

March 24, 2008

As we compose our spring newsletter our thoughts are more on making what we are already doing better and easier and more efficient rather than introducing something new. Maybe you are doing the same. So our topics will be:

1. Creating a principle rather than a rule based practice.
2. Occlusal concepts.
3. Efficient and effective periodontal therapy.
4. The new Curvy abutment.

We find that the performance of staff has a lot to do with our business and clinical practices being high quality, predictable, efficient, and enjoyable. Recently at an AAP Conference, a lecture was given describing two very different types of practices: The **Rule** and **Principle** based practice.

A Rule based practice is based upon telling staff members what to do and therefore limiting your practice potential. A **Principle** based practice employs smart, hard working and mature people who exhibit high integrity. The Rule based team is told how to think where as a **Principle** based practice allows staff members to be more efficient and productive because limiting rules are not imposed. This is an ideal practice situation. We understand that all practices are at different levels and establish a more efficient, productive, profitable **Principle** based practice. One must be dedicated to achieve long-term results. In this newsletter our intention is to help us all realize our maximum potential as quality health care providers.

At a recent meeting of the Great Basin Academy Drs. Darron Taylor, Mark Taylor, and A.J Smith presented on **Occlusal Concepts**. It wasn't that their concepts were new, it is that we cannot ignore occlusion. The party line that occlusal trauma is not an etiologic factor in TMD nor periodontal breakdown is clearly politically motivated (avoid malpractice issues). As our practices mature we realize occlusion and occlusal trauma must be part of the way we think and practice. As periodontists we deal with compromised periodontiums and record mobilities, fremitis, wear of teeth, abfractions, recessions, buttressing bone, clefts, patterns of bone loss, etc. We consider with every patient if occlusal trauma is playing a role. Many times it isn't. But when it does play a role we are not serving the patient well if we ignore it. In our letters we state what we feel the etiologies are. "The etiology of these recessions is genetically thin areas of facial tissues and toothbrush trauma." A recession patient last week was scheduled first for occlusal adjustment and night guard therapy for 6 months even though there were 4 teeth with no keratinized tissue which for certain we will graft. But there were 10 other teeth close to needing grafting with "V" clefting and other signs of occlusal trauma. We can heal the peridontium significantly with at least 2 sessions of freeing up the occlusion and sharing the excursive forces well, let the occlusion settle in, then wear a hard acrylic, full

arch, well-adjusted night guard for at least 4 months. Teeth can tighten up and “V” recessions heal to “U” recessions. As a result some of the teeth may have enough attached gingiva to not need a graft. If etiologies are well controlled, then patients won’t experience more breakdown in the future. Quality service includes occlusal therapy.

Effective communication with periodontal patients is necessary if they are going to “own” the control of their disease. But that communication can be efficient too. We have 2 visual aids, one showing stages of periodontal disease, the other showing oral hygiene aids. Before probing show them what a 3mm, 6mm, and 8mm pocket looks like so they understand what you are doing. With the visual aid show them why a proxabrush is superior to floss where loss of tissues results in root concavities and furcation invasions that floss bridges. The proxabrush also massages/compresses tissues and reduces pocket depth more than floss. But don’t spend too much time with visual aids and models. Be efficient and effective by having them brush, floss, proxabrush, or use the perio aid as you watch. When you start to evaluate the oral hygiene techniques of a patient, look first at their tissues, touch some pockets with a probe. You can tell if they are not getting low enough lingually with the brush, if they are not wrapping the floss and going under the tissue inside, because it is inflamed and bleeds there. “Mrs. Jones, it is bleeding here, let me show you how you can heal it better,” is very motivating. Oral hygiene is worth the time, but be as efficient as possible.

Consider using the new **Curvy abutment** by Nobel Biocare. It is designed to stabilize and promote a soft tissue seal, prevent soft tissue recession, provide long lasting tissue esthetics, and increase the surface area on which soft tissue can grow. It, like platform switching, is supported by strong documentation in clinical studies.

