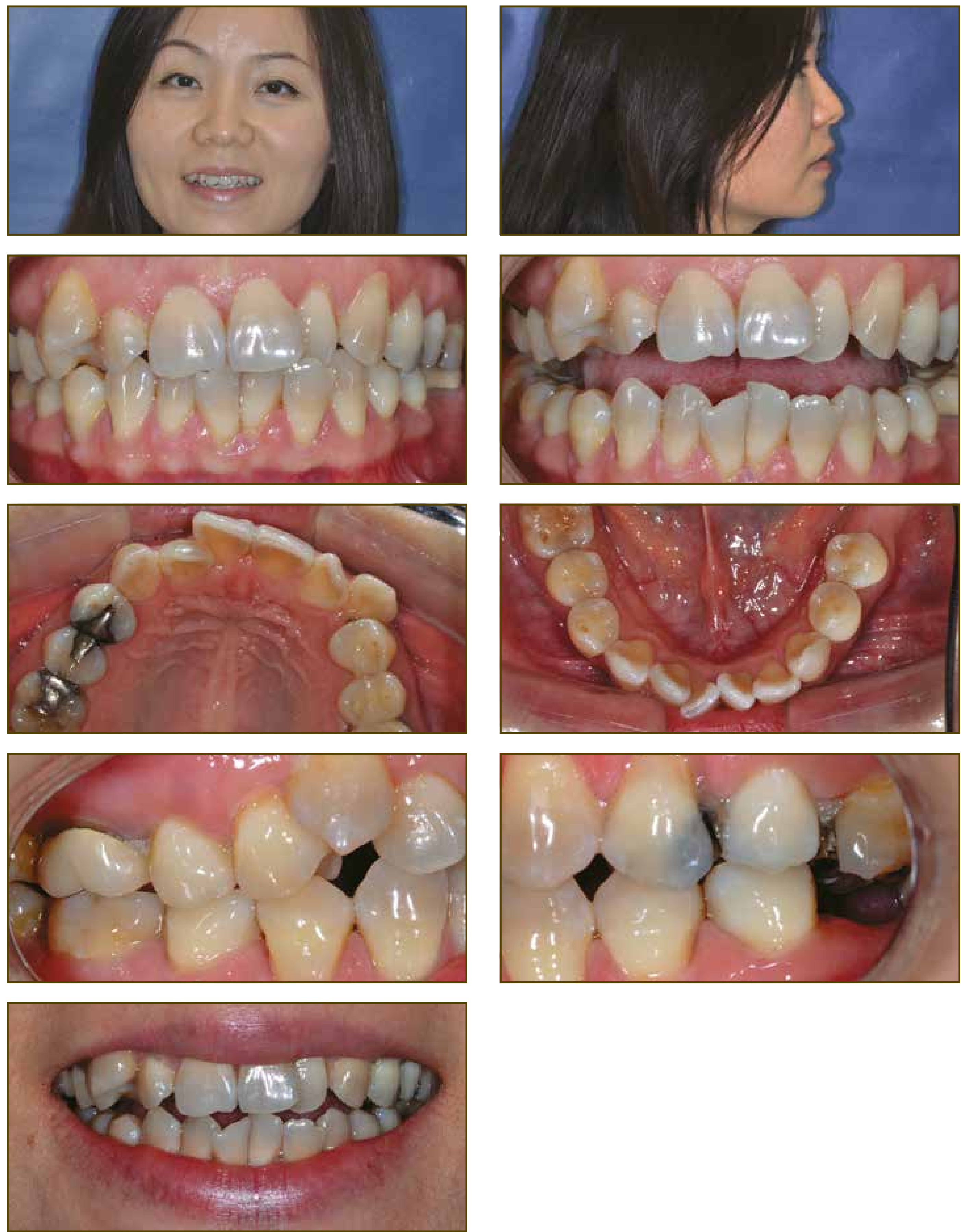
Patient compliance was excellent. At the end of the 33 aligners, tooth #6 had not quite reached ideal position. I also felt that we could achieve a more ideal overbite and overjet. Hence, we submitted refinement photos and records. This time, we chose to retract the mandibular incisors using IPR instead of further proclining the maxillary anterior teeth, gaining better anterior guidance.

The refinement entailed 17 sets of aligners and 0.2 mm of IPR of the mandibular anterior teeth. Lily gained a better alignment and anterior coupling. The space between her teeth #18 and #20 was improved. While results were not perfect, our patient was pleased and did not desire any further refinements. Placement of implant #19 is planned for this year.

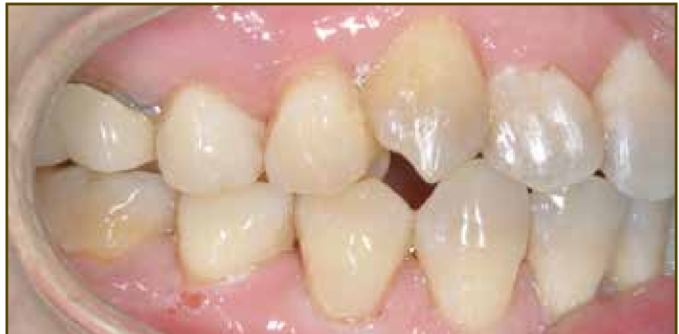
Had Lily been interested in proceeding with another refinement, I would have recommended completing the rotations of teeth #6 and #10, for even better alignment. I would also have liked to perform additional nonorthodontic procedures to make the incisal edge of tooth #7 symmetrical with that of tooth #10, using composite material as well as via gingivectomy.

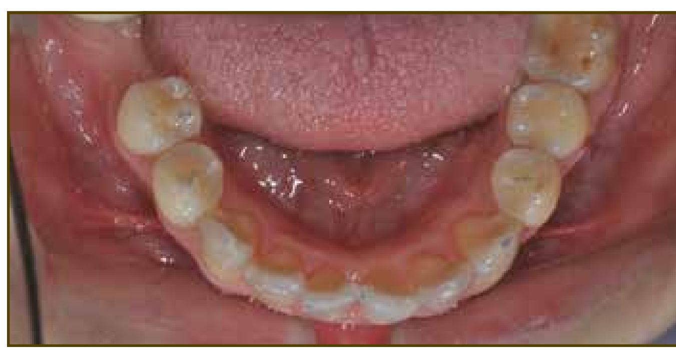
Final thoughts on this case

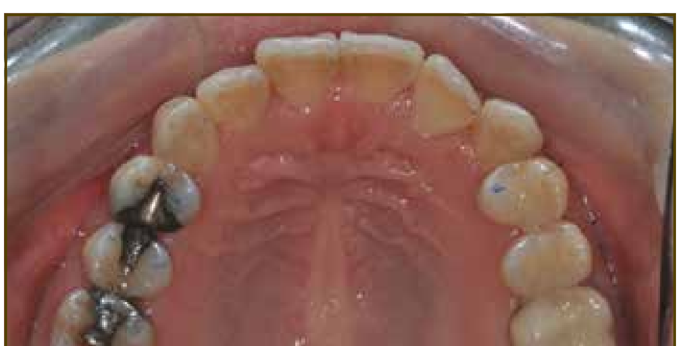
It was extremely satisfying for me to help Lily get the smile she always wanted while fulfilling her desire to do so without extractions. I was very happy to have transformed her dentition from one of misplaced teeth causing trauma, to one with a harmonious anterior occlusion and a beautiful smile. ■



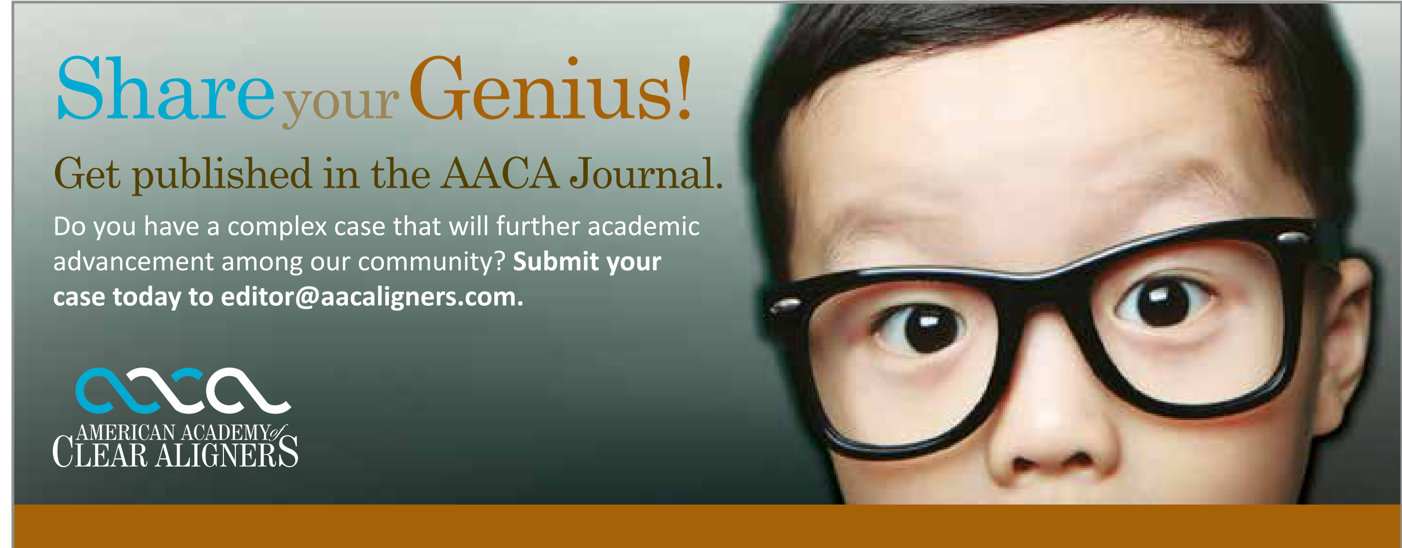
Lily: before.







Lily: refinement.



Lily: after.

Feature Article

Orthodontic Treatment for Adults With a Reduced Periodontium

by Maureen Archer-Festa, DDS

Dr. Maureen Archer-Festa has been a practicing dentist for 30 years. Currently her primary mission is in education: she is an associate professor at New York City College of Technology, Department of Dental Hygiene, located in Brooklyn, New York. In her seminars she covers a wide variety of topics, including principles and strategies for implementation related to CaMBRA, the management of medically complex patients in the dental setting.

Dr. Archer-Festa is a clinical consultant with the Northeast/ Caribbean AIDS Education and Training Center and has strong foundational knowledge about the HIV disease process and the other bloodborne pathogens, hepatitis B & C. She has been invited to lecture at the Greater New York Dental Meeting as well as at the Nassau, Suffolk and Westchester Dental and Dental Hygiene Associations. She has published articles related to the topics of Hepatitis C, HIV, erosive tooth wear, and periodontal conditions.

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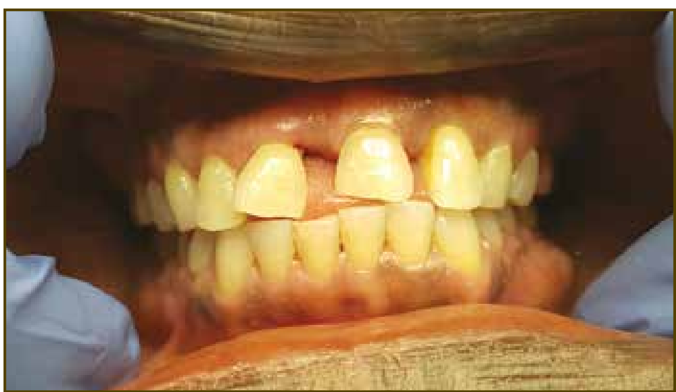

Figure 1: the patient presented at the dental clinic complaining that his upper right central had drifted out of position. The obvious etiology was periodontal disease. After successful treatment, Clear Aligner Therapy can reposition the malposed teeth.

You and your patient agree that Clear Aligner Orthodontic Treatment would greatly improve the patient's esthetics, occlusion, and ability to better perform routine oral home care. But there is a problem: although the periodontium is now healthy, previous bouts of periodontal disease have resulted in greatly reduced bone support around the teeth. Is it safe to proceed with orthodontic treatment?

Introduction

The American Association of Orthodontists uses a biennial survey of its members in the United States and Canada to obtain pertinent information regarding orthodontic therapy. The results of the 2014 survey revealed that more than a quarter (27%) of American and Canadian orthodontic patients are adults. Additionally, from 2012 to 2014, the number of patients 18 and older seeking treatment in North America increased by 16%, resulting in a record high number (1,441,000) of adult orthodontic patients.[1]

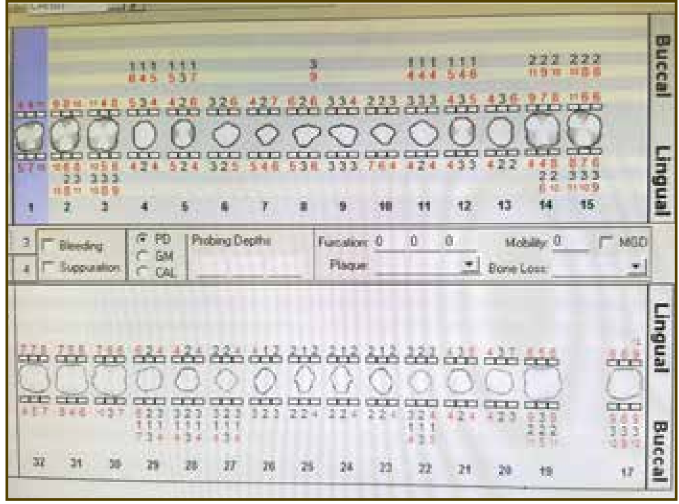

Figure 2: periodontal charting.

Recent studies have explored the reasons for this rise and suggest that adults are seeking orthodontic therapy to improve the alignment of their teeth and facial esthetics. Improvement of facial esthetics has been linked to improvements in self-esteem, especially in women.[2] Adults' increased willingness to undergo orthodontic treatment is related to the technological advances which have reduced treatment length to, on average, approximately 22 months and to the availability of orthodontic tooth movement using clear aligners.

According to the most recent (2009-2012) National Health and Nutrition Examination Survey study, 47% of adults aged ≥30 years in the United States (approximately 65 million adults) have periodontitis.[3,4] This is further broken down to 8.7% with mild periodontitis, 30.0% with moderate, and 8.5% with severe periodontitis. Incidence of periodontitis increases with age. As the U.S. adult population ages and is more likely to retain more teeth than previous generations, the prevalence of periodontitis is expected to increase, and consequently, so could the need for expenditures related to preventive care and periodontal treatment.[4]

Since it is common knowledge among oral health professionals that the incidence of periodontal inflammation and bone loss increases with age, it is fair to assume that many adult patients seeking orthodontic treatment may exhibit periodontal breakdown. So, it is wise to consider the effects of a compromised periodontium on the effectiveness of adult orthodontic therapy.

This author used the PubMed data base to conduct a search using the following keywords: adult orthodontics, periodontal disease, periodontal flora. The search located 1 systematic review[5] and 8 prospective cohort studies.[6-13] The goals of this paper are (a) to summarize the literature results as they relate to orthodontic therapy on a reduced or compromised periodontium, and (b) to summarize the role of Clear Aligner Treatment in patients with a reduced periodontium.

Periodontal disease impact on tooth position

Periodontitis is a chronic inflammatory disease process characterized by progressive destruction of the periodontium (the gingiva, cementum, periodontal ligament, and alveolar bone). Moderate to severe loss of alveolar bone height, linked to the interaction of biofilm, host response and inflammatory mediators, is a primary factor for pathologic tooth migration. Pathologic tooth migration is defined as a change in tooth position resulting from disruption of the forces that maintain the teeth in a normal position, with reference to the skull. The clinical manifestations of pathologic migration, such as proclination, diastema, rotation, extrusion, and drifting, have been found in 30% to 55% of patients with moderate to severe periodontal disease.[14]

Since early and moderate periodontal disease can occur without pain, many patients' first inclination to seek a dental consultation comes from the formation of a diastema (**Figure 1**). Once pathologic tooth migration has occurred, it frequently needs to be managed, first by stabilizing the periodontal disease, and then through correction of the esthetics with orthodontic tooth movement. The literature recommends light intrusive forces to correct the appearance of pathologic tooth migration.[11,15] Histologic observations in animal experiments have confirmed that when light forces are applied to move a tooth bodily into an area with reduced bone height, a thin bone plate is recreated ahead of the moving tooth.[16]

Realignment of teeth with a reduced periodontium

In patients who require both periodontal therapy and orthodontic correction to improve their dental and facial esthetics, the necessary periodontal therapy should occur first. It must be preceded by a thorough periodontal assessment, as is the standard of care. The American Academy of Periodontology also recommends an annual comprehensive periodontal evaluation (CPE) to assess periodontal health and identify conditions that may need additional treatment.

Are adults with reduced but healthy periodontal tissues at greater risk for periodontal breakdown or tooth loss during fixed orthodontic treatment than adults with normal periodontal tissue or adolescents?

The CPE includes gingival description, periodontal pocket probing depths, measurement of clinical attachment level, mobility, fremitus, mucogingival defects, oral hygiene assessment, contributing factors, radiographic assessment, and a risk assessment (modifiable and unmodifiable factors) (**Figure 2**).When a combined periodontal-orthodontic treatment is planned, it is most important that the dentist consider the clinical attachment level, the inclination of the anterior incisors, and mobility of the teeth, as well as the ability of the patient to maintain adequate oral hygiene. After assessment, the patient can receive nonsurgical periodontal therapy and, if indicated, periodontal surgery.

The dentist must assess alveolar bone topography for the presence of infrabony pockets to determine whether periodontal regenerative procedures would be beneficial. For patients who present with infrabony periodontal pockets and pathologically migrated teeth, the use of periodontal regenerative procedures in conjunction with orthodontic movement of the teeth is the recommended course of treatment. Teeth can be moved into infrabony defects, leading to defect closure, bone fill, and possibly new attachment formation.

When the infrabony defects are subject to augmentation procedures, the graft material does not impede orthodontic tooth movement that seems to enhance defect healing.[17] Most commonly, the periodontal regeneration techniques are performed 10 days to 4 months prior to orthodontic movement, but in some cases, periodontal regenerative procedures may be done after orthodontic treatment is completed.[18] The dentist must evaluate this decision on a case-by-case basis in consultation with the periodontist.

Once the adult is periodontally stable, studies recommend a waiting period of 2 to 6 months, depending upon the complexity of the bone loss, prior to the start of orthodontic therapy.[18] During the orthodontic therapy, the patient should schedule frequent (at least quarterly) professional dental hygiene appointments.[19]

In 1989, Boyd et al.[9] conducted a well-known study which investigated the relationship between orthodontic therapy and compromised periodontium. The aim of this study was to answer the question: "Are adults with reduced but healthy periodontal tissues at greater risk for periodontal breakdown or tooth loss during fixed orthodontic treatment than adults with normal periodontal tissue or adolescents?" The results of this study showed that the adult group with a reduced periodontium tolerated orthodontic tooth movement well, as long as the periodontal condition had been stabilized. The same researchers also concluded that tooth movement in patients with a reduced but stable healthy periodontium does not result in significant additional loss of periodontal attachment. Tooth loss may occur, however, in adults with severely periodontally compromised teeth that have pocket depths exceeding 6 mm and/or furcation involvements.

> Orthodontic tooth movement on a reduced but stabilized healthy periodontium does not necessarily lead to bone loss, but may actually increase alveolar bone height around teeth.

Since 1989, numerous studies have been conducted and have come to similar conclusions: that adult patients with a reduced but stabilized periodontium are good candidates for orthodontic tooth movement. Research by Melsen et al.[20-22] has established that orthodontic tooth movement on a reduced but stabilized healthy periodontium does not necessarily lead to bone loss, but may actually increase alveolar bone height around teeth. Therefore, based on decades of research, we can say that orthodontic tooth movement on a reduced periodontium, combined with maintenance of long-term results, has been proven to be an effective treatment to improve the dental and facial esthetics of patients with a history of periodontal disease.

Clear Aligner Treatment in patients with a compromised periodontium

In 1999, sequential clear aligner appliances produced using computer-aided design were introduced to the dental profession. In the first several years of Clear Aligner Treatment in orthodontics, case reports and early clinical studies indicated that this type of orthodontic appliance was effective at closing spaces through a tipping motion, at correcting rotation of incisors, and at movement which intrudes teeth.

More recently, a 2015 systematic review by Rossini et al.[23] established that Clear Aligner Treatment is recommended for correcting simple malocclusions. This systematic review concluded that Clear Aligner Treatment:

- is an effective procedure to align and level the dental arches in a nongrowing subject
- can achieve anterior intrusion movement similar to that reported for straight wire technique
- is effective in controlling maxillary molar bodily movement when distalization of 1.5 mm is prescribed
- is **not** effective for anterior extrusion movements and controlling rotations of round teeth such as canines

Han[24] conducted a study comparing the orthodontic tooth movement of a fixed wire against that of Clear Aligner

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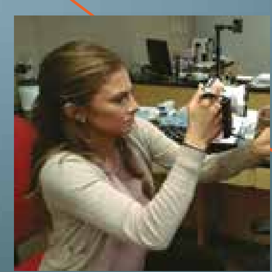

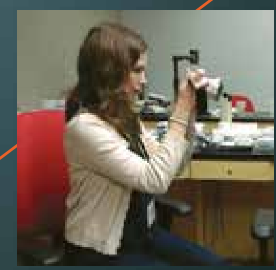

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Treatment and determined that both types of appliances achieved similar outcomes in anterior intrusion movement.

Once Clear Aligner Therapy is indicated after clinical and radiographic assessment, then this method of orthodontic movement carries several advantages over conventional fixed appliances, for a patient with a reduced periodontium. First, the patient's ability to maintain the recommended oral hygiene protocol in order to prevent recurrence of periodontal disease is facilitated by use of clear aligners. Second, there is no risk of demineralization, which is often seen with conventional orthodontic fixed appliances. Finally, incidence of root caries (which occur more often in adult populations) is negligible.

Conclusion

Present trends in the United States population indicate that more adults will be seeking to improve their appearance, self-esteem and oral health through a combination treatment plan including both periodontal and orthodontic treatments. The scientific journals in the field of dentistry have verified that orthodontic treatment on a reduced periodontium is safe and produces long-term stable results. Advances in knowledge and technology in orthodontic tooth movements have documented that many of the cosmetic issues associated with pathologic tooth migration are well suited to be treated with Clear Aligner Treatment. ■

> Tooth movement in patients with a reduced but stable healthy periodontium does not result in significant additional loss of periodontal attachment. Tooth loss may occur, however, in adults with severely periodontally compromised teeth that have pocket depths exceeding 6 mm and/or furcation involvements.

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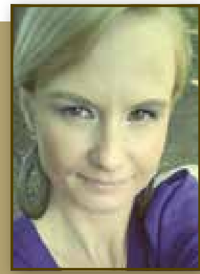
Focus on Photography

Common Mistakes in Clinical Photography and How to Prevent Them

by Anna Kataoka, MS, MBA



Anna Kataoka is an employee of Shofu Dental Corporation. She is a graduate of the MBA dual program in marketing and international business at Baruch College in New York City. She also holds MS degrees in mechanical engineering and in management from Gdansk Polytechnic, in Poland.

This article elaborates on frequently encountered errors in clinical photography and provides recommendations on how to avoid them.

Introduction

When captured correctly, dental photographs will provide more accurate evidence about malocclusion and possible treatment options than any other clinical record. In the first article in this series, "Excellence in Dental Photography" (*AACO Journal*, Winter 2016), we acknowledged the importance of dental photography in developing a patient's record, documenting treatments, and monitoring the progress of selected modalities, and as a medicolegal aid in complying with insurance requirements or preventing legal actions.

However, errors committed while obtaining these invaluable records can compromise or even negate their usefulness. Furthermore, photographs of a substandard quality may misrepresent anomalies and defects in a patient's oral environment, or inaccurately reflect the progress of a treatment. Furthermore, when featured on the dental practice's website or social media platforms, less-than-perfect clinical photographs may discourage office visits from prospective patients, and therefore lead to a loss of revenue for a practice.

The errors most often encountered in clinical photographs can be divided into two categories. The first category consists of errors that result from an inappropriate selection of photographic gear—the camera, lens, flash, backdrop, and auxiliary equipment such as mirrors and retractors. The second category of errors involves incorrect patient-operator positioning.

Comparative clinical photographs

To mitigate the problem of an appropriate selection of equipment, investing in quality retractors and mirrors as well as in a digital camera capable of capturing images with accurate human color, full tonal range, and adequate depth of field, and providing the ability to produce photographs with good light control, is essential.

With the proliferation of innovative, high-quality photographic apparatus, there is a vast array of dental cameras appropriate for an orthodontic practice. One such option is the staff-friendly digital dental camera from Shofu Dental Corporation, the EyeSpecial C-II. This universal camera features preset dental shooting modes and a variety of other smart attributes. (**Figures 1a-b**).

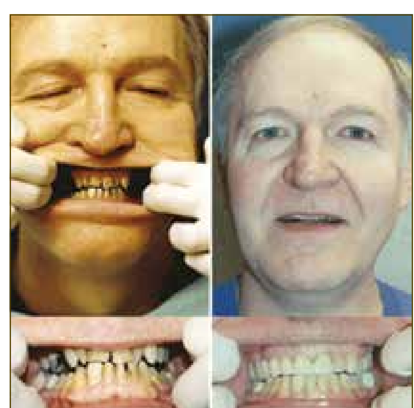
To allow direct comparison of photographs taken at different times, it is fundamental to maintain a standardized environment with congruent settings, a dental camera set to a consistent calibration, corresponding retractors, and correct patient-operator positioning. A dental practice that is noncompliant with these prerequisites will produce unpredictable and inconsistent photographs (**Figures 2a-c, 3a-e**).

Standardization

Admittedly, it may be challenging to standardize the process of clinical photography when images can be taken during different stages of a treatment, by different team members, in different operatory rooms, using different equipment, settings,

Figure 1a: the EyeSpecial C-II dental camera.

Figure 1b: incorporating appropriate mirrors and retractors in both Before and After images will help the dental team capture excellent photographs.



Figures 2a-c: inconsistent clinical photographs make the clinical evaluation more difficult and create unconvincing evidence.

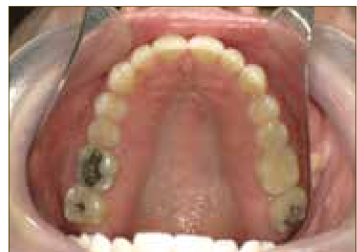
and more. Still, when comparing photographs to demonstrate the treatment's progress, the only variable component should be the captured development. Everything else should remain constant. Although the implementation of photographic procedures and protocols does require a team effort, the ability for every staff member to achieve predictable and consistent records will help diminish the probability of an error and the need for a retake.

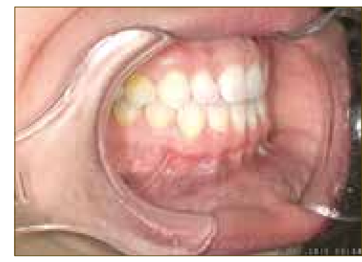
Common errors in extraoral photographs

The American Board of Orthodontics (ABO) reports that the most prevalent errors observed in extraoral clinical photographs are

- The absence of a plain, nondistractive backdrop (**Figures 2b, c**)
- An incongruous, asymmetrical frame with too much background, or overtrimmed areas of interest, including cropped head or smile (**Figures 2a, b, c**)
- An incorrect distance between the patient and operator (**Figure 2c**)
- Capturing images that are too bright or too dark (**Figure 2c**)
- Portraying patients wearing excessive jewelry and accessories; hair disguising the patient's face; ears with no visible landmarks (**Figure 2a**)
- Allowing patients to tilt the head, or to look away, up, or to the side of the camera (**Figure 2b**)

To minimize these errors, place a plain, nonreflective backdrop behind each patient for pre-, mid-, and post-treatment photo sessions. The ideal framing for full-face photographs should include the whole of the patient's face, neck, and shoulders, with reasonable margins around the areas of interest. Furthermore, to achieve a symmetrical portrait, the clinician should be positioned at the same height as the patient, with the camera level with the patient's interpupillary line and centered on the tip of his or her nose. The patient's eyes should be open and looking straight into the camera. Obtrusive jewelry, distractive accessories, and oversized eyewear should be removed. Hair should be gathered together and pulled back to expose ears for the purpose of orientation. The same consistent staging, framing, and patient-operator positioning





Figures 3a-e: photographs of inadequate quality may misrepresent the patient's malocclusion or inaccurately reflect the treatment's progress.

should be maintained when recording all stages of an orthodontic treatment.

Common errors in intraoral photographs

When evaluating intraoral photographs, it is common to observe

- Inadequately retracted soft tissue (**Figures 3a, b, c, e**)
- A lack of focus or an inappropriate depth of field (**Figures 3a, b, c**)
- An asymmetrical frame with a canted plane (**Figure 3d**)
- Obscured or overcropped mandible or maxilla (**Figure 3b**)
- Over- or underexposed images (**Figures 3c, e**)

To minimize these mistakes, proper operator-patient positioning is mandatory, notably when capturing the occlusion. Optimally, intraoral photographs should be taken in the operatory, with the patient and the clinician positioned on the same level to avoid producing images in an asymmetrical plane. To achieve an ideal mandibular occlusal view, the operator should be standing in front of the patient, while leaning the mirror perpendicularly to the maxilla. Maxillary photos should be executed with the clinician standing behind the patient, operating the camera from above and leaning the mirror against the mandible.

A set of the largest retractors that the patient can comfortably tolerate should be used to prevent the tissue from collapsing and thus obstructing the images. C-shaped retractors should be used to capture anterior photos, while V-shaped retractors are ideal for photographing buccal images. A set of metal retractors and high-quality mirrors is indispensable to record the occlusion.

Closing comments

Many of the aforementioned errors can be prevented by compliance with standardized photographic procedures. Furthermore, using the tips discussed herein and being aware of the prevalent types of errors in intra- and extraoral clinical photographs will help increase the likelihood of obtaining quality images. Although some errors can potentially be compensated for by retouching or correcting using digital applications such as Photoshop, such manipulation can lead to a distortion of the original images or the need for a retake. An open question would be whether such manipulation, if performed on photographs posted on websites or social media, could also lead to accusations of fraud.

Disclosures

The author is an employee of Shofu Dental Corporation. Figures 1a, 2b, 2c, 3a, 3b, 3c, 3e courtesy Shofu Dental Corporation. Figures 1b, 2a, 3d courtesy Shannon Pace Brinker. ■

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Perspectives
From the Hygiene Chair

Your Orthodontic Patient With Gingival Bleeding: The Hygienist's Role

by Joycelyn A. Dillon, RDH, MA

Joycelyn Dillon is an Associate Professor and Chair of the Dental Hygiene program at New York City College of Technology. She also practices clinical dental hygiene, and is an extended member of the New York State Board for Dentistry. Passionate about her profession, Professor Dillon teaches periodontics and clinical dental hygiene. She lectures on a variety of topics and also provides community services.

...in some cases gingival bleeding can stem from conditions that if untreated could lead to a more severe condition of periodontitis and eventual tooth loss.

Your orthodontic patient reports "bleeding gums." She has been somewhat startled by finding that whenever she brushes, her toothbrush is pink. She asks, "I brush and floss twice a day and use mouthwash as my dentist told me to. Why are my gums still bleeding?" How do you as the clinician solve this dilemma?

Many dental clinicians begin by nonchalantly reassuring patients that, in many cases, this condition is not major. While this may generally be true, the fact that there are multiple causes of gingival bleeding necessitates reconsidering this initial reaction. Indeed, in some cases gingival bleeding can stem from conditions that if untreated could lead to a more severe condition of periodontitis and eventual tooth loss. Instead, the first response should be to reassure the patient that a thorough assessment will be done to determine the cause of the bleeding.

The first and most likely cause is inadequate oral hygiene. We know, based on the classic study "Experimental Gingivitis," that plaque causes gingivitis, of which bleeding is an initial sign.[1,2] If checking the patient's oral condition reveals an accumulation of plaque, despite her assertion of brushing and flossing twice a day, the hygienist must gently offer to review her technique and make necessary adjustments.[3]

The review of the patient's oral hygiene techniques may also disclose self-inflicted traumatic lesions, resulting from improper brushing or flossing technique, that are causing bleeding. Again, a lesson in brushing and flossing technique is called for.

This intervention by itself may alleviate the condition. However, there are other possible causes of bleeding which need to be investigated.

A second potential etiology is that bleeding might be treatment related. Ill-fitting orthodontic bands or appliances may trap plaque, which can then irritate the tissue, causing bleeding.[4,5] Or the appliance may rub against the inside of the mouth until abrasion and bleeding result. In the latter case, the patient might be unable to identify the specific site of the bleeding, and so might report this irritation as "bleeding gums." The solution to this iatrogenic problem may involve a simple adjustment of the appliances, or the provision to the patient of a protective wax that can be used to coat the appliances and prevent abrasion.

As part of the orthodontic team, the hygienist should educate the patient to make him/her aware that "bleeding gums" (gingivitis) is not normal.

A third avenue of inquiry is the patient's medical history: a thorough history should have been taken at the initial visit, but this complaint warrants a review. Is there a medical condition that might lead to bleeding?

Bleeding may be caused by a low platelet count, known as thrombocytopenia. Thrombocytopenia may be a result of leukemia, bone marrow problems, anemia, viral infections, exposure to chemotherapy, overconsumption of alcohol, or cirrhosis.[6]

A fourth factor is the use of blood-thinning medications. Patients using specific medications to help prevent clotting, such as Coumadin, Plavix, warfarin and similar drugs, experience varying degrees of oral bleeding. In addition, patients who use aspirin, or other nonsteroidal anti-inflammatory drugs (NSAIDs), also may experience gingival bleeding. Herbal products such as St. John's wort, ginkgo biloba, ginger, garlic, ginseng, and others have also been known to cause gingival bleeding. Nutritional supplements such as vitamin E and fish oil may also increase bleeding.[7]

A final consideration is injury as a result of an accident. Wilson[5] states, on his website, that "injury to the orthodontic appliances as a result of an accident or a blow to the mouth may lead to oral bleeding because of parts of the appliance being displaced and injuring the gums, teeth and lips. Eating certain prohibited foods may also damage the appliance. A blow to the jaw during sports or recreation may cause the wires and brackets to cut into the gums, cheeks or lip and cause bleeding and pain."

In conclusion, the dental hygienist's role in addressing the complaint of bleeding gums in an orthodontic patient must take multiple factors into account. It is first an investigative role, and depending on the findings, the hygienist may also be able to provide corrective treatment by addressing inadequate oral hygiene.

As part of the orthodontic team, the hygienist should educate the patient to make him/her aware that "bleeding gums" (gingivitis) is not normal; that while it may be reversible, if it is not dealt with, it can lead to more severe problems; and that it may indicate a systemic problem that needs to be approached medically. The hygienist's role also includes assessing the problem and its cause, and sharing the information with the orthodontist, in order to determine appropriate diagnosis and treatment. Being well informed regarding the medical conditions, medications and herbal supplements that affect bleeding is imperative in handling this common problem. ■

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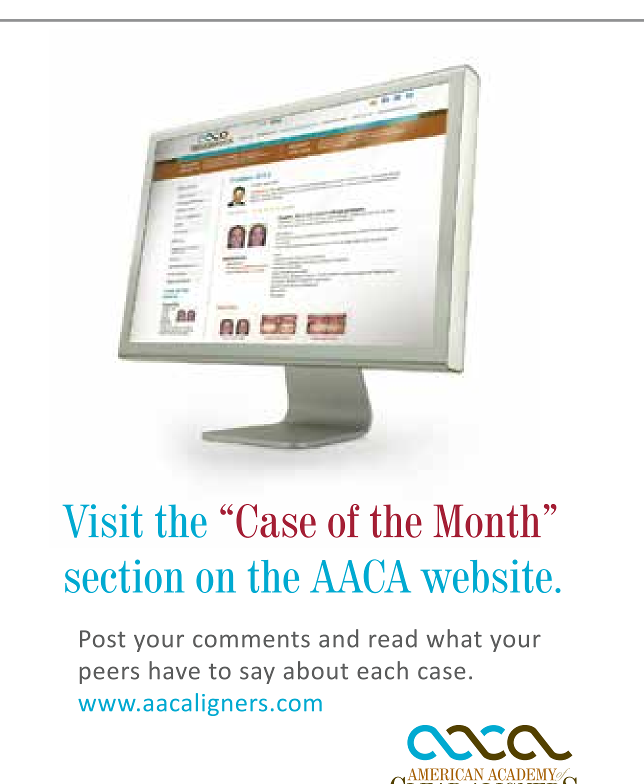

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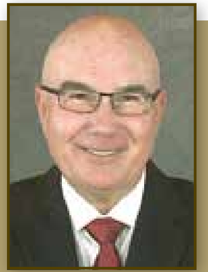
Practice Management

Saying Thank You

by Jim Du Molin



According to his website, Jim Du Molin "is a leading Internet marketing expert for dentists in North America. He has helped hundreds of doctors make more money in their practices using his proven Internet marketing techniques. He developed **TheWealthyDentist**® email newsletter as a way to share the 30-plus dental management and marketing strategies he has developed and tested over the last 20 years working with dentists."

I want to push the idea of sending a referral thank-you letter and token of appreciation.

Whenever a current patient refers a new patient, you should give some sort of thanks to the referring patient.

There are a lot of ways to send a gift or a thank-you letter. Whatever you do, I must advise: don't wait! Patients are straightforward, and they like to be thanked immediately when they do something good.

I find myself thinking of Pavlov and his dogs. Pavlov learned that if you gave a dog a treat immediately after he did a trick, the dog did the trick a lot faster the next time because he expected to get a treat.

You do the same thing with your patients. When they send you a new patient, send them a treat right away, and they'll repeat that positive behavior again. **Always reward positive behavior with a positive reward immediately.**

How? In the case of referrals, I like to use gift certificates, but it's entirely up to you. You can send them flowers. You can send them balloons. You can do anything you want.

But whatever you do, don't overlook this step. Thank-you letters and tokens of appreciation can really go a long way! ■

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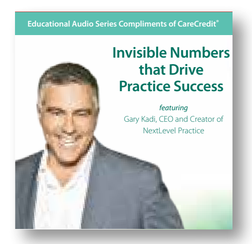

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Social Media & Technology

3 Reputation-Saving Tips: What Not to Do on Social Media

by Melody Gandy-Bohr

With just a few keystrokes on a computer, your practice's online reputation can be built up or torn down. It's not just negative reviews on Yelp or Google that can affect your practice. Your own social media habits can be doing more harm than good. Where social media are concerned, no one can hurt your practice as badly as you can by posting too much—or worse, not taking any action at all. Avoid making these 3 social media mistakes to protect your practice's online reputation.

Don't post infrequently

It's not enough to set up social media accounts for your practice. If you want to develop a thriving Web presence, post regularly and engage with followers. After all, a study released by Pew Research Center shows that 72% of Facebook users log on daily and 43% log on multiple times a day. Followers won't engage with you if you're not active on social media. Posts with practice updates and interesting articles encourage your followers to engage with you. Be sure to post often and respond to comments to show your followers that you're listening to them.

Avoid irrelevant, "spam" content

Keeping your followers means keeping them happy, and avoiding pitfalls that may drive them away. A news feed full of "spam" posts is perhaps one of the fastest ways to lose your hard-won following. This includes posting on topics that are unrelated to your industry or your patients, blatant sales pitches, and posting the same thing numerous times in a row. This type of social media behavior can paint your practice as inept and uncreative, and will likely cost you Facebook and Twitter followers. Keep your posts focused and try not to overwhelm your followers' news feeds.

Don't focus solely on your practice

No one enjoys being stuck in a conversation with someone who only wants to talk about him- or herself. Arguably, social media mimic that same one-sided conversation with billions of users. When it comes to your practice, it's best to find a healthy balance between self-promotion and catering to your followers. Sharing the occasional offer is acceptable, but try to mix it up with useful content. Your followers will be thankful and more likely to share your promotional posts.

Avoid making these social media mistakes, and your followers may turn into loyal patients. Remember, like most things, mastering the art of social media will take time! Post consistently and engage with your followers, and your online reputation will flourish. ■

For further information, see this website: http://bit.ly/2nrUVSi.

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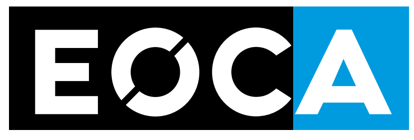

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How to Respond Gracefully to Yelp Negativity–Without Violating HIPAA

by Melody Gandy-Bohr

It doesn't matter if your practice is the perfect example of professionalism and patient care; at some point you will receive a negative review. While you certainly have the right to defend your practice when responding to reviews, it's important to exercise caution. Doctors, dentists, and other physicians are bound by the Health Insurance Portability and Accountability Act (HIPAA) to protect their patients' private health information. Violating HIPAA can lead to serious consequences for your practice. Read this guide before hastily responding to a negative review.

Understand what you cannot disclose

More often than not, negative Yelp reviews are complaints about rude receptionists or long wait times. However, when a patient leaves a review regarding treatment, your response to that review cannot reference the treatment—even if the patient mentioned it first. While trying to combat a negative review, one dentist in Washington disclosed details of the patient's dental records. It is a HIPAA violation to disclose any aspect of the patient's diagnosis or treatment. Knowing the law can save your practice from being reported or fined.

When in doubt, take the conversation offline

Depending on the nature of the review, it may serve your practice to refrain from responding online. Whether you need more information or the complaint is very inflammatory, err on the side of caution and take the conversation offline. If you need more information to address a concern presented in a review, never ask the reviewer for any private health details. Instead, direct the reviewer to contact your practice to further discuss the matter. Innocent inquiries, such as asking on a public forum for the date the patient visited your practice, could result in a HIPAA violation.

Reread, reflect, then respond

The most important lesson when responding to negative reviews is to think before you act. Never respond to a reviewer when you're feeling angry or defensive. Take a moment to reread the review, take it in, and then carefully respond. At the end of the day, the patient is always right (even when they're not). Take the high road and apologize to the reviewer for the bad experience, and offer a solution if applicable. A professional response not only protects your patient's privacy; it also protects your practice's reputation.

As long as online review sites like Yelp exist, so will negative reviews. If you can learn not to take negativity on Yelp personally, you can keep your practice's HIPAA compliance intact. ■

For further information, see this website: http://bit.ly/2nrUVSi.

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the Lighter Side

Anatomy of a Career Change

by Jack Von Bulow, DDS

Dr. Jack Von Bulow was born and raised, and still resides, in Southern California, currently in Pasadena. He's practiced restorative dentistry at Temple City Dental Care since somewhere around mid/late Disco. After well over 30 years in dentistry, the math notwithstanding, he assures us his physiological/maturity age remains somewhere in the mid-30s.

Dr. Von Bulow received his BS from Cal State University, Los Angeles, and his DDS from the University of Southern California. He is a member of the American Academy of Cosmetic Dentistry, the Academy for Laser Dentistry, the American Academy for Clear Aligners, and the Crown Council. He's a Premium Preferred Invisalign provider and president of Invisalign's Reingage Los Angeles component, Los Aligners; he was also a finalist in the 2015 Invisalign GP Summit.

Dr. Von Bulow enjoys reading, the movies, and exercising at OCD levels (as long as the exercise is not life threatening). He is an unreformed USC Trojans apologist and has been a weekly contributor to local newspapers for almost 20 years. Dr. Von Bulow has published two books: *Can We Smile?* and *Molar Jockey Memoirs*. He asks, "Why not practice effective business, health care, and dentistry within a culture of love, humor, and compassion?"

So I owe Bruno the Terrible big time.

I was a tenth grader on my way to being the next great commercial artist/NBA point guard…until Bruno showed up.

First day of sophomore art class, the dreaded, legendary Mark Keppel High thug was seated on my right as we shared a rectangular table. And Bruno's ultrahot girlfriend sat directly across from me. When I closed my eyes, I saw the words "awkward," "dangerous," and "death."

Bruno only stood about 5'3"; he looked like the felony version of the Fonz. On his left forearm, a tattoo read "Born to kill"; on Bruno's right I noticed some serious Black Widow art.

Bruno looked like he was about 23 years old (coulda been the shaved head). I wondered how many attempts at grade 10 the little punk had actually had. And I'm not so sure he ever did make it out of high school; Bruno undoubtedly had a better chance of being paroled outta Folsom.

But one thing's for sure; Bruno could really draw. When I glanced over at the little criminal's work, I saw what Picasso might have been had he chosen an assault-and-battery career. And at 15 years old, I'd never been more excited by elaborate sketches of low-rider cars and incredibly beautiful naked women.

Yeah, Bruno could really draw. But sadly, while sketching, Bruno could also kick my butt without even trying.

In a moment of clarity, I made a career change. I picked dentistry. What could be easier?

And the journey might have been a little bumpy at times. That first-quarter 2.13 GPA at Cal State LA and my Dad's wake-up call that followed pretty much transformed me into a stellar student, a passable warehouseman, and a social activist. I also acquired a fear of lifting heavy things and being shot at in the jungle.

I was accepted into every dental school to which I applied. I was first welcomed by Creighton University, and compared to looking over my shoulder for the Viet Cong version of Bruno Lomelli, freezing half the year in Nebraska and actually going to Mass every Sunday seemed like a fairly cool option.

But my family had suffered the tragic loss of my brother, and it was a blessing that I received a letter of acceptance from USC. I could stay close to home. But I wasn't so sure about the "total" part of the blessing when my dad got the bill.

Back in the day, if USC had been a person, it would have been slightly more conservative than Mike Pence's redneck uncle. At my interview, the dean of admissions shared that he was impressed with my work and thought I looked more or less normal; he then asked what my dad did for a living. When I answered, "Teamster Business Representative," the dean shared, "…unions were good in their day." I asked the dean what he thought about slavery. Maybe a tactical error, but nobody talks mess about my dad.

What followed were arguably the worst four years of my life. It seemed like every pipsqueak who'd ever wanted to wear a barber's smock with red stripes on its sleeves and would later watch the first half of *Full Metal Jacket* at least 30 times was in my freakin' face nonstop.

USC's dental school is located at 925 West 34th Street. I've called my escape the Miracle on 34th Street ever since. I think I'm still looking over my shoulder for Bruno Lomelli; sometimes even when I'm presenting care I know I can deliver. Only this time, Bruno is suited up in a barber's smock with red stripes on its sleeves.

So this past weekend, I attended Dr. David Galler's Reingage course for the second time. And no, the Wolf of Invisalign didn't make me do it; it wasn't remedial. I volunteered.

As Day Two was drawing to an end, David talked about dentists as a group: about how ours was different from other professions. It was as if somewhere deep down, we were all somehow broken. It was as if we were prone to second-guessing ourselves even when we were trained and prepared almost to an OCD fault.

But thanks to David, one of the most generous souls I've ever met, I now know the answer and I'm totally on my way from Premier to Elite. Nothing's gonna stop me. I'm leaving the past in the past and movin' on.

So goodbye, Bruno Lomelli, and goodbye, dental school Brunos, too! You're both dead to me now—unless I see you on Highway 5, where in my mind, you'll both be driving between LA and Anaheim…for eternity!

Think I'll sit down and maybe have an Arnold Palmer or something. I know; I'll watch the Wolf's viral YouTube wave thing for a little while…that's the ticket.

But…watch out Monday, there's a new artist in town! ■

So goodbye, Bruno Lomelli, and goodbye, dental school Brunos, too! You're both dead to me now—unless I see you on Highway 5, where in my mind, you'll both be driving between LA and Anaheim…for eternity!

Industry News

CareCredit and Henry Schein Financial Services complete multi-year agreement

CareCredit, a leading provider of promotional healthcare financing through its health, wellness and personal care credit card, has announced a new multi-year agreement with Henry Schein Financial Services, LLC, a subsidiary of Henry Schein, Inc., the world's largest provider of healthcare products and services to office-based dental, animal health and medical practitioners.

Under the new agreement, CareCredit will provide patient financing services and offer integrated solutions with Henry Schein's practice management software programs—Dentrix® and Easy Dental® for dental practitioners. The added feature will make it convenient for dental practices to offer financing options to help patients receive needed care and services. The alliance will also include co-marketing programs and collaboration on prospective, value-added services, and the availability of the patient financing services will be promoted by Henry Schein's field sales consultants.

CareCredit research shows the availability of financing options plays a key role in how patients approach their healthcare decisions. According to Path to Purchase healthcare research, more patients considered or researched financing (73%) than researched procedures or treatments (70%). The same study showed the likelihood of patients applying for or using a healthcare credit card increases as the cost of care increases. Additionally, half of respondents (50%) who did not have a CareCredit credit card stated they would consider financing if it enabled them to purchase the healthcare service, or related items, immediately. ■

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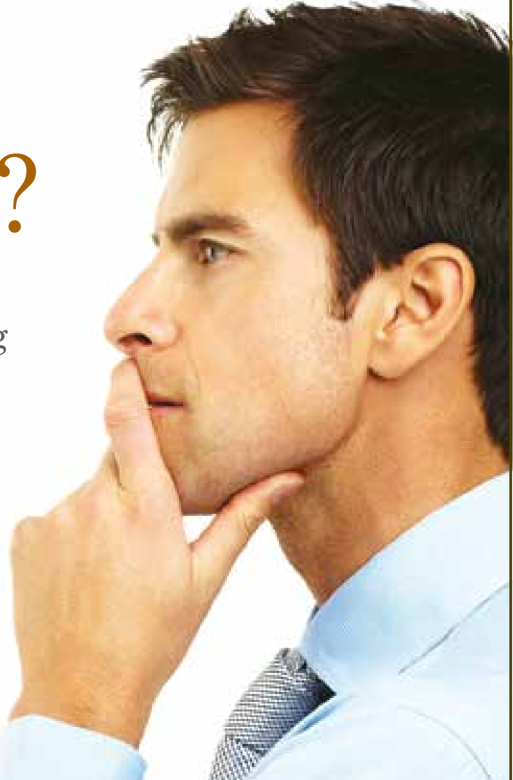

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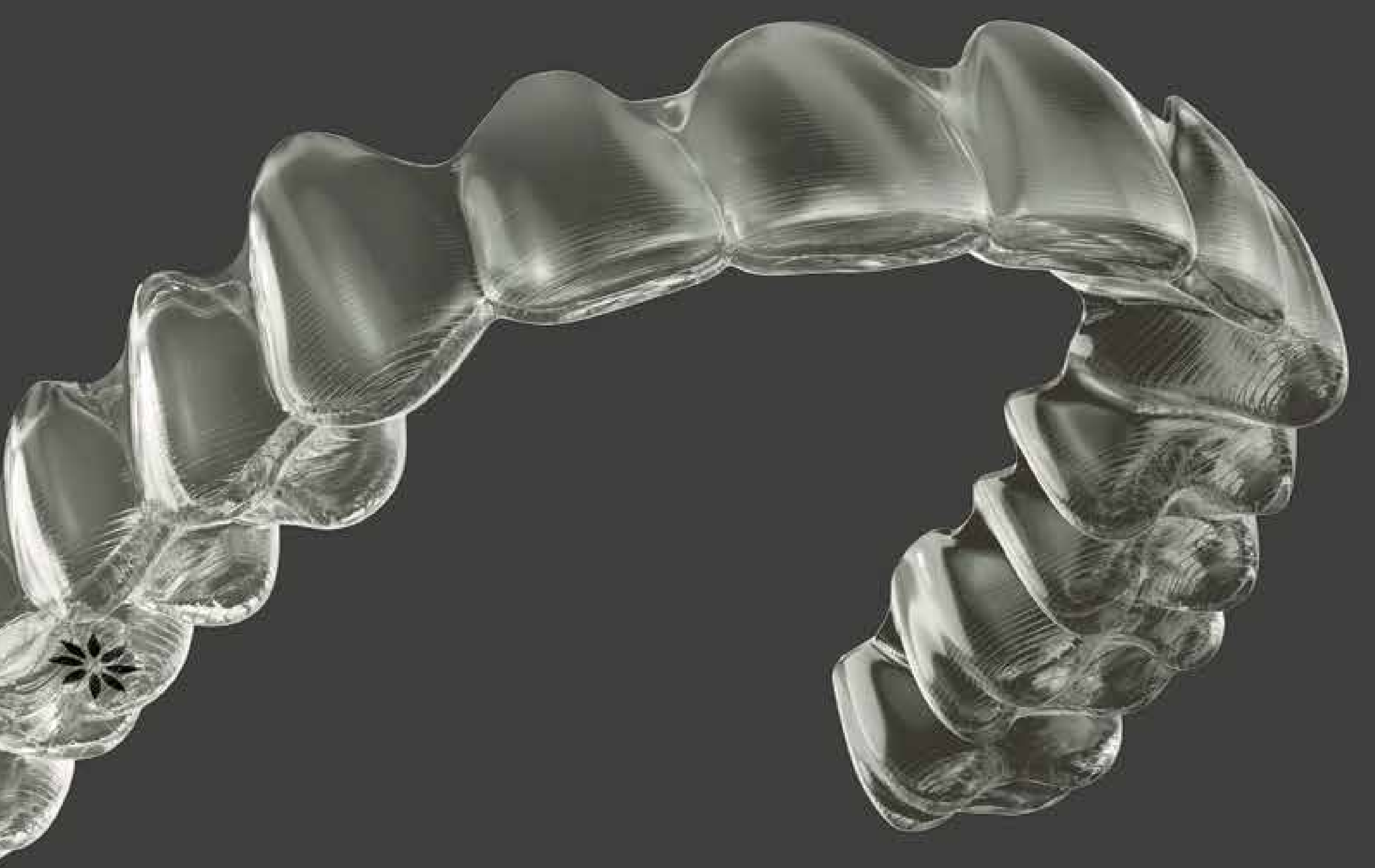

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