

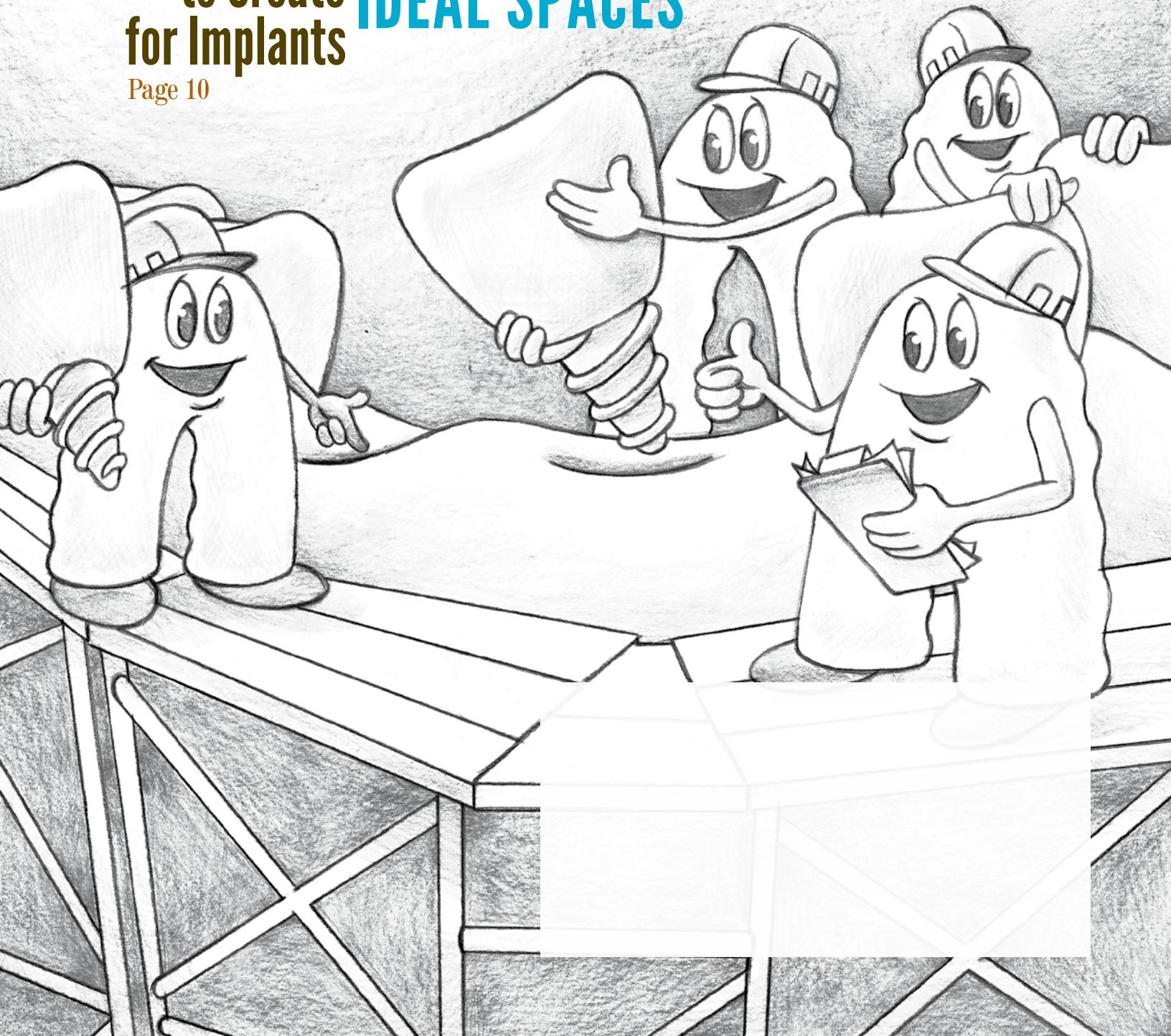
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Editorial

I recently heard two contrasting ideas from two different patients. The first was a math professor at Brooklyn College, who enjoyed teaching his course during the shortened, intense summer session.

"I get to teach my entire syllabus in six weeks," he explained. "I can immediately evaluate if my students succeed in absorbing all of the material. I love getting instant gratification."

The second patient was the director of a city agency that deals with developmentally disabled children.

"In this line of work," he explained, "slow, small steps of deferred gratification are the norm. I need to hire people who can enjoy small increments of professional fulfillment over a long period. Anyone who demands instant gratification will likely be frustrated, unhappy, and even abusive to clients."

These conversations led me to reflect upon the modes in which we dentists can transform our patients' lives.

Sometimes we aggressively rehabilitate a patient's dentition with very invasive preparations. This provides relatively fast, almost instant gratification. Our treatment, though, is aggressive, invasive, and irreversible, and will often need future re-treatment.

Other times, we slowly transform a patient's smile with Clear Aligner Treatment. We induce changes with small incremental steps, over a longer period. This treatment yields deferred gratification, rather than instant gratification, but does not involve aggressive, invasive treatments.

In our dental offices, does it have to be only one or the other? We can provide both modes of treatment, depending upon the patient and the clinical circumstance. There are many roads to professional satisfaction, if we carefully provide patients with ethical treatment options and state-of-the-art care.

Dr. Jeffrey Galler
Editor

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Case Report

Manual Osteoperforation and High-Frequency Vibration: the Dynamic Duo

by R. Bruce McFarlane, DMD, BSc (Dent), MCID, FRCD(C)



Dr. R. Bruce McFarlane is a 1984 dental graduate of the University of Manitoba and attained his master's degree in orthodontics from the University of Western Ontario in 1992. He is a clear aligner pioneer, educator, mentor, and master. He travels and teaches extensively for Align Technology, Henry

Schein Orthodontics, and Propel Orthodontics. He is a board member of the AACFA. In his spare time, he enjoys fitness, technology, and philanthropy.

When darkness falls over Gotham City, Batman and Robin spring into action to save the citizens from the evil that lurks in the underworld. Similarly, when it comes to providing first-class orthodontic treatment, manual osteoperforation (MOP) and high-frequency vibration spring into action to save the day.

Manual osteoperforation is a scientifically proven¹ method of orthodontic acceleration with a good track record of success in my practice. There is demand for acceleration solutions: by far the most common question faced daily by an orthodontist is "How much longer do I have?" Add high-frequency vibration for better aligner seating to the mix, and you have a one-two punch. **Wham!**

MOP works at the cellular level, via small perforations through the mucosa and into the bone near the roots of teeth that are to be accelerated (**Figure 1**). This minor injury causes a local area of inflammation that recruits a cytokine cascade, and ultimately osteoclasts, to accelerate the rate of tooth movement. The "halo" of influence of the perforation is about 6 to 10 mm beyond the site of perforation. The biological effect initiates immediately and reaches peak levels within the first 24 hours; the total effect can last about 12 weeks.



Figure 1: MOP performed with a reusable manual driver.

MOP can be used with any age group, but is especially useful in older adolescents and adults, as the cellular activity necessary to move teeth is not as effectual in them as it is in children.

In my experience the effect of MOP is enhanced with an aligner that is well seated.

Certain orthodontic movements with aligners are slower and less predictable than others. These can include, but are not limited to:

- Space closure
- Guiding in ectopic or impacted teeth
- Unraveling very crowded teeth
- Uprighting
- Derotation
- Expansion

Historically, when faced with particularly slow or difficult movements, the practitioner could turn to invasive procedures such as corticotomy and luxation, or simply wait it out. The advent of MOP has given us a less invasive but seemingly effective method of speeding up slow or difficult movements.



Figure 2: Excellerator RT.



Figure 3: Excellerator PT.



Figure 4: VPro5 high-frequency vibration device.



Figure 5: aligners and VPro5.



Figure 6: MOP and vibration in a space-closure case.

In many cases it is the patient or parent that acts as the catalyst, by expressing impatience and asking if there is a way to move things along mid-treatment. It is often these enquiries that prompt the discussion about the application of MOP.

MOP treatment

The MOP treatment itself is very simple in nature. There is a choice of devices to deliver the MOPs: the hand-driven Excellerator RT (Figure 2) or the motor-driven Excellerator PT (Figure 3). The patient is anesthetized and we perform the osteoperforation. Afterwards, patients may experience some tenderness around the treatment site for 24 to 48 hours. NSAIDs should be avoided, as they inhibit inflammation and therefore the beneficial effect. Any discomfort should be treated with acetaminophen.

MOP can be applied to orthodontic movement, no matter how it is delivered: via fixed, removable, or clear aligner devices. With the latter, I've found that osteoperforation can often contribute to recapturing the "tracking" of the devices, thus eliminating the need for a case refinement or midcourse correction. As well, it should shorten aligner intervals.

High-frequency vibration

High-frequency vibration is delivered via the VPro5 mouthpiece vibrator with a rechargeable power unit (Figure 4). The patient bites lightly on it for five minutes per day with aligners in; we recommend after dinner or at bedtime. The high-frequency vibration is transmitted through the mouthpiece and onto the aligners and teeth, leading to better aligner seating (Figure 5).

MOP benefits

I've found that the tangible advantage of the use of osteoperforation is to move the case along, thus finishing sooner, with fewer visits, and hence more profitability per visit. Perhaps less tangible but just as important is the patient satisfaction aspect: one can speed up the difficult movements, keep on-time promises, and save reputations!

Overall, MOP and high-frequency vibration (Figure 6) are among the least expensive orthodontic acceleration techniques, and many fee guides have a fee code and value for the MOP procedure.

Clinical case application

I present here an example of a clear aligner case that was not tracking well owing to difficult tooth movements.

This case illustrates reactive application of MOP and high-frequency vibration in a clear aligner case. A 49-year-old female with a Class I crowded malocclusion requested Clear Aligner Therapy (Figures 7-8).

Six months into Clear Aligner Treatment, the upper right canine stopped tracking (Figure 9). There was a discussion about midcourse correction, but instead we chose to use MOP (for acceleration), high-frequency vibration (for better aligner seating), and IPR (for reshaping/resizing teeth)



Figure 7: original malocclusion: right side.



Figure 9: nontracking upper right canine.



Figure 8: original malocclusion: center.



Figure 10: MOP around the canine root.

(Figure 10). Eight weeks later, the canine was back on track without auxiliaries or midcourse correction (Figure 11).

In conclusion, the dynamic duo of MOP and high-frequency vibration is a useful, effective, and economic solution to help you provide first-class orthodontic tooth movement. **Pow!** ■

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Figure 11: canine back on track.



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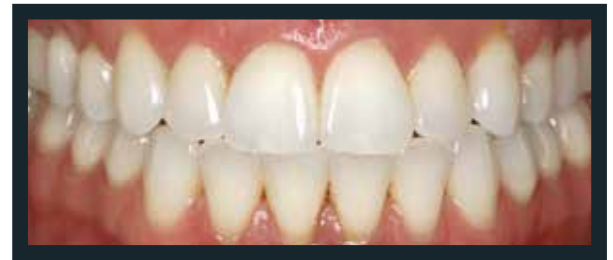
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Feature Article

Restorative Solutions: Managing a Single Implant and Invisalign Tooth Movement



by Perry E. Jones, DDS, MAGD, IADFE



Dr. Perry Jones is a graduate of Virginia Commonwealth University School of Dentistry, where he now serves as Director of Continuing Education and Faculty Development, as well as Adjunct Faculty, Associate Professor, Department of Oral Maxillofacial Surgery.

He is Director of the Virginia Academy of General Dentistry MasterTrack program, and is a Master of the Academy of General Dentistry. One of the very first GP Align Technology education speakers, Dr. Jones lectures extensively and has given some 300+ Invisalign and iTero presentations.

Currently, Dr. Jones serves as Director of Education for AACA, and maintains an active private practice in Richmond, Va.

Introduction

This case presents a not uncommon finding of a retained deciduous tooth with a congenitally missing permanent bicuspid. Restorative solutions typically include implant restoration. Many if not most of these cases are also candidates for tooth movement with Clear Aligner Treatment (CAT) to resolve other issues such as crowding/spacing, rotations, arch form coordination, etc.

So often, we as clinicians see only the opportunity to place/restore an implant, when the case may actually benefit from simple tooth movement as well. Time is of course a factor, as patients most often wish to finish the treatment as soon as is reasonable. As we will see, several treatment options are available to help reduce the overall length of treatment time. These strategies include:

- Planning placement of the implant at the same time as the extraction, saving healing time



Figure 1: pre-treatment Panorex image showing favorable conditions for implant at site #29.

- Allowing the implant integration to be completed during aligner wear, saving overall time

The overall goal is to restore proper fit, function, and esthetics for a lifetime of dental benefit.

Clinical examination

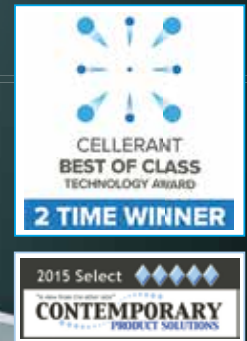
The patient presented as a 25-year-old healthy male with a noncontributory medical history. The patient's chief complaint was his desire to have his retained deciduous second molar extracted, and to have an implant/restoration placed to replace his congenitally missing lower second bicuspid. He also stated that he had always been interested in resolving his crowding, but had not pursued this as he did not want "braces."

We completed a comprehensive assessment to evaluate both restorative and tooth movement options.

Diagnostic findings

Periodontal: the patient's periodontal health was excellent, with probing depths of 2-3 mm with no bleeding on probing. Radiographic data revealed no loss of crestal bone density.

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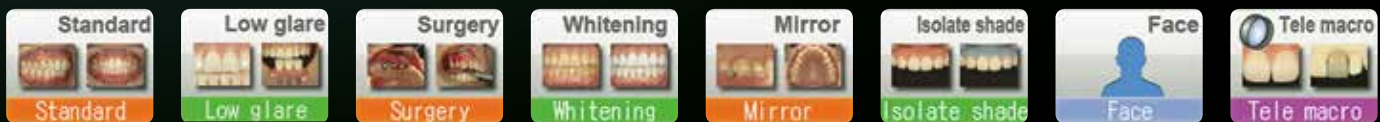
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Restorative: Several posterior teeth had small occlusal restorations.

Temporomandibular joint (TMJ)/muscles of mastication:

Evaluation revealed an apparently healthy TMJ with no pain on palpation, a full range of motion, and no joint pain or noise. The patient denied bruxing or clenching.

Occlusion: Right side, compromised intercuspation due to retained deciduous tooth. Left side, good intercuspation. Anterior edge-to-edge relationship.

Radiographs: Evaluation of Panorex and periapical information indicated abundant bone at the proposed implant site #29, with minimal anatomic concerns (**Figures 1-2**).

Summary of orthodontic information

Study models (**Figures 3-7**)

Photo template (**Figure 8**)

Extraoral photos (**Figure 9**)

Pre-treatment photos (**Figures 10-14**)

Radiographs: Panorex (**Figure 1**), periapical (**Figure 2**)

Sagittal dimension:

- Cuspid: right & left side Class I
- Molar: right & left side Class I
- Overjet: edge to edge
- Incisor profile maxillary (Mx): upright
- Incisor profile mandibular (Md): upright
- Curve of Spee: slightly concave

Vertical dimension:

- Overbite: edge to edge
- Anterior leveling: Mx anterior moderately high, teeth #7, 8, 9, 10
- Anterior leveling: Md low, tooth #23

Horizontal dimension:

- Midline upper to facial: centered
- Midline lower to upper: 1 mm to the left
- Anterior crossbite right side, tooth #6
- Posterior crossbite: none
- Arch shape upper: square
- Arch shape lower: square
- Inclination of posterior teeth: slightly lingual

Arch length:

- Upper arch: crowding 3 mm
- Lower arch: crowding 3 mm
- Missing teeth: #29
- Bicuspid/canine rotations: #5, #11, #12, #22, #27

Treatment objectives

Tooth movement objectives include:

- Resolve upper and lower crowding
- Resolve canine rotations

- Effect maxillary expansion and proclination with no Interproximal Reduction (IPR)
- Resolve mandibular right canine crossbite
- Reduce space of retained deciduous tooth T for space management and to aid implant restoration. (Deciduous second molars are 1.5 mm larger than the permanent bicuspid that will replace them. This excess space is called the "E" space. Normally, this space closes as the permanent second bicuspid erupts following exfoliation of the deciduous second molar. In this case, as there was a congenitally missing second permanent molar, we planned to use that space to help correct the midline and help resolve the anterior crowding. Subsequently we would use tooth movement with Invisalign to close the "E" space.)
- Place implant fixture prior to Invisalign to allow integration during tooth movement to reduce overall treatment time
- Maintain Class I anterior-posterior (A-P) relationships

Implant placement objectives include:

- Construct a guided surgical guide
- Remove deciduous tooth T
- Place implant fixture at time of extraction (to reduce wait time for extraction site healing)
- Carry out all the above in a single stage with healing abutment

Clinical treatment

After a discussion of consent alternatives, benefits and complications, the patient agreed to a CAT plan with the Invisalign movement system, extraction of tooth T and immediate implant placement using a guided surgical guide.

Presurgical treatment

Prior to the surgical procedure, we created a stone model from a vinyl polysiloxane (VPS) impression of the lower arch. Given the abundance of available bone in all dimensions, we constructed the guide on the stone model (**Figure 15**).

We used a drill press to center the implant location and parallel the long axis of the proximal first molar. The drill press position was made slightly more distal, as we planned to effect the deciduous space closure via distal crown tipping of the first bicuspid (**Figure 16**).

Using the NobelGuide system, we placed an implant analogue in the drill press hole. We adjusted the Nobel RP implant analogue to about 3 mm apical to the gingival height, and cemented it with Triad pink gel. We then secured the guide parts to hold a metal cylinder at the proper height for the Nobel Biocare guided surgical guide system.

We painted a separating medium on the model, and formed Triad material around the cylinder and over the occlusal surface to the height of contour of the lower teeth (**Figure 17**). The Triad was light cured and the guide trimmed and polished. The guide could not be clinically tried for fit until the retained deciduous tooth was removed.

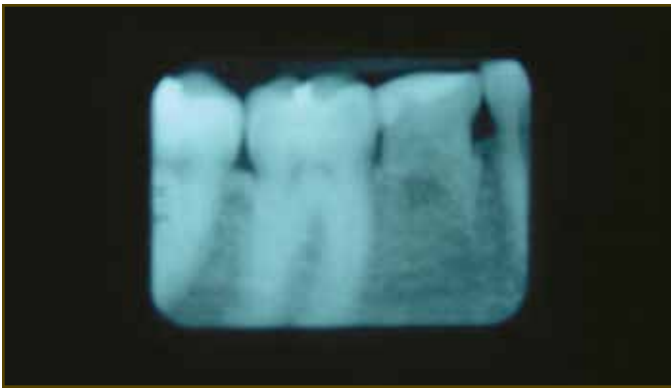


Figure 2: pre-treatment periapical image at site #29.



Figure 6: study model, maxillary view.



Figure 3: study model, anterior view.



Figure 7: study model, mandibular view.



Figure 4: study model, right view.



Figure 8: photo template.



Figure 5: study model, left view.



Figure 9: pre-treatment smile.



Figure 10: pre-treatment retracted view.



Figure 14: pre-treatment mandibular view.



Figure 11: pre-treatment right side view.



Figure 15: surgical guide constructed on the stone model.



Figure 12: pre-treatment left side view.



Figure 16: drill press hole in the stone model, centered slightly more distally than the deciduous tooth.



Figure 13: pre-treatment maxillary view.



Figure 17: Triad material formed around metal cylinder positioned in the model.

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Figure 18: deciduous tooth T about to be sectioned.



Figure 22: placing the implant fixture.



Figure 19: deciduous tooth T after sectioning.



Figure 23: implant positioned.



Figure 20: after removal of deciduous tooth T.



Figure 24: Occlusal View with abutment in place.



Figure 21: fitting the surgical guide.



Figure 25: Buccal View with abutment in place.



Figure 26: radiograph with abutment in place.



Figure 29: mandibular view showing integration of implant.



Figure 27: cephalometric radiograph with abutment in place.



Figure 30: placement of plastic implant impression coping.

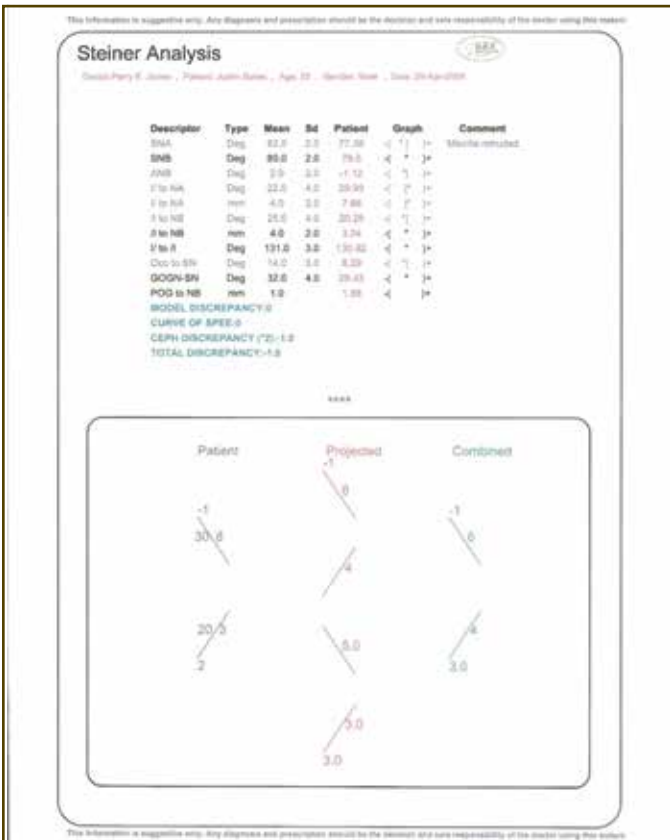


Figure 28: Steiner analysis before developing Clear Aligner Treatment plan.



Figure 31: placement of plastic implant impression coping.



Figure 32: PFM screw-retained crown restoration.

Surgical treatment

After administering local anesthesia, we used a high-speed handpiece with surgical bur to section tooth T into two mesial-distal (M-D) segments with a full-length buccal-lingual (B-L) cut (**Figure 18**). The two segments of tooth T (**Figure 19**) were removed with care to preserve bone height (**Figure 20**). Following removal of tooth T, we tried the premade surgical guide for fit (**Figure 21**).

Using the NobelGuide kit of sequential drills and collimators, we prepared the site for implant placement. We then placed a Nobel Replace Select RP implant fixture (**Figure 22**).

As designed with the implant guide, the implant was placed slightly more toward the molar to allow the planned distal bicuspid movements (**Figure 23**).

Next, as planned, we placed a standard 4.3 mm healing abutment; this can be seen in the Occlusal View (**Figure 24**) and Buccal View (**Figure 25**). A radiograph taken immediately following placement (**Figure 26**) verifies proper implant location in the vertical dimension, as well as excellent angulation.

Invisalign treatment

Following implant placement, we took a cephalometric radiograph (**Figure 27**) and performed an analysis to help develop the proposed treatment plan to be submitted to Align. A Steiner analysis confirmed a slightly retruded maxilla, and otherwise WNR (within normal range) values that were within mean standard deviation (**Figure 28**).

We made several changes to the ClinCheck treatment plan so that the movements would qualify for the Express 10 product.

- We removed initial maxillary IPR from the ClinCheck.
- We removed mandibular arch asymmetrical IPR, initially added for midline correction. Instead, we added midline correction using space closure of the M-D width at tooth T via distal movements of adjacent teeth mesial to the space.
- Given the cephalometric analysis of a retruded maxilla, the sagittal edge-to-edge anterior relationship would be best resolved with maxillary expansion and proclination. Hence we added these features, as well as adjustment to help optimize the anterior esthetics.

Treatment outcomes

Integration of the implant progressed uneventfully (**Figure 29**). We removed the implant healing abutment, placed a plastic implant impression coping (**Figures 30-31**), and took a VPS impression to capture the impression coping. Using conventional model technology, we fabricated a porcelain-fused-to-metal (PFM) screw-retained implant crown restoration (**Figures 32-33**). We then secured the crown with a titanium retention screw and torqued it to a value of 35 N-cm. The titanium retention screw was protected with Teflon tape and the access hole filled with composite resin (**Figure 34**).



Figure 33: PFM screw-retained crown restoration.



Figure 34: post-treatment mandibular view showing finished crown restoration.



Figure 35: post-treatment maxillary view showing crowding resolved.



Figure 36: post-treatment retracted view showing crossbite correction and midline correction.

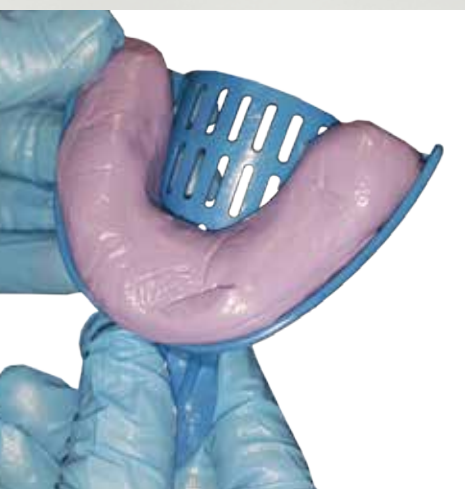


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Figure 37: post-treatment right side showing improved intercuspation.



Figure 38: post-treatment left side.

Simultaneous with implant integration, tooth movement results progressed in an uneventful manner. The final photos demonstrate:

- Maxillary crowding has been resolved with arch form improvement (**Figure 35**).
- Lower arch crowding has been resolved with proper space closure and ideal M-D width at implant restoration area #29 (**Figure 34**).
- The anterior view demonstrates the anterior crossbite correction as well as midline correction (**Figure 36**).
- The right side A-P relationship has been maintained and intercuspation improved (**Figure 37**). The left side A-P has been maintained (**Figure 38**).

Conclusion

Tooth movement with Invisalign can be used in conjunction with management of implant planning, placement, integration, and restoration to optimize results. Treatment times can be reduced by planning for simultaneous implant integration and space management. In this case, the clinician used a simple inexpensive guided prosthetic surgical guide to precisely plan and execute implant location to help optimize the final restoration.

As previously discussed, dentists often treat tooth movement as a separate consideration and not a coordinated solution. Similarly, we tend to view implant placement/restoration as a stand-alone procedure. The case demonstrates a coordinated treatment plan that integrates tooth movement with Invisalign and planned implant placement and restoration. The goal remains to help our patients achieve a lifetime of health, function and esthetics! ■

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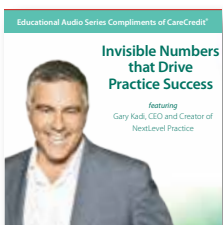
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Clinical Techniques

Attachment Placement Utilizing Injectable Composites

by Geri Holmes, RDA, and Christie Scott, CDA, EDDA



Geri Holmes began her passion for and dedication to dentistry 25 years ago, and received her certification in dental assisting from Tulsa Technology Center in 1991. She currently is the clinical supervisor/lead assistant for Kenneth Garner, DDS, at his three practices in Tulsa, Oklahoma.

Ms. Holmes is also a product evaluator and team trainer for Contemporary Product Solutions. She travels all over the United States and Canada educating dental auxiliaries about Invisalign. Ms. Holmes has attended numerous continuing education courses during her career, and holds an Align Certificate of Excellence (A.C.E.) as well as certifications in radiation safety, coronal polishing, and monitoring nitrous oxide anesthesia.



Christie Scott began her dental career as a dental laboratory technician and bookkeeper for Advanced Dental Studio in Bowling Green, Kentucky. Over ten years, she has expanded her skills and has held almost every staff position in the dental office, with the exception of dentist and

dental hygienist—including assisting orthodontic and surgical cases. In her spare time she volunteers at the local free dental clinic and travels as a volunteer with the “Smiles from the Heart” program.

Introduction

Many courses of Clear Aligner Therapy are accomplished using nothing in the patient’s mouth other than the aligners themselves. For some cases, however, the desired tooth movements require attachments in combination with the aligners for proper tooth positioning.

Attachments enhance the aligner trays’ ability to grip and move a patient’s teeth by providing greater surface area retention. Attachments for Invisalign aligners also serve as anchors for specific segments of teeth, so that some can move while others remain stationary. Easily removed at the end of therapy using a polishing tool, Invisalign attachments do not cause any permanent alteration to the tooth surface(s).

During initial treatment planning, and when treatment planning for Invisalign via ClinCheck, dentists can determine whether attachments are necessary and where they will need to be located (**Figure 1**). Dentists or dental assistants can then create the attachments by affixing small amounts of enamel-colored composite to the teeth, using a bonding agent and Invisalign-designed template aligners. Although this is a simple procedure that requires no anesthesia, dental attachments for Invisalign treatments do require precise placement to ensure that they properly facilitate optimal tooth movement. Complications can occur, especially when improper adhesion delays treatment and/or affects the esthetics of an overall successful orthodontic treatment.

Material and equipment selection

Invisalign provides template aligners for creating optimal attachments, reducing the possibility for variations in attachment shapes and locations. After the practitioner submits the diagnostic records and approves the ClinCheck, Invisalign fabricates the aligners and the template aligners as well. When the patient returns for his or her first aligner appointment, it can include attachment placement and/or Interproximal Reduction.

Many clinicians, however, prefer to only insert the aligners at the first appointment, give the patient a chance to get used to wearing the aligners, and then place attachments and perform Interproximal Reduction at a second visit.

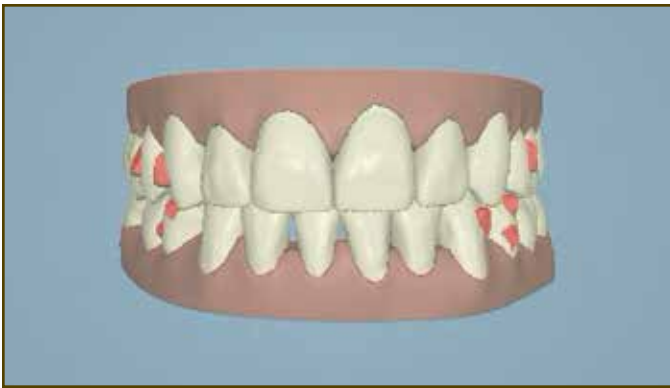


Figure 1: patient's ClinCheck to review for attachment placement.

Attachments require a bond strong enough to anchor aligners, but weak enough to avoid altering the healthy tooth structure during removal. Although many options in bonding materials are available, G-Premio BOND™ from GC America (gcamerica.com) provides enhanced adhesion with quick working time. G-Premio BOND is a universal, eighth-generation bonding agent that is compatible with total-etch, self-etch and selective-etch techniques, providing excellent versatility.

Additionally, because maintaining high esthetics remains an important characteristic of Invisalign treatment, and because placement of the attachments frequently occurs on anterior teeth, a shaded composite (e.g., G-aenial Universal Flo from GC America) that matches the patient's enamel should be selected. This prevents the attachment from interfering with case esthetics throughout the treatment, and reduces patient anxiety regarding the appearance of the attachments. G-aenial Universal Flo composite demonstrates enhanced wear resistance, color stability with higher gloss retention than other tested flowable composites, and great sculptability to achieve the optimal attachment shape.

With many shades to choose from when using G-aenial Universal Flo, the clinician can use a standard Vita shade system, or new outside special shades that will help the clinicians create restorations with age-appropriate value, such as JE (Junior Enamel) and AE (Adult Enamel) from GC America.

Many attachments can be prescribed when it comes to Invisalign treatment. Depending on the complexity of the case, patients can have multiple attachments on one tooth.

Some clinicians are more comfortable using an injectable, flowable composite in creating attachments, while others find they obtain better results with a sculptable composite. The choice of composite is purely a matter of the clinician's preference. With that said, injectable composites are usually much easier to handle, especially when there are multiple attachments to place. When placing attachments, there is a risk of over- or underfilling the attachment window of the template; therefore, most trainers who teach attachment placement for Invisalign prefer to use an injectable composite. The injection method provides the clinician with better control for filling the attachment window areas of the template.



Figure 2: trying in the attachment template and the patient's first aligner to ensure that it snaps into place and fits properly.

The dental armamentarium provides dental assistants with other tools for use in successfully placing attachments. The assistant should use a retractor that comfortably isolates teeth, and saliva ejector or high-volume evacuation to reduce excess saliva and fluid in the oral cavity that could potentially interfere with bonding. Additionally, if the practitioner chooses a heavier, sculptable composite (e.g., G-aenial Sculpt® by GC America), it is essential to use composite placement tools that allow the clinician to press the composite into the template well, ensure that the optimal amount of material is present, and stabilize the template aligner during light-curing.

On occasion, attachments may debond during Invisalign treatment for a variety of reasons, most commonly improper placement technique. A slightly wet template aligner decreases the bonding agent's ability to bond the tooth with the composite and reduces the bond strength. If an attachment debonds, locate the Invisalign Doctors Site (IDS) and request a new template for the patient based on the stage or aligner the patient is wearing at that point in the treatment. (It is extremely difficult to place a new attachment using the aligner the patient is currently wearing, because the actual aligners are stiffer than the template aligners.) In 2 to 3 days, Invisalign will ship the new template aligner, and the missing or debonded attachments can be placed again.

Clinical technique

1. Prior to treatment, explain the attachment process so that the patient knows what to expect.
2. Insert the retractor into the patient's mouth prior to treatment, to isolate the teeth and reduce salivary contamination.
3. Try in the attachment template and ensure that it snaps into place and fits properly. Remove the template and try in the first aligner to ensure that it also fits properly (**Figure 2**).
4. Use an air-water syringe to completely air-dry the template.
5. Review the Invisalign attachment instructions regarding shape and location.



Figure 3: acid-etching the enamel where the attachment will be placed.



Figure 5: filling the attachment template window with the composite.



Figure 4: applying the bonding agent to the etched surface.



Figure 6: light-curing the bonding agent.

6. Acid-etch the enamel of the tooth or teeth that will receive an attachment (**Figure 3**), as per the manufacturer's instructions. Etch only the specific shape and location where the composite attachment will be placed; avoid covering any of the rest of the tooth.
7. Rinse the etched tooth/teeth for 15 seconds and dry until the tooth surfaces have a frosted appearance. If you do not see this, then repeat the step of etching the tooth.
8. Mix the bonding agent and apply it to the etched surface (**Figure 4**), then wait 10 seconds. Dry with light air for 5 seconds (**Figure 5**). Light-cure the bonding agent for 10 seconds, placing the curing light right on the tooth/teeth (**Figure 6**).
9. Load the shade-matched composite into the window of the attachment template (**Figure 7**). Make sure the attachment window is slightly overfilled.
10. Fully seat the loaded template onto the teeth. Use a spatula to apply gentle pressure around each attachment to ensure full adaptation, and squeeze excess composite away from the etched area.
11. Firmly hold down the composite and light-cure according to composite instructions.
12. Remove the attachment template, and then remove all flash and bonding resin between teeth. Floss interproximal areas and remove any excess resin or composite.



Figure 7: filling the attachment template window with the composite.

13. Repeat the procedure for any additional attachments. Seat the patient's first aligner, demonstrating how to put the aligners in and take them out.
14. Keep the template in the patient's Invisalign box. The attachment template is never to be given to the patient.

Conclusion

Invisalign treatments may sometimes require attachments as a fundamental tool to correct tooth alignment and manage occlusion. Accurate and secure placement of attachments ensures that the optimal movement of teeth occurs and avoids wasted time in fixing failed attachments. Dental clinicians can easily place attachments by practicing the optimal placement technique and using the proper tools and materials. This helps to achieve esthetic and functional Invisalign treatment results. ■

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Focus_{on} Photography

Interview with Sammy R. Bryan, DDS, of Bryan Orthodontics

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.

In a recent series of articles dedicated to excellence in photography in an orthodontic practice, we discussed the basic components of successful clinical photography, including selection of camera equipment, accessories, and adherence to protocols. We also highlighted the importance of involving the entire dental team in performing clinical photography tasks. Subsequently, we introduced a new digital dental camera, the EyeSpecial C-II from Shofu, which seems to be helping clinicians overcome some of the challenges associated with traditional cameras.

Dr. Sammy R. Bryan is an early adopter of this new technology, and in this article he shares with the readers his experience with incorporating the EyeSpecial C-II into Bryan Orthodontics, his orthodontic and dentofacial orthopedic practice in Huntsville, Texas.

JAACA: What was your first experience with clinical photography? When did the journey begin?

Dr. Bryan: While in my orthodontic residency, I had the opportunity to incorporate patient photography into all of my cases. I found that having the appropriate camera is vital to documenting cases. Later, after I had been in private practice for a few years, digital cameras were introduced, and that new technology allowed us to instantly view pictures on the camera screen, which meant we no longer had to wait for film to be developed. There are many other advantages of a



Figure 1: full orthodontic photo series achieved with the EyeSpecial C-II digital camera from Shofu.

digital camera, such as incorporating photos into everyday correspondence with other dentists, patients, and insurance companies.

JAACA: Could you describe the photography work flow in your practice?

Dr. Bryan: We take photographs of every patient who is ready to start treatment. The initial records include a full series of facial and intraoral photos (**Figure 1**), appropriate radiographs, iTero scans, and plaster models as needed. We also take photos during treatment to monitor progress. Finally, we take another set of photographs at the end of the treatment, after appliances have been removed. All of our captured images are transferred from our camera via an SD card to our OrthoTrac software.

JAACA: Do you also use a digital camera for patient communication and education, specifically to improve consent and compliance?

Dr. Bryan: Absolutely! Photographs are immensely helpful when I discuss with the patient a proposed treatment plan, or underscore the need for compliance. Showing patients and/or

their parents large, clear, crisp photographs of the problematic areas makes a notable visual impression. For even a greater impact, especially with patients exhibiting very poor oral hygiene, we often transpose the camera images to a 55-inch display to further emphasize the areas of concern and to ensure that the patient visually grasps the gravity of the situation.

JAACA: What camera(s) do you use to take clinical photographs? Do you have different cameras for specific types of photography?

Dr. Bryan: Until recently, we used Kodak's EasyShare DX7590 to meet all our clinical photography needs. However, in May 2016, we acquired the EyeSpecial C-II, and since then have incorporated this camera into our everyday clinical practice.

JAACA: What do you like about this new camera? Are there any specific features that stand out?

Dr. Bryan: The EyeSpecial C-II has many qualities that have remarkably improved the process of taking clinical photographs in our practice. This camera is lightweight, allowing for one-hand operation while holding a cheek retractor or a mirror with the other hand. It has preset modes for the types of images that we take in our practice, making the photography-taking process predictable and easy to achieve for everyone. The camera's pressure-sensitive touch screen is large, and it can be navigated with a gloved hand. The motion-stabilization feature and the gridlines are very helpful in obtaining clear images almost every time. My team finds the EyeSpecial C-II camera to be efficient and very easy to work with.

JAACA: How does this new camera deal with compliance to infection-control protocols?

Dr. Bryan: Since the EyeSpecial C-II camera is water and chemical resistant, we are able to maintain recommended infection-control compliance utilizing our normal surface-disinfecting wipes.

JAACA: Are there any challenges associated with utilizing the EyeSpecial C-II camera? If so, are they camera related? Operator related? Patient related?

Dr. Bryan: With the new camera, the few challenges we experienced were found to be operator related. Initially we had an issue with the camera screen occasionally freezing up, requiring the camera to be turned off and then back on to fix the problem; but that turned out to be a problem with our SD card. Overall, the EyeSpecial C-II camera has been very easy for our staff to use and has definitely improved the quality of our clinical photographs. In our practice, we have a records technician who is in charge of taking most of the clinical images, but with the new camera and its ease of navigation, other clinical staff are also capable of and do take quality photographs.

JAACA: Do you have any advice for dentists looking to adopt smart digital-camera technology into their practices?

Dr. Bryan: I recommend that anyone looking for a new camera for intraoral and facial photography consider the EyeSpecial C-II. Just like with every new technology, there is usually an initial learning curve, but with a little instruction, the implementation soon becomes very easy. The major advantage of the EyeSpecial C-II is that the camera is made for dentistry. It is user friendly and lightweight, which my team really appreciates, and it consistently produces great results.

Disclosure

Anna Kataoka is an employee of Shofu Dental Corporation. ■

This article was originally published in Tribune America's 2016 Greater New York Dental Meeting Show Daily, Vol. 11, Issue 1.



Dr. Sammy R. Bryan is the founder of Bryan Orthodontics, a state-of-the-art orthodontic and dentofacial orthopedic practice in Huntsville, Texas. He graduated from the University of Texas Dental School at Houston. After practicing general dentistry for several years, Dr. Bryan returned to his alma mater to complete the Graduate Orthodontic

Program and receive his orthodontic certification. Dr. Bryan is an active member of several professional organizations, including American Association of Orthodontists, Texas Orthodontic Association (past president), American Dental Association, Texas Dental Association, and International College of Dentists. Besides providing outstanding orthodontic services for over 29 years, Dr. Bryan has also dedicated his time and resources to community-oriented projects and organizations such as the Boy Scouts of America, Huntsville YMCA (past president) and American Heart Association of Walker County (past president). He was a Texas Dentist of the Year nominee in 2015. Dr. Bryan is happily married to Connie, his wife of 37 years. The couple has two children, Kody and Dana, who are also part of the Bryan Orthodontics practice



Figure 2: Clinical team. Left to right: Myosha (clinical assistant and lab coordinator), Ann (clinical assistant and inventory coordinator), Alex (scheduling coordinator), Kody (financial coordinator), Dr. Bryan (founder, Bryan Orthodontics), Dana (treatment and marketing coordinator), Mindy (clinical assistant), Naomi (clinical assistant and records coordinator).

Financial Management

The Commercial Lease: What to Look For

by Sanford D. Bosin, DMD, FAGD

When you begin your practice or relocate your business, your lease is one of the first items to consider. It lays the foundation for the infrastructure of your practice, and can set the direction for its future growth.

You'll want the detailed advice of a professional before you agree to any lease, but a basic knowledge of the parameters of a lease can help you when searching for a space and discussing plans with prospective landlords. The number of variables can initially be overwhelming, but I can offer you some guidelines that will assist you through this often arduous and frustrating



Dr. Sanford D. Bosin is an orthodontist who has maintained private practices in both New York and New Jersey for over thirty years.

Dr. Bosin graduated from dental school at Fairleigh Dickinson University in 1981. He completed a four-year general practice

residency in the United States Navy Dental Corps, and completed his education with a postgraduate degree in orthodontics from New York University.

Dr. Bosin is a certified premier Invisalign provider, and he has numerous professional affiliations that include the American Association of Orthodontics, the American Dental Association, and the Middlesex County Dental Society, and has attained Fellowship status in the Academy of General Dentistry. In addition, Dr. Bosin has been named "Top Dentist" by *New Jersey Monthly Magazine* for the past four years running. Dr. Bosin also holds several patents pertaining to prosthetic dentistry. He has published in the *Journal of Clinical Preventive Dentistry* and *Dental Student Magazine*.

In his leisure Dr. Bosin enjoys spending quality time with his wife Susan and their three children, and grandchildren Elliot and Mason. He also enjoys playing tennis and golf, traveling, and helping support the local community.

process. Let's take it step by step to familiarize you with the provisions of the landlord-tenant (lessor-lessee) contract.

Location: Or proverbially, Location, location, location!

The location you choose is almost certainly the most important part of the lease. Visibility is crucial and often related to the time line of growth of your business. It is important to research your demographics to determine where the premises are situated in relation to traffic flow and population density.

Whether a rental unit is freestanding or part of a medical facility is of paramount importance; so is the floor level on which the space is located. Handicap access and accommodation for children are equally important, but more often than not, these aspects have already been addressed by the ADA (Americans with Disabilities Act) and the unit is in compliance. (Nonetheless, they should be covered explicitly in the lease.)

Square footage: When considering the size of the space you will lease, it is important to consider future growth of your business, not merely your present needs. In addition, consider the need for storage space and staff accommodation. A well-thought-out architectural design is worth its weight in gold—which leads us to...

Architectural design: Your space should be designed specifically for the ergonomics of your practice. Patient flow, as well as layout of treatment areas, should be well thought out for the individual practitioner's needs and convenience. All bathrooms and plumbed areas should be well distributed for patient access, and designated for staff as well as customer usage. There should also be a separate, designated area for staff that can be used for dinner breaks and office meetings, and a changing area for office apparel.

Term: This is nearly as important as location. The questions you need to ask yourself are: "How long a lease do I want?"; "Do I wish the option to extend beyond the initial term of the lease?"; and "How many extensions should I ask for?" (See **Extension** below.) You want to be able to maintain your business at this location as long as the location is compatible with your long-term growth.

This aspect is typically spelled out as: Five-year lease with two (2) three-year options to renew. **Note:** the option to renew (extend) is usually provided to the tenant by default, unless the tenant is in breach of the lease at the time of renewal.

Exclusivity (or restrictive covenant): You most definitely wish to include a provision to block the building from renting an office to another tenant in the same (or similar) business as yours. This may prevent a competitor from siphoning off clients on your home ground.

Rental per square foot: What is the usual and customary price in the area and within the building for a rental similar in location to yours? What is the escalation cost (expressed as percent per year)? Are there any additional costs over the base rental? In particular, are utilities, taxes, maintenance or other “common area costs” included within the base rental, or are they additional and billed separately? If there are common area costs, how are they calculated?

A lease that includes separate charges for common area costs is sometimes referred to as a net-net (base rental plus property taxes) or triple net (base rental plus taxes plus maintenance) lease.

With every lease, there is a negotiation process whose result has to be mutually agreed upon by landlord and tenant. For example, the leased monthly rental amount can sometimes be creatively altered if renovation or leasehold improvements are required to accommodate the business prior to the tenant’s taking possession of the premises. The landlord may agree to complete these renovations at his own expense and raise the rent to amortize his initial outlay. Such a consideration can help you to preserve working capital for the initial start-up of your office.

Assignment/sublet:

This item is specific to the individual lease, as it

dictates whether or not the tenant can assign the terms of the lease to a third party, or allow the space to be occupied by a third party while continuing to be responsible under the original terms of the lease. This can cause problems for a landlord, as it limits the landlord’s control over the property and over the people and businesses occupying it. Hence it is rarely acceptable to the landlord, and must be negotiated if desired by the prospective tenant.

Insurance: The landlord will require you to obtain insurance, both liability and property, which names the landlord (an individual or corporate entity) under the rental agreement as the insured. The limits of insurance required may vary from landlord to landlord. Finally, you will need to present the declaration page of your insurance policy to your landlord annually upon renewal of your policy.

Waiver of trial by jury: If a dispute should arise between tenant and landlord, this option allows an arbitrator to settle the dispute without the burden of excessive legal and court costs.

This provision may be added to your lease, if mutually acceptable, to enhance an amicable outcome between both parties.

Signage: The size, illumination, design, and location of your sign(s) are just a few aspects that may be addressed within a lease as adjuncts to advertising your business. The cost of placement, construction, and installation may be either absorbed within your lease, carried as a separate financial responsibility by the tenant, or compensated entirely by the landlord and included in the rent. Any signage to be displayed, however, must be approved by the landlord in writing.

Personal guarantee: Whether you enter into a lease as a sole proprietorship, an LLC, or a corporation, the landlord will probably require you to sign the lease with a personal guarantee—rather than under the



business name or trade name. This ensures that the terms and all stipulations within the lease are honored if the company under which you operate is dissolved or altered in any way or form. It provides the landlord with legal recourse for damages in the event that a tenant departs the property prior to the completion of the term of the lease.

Holdover: This provision is placed in the lease to protect the landlord at the end of the lease term. If a tenant decides not to renew his or her lease in writing, but still remains in the premises beyond the lease term, the landlord has the right to charge a penalty over and above the rental amount for each additional month the tenant remains.

By remaining in the premises on a month-to-month basis, the tenant is preventing the landlord from re-renting the premises and procuring a long-term lease from some other tenant. Further, if the landlord has entered into an agreement to list the property with a real-estate agent, he may be placed in an awkward situation if the property is not available for rental. The holdover penalty compensates the landlord for this risk. Holdover may cost the lingering tenant in excess of 150% over the basic rental amount.

Right of first refusal: Most tenants who enter into a lease agreement consider at least briefly the thought of ownership. The prospect of owning the property rather than being a tenant is appealing to some; however, whether owning or renting offers you the greater financial benefit is a question that your tax advisor can best address.

In any case, when this clause is included within the lease, it allows the tenant to place an offer on the property if the owner/landlord decides to sell. If the clause is structured properly in the lease, it protects you as the tenant even if the property comes under new ownership; the new landlord must abide by the present lease in effect. It should be noted that even without

this clause, a properly structured lease protects the interests of the tenant.

Security deposit: This sum is paid to the landlord upon the signing of the lease, and provides monetary assurance for the landlord should damage to the property be found upon termination of the lease, or should the tenant terminate the lease before the end of the agreed-upon term. The amount of the security deposit is usually equal to 1 to 2 months' rent, but this can be a point of negotiation. The security deposit should be placed in a separate (escrow) bank account (interest-bearing or not) under the name of the business.

Extension: The lease will specify the initial term for which the tenant is renting the property (1, 2, or 3 years, for example). The lease may then provide options, which the lessee can exercise, to extend occupancy beyond the original term. For example, a 5-year lease may grant the lessee two 3-year extensions, so that the lessee has the option to occupy the premises for a total of 5, 8, or 11 years in total without renegotiating the lease. The only caveat to be aware of is that the lessee must formally (usually in writing) notify the lessor of the decision to exercise the option to extend. The lease will specify how, and against what deadlines, this is to be done. It is always the tenant's responsibility to be cognizant of the lease's terms and time lines.

And with that, you are on your way! I've attempted to present a step-by-step method for you as a layperson to review a commercial lease, but of course you should make no commitments without the advice of your attorney.

A little knowledge can go a long way. These bullet points should help you to know what features to look for, and to better understand the contract you're entering into.

Good luck in your future endeavors, and remember, even though this process may feel enervating, just be positive! ■



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Practice Management

Proud of Our Fees

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'd like to talk about how to respond when someone questions your fees.

How many times have you heard this? *"Your fees for this treatment seem awfully high to me."*

What do you do?

Well, you could cave in and cut your fees. But I have to tell you, cutting your fees is like cutting your throat!

Or you could become irate and lose the patient. I've actually seen dentists do this! But this reaction denigrates you and embarrasses the patient. It's not the way to deal with the problem.

Your third choice is to **stand firm**. It's a negotiation and you don't want to take it personally. But you want to deal with it properly so that you can deliver quality care, and so that this person understands the value of your services.

When a patient questions your fees, you've got to answer him or her intelligently. Just be calm and use this phrase:

"We are very proud of our fees."

And you have to be quiet. The next person who speaks loses the negotiation.

The patient may ask, *"What do you mean by that?"* You answer this: *"Our fees are based on the quality of the materials we use and*

our experience in delivering this treatment." And you stop speaking.

What if the patient says, *"I called Dr. X's office down the block and they said they could do it for a lot less?"* Then you say: *"We appreciate your concern over the cost of your treatment. If you'd like, we'll be happy to send your x-rays down to Dr. X's office."*

Just remember this key phrase: ***"We are very proud of our fees."***

Take care! ■

For more ideas and in-depth training on setting fees at your practice, take a look here: <http://thewealthydentist.com/setting-dental-fees.htm>



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Through March 3, 2018, Align Technology will donate \$1 for every public share of a photo of a person's smile on Facebook, Twitter, or Instagram with the hashtag **#3millionsmiles**—for a total donation of up to **\$1 million**.*

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