Dentaltown®
REAL DENTISTRY FOR REAL DENTISTS
JANUARY 2024 VOL. 25, ISSUE 1

DRS. KHA NGUYEN AND LYNN DOAN

Creating a Buzz

These Townies built a secret speakeasy in the waiting room of their new Colorado practice, but it's the experience in the operatories that keeps patients coming back

REGENERATING TOOTH ENAMEL

USING SDF ON ADULT PATIENTS

3 situations where it makes the most sense

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OFFICE VISIT

The Dental Bar

Inside the Dental Bar in Aurora, Colorado, patients can enjoy not only creature comforts, such as aromatherapy and warm blankets but also a one-of-a-kind hidden speakeasy with a full (nonalcoholic) cocktail bar. In our exclusive Q&A, Drs. Kha Nguyen and Lynn Doan share how the concept came to life, go over the impressive clinical tech also included in the practice and explain how young doctors can (and should) invest in themselves.

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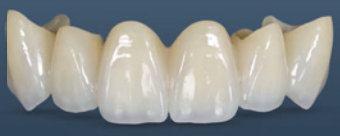

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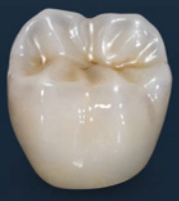

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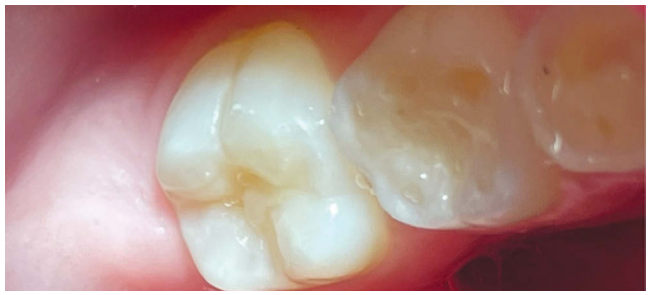

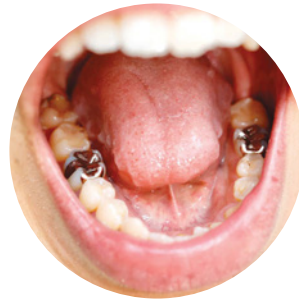

Departments

Message Boards

Columns

Board Profile

BY SAM MITTELSTEADT

Each month this year, Dentaltown will spotlight a member of its editorial advisory board—the doctors who've agreed to help our staff determine whether an article is a great fit for publication, vet those articles for accuracy and clarity, and suggest ideas and sources for content that will run in future issues.

3 QUESTIONS WITH

Dr. Jeanette MacLean

Who better to kick off this series designed to spotlight the doctors who help direct and dictate the direction of Dentaltown's editorial content than **Dr. Jeanette MacLean**? The Arizona-based pediatric dentist has been a member of the board for more than five years and regularly contributes articles herself. Plus, MacLean's online CE courses for Dentaltown about silver diamine fluoride (SDF), the Hall technique (HT), atraumatic restorative treatment (ART) and other pediatric and minimally invasive dentistry topics have been viewed more than 6,000 times. (To watch her courses for the chance to earn up to 12 CE credits, head to dentaltown.com/jmaclean-ce.)

What first interested you in pediatric dentistry?

I did externships at various dental offices and specialties in college, and I loved my time at the pediatric office so much I ended up getting a job as a dental assistant there my last semester. I am a big kid at heart, and what better place to work than one where you can be silly for the kids and sing along to the radio and have movies like *Charlie and the Chocolate Factory* playing in the background?

How does your affiliation with E&S Orthodontists work, and how/when was that partnership created?

Our practice is more than 40 years old and has partnered with an orthodontist since the very early days. It's a great way to help share expenses and reduce overhead. Pediatric dentistry and orthodontics go hand in hand, so it's an easy, natural partnership. Our patients' parents appreciate the comprehensive care and convenience we offer with both specialties under one roof.

You're a big proponent of less invasive treatments such as SDF, ART and HT. What hesitations have you heard from dentists, and what's your response?

I mainly hear from dentists who are eager to learn about these treatments, which is exciting, but they sometimes express frustration about dealing with a partner, employer, program director, etc., who is resistant to change. Some hesitance stems from baseless assumptions. For example, some dentists assume patients will reject SDF because of the staining, when in fact many consent to SDF treatment when given the option, so the dentists are losing patients when they don't offer noninvasive options. Every day, we get patients who drive across town to see us because we have "more on the menu."

Others assume less invasive means less production. I'm happy to report that our hourly production actually *increased* once we started using SDF, glass ionomer cement sealants, etc. The cost to treat the individual may be lower, but when you're able to see a higher volume of patients, your productivity increases. Minimal interventions help increase access to care, reduce cost and risk, and improve outcomes, satisfying the triple aim of health care.

Another reason some dentists are reluctant to change is a phenomenon known as "willful ignorance," where the subject chooses not to learn more about a topic perhaps because it challenges his or her current beliefs. Treatments like SDF, selective caries removal or no carious tissue removal (as done in ART and HT) are supported by the ADA's most recent evidence-based clinical practice guidelines. Choosing to ignore the evidence is problematic on many levels. We owe it to ourselves and our patients to keep up to date with the current best practices and never stop learning! **DT**

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DR. HOWARD FARRAN, DDS, MBA
Founder and CEO

Did They Get the Message?

In this column, I'll be explaining how effective communication with your patients is essential for success.

[*Brief delay as column recognizes you've begun reading.*] Dr. Howard Farran here. Did you know effective communication with your patients is essential for success? Press "1" to agree.

Hello, «Valued Townie». In this column, I'll talk about the importance of effective communication with your patients.

How fast did that repetition become annoying? Did you think it was overkill? A mistake? Did you start to tune out?

Your practice might doing the same thing to your patients right now.

Too much is as bad as not enough

With so many avenues of communication available—especially automated ones that promise to save your team time—you've got to be thoughtful about how yours are deployed.

One of our editors (who insists on being treated by the dentist he had before he started working at Farran Media) receives a text message reminder about a week before his semiyearly cleaning, asking him to confirm he'll be at the appointment. He also gets an email reminder. And an automated phone call. And another text closer to his appointment date.

Having seen enough message board threads about the no-shows that plague some dental practices, he understands the goal of these messages, but he hates the replication—especially the ones that arrive after he's already confirmed the appointment in the first text message. "Their emails are flagged as junk now," he said. "And calls automatically go straight to voicemail."

Which means if the practice sends an email promoting a special or discount, it goes unseen. If the scheduling team needs to call and reschedule his appointment, they'll have to leave a message and wait for him to call back. And this is a patient who actually likes the practice! All because of the communication overkill about even the simplest of appointments—a cleaning.

Adjust and personalize

Back in April, practice management expert Casey Bull wrote that "people are already prone to ignoring digital messages, so patients will begin to ignore your messages if they continuously receive redundant, unnecessary or irrelevant messages from your practice." [*Editor's note: A link to that article is embedded in the digital edition of this column at* ***dentaltown.com/magazine***.]

What are your practice appointment reminder settings like right now? Do you ask patients how they prefer to be contacted? Or have your helpful reminders morphed into bothersome annoyances, redirected straight to the trash?

When a patient has a history of no-shows, sure, ramp up the communication. But for patients haven't previously missed appointments, dial back the messaging. Respect their loyalty and trustworthiness!

As Bull wrote: "When a practice implements technology and lets it run automatically, this can have a *detrimental* impact to patient experience and practice reputation. The practice team can't rely on the technology to communicate for them; they must leverage the technology and communicate as humans." Make sure you're treating your patients like people, not problems. **DT**

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THOMAS GIACOBBI, DDS, FAGD
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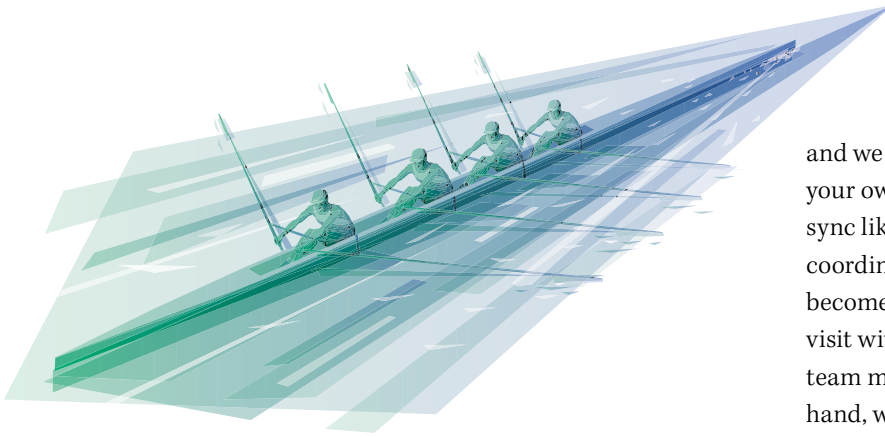

Who's in Your Boat?

A few weeks ago, the movie adaptation of the bestselling book *The Boys in the Boat* arrived in theaters. Audience members are sure to appreciate the story of the 1936 University of Washington rowing team and their appearance at the Summer Olympics in Berlin. Reading the book or watching the movie, you certainly gain an appreciation for the keys to success in rowing—precision, synchronized movements, working together, harmony, efficiency … starting to sound familiar? The similarities to working in a dental practice go far beyond the chance that you might get splashed with some water along the way.

When I'm working at my best with my assistant, every move is anticipated and to a casual observer might appear as a carefully choreographed routine; I have had patients comment about how well we work together. When I enter a hygiene operatory to do an exam, the hygienist is prepared to introduce the patient, review concerns, share their findings and discuss pending treatment, and all of this happens within the context of a conversation with the patient. What does the patient come away with? Two professionals exchanging information in a seamless manner—each anticipating what the other might ask and making sure the patient is part of the conversation.

These exchanges don't happen by accident or on the first day working together. In our practice, this level of efficiency is part of our culture. Contrary to some of the mainstream business advice, we *do* sweat the small stuff—we focus on the details and we don't subscribe to the school of "just do it your own way." Working as a team means we're in sync like members of a rowing team, and the more coordinated our movements, the more efficient we become. This improved efficiency allows time to visit with patients, have conversations with fellow team members and enjoy our day. (On the other hand, when people forget their roles, skip steps or find themselves out of sync with their teammates, stress increases, patients experience disorder and mistakes happen.)

Becoming a better captain

If you're looking for advice on how to best get everyone on your team rowing in the same direction, look no further than the Dentaltown message boards. 24/7/365, dental professionals from around the world are asking questions and sharing answers on a myriad of clinical and nonclinical topics. I know there are many places you can have dental conversations online, so I challenge you to share your next case or question on Dentaltown and whatever other platform you like to use, then compare the quality of feedback you receive in both places. I trust you'll find the members on Dentaltown will steer your boat in the right direction!

The message board conversations that appear in the magazine each month are a tiny fraction of the activity that can be found in our community any day of the week. We share these edited threads each month because they are timely conversations among dental professionals serving the patients in your community every week. Some days you'll find a clinical tip that will solve a current challenge, other times you might read about a way to improve systems in your office, and occasionally you'll find that you aren't alone when you start to feel the pain of burnout.

Log on to Dentaltown.com today and see the latest news from dental professionals around the world. If you have any questions about our website or you have a topic you would like to see covered in the magazine, send me an email: tom@dentaltown.com. **DT**

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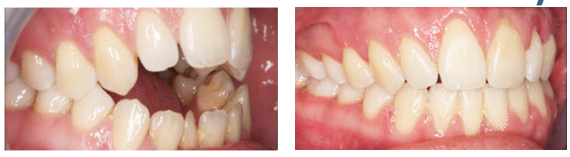
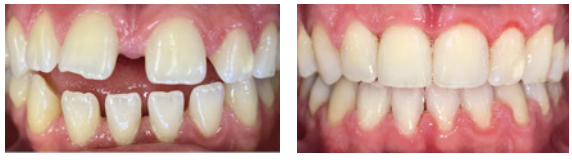
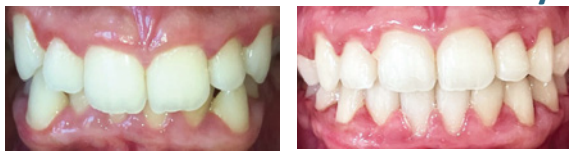


113 Days



97 Days



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NAREG APELIAN, DMD
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by Dr. Timothy F. Kosinski

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IMPLANT DENTISTRY

Front-Line Work: Anterior Immediate Implant Strategies for General Dentists

by Dr. LeRoy Horton

This dental CE course takes readers through a step-by-step process of performing an immediate implant placement in the anterior maxilla, with discussion of specific principles that will aid in surgical, restorative and aesthetic success. This particular protocol is a streamlined process for solo general practitioners of moderate implant experience who are responsible for the surgical and restorative phases.

IMPLANT DENTISTRY

Efficient Workflow for Guided Implant Surgery

by Dr. Riley D. Clark

This informative CE course discusses the complete workflow for guided implant surgery. Topics included are how to effectively acquire CBCTs and merge with STL files, the details of the edentulous workflow with dual-scan protocol and clinical pearls for guided surgery.

IMPLANT DENTISTRY

Bridging the Orofacial Pain/Restorative Dentistry Divide

NEW COURSE

by Drs. Barry Glassman, Lane Ochi and Don Malizia

This is the first in a planned series of a new, exciting format for the Dentaltown CE program. Some of your favorites on Dentaltown have joined together in a "fireside chat" format to discuss relevant and critically important dental topics. The goal is to experience high-level education in a relaxed, entertaining format.

TMJ AND OCCLUSION

Dental Sleep Medicine Implementation in Practice: Treatment and Comparison of Devices

NEW COURSE

by Dr. Mark T. Murphy

This course helps general practitioners survey the current landscape of medical and dental treatment for sleep apnea and decide how and if they want to evolve into this lifesaving arena. Discussed is an actual treatment for sleep apnea that can be done by dentists and the comparison and proper use of the various devices.

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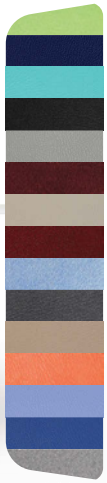

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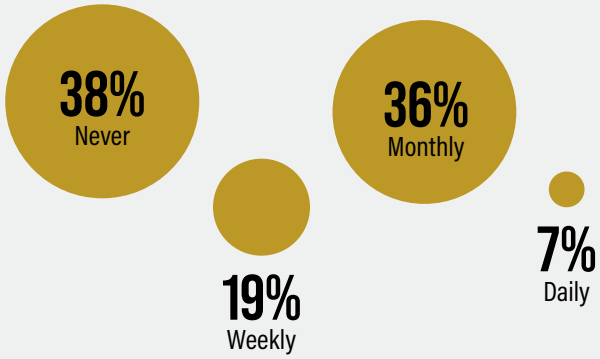
Sleep Dentistry

Dentaltown's monthly poll helps you see how other practices operate—what's working, what isn't—and how dentistry is evolving. This poll was conducted from Nov. 11 to Dec. 16 on Dentaltown.com.

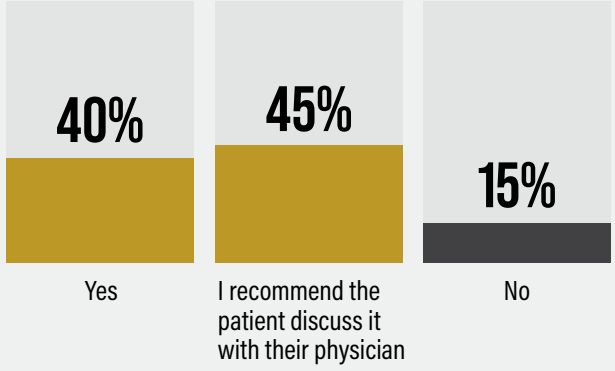
Scan here to take this month's poll!

Hold your phone's camera over the QR code at left to go straight to this month's poll questions about endodontics. The final tallies will appear in the February issue of *Dentaltown* magazine.

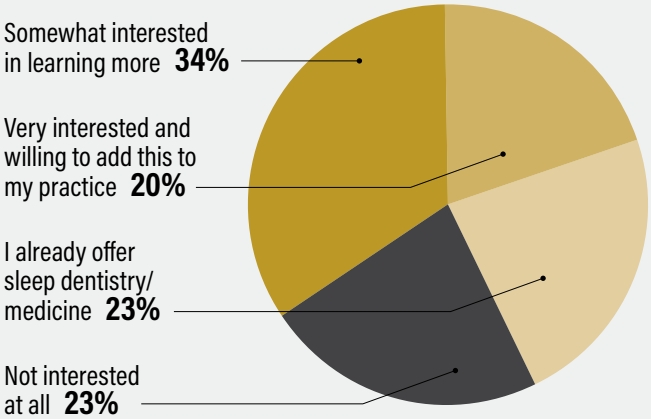
How often do patients ask questions regarding snoring or other sleep issues?



Do you refer patients directly for a sleep study if you suspect sleep apnea?

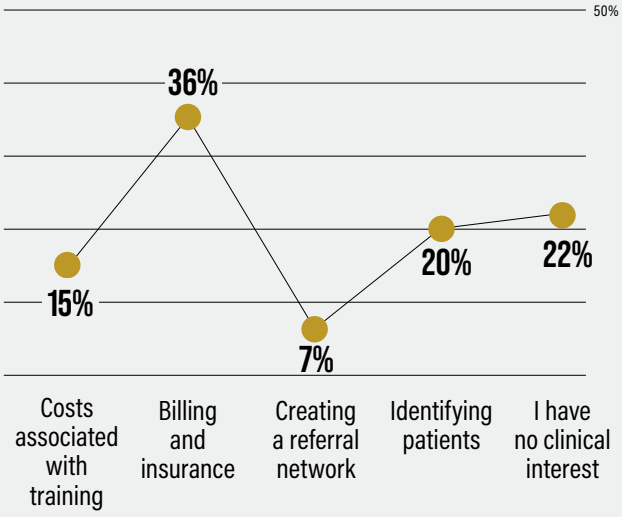


How would you rate your interest in incorporating sleep dentistry into your practice?

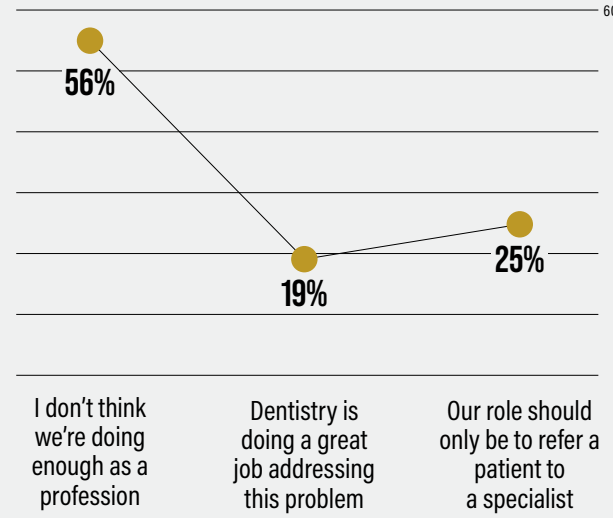


Will the average general practice screen and treat patients for sleep-related issues by 2030?

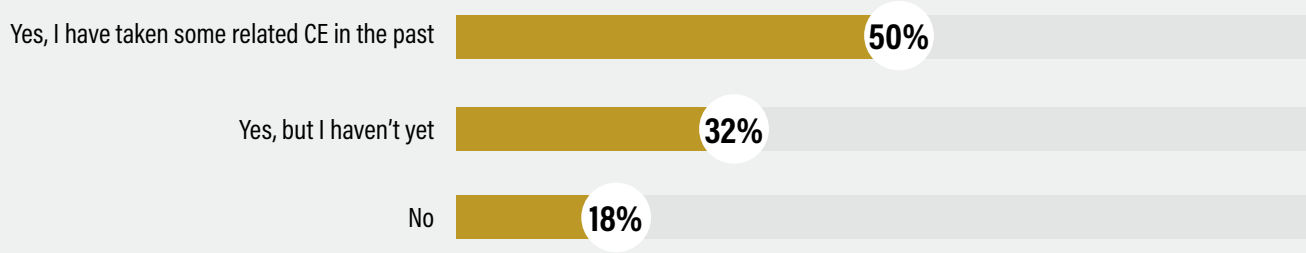
What is the biggest obstacle to bringing sleep dentistry into your practice?



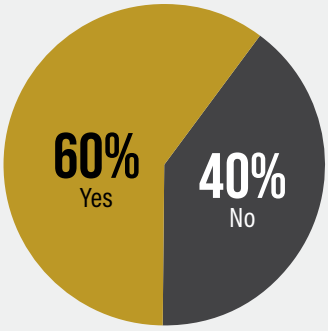
Which statement best describes your position regarding sleep apnea and dental offices?



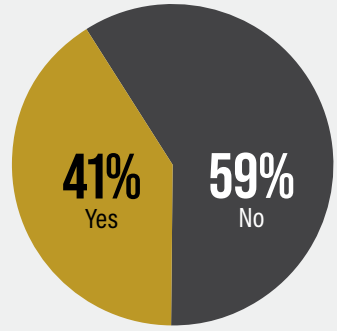
Do you have any interest in learning more about the dental appliances used in the treatment of sleep apnea?



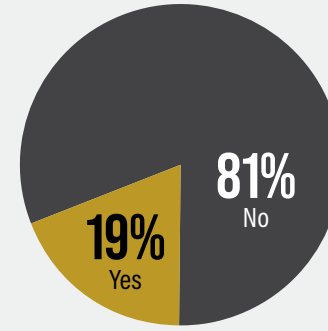
Does your health history form screen for any sleep issues?



Does your practice screen for sleep apnea?



Have you personally ever taken part in a sleep study?



Is Practicing Like This Normal?

This Townie gains perspective and feedback on his journey into practice ownership thus far

semidoc *Post: 1 of 101* 12/1/2021

I think I'm going crazy or en route to burnout. Three years into ownership. Running three columns: one production, one exams/emergencies and one overflow.

Literally running around from production patient to exam to having to do a cleaning to back to production patient. Not to mention any hygiene exams that might be present. Everything PPO: removable, restorative surgery, implants, endo, etc., plus we see HMO even though we are not in-network. We just honor PPO rate, which is not great.

My quality is very high: I treat my patients like FFS, but high volume due to insurances and low fees. We do $1M+/year (90% DR, 10% HYG) but it's so damn stressful. Staff headaches all the time. I get chewed up every time I hurt staff feelings or inconvenience one of them. Multiple threats of walkout. I can't deal with all these emotions. Hygienists are impossible to find. I give mine one hour for patients, yet I'll be doing a crown, exam and cleaning all within a 90-minute block on the doctor's side. I'm mentally drained and emotionally numb. Is this the norm? I don't know how much longer I'm willing to do this. ■

eeznogood *Post: 4 of 101* 12/1/2021

This is the norm for a low-fee office. Your problem is that you are treating low-fee people as you would higher-fee people. While honorable, it is nuts and, as you can see, unsustainable. What you need is an expanded duties assistant to help you do fillings, temporaries and maybe even impressions. You will then decrease your workload by half. Or you need to transition to a higher fee structure. Not a million ways about it. ■

drtommymurph *Post: 6 of 101* 12/2/2021

I used to be you. In 1998, my office was seeing on average 60 patients a day with a staff of nine and two hygienists and did $2.2 million. I burned out. My body was so sore, and my mind finally gave up and I had a breakdown on a Saturday night after having worked 13 hours and having seen around 125 patients on Saturday. But there is hope. You can change. I did the complete light switch and went cash-only on Monday morning. By Tuesday morning, I went from a staff of nine to a staff of three (by the end of the month, it was two), and I went from seeing 60 patients a day to seeing four a day on average. And did I mention that I made more money? Crazy but true. You don't have to work for lower fees, and you don't have to see everyone. And what insurance companies don't want you to know is that patients will pay your fee if they like you, they are in pain or they can't be seen by the "insurance dentist."

I wish you the best of luck and I encourage you to change. Do it for yourself. Do it for your health, both physically and mentally. When you reopen, go cash-only and surprise yourself at how much you will actually enjoy dentistry when you are not rushed, you get paid and you don't have so many daily issues to deal with during the day from a large staff and a large patient base. Ten to 15 whiners/complainers a day is way more than one or two a day (staff and patients combined). ■

semidoc *Post: 7 of 101* 12/2/2021

Not sure what to do. Staff don't want to change; they balk at any new policy I put forth. Can't find new staff. The hygienist refuses to do team hygiene to increase production. The office manager refuses to charge extra lab fees for removable or no-show fees. I admire their altruism, but it's kind of ridiculous when the fees are this low. They don't understand that we have to play the game with the insurance companies or go FFS. At least I don't have to worry about them embezzling. Assistants are changing out regularly but I can't seem to find one who's good and mentally stable. ■

kidesperanto *Post: 10 of 101* 12/2/2021

I currently run three columns plus hygiene checks plus a no-doctor DA column. I'm FFS. It can be done well, but I also have three DAs helping me and am paid well enough that I can block columns as needed and make sure the appointments are long enough to handle it. Without distractions, I can do a crown in 40 minutes. With the other stuff, I'll give myself 50 minutes or an hour. Also, I've been doing this for a while and predictably know how long things take.

So, can you run columns like this? Yes. It can be quite profitable. But unless done properly, you will burn out. Given your PPO fees, you absolutely must have your DAs doing all work they legally can. ■

wdhenry *Post: 12 of 101* 12/2/2021

I think when we buy a practice, we are buying an opportunity to be busy. When you are busy, you are making money, and that is the goal. So many dentists are not busy enough. That being said, this practice style does not seem to fit you well (would not fit me well either, and I consider myself to be pretty busy most of the time too). Lots of things need to change to make this practice what you want based off what you said. That being said, if you can sell your office at this point with the real estate and be free of all practice debt and your student loans, I would strongly consider cashing in your chips and starting over with a practice that is more like what your ideal practice would look like. You can make changes over time to make your current practice what you want, but your stress levels may be much less just starting over somewhere else completely debt-free. ■

CWWD *Post: 15 of 101* 12/2/2021

I feel you! I am about 75% PPO practice myself, solo doc. I produce about $1.25 million a year. Some days, I am so tired, I feel like crying. I go home physically and mentally drained. However, if I have a "slow" week, I freak out that I did something wrong and things are going south. I know it is irrational, but I cannot help but feel dread. I have been doing this for seven years and my body feels it. (I have an autoimmune disease and have already had to have open heart surgery because of it). I am also heavy in debt. Not quite as much as you, but enough to make me scared to drop all the insurance. Since I have opened, two Heartland offices have opened within two miles of my office. They heavily market and accept all insurance. I have one son and my husband has not worked since March 2020. The pressure to produce is enormous.

When I feel overwhelmed, I go over alternative scenarios like you. I could sell and walk away with a profit. Sounds nice, but I would still need to work afterward. I am set to pay everything off in five years. At that point, I think I will enjoy dentistry again when the pressure is lightened.

I have also changed my working hours so I get off at 3 p.m. a couple of days so that I can take my son to after-school activities. (He is in first grade). I do believe there is light at the end of the tunnel. It helps to talk to people who are going through the same thing. ■

MESSAGE BOARD 1

IndieOuting *Post: 20 of 101* 12/2/2021

I bought an identical practice in January 2019. I bought low-fee FFS/PPO/HMO/payment plans all around, but today I am PPO/FFS with the same collections, lower overhead, working Monday through Thursday. It was not easy and I lost sleep, but I weathered the storm. You can do it too.

Quick list for a long fix. You really need to look at your area's employers and insurance plans that are most prevalent and thin the herd. Stop doing unprofitable procedures. You need to fire someone and take control, but with a plan. You need to take a few days off to breathe.

Do not sell until you have exhausted all options in turning the tide to create a closer-to-ideal practice. Feel free to shoot me a message. I couldn't have done it without help from DT, mentors and advisers. ■

ToothNinja99 *Post: 21 of 101* 12/2/2021

I was in talks to buy a nice lady's office once. She and her associate boasted they provided FFS service at PPO prices. They took home a combined $200,000 per year.

If you could combine them both, everyone would do it, boss. You're not a special snowflake. Pick one. Also, you need to look into that hygiene percentage—something is very off.

You shouldn't be burning out at $1 million per year. That's Candyland.

Three ops with your structure are the only way I've ever worked and I imagine it's the way most dentists work. Do you have an assistant for each op? I am not sure what you mean by you take HMO but you honor PPO rate. It's either-or, I believe. If you're taking HMO and getting $200 per crown, that may be why you feel overworked. There's a very specific way to do HMO right, and judging from your post you're not doing it. ■

barstoolpigeons *Post: 26 of 101* 12/2/2021

Sounds like this is the classic "staff attempting to hold a dentist hostage" move. Fortunately for you, there is only one person in the office who is not replaceable, and that is you.

Tell your office manager that what you tell her is not a request: She will do as she is told or she can quit. I was ready to fire an OM who thought she ran the office, but she tried to pull some ultimatum BS about how I needed to hire someone to help her. (She ran the last employee I had hired to help her off.) I told her, "I expect you to do the work like you used to and that's the bottom line." So she turned in her two weeks' notice, and I was thrilled.

Also, any threats of walkouts should be met with, "The door is right there. Leave a written notice on my desk." Even if you had to close down for a week or two to find staff (which I know is almost impossible right now), I'd do it. Just tell patients "labor shortage." They know the entire country is having the same problem. ■

ttowndds *Post: 29 of 101* 12/2/2021

This. I'd rather have a $1 million practice with 50% overhead than a $2 million practice with 75% overhead. Same profit, half the work and headache. ■

Read more practice tips online!

These few pages are only the tip of the iceberg. If you're looking for more advice from other practice owners or you have a tip a new doctor might appreciate, head online and jump into this thread—or more just like it. Get started by going to **dentaltown.com/magazine**, where you'll find this and other message board threads waiting for you.

AO4 Gone Bad

A doc shares a crack at a prosthodontic transfer case

toofache32 *Post: 1 of 45* 11/27/2023

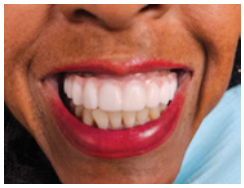
This nice lady had an upper AOX at a local office more than a year ago. She somehow made her way to a restorative dentist, who referred her to me. She has three complaints.

1. The teeth keep breaking.
2. She gets food stuck under the prosthesis and cannot keep it clean.
3. She does not like how the teeth look unnatural against her gums.

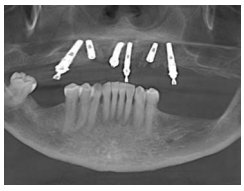
I am not one of the AOX gurus and I don't claim to be. I do two or three arches a week and there are plenty of people on here who do it every single day and I learn from. However, some very basic principles in this treatment were overlooked. The two things that come to mind are the concepts of restorative space and managing the smile line with a hybrid prosthetic. The prosthodontist and I tried to talk her into something removable on existing implants but she was adamant that she wanted something fixed like she was originally promised.

While I did not evaluate the patient before her initial treatment, I suspect she had a high smile line from the beginning. This increases the difficulty of these cases because the transition line where the prosthesis meets the native gingiva has to be hidden high under the lip. With a high smile line, not many people have enough bone for this treatment. This patient fortunately did, which means not enough bone reduction was performed the first time.

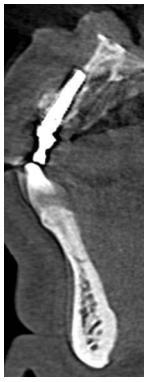
The second issue is restorative space. While the actual number is debatable, you need a minimum of 15 mm of vertical space between the platform of the implant and the occlusal plane. Yeah, I know people say with zirconia you can do like 12. Whatever … but this case was not set up that way when the smile line was not respected. The AOX treatment is not for every patient, but I'm hoping we salvaged this to the patient's satisfaction.

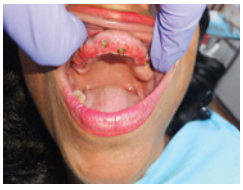


This is her "regular" smile and not even exaggerated.

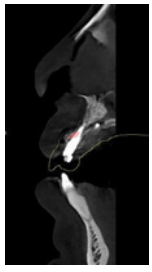


Her panoramic view from a CBCT. My measurements show that the two deeper implants (not used) are at 15–16 mm from the occlusal plane. Not sure why they were placed when they were not used.

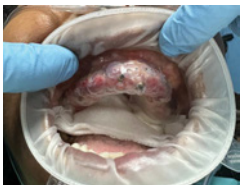




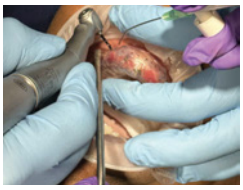
Cross-section from the CBCT. This is with the patient in occlusion. What's that phrase the kids use these days? "If you know, you know," or something like that.



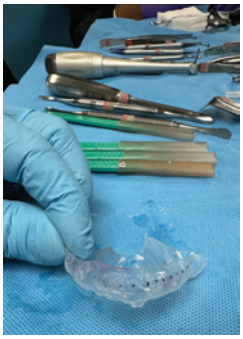
This is a sagittal view in occlusion with the current prosthesis outlined. Even for a single tooth implant, the implant is not deep enough.



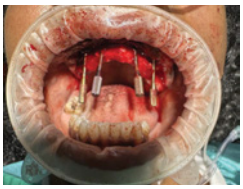
To determine the transition line, the prosthodontist made a stent on the gums and placed radiographic markers at the smile line for a new CBCT to measure if there is enough bone above this level. She had enough bone. This is that stent in place during surgery.



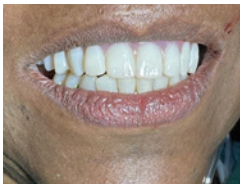
This is the stent in place with me drilling holes in the bone to mark where the bone reduction needs to be.



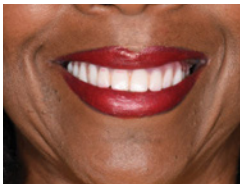
This is that stent on the table.



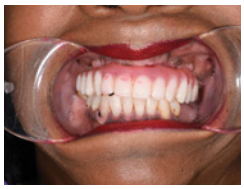
Bone reduction done and implants with MUAs placed.

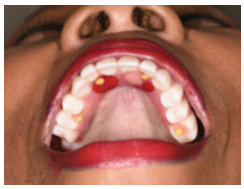


Conversion immediately after surgery.

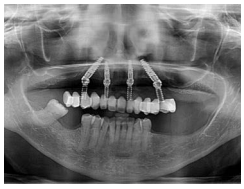


Two weeks later, showing the smile. She is excited with the results so far.





Midline is off from the nose/lip, but is fairly congruent with the lower teeth. I think there can be a small improvement with the final prosthesis. I think we dentists are more concerned about midlines than patients are.



Postop panorex. Got into the sinus a little on her right but closed it.

This is the first time I have done a redo on a case like this. She is a rare patient with a high smile line but with enough bone for appropriate bone reduction. The vertical space I think ended up being around 18 mm. I welcome any critique on how this could be done better next time. ■

Mk9 *Post: 3 of 45* 11/28/2023

How did you remove the implants—reverse torque? Especially on the posterior right, I would have been very nervous about finding a spot with good bone for stability after removing the used implant and the rogue one, even knowing I'd be having my platform about where they had the apex of their original implant. Nice result and a nice save for the patient. In a case like this, I would have definitely prepared her for the possibility of a denture temporarily.

Also, what did you mean by you "closed up the sinus"? Your first attempt at placing the implant went into the sinus. So, I assume you just moved slightly anterior and made a new osteotomy. Closed it just by closing the soft tissue over it? Maybe some APRF over the OAC before closing? ■

toofache32 *Post: 6 of 45* 11/28/2023

I trephined the four shallower implants about halfway or more down the implant because that bone was going to be removed anyway for vertical restorative space. Then torqued them out. Then trephined the two deeper ones, I think. I studied the CBCT for a long time preoperatively to have a good feel for where I could place implants,

The sinus exposure occurred during the bone reduction in the right posterior. The implant never went into the sinus. It wasn't big, so I placed a collagen plug or something and closed the gingiva over it because there was lots of extra gingiva when we were done. ■

Dah *Post: 8 of 45* 11/28/2023

Looks good. Also I think the patient may want a darker gingival color. You can show her the different Lucitone shades and have her pick it out. ■

maxpros *Post: 9 of 45* 11/28/2023

Great salvage, "toof," but I think the patient would have saved significant money, stress and surgery if this had never been an AOX to begin with. The only reason to do an AOX is to save money and many dentists don't realize this. If she had six properly placed implants with sinus lifts, she would have had a much better long term result ... and saved money. AOX is like amputating your foot so the shoe fits better—should only be used in certain cases—but we are now in an age where the labs are promoting this treatment and we technicians ... I mean *dentists* ... are following their treatment recommendations.

Six to eight implants with a Ceramometal or ceramic prosthesis eliminates the need for amputation of a third to a half of the patient's alveolar bone. I only do AOX when the bone has resorbed enough to allow placement without significant bony amputation. I see too many cases of failed AOX because of the bulky contours where the patient has to

start again. I see it as a class action lawsuit waiting to happen.

"Doc, did you give the patient options for her treatment where she didn't have to amputate half their mouth?"

"No, our *insert major brand name here* company uses it for all their full arch cases."

"Ah, you treatment-plan according to company policy. Why so?"

"Because it is more cost-effective."

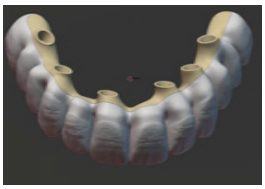
"Not because it was the best treatment available? How much is this cost-effective treatment?"

"Fifty thousand."

Ouch. ■

Rory Byrne *Post: 17 of 45* 11/28/2023

I've been seeing a lot of I-Bar cases from Blender with a milled titanium bar with a solid zirconium overlay styled after an FP1 prosthesis. This is not my case, but one posted on the Blender FB page.



What is your opinion of prosthetics such as this? ■

maxpros *Post: 18 of 45* 11/28/2023

No issues with the ideology or material choice, but that buccal is way overcontoured for an FP1.

Look at it this way, "toof" inherited a bad situation and made the best of it, but if you had that beautiful ridge at the very beginning, why not sink six implants and contour some ovate pontics in the anterior? It's a very predictable, aesthetic and amputation-free recon. Now the patient has had to go through the procedure twice, paid twice and has lost a significant amount of bone. If the patient wanted to sue her original dentist, she would easily win. ■

mouthjanitor *Post: 20 of 45* 11/28/2023

I still wanna know how much money she's into this. ■

toofache32 *Post: 21 of 45* 11/28/2023

I charged her $15,000 for my part. I have no idea about the previous treatment or my prosthodontist with current treatment. ■

petit trianon *Post: 22 of 45* 11/28/2023

Excellent revision! Shame the first doc didn't address the smile line, among other things. Patient will no doubt be really happy with this result when it's all finished. ■

Bifid Uvula *Post: 23 of 45* 11/28/2023

Nice case and a job well done. My only critique would have been to also remove that tilted #31/#32 because it will be a potential issue later.

Every time I've left one like that my prostho ends up asking me to take it out before they go through the PMMA phase. ■

toofache32 *Post: 24 of 45* 11/28/2023

Good catch. We had trouble with that because it occluded on the denture, but I did not have consent to remove it, will probably do it later. ■

Share a case or get case advice!

This thread is a great example of the kind of feedback Dentaltown's message boards are famous for. If you have an ongoing case, past case or just want to lend an ear or eye to a doc in need, head online and take part in conversations like the one you just read. Visit **dentaltown.com/messageboard.**

Simple Road to a DSO

A Townie with seven practices shares his process and his path

SouthTampaDentistry *Post: 1 of 46* 12/15/2022

Well, it's not simple, but it's been challenging and fun. Here are a few pointers that I learned along the way.

Learn the basics and become efficient in general dentistry first. Forget FMR, sinus lifts, implants, LANAP and Invisalign. Learn how to perform extractions, fillings, single-unit crowns, etc., and go from there.

Appreciate your staff. Finances aren't enough. Communicate to them how appreciative you are of them. Saying a genuine "thank you" and "great job" goes a long way.

Develop a relationship with your lab. This will improve your dentistry when there are issues. Picking up the phone and talking to a lab tech is much easier than blaming the lab when something goes wrong. I use Keating Dental Labs and am extremely pleased.

Invest in your interests. I enjoy easy, predictable dentistry. Dr. Cory Glenn got me going placing implants and I highly recommend taking his courses here on Dentaltown. Placing an implant with a guide is incredibly easy and profitable.

Develop a relationship with your vendors. Asking questions and listening are tremendously important. For example, we use Great Dental Websites and Jeff Gladnick is amazing. When we created our Google domain, he allowed his team to help me learn how to use it. His customer support and product are amazing. The same goes for developing a relationship with your accountant. I can't speak highly enough of Tooth & Coin. They've been great to work with.

Have a vision for the type of practice you want to create. We are a "bread and butter" practice and I repeat to our staff that we "provide honest, affordable, quality dentistry." Set the expectations on how to achieve your vision. Reading *The Four Agreements* helped me tremendously.

Attend a Breakaway Seminar or two. Dr. Scott Leune is a great lecturer and has gone far beyond expected in helping me. "Don't lose sight of your main practice" was an early great piece of advice he gave me. I've learned a lot from him and he's still kind enough to schedule calls with me and answer questions. You'd be surprised how much help people are willing to help when you reach out. Dr. Rick Workman has been great in providing me with guidance as well. I'm thankful for both of them.

Find a great IT company. Pedro Becker with Zenith IT is phenomenal. He has a true passion for dentistry and IT. He set up our care center (what we call our call center). His team is invaluable.

Set goals. This one is perhaps the biggest part of our success. We signed up with Practice by Numbers years ago and created goals. One such goal was preappointments. At one location, we noticed patients were coming in the "front door and exiting the back." Setting goals and troubleshooting with your team may be the biggest attribute to our growth. Side note: Rohit Garg has transformed Practice by Numbers from a data company to a must-have addition to your practice management software. We recently sent out a "Use It or Lose It" end-of-the-year email campaign with a couple of clicks of the mouse. The amount of revenue generated pays our monthly due tenfold. Custom campaigns are only a small portion of the services they provide within the platform.

Find great representation. We used Dykema to set up our DSO and they did a wonderful job. I had several calls with them. Each time they were responsive and explained all the legal jargon in a way that I could understand.

A few final pieces of advice: Commit to your business, believe in yourself, learn from your mistakes, and ask lots of questions. ■

MESSAGE BOARD 3

CrosstownDDS *Post: 2 of 46* 12/15/2022

How many practices do you own in your DSO? ■

SouthTampaDentistry *Post: 5 of 46* 12/15/2022

Seven practices and yes, I still own them. Dykema helped set up a profit-sharing plan that will start next year at one of the locations. ■

dds4life *Post: 7 of 46* 12/15/2022

And your plan is to sell to a larger DSO in the future? ■

SouthTampaDentistry *Post: 8 of 46* 12/15/2022

I get asked this a lot and I don't have any plans to sell. I'm 40 years old—too young to sell, especially when I enjoy what I'm doing. ■

NY sent *Post: 9 of 46* 12/16/2022

You have a dental practice with seven locations. You own 100% of everything and are 100% the boss. Am I understanding this correctly? As in, this practice arrangement you described is a DSO because it is an organized multilocation practice with a single dentist owner? ■

SouthTampaDentistry *Post: 10 of 46* 12/16/2022

Correct, and I've been fortunate to purchase eight buildings; seven that the practices occupy and the eighth has our call center. I should have added LoopNet to my list of things that have helped me. ■

NY sent *Post: 11 of 46* 12/16/2022

If I had to loosely say I have business goals in dentistry, it would be to achieve something similar to what you described. Right down to the treating your employees well.

I turn 43 tomorrow and I am very close to purchasing only my first building. I'd like to think I still have time. ■

Steve27 *Post: 16 of 46* 12/16/2022

Good to hear from you again! The man who makes everything "simple." Are your practices set up with associates or partners? Do you still do dentistry? Did you practice part-time in each of the practices to get them started, or did you just plug in a dentist? How do you train eight teams!? You're the man! ■

SouthTampaDentistry *Posts: 19 and 20 of 46* 12/19/2022

K.I.S.S.! We are set up with associates. I'm interested in partnership but I'm getting my feet wet to understand the DSO legality and operations first.

Yes, I still practice dentistry 30 hours a week. It's my favorite part of the day.

I hired an associate for each startup. The two newer offices are close together, so we did one doc for two offices, then last month went full time at each office with two docs. For training, we have them come to South Tampa for training and the operations manager takes the training from there. ■

Read OP's full story online!

Interested to read more details on the inner workings of running and maintaining a small dental empire? Visit this message board online where there's more updates, more details and more answered questions. Start by going to **dentaltown.com/magazine** and clicking the link to this thread inside the January issue online.

GC Initial LiSi Block

Fully crystallized, no firing required

GC Initial LiSi Block is a fully crystallized lithium disilicate block that delivers optimal physical and aesthetic properties without firing. GC's high-density micronization technology delivers high wear resistance, smooth margins and aesthetic final results, which makes it an efficient time-saving solution for single-visit chairside treatment.

GC Initial LiSi Block features equally dispersed lithium disilicate microcrystals, making it easy to process and quickly mill. High gloss and natural opalescence can be obtained in a few minutes by simply polishing, and the restoration is ready for luting. The aesthetics of the restoration will be maintained over time.

GC Initial LiSi Block is available in six aesthetic shades and two translucencies. And when more characterization is required, the GC Initial ceramic line contains synergistic aesthetic solutions.

Additional benefits include:

- **Reduced chair time.** GC Initial LiSi Block reduces processing time. Because it's already fully crystalized, there's no need for firing, which saves up to 40% of the time required to create restorations when using similar systems.
- **Durable aesthetic and smooth margins.** High resistance to acids and wear helps preserve the aesthetic of the restoration over time; excellent edge stability provides restorations with smooth margins.
- **Natural opalescence.** Available in high and low translucencies, GC Initial LiSi Block offers natural opalescence in any light.
- **Choose your preferred finishing procedure.** With simple polishing, high gloss is achieved and the restoration is ready for luting. If characterization is needed, three-dimensional effects are possible with GC Initial Lustre Pastes NF. Use the ready-to-use ceramics to adjust chroma, value and brightness.

For more information, visit **gc.dental**.

Dentists spend most of their working hours inside their own practices, so they usually don't get many opportunities to see what it's like inside another doctor's office. Dentaltown's recurring Office Visit profile offers a chance for Townies to meet their peers, hear their stories and get a sense of how they practice.

Creature Comforts

This Colorado couple's first private practice has a unique speakeasy-style design, complete with faux cocktails and real attention to patient satisfaction

BY KYLE PATTON, ASSOCIATE EDITOR

As cookie-cutter corporate offices continue to pop up with alarming frequency, unique spaces like The Dental Bar in Aurora, Colorado, help remind the profession at large just how personal and personalized private practice can be. **Drs. Kha Nguyen** and **Lynn Doan,** the husband-and-wife team behind this fresh build, set out to reshape patients' expectations of what going to the dentist could be like. Beyond the full range of clinical offerings—including root canals, implants and sedation—the office hits on all five senses with aromatherapy, luxury seating, high-end audio and, as its name suggests, a wide selection of beverages offered in a waiting room that is one-of-a-kind.

In our exclusive Q&A, Doan and Nguyen talk about crafting their dream practice, how they use artificial intelligence tools to help improve diagnostics and patient communication, their hopes for expansion, what's on the drink menu and more.

PHOTOGRAPHY BY JIMENA PECK

OFFICE VISIT

OFFICE HIGHLIGHTS

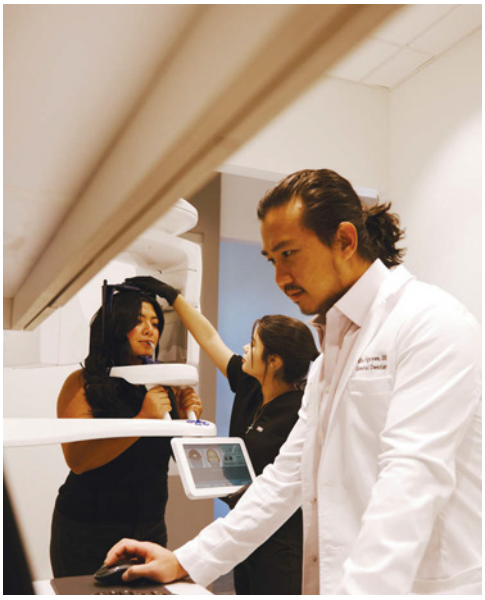
NAME:
Drs. Lynn Doan and Kha Nguyen

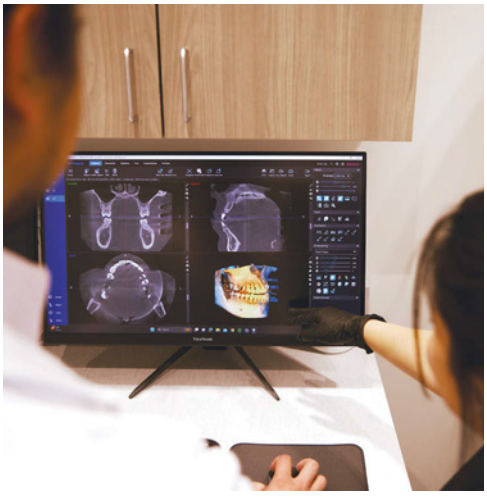
GRADUATED FROM:
Doan: University of Colorado School of Dental Medicine; Nguyen: University of Missouri-Kansas City School of Dentistry

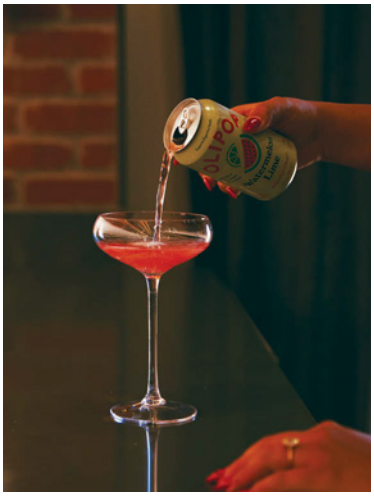
PRACTICE NAME:
The Dental Bar, Aurora, Colorado
thedentalbar.com

PRACTICE SIZE:
2,886 square feet

TEAM SIZE:
7







"The whole speakeasy concept wasn't part of our original plan," says Dr. Lynn Doan, who opened The Dental Bar in Aurora, Colorado, with her husband and fellow dentist, Dr. Kha Nguyen. "It popped up as a spontaneous idea when we stumbled upon some extra space in our floor plan." (All of The Dental Bar's beverage offerings are nonalcoholic, Doan clarifies: The bottles of alcohol on the shelves are purely for decoration.)

> While our practice is stylish and the speakeasy has turned heads, it's important to remember that it's just one piece of the fantastic experience we offer our patients.

Let's get right into the obvious: This practice is as stylish as it is unique. How did this idea come about?

Dr. Lynn Doan: The idea came from our desire to make going to the dentist an experience people look forward to. We wanted to shift the mindset from "I *have* to go to the dentist" to "I *want* to go to the dentist." Right from the beginning, we set out to create a space that's not your typical, run-of-the-mill clinic. We wanted it to be modern and innovative and to stand out in a big way. We thought through every little detail, all with the goal of making the patient experience the best it could be.

Here's the fun part: the whole speakeasy concept wasn't part of our original plan. It popped up as a spontaneous, exciting idea when we stumbled upon some extra space in our floor plan. We're the kind of people who like to have fun in everything we do, and we happen to be foodies and cocktail enthusiasts. The speakeasy vibe just clicked with us, and we thought, "Why not bring that unique personality into our practice?"

And while our practice is stylish and the speakeasy has turned heads, it's important to remember that it's just one piece of the fantastic experience we offer our patients. We're thrilled with the positive buzz it's generated, and we're super proud to see our patients loving their experience from the waiting room to the high-quality care as well.

Tell us about the planning, construction and design.

Dr. Kha Nguyen: The foundation of the design and construction began when we both attended Breakaway Dentist Seminars' advanced startup and business masters courses. Once we learned how to create a dental office with modern systems and designs, we teamed up with a dental-specific architect and a dental-specific general contractor to make that vision come true. Lynn and I had an idea of what the speakeasy would look like, but it was truly and expertly designed by our architect, who had experience creating hotels in Las Vegas as well as various local restaurants. The finishing touches couldn't have been done without our interior designer, either, because she helped select the best furniture and lighting to go with our atmosphere.

So, what's on the drink menu?

LD: After patients check in, they get to embark on a little adventure through a hidden bookcase door, revealing a selection of booze-free beverages stored in the fridge. Options include coffee, seltzers, coconut water, low-sugar sodas, and nonalcoholic wines and spirits.

The best part is that it's a self-serve beverage bar. So, our patients are free to pick their drink of choice or get creative by making themselves a mixed drink using the nonalcoholic spirits. Some curious folks have asked about the bottles of alcohol on the shelves, but those are purely for decoration and ambiance-setting purposes. Rest assured, none of our patients come here purely for the drinks! Our main focus is, of course, providing top-quality dental care with a side of unique enjoyment!

You worked with brokers, architects and a dental coach to help bring the office to fruition. What lessons did you learn going through this process?

KN: There are a lot of brokers, architects and dental coaches out there. My tip is to choose only dental-specific companies because they know the nuances of dentistry and can get you the best results.

For example, when we started to design our operatories, we told our architect we would use only handheld X-ray units. He suggested that we nevertheless add specific studs to our walls in the operatories, because he's had a case where a dentist didn't and their pregnant team members didn't want to take X-rays using a handheld unit. When the dentist wanted to add a wall-mounted X-ray unit to that specific room, he wasn't able to because the wall couldn't support the weight of an X-ray arm. These are the small details that dental-specific firms can point out when you're too busy dealing with other things regarding a startup.

Patient comfort seems to be a strong focus. What are the elements patients notice the most or comment on the most?

KN: When we designed the office, we wanted to somehow transport patients from being in a dental office

"Using AI tools allows us to personalize and enhance the way we communicate complex dental information to our patients," says Doan. "This has been a great improvement for our patient case acceptance because patients can see what we're talking about."

to being somewhere they'd enjoy and feel relaxed. We did this by hitting all five of their senses: sight, sound, smell, taste and touch.

When patients walk in, they tell us how it smells like a new dental office, but in reality, that is the ScentAir scent diffusers we have running throughout the office. We've been told it also looks like a model home and nothing like a dental office; we've even had some people coming by thinking we were an actual bar!

When the patient is in the dental chair, they only see what's playing on the ceiling TV, hear what's playing through their Bose noise-canceling headphones, feel the warm, soft blanket on their skin and taste the pleasant ultrasonic water that's been premixed with a 1:5 Scope mouthwash concoction. We wanted everyone to feel comfortable at the dental office and, consequently, a lot of our patients have mentioned it feels like they're going to a spa instead.

But there's much more to it than just patient comfort. The two of you also designed a place you and the team would love to come to every day.

KN: We believe that to have great customer service, we need to have a happy team. Consequently, we based our systems around making sure our team is happy to work here.

On the surface, that means surrounding them with their favorite snacks in the break room, investing in their preferred tools to make sure they're efficient with their work, and providing comfortable, cushy chairs to sit on all day. But on a deeper level, we get to know them personally on their first day by having them fill out a complete personality form that tells us their favorite food, color, drink, etc. That way, when it's their birthday, we know exactly what each team member likes and dislikes and can help make their day perfect.

The test also helps us understand each person in a way similar to the "five love languages," so we can make sure to treat each person in their specific way and make it easier for them to love working here.

LD: In addition to the systems that Kha mentioned, one thing we absolutely love about our workplace design is the focus on being super-organized. We believe that having everything in its place and running smoothly makes a huge difference. It's not just about looking good—it's about creating a space where everyone can work efficiently and feel supported.

The spare-no-expense feel permeates into the clinical side of the practice. What are some of the tools you especially love?

LD: We absolutely love the online scheduling feature integrated into our practice management software (Curve). It operates in real time, allowing new patients to book appointments seamlessly, much like booking a flight or shopping online. More than 50% of our patients schedule their initial visits online. It's fantastic because it's accessible 24/7, enabling us to attract new patients even outside regular business hours.

KN: We invested in Pearl for AI integration with our X-rays. It's a game-changer because we can now show patients the layers of their teeth in color, their cavities in color, and even their bone loss/calculus in color. Not only is it an amazing tool for patient education, but it also helps new patients trust our diagnosis even though it's their first time meeting with us.

Aside from the AI in our X-rays, we've also really enjoyed making use of our iTero. There's a big division among dentists about whether Invisalign is worth the premium cost in comparison to other clear aligner brands out there, but for our patients, who love to be educated and understand what is happening inside of their mouth, it's transformative. During the exam, we're able to show our patients on the big screen how their teeth look and the cause of their damaged teeth, and they usually ask us after, "How do we stop that from getting worse?" Similar to Pearl, it makes treatment acceptance that much easier when they can see with their own eyes that something is wrong.

How do you two balance the clinical side of the business?

LD: While each of us has our preferred procedures, we prioritize continuity of care, steering away from cherry-picking based on personal preferences. Our patients really value the consistency in their care.

KN: We both take on all cases because we have similar skill sets. The only time one of us will see a specific case is when the patient has followed us from a previous practice and requested to see one of us. I think once our practice is established enough to have minimal provider availability, then we will be more selective on which cases we take on.

What are some lessons you've learned in transitioning into practice ownership roles versus associate roles?

LD: I really enjoyed my time as an associate. Being the primary dentist in a small clinic on most days allowed me to gain extensive experience that helped so much with the transition. In my associate role, the owner doctors provided valuable mentorship, guiding me through the financial aspects of running a practice, insurance verification and breakdowns, and effectively presenting treatment plans to patients. Learning the ropes as an associate showed me the power of having an awesome mentor. Even if the financial gains aren't immediate, being open to soaking up all those ownership skills is absolutely worth it for your future as an owner. Trust me, it pays off big-time!

KN: One lesson I've learned from being an owner is to properly manage work-life balance.

As an associate, I'd go to the office, do my clinical work and go home, leaving my work at the office most of the time. But as an owner, the work doesn't end once you exit the building.

I remember during our first two months before opening, we were at the office from 7 a.m. to 2 a.m., getting everything ready for opening day. The constant grind made me irritable, and I was short with the people I interacted with. I felt guilty about it and subconsciously knew it was happening, yet I couldn't stop it. Once I learned to force myself to take some leisure time and enjoy my hobbies in between work times, it made for a much more pleasant ownership lifestyle.

TOP PRODUCTS

ITERO ELEMENT 5D SCANNER

This scanner has significantly improved our chairside patient communication and education. Our favorite feature is the occlusalgram, which visually represents a patient's bite and highlights the teeth that make the most contact.

PEARL AI SOFTWARE

Pearl AI has been a game-changer for patient education and case acceptance. When reviewing X-rays, many patients struggle to discern the different shades of gray. But with the Pearl AI "tooth parts" feature, each layer of the tooth is presented in a distinct color, making it engaging and informative for patients.

PLANMECA CBCT

The quality of the CBCT images makes it remarkably easy to examine vital structures in great detail, which is crucial for precise treatment planning and minimizing complications.

CURVE DENTAL SOFTWARE

The majority of our new patients now schedule their appointments online, and we love that these bookings are captured in real-time on our schedule, streamlining our administrative processes.

BOSE NOISE-CANCELLING HEADPHONES

Our patients greatly appreciate the ability to block out the sound of the drill or scaling with these headphones. This, in addition to the ceiling TV, allows them to relax to their favorite show and makes their treatment experience more enjoyable and seemingly quicker.

How do you manage marketing?

LD: When we started the practice, we knew marketing would be a big deal to get the word out and bring in new patients. We decided to dive into marketing even during our construction phase, and we tried a bit of everything to see what had the best return on investment: We experimented with grass-roots marketing, magazine ads, social media and even used a digital ad agency.

After the first three months, we were surprised to find that social media marketing, especially unpaid posts, gave us the best results and the highest return on investment. It outperformed what most sources were saying about Google Ads being the best method.

We manage our social media account in-house and have a team member who plans and posts the content for us. Before our practice, we weren't active on our personal social media accounts, but we set a goal to get good at it and just started posting daily to see what worked. If we can do it, we're pretty sure anyone can!

For someone just starting out, our advice is simple: Don't be afraid to start and try new things. Keep an eye on the latest trends and best practices in social media marketing, because things change fast. Be ready to adjust your strategy based on what your audience likes. Try different types of content and posting schedules to see what connects best. If you want to up your social media game and consistently put out great content, think about bringing in a local expert who knows the tech stuff and can help you create cool, trending content.

Start small with that before diving into an agency or paid ads. It's all about growing your presence organically and engaging with the people you want as your patients.

What are your short-term and long-term goals for the practice and for your professional lives?

KN: For the short term, I want to grow our team, practice to be one-of-a-kind and give patients a top-notch experience, and at the same time provide our fellow team members with a financially stable and mentally supportive environment where they can live a great life inside and outside of work. For the long term, I would like to grow our company to multiple locations and create a group practice that stands out from the typical corporate, numbers-driven DSOs out there.

My ultimate goal, however, is to one day hang my handpiece up and enter the world of technology, creating a product that everyone needs in their life. It's always been my passion to innovate new technologies, and I believe dentistry is a good stepping stone towards that.

LD: Expanding on what Kha shared, we're aiming for something big in the long run, turning The Dental Bar into a brand that instantly brings to mind a positive dental experience. Think advanced tech, comfy care and a fun vibe. I want people to look forward to heading to The Dental Bar and change their whole outlook on dentists for the better. On a personal note, being an entrepreneur has been a lifelong dream, and I'm thoroughly enjoying this journey until the next exciting entrepreneurial chapter.

As practice owners, both of you are experiencing the business side of dentistry more than ever before. Tell us how you went about building your team, what you looked for, and how managing the nonclinical side has gone so far.

LD: During my three years as an associate, I had a crash course on the business side of dentistry. I learned from my many mistakes, including what to do and what not to do as far as team management. A big lesson was realizing the importance of aligning everyone with the same vision. When building our team, we made a point to share our vision and sought their input during interviews. Regularly revisiting this vision in our monthly meetings ensures everyone is on the same page.

But let's be honest, there are still curveballs that come up. That's why it's important to have mentors and coaches you can go to for advice. We feel fortunate to have a network of experienced individuals who've been instrumental in guiding us through various business challenges.

KN: When it came to building our team, we wanted to start with strong team members who have experience working in dentistry, are personally driven and have easygoing personalities. To do this effectively, however, we decided to create our six core values using the principles found in *Traction: Get a Grip on Your Business* by Gino Wickman and ensuring all of our hires exemplify these attributes.

For example, one of the core values Lynn and I decided on is, "We like to keep it light and have fun." To this day, we haven't had any drama in our team, and I think it has a lot to do with

choosing the right team members from the start.

In addition to the first-day personality test mentioned previously, we'll try to sprinkle in questionnaires here and there, as well as frequent one-on-one check-ins to discuss any changes or concerns they have with their jobs. Ultimately, it helps each team member ensure they love working here because they're constantly being showered with what they like while minimizing what they dislike.

What's your favorite patient story?

LD: In our first month of opening, this patient had a dental emergency and couldn't get an appointment anywhere else because all the dentists in town were fully booked. She was in so much pain she couldn't eat or sleep and was on a desperate search for help. She finally found our clinic and emailed us at 4 a.m. asking if we could see her the next day.

We managed to get her in and take out the troublesome wisdom tooth on the same day. Since then, she has been a loyal patient—and not only that, she brought in her two kids and her husband too. We even run into them at local church events, and they've been spreading the love on neighborhood Facebook and Nextdoor pages. Patient relationships and the trust patients have in us make opening this clinic worth it!

KN: My favorite patient story took place about a month after we opened. I remember seeing a college student for an examination and him telling us he's autistic and has severe dental anxiety. Every single time he'd had dental treatment in the past, he had to be sedated. However, after discussing with the patient and his mother, we decided to attempt a root canal and crown without sedation. We completed the procedure successfully without any complications.

When I asked the patient what was different from his previous experiences, he mentioned that when he was in our lounge, he felt calm because it didn't feel like a dental office. (And no, he did not have anything to drink!) During treatment, he was distracted by the ceiling TV and didn't notice us working in his mouth.

That was an eye-opener for me. Initially, when Lynn and I decided to build our hidden speakeasy, we just wanted something different from other dental offices and to put our personal touch to the practice—we never thought that it could be used as an alternative to traditional sedation methods. We believe that experience already made it all worth it.

What's a trend in dentistry you love, and one you're not a fan of?

LD: I'm super excited about the trend of integrating artificial intelligence tools into dentistry, particularly in patient education. Using AI tools allows us to personalize and enhance the way we communicate complex dental information to our patients. This has been a great improvement for our patient case acceptance because patients can see what we're talking about. Seeing is believing!

> **More than 50% of our patients schedule their initial visits online. It's fantastic because it's available 24/7, enabling us to attract new patients even outside regular business hours.**

A trend that I don't like is patients trying home remedies they've seen on the internet or TikTok … but I don't think that'll ever go away.

KN: I love it when I see dentists step out of their comfort zone and start their journey toward practice ownership. (Maybe I'm a little biased here.) Although it's not easy, I believe there will always be a need for private-practice dentists to provide patient-centered care.

Unfortunately, in my experience, a lot of the DSOs focus on the numbers and metrics, and are so out of touch with what's going on in their dental offices that they've forgotten how to provide quality care to their patients (and their employees). I hope the trend toward a DSO dental field will slow down and dentists will fervently take control of their industry.

How did each of you find your way into dentistry?

LD: My journey into dentistry began when I got braces at the age of 13. Before then, I rarely went to the dentist and had no family members in the field. I was super self-conscious about my smile, felt awkward when talking and I'd dodge the camera in photos—it would drive my parents crazy during family photos. But once I got those braces, it was like a complete transformation: It affected my self-confidence and everyday life in ways I never expected.

That experience lit a fire in me to pursue dentistry. I realized how dentistry could make such a huge difference in someone's life. I wanted to help others experience the same boost in confidence and well-being that I had felt through oral health.

KN: I discovered dentistry when I was in seventh grade. My older brother discussed the field's great work-life balance and how if he could go back in time, he would've highly considered it as a profession. I shadowed dental offices every week during my senior year. I loved the sciences and working with my hands, so it worked out well. In college, I pursued becoming a trauma surgeon and shadowed/interned alongside some excellent chief of surgeons. However, the lack of work-life balance pushed me back toward dentistry and solidified my decision to stick with that goal.

Give us a snapshot of your lives outside of dentistry.

LD: Lately, picturing a life beyond dentistry has been a bit of a challenge. I've found myself deep in the work zone, and honestly, my work-life balance is completely off. Even when I'm at home, I'm constantly thinking about dentistry, especially about marketing and our social media.

However, when I'm not working, I am all about quality time with my family. You'll always find us eating out and trying new restaurants with our family and catching up over a good meal. During the summer, I enjoy being outside playing tennis or pickleball, or lounging at the neighborhood pool.

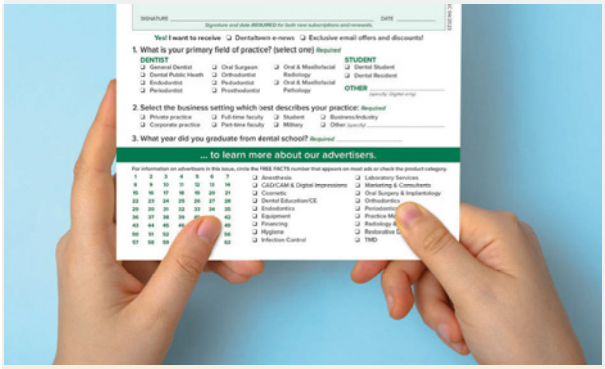
I'm also a huge introvert so after all my socializing, I need to recharge by journaling, diving into a good book or indulging in some online retail therapy.

KN: I know it's hard to believe, but dentistry isn't something I want to do for the rest of my life. Outside of dentistry, I have many hobbies I try to keep up with, so my wife will stay interested in me. (I'm joking!)

On the warmer Colorado days, I enjoy playing singles tennis and hard court volleyball and golfing in the mountains … basically, anything active that has a ball involved. On colder days, I enjoy staying in and playing nostalgic Blizzard video games or swinging away with my golf simulator in the basement.

Regardless of the time of the year, however, we both love to try new restaurants and travel to destinations if it means good food is involved. **DT**

AD INDEX



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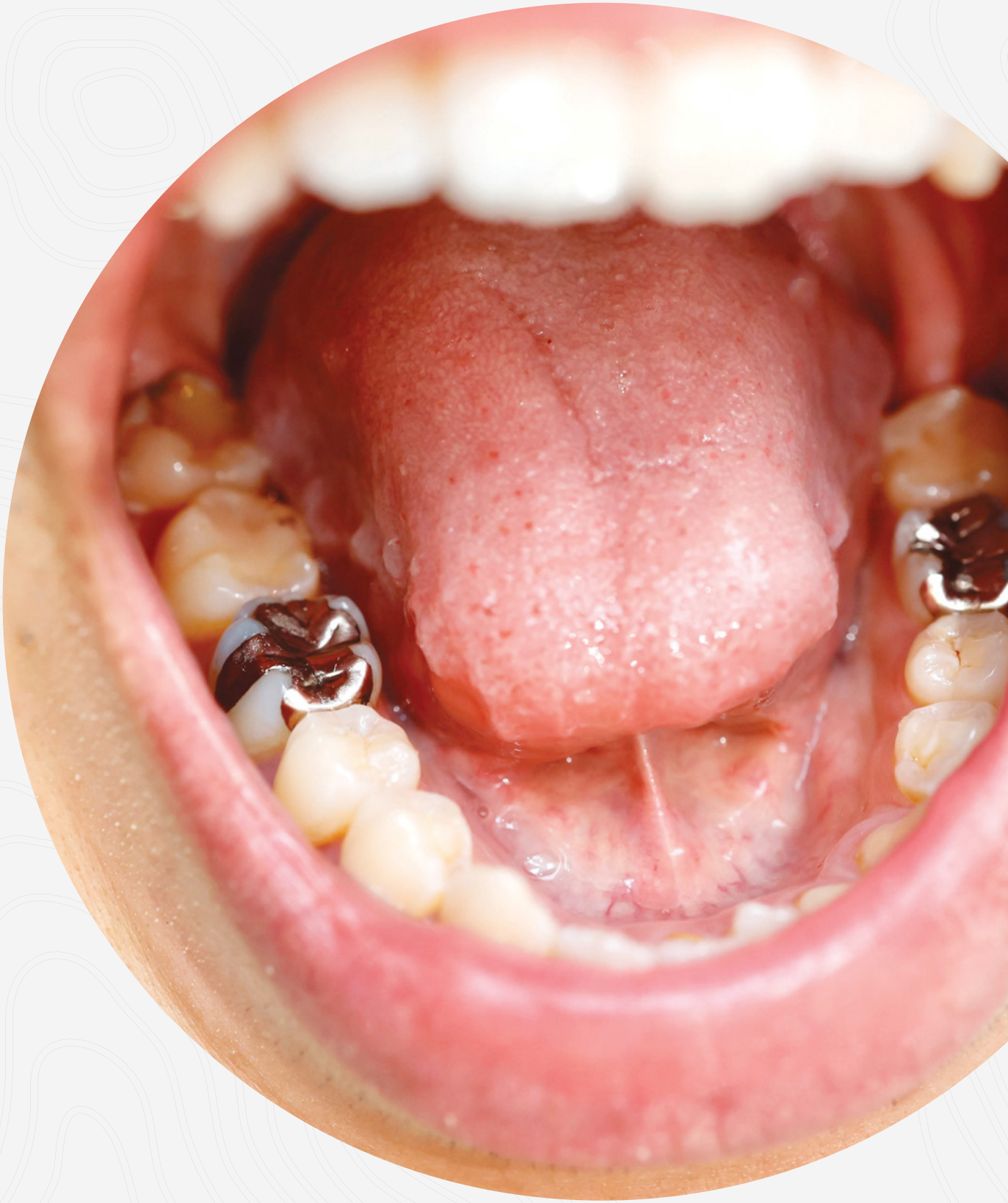
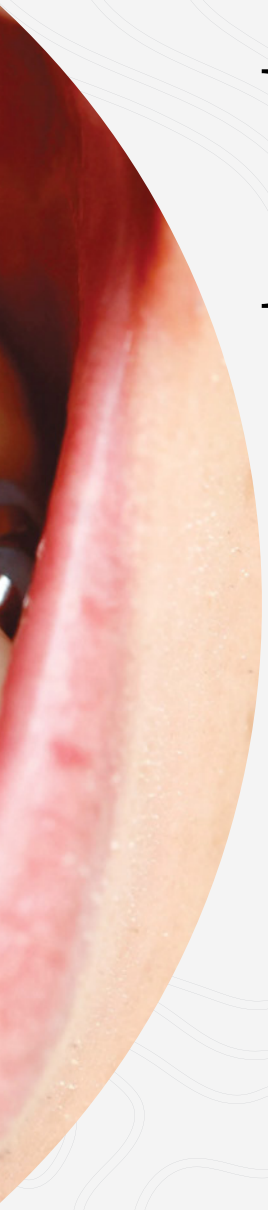
Pac-Dent	21	7
Productive Dentist Academy	IBC	9
Ritter Implants	13	6
Scientific Metals	IFC - 1	1
VOCO America	BC	10





Hi-Ho, Silver!

When SDF makes sense in treating adult patients

BY DRS. JUSTIN J. CARDARELLI AND MARMAR MESGARZADEH

Although not new in its use in medicine, silver is experiencing a bit of a renaissance in the dental industry in the form of SDF. Silver diamine fluoride (SDF) has been used as a therapeutic agent for arresting caries in teeth since the 1970s.[1,2] SDF was developed by Reichi Yamaga, Misuho Nishino, et al. when ammonia was added to silver nitrate to make it stable for use as an antibacterial agent to prevent and treat dental caries.[2]

The U.S. Food and Drug Administration approved the use of SDF as a desensitizing agent in 2014.[3] The use of SDF off-label as an interim caries-arresting medicament has been popular around the world because of its economic benefits and ease of use for children, the elderly population and disadvantaged communities with difficult access to dental care.[4,5] Today, SDF should be considered an integral part of the of the restorative treatment regime for patients of all ages, not just children or the elderly.

SDF at work

The antibacterial effect is one of the key modes of action of silver diamine fluoride.[1,3,4] The interim arrest of caries occurs partly because of SDF's ability to interrupt the caries process. The caries process begins with demineralization of enamel from acids released by the bacteria that cause tooth decay. In vitro studies have supported the clinical efficacy of the fluoride ions in SDF in reducing the solubility of tooth tissue against chemical acid challenge. Research shows that the antibacterial action of the silver ions acted specifically against cariogenic strains of *S. mutans* (MIC, 0.12 mmol/mL).[6,7]

SDF affects the caries process as well as the tooth structure. The effect on enamel is primarily caused by fluoride, while the effect on dentin is predominantly because of silver.[8,9] Along with reducing the chemical acid effect, the fluoride ions facilitate enamel remineralization.[10,11] In turn, silver ions act like rebar to occlude the dentin tubules and reduce sensitivity.

SDF was primarily introduced for use in pediatric patients because of its quick and simple application, but it is often avoided in adults because of its tendency to stain infected tooth structure. Staining, the most reported side effect of silver diamine fluoride, occurs from the reduction of silver ions to metallic silver and silver oxide. Ionic silver absorbs onto any protein surface, but is especially bound to denatured proteins. This accounts for the specificity to carious collagen over healthy collagen.

Staining, however, is not the same for every individual case. The amount of caries, the concentration of the SDF and the frequency with which the SDF if applied, as well as the specific product used, can all affect the level of the staining.

Indications for use on adults

Just like every product in dentistry, SDF works best when used in the right situation. In our opinion, there are three general case types where we have found SDF acceptable as an adjunct or interim treatment in adult patients.

1. Cases in which the stain is acceptable (hard to see or hard to treat).

Distal buccal caries on the last lower molar can always be difficult to access and seal properly; sometimes in attempts to do so, we destroy more healthy tooth structure than we save. If we can arrest the caries without destroying form and function in the process, it may present a better treatment alternative.

If the patient's pretreatment caries is difficult to access and visualize without cheek retractors and a hygiene mirror, the treatment itself may remain similarly unnoticeable even if it stains or darkens the teeth (Figs. 1 and 2). These "acceptable" cases can also be a case of the patient choosing the resulting staining over outcomes of alternative treatment plans. If we can use SDF to arrest decay on a tooth that could otherwise have the potential to be extracted, the patient may find that an acceptable alternative.

2. Cases in which the stain is reduced.

Certain SDF products on the market have introduced potassium iodide as a second step that helps reduce staining during the interim treatment until a final restoration can be placed. These products are also great for areas of root exposure, where a patient may have dentinal hypersensitivity but no true lesion or plaque retentive area that requires a final restoration.

If a patient presents with noncarious cervical lesions with sensitivity and no need for preps, but can see their symptoms alleviated with little to no staining, they may jump at the treatment plan that doesn't include "the drill."

When silver diamine fluoride is used in these first two case examples, it has to be confirmed that the site is not

Fig. 1: #18 before treatment.

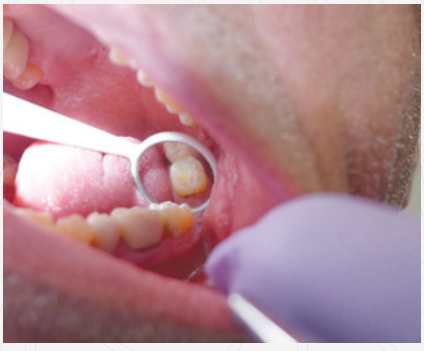
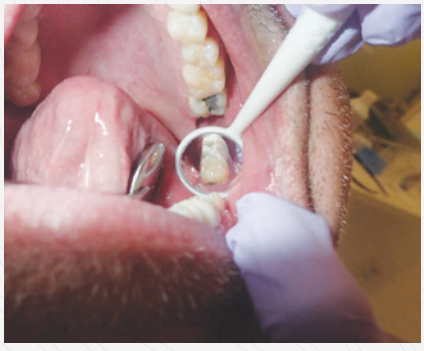


Fig. 2: #18 after SDF.



PHOTOS BY MONTEZ DELVER HALLBACK, A STUDENT AT TUFTS UNIVERSITY SCHOOL OF DENTAL MEDICINE

plaque-retentive or a food trap. SDF works at halting decay but it will lose the battle if the patient has poor home care or debris constantly accumulates.

3. Cases in which the stain is covered up. (Most adult patients will need a final restoration.)

With the adult patients who normally visit a dental office, carious lesions are more likely to require a restoration to restore full form and function and eliminate food traps. This is also an ideal opportunity to cover SDF staining with an opaque restoration (Figs. 3 and 4).

Fig. 3: #15 treated with SDF after patient presented with fractured cusp. Tooth is asymptomatic and tests vital. Patient does not have funds for final crown and often fails appointments.

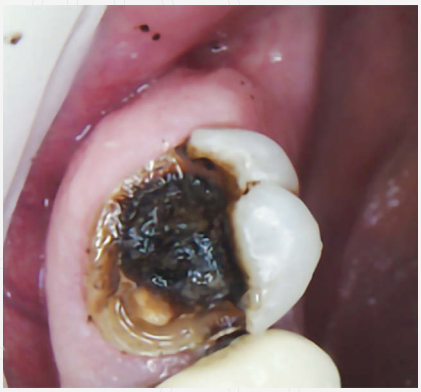
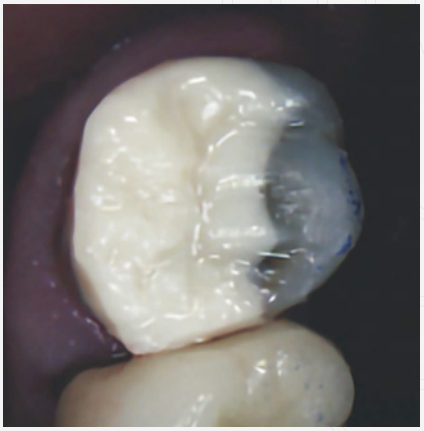


Fig. 4: #15 after glass ionomer restoration was placed during the same visit.



The SMART (silver modified atraumatic restorative treatment) restoration is a technique to halt decay and seal teeth using SDF and glass ionomer cement (GIC) or or resin-modified glass ionomer. SDF is applied as usual in two appointments to arrest decay. With this technique, the second application is followed by the placement of GIC or other restorative material over the arrested decay, which seals out the nutrients carious bacteria feed on and restores some form and function, leaving a non-plaque-retentive surface for the patient to keep clean. Although other treatments may be used, this is a helpful technique for any patient you may see with limited access to care or difficulty making or keeping multiple appointments.

This technique can be tapered to your patients. If patients are unlikely to return or access to care is limited, silver diamine fluoride can be applied and immediately sealed with GI in the same day. If the patient is likely to return, SDF is an ideal interim step to arrest the decay; then, even if the patient is delayed in returning, there is no progression and the lesion can be restored with your preferred restorative material.

Possible additional uses

In more complex cases with significant decay throughout the oral cavity, treatment planning may take several visits. Silver diamine fluoride can be used to halt decay while complex diagnosis and planning is completed; this allows for comprehensive treatment while not allowing lesions to progress. Once a comprehensive plan has been decided, final restorations can be placed over the SDF to restore form and function, eliminate food traps and mask the potential staining resulting from the caries arrest.

Unfortunately, we have also seen situation where finances can limit treatment options. There are cases where the patient needs time to save for a new crown, or insurance will not cover a new crown just yet because of time restrictions. For these patients, SDF can be used along the margin to arrest decay until finances or insurance coverage can be obtained.

> **Just like every product in dentistry, SDF works best when used in the right situation.**

When the time comes to replace the crown, the crown is removed, recurrent decay under the crown is excavated and the margin is dropped to eliminate any trace of the potential staining from SDF (barring any other potential complications that may exist under the crown that you have already discussed with the patient at the start of treatment).

These cases are a small sample of the benefits of using SDF in a general practice. SDF is quick, simple to use, can be applied by a hygienist and, because of its minimal side effect, it is a safe adjunct for treatment in adults as well as children. A few cases have reported a mild gingival irritation on the mucosa adjacent to the area treated after SDF application,[12] which can be prevented by applying a thin layer of petroleum jelly to the adjacent gingiva before applying SDF.[13]

As far as placing restorations after silver diamine fluoride, it has been reported that SDF does not affect the bond strength of composite resin to noncarious dentin, but may reduce bond strength to caries-affected dentin. SDF is compatible with glass-ionomer cements and may increase resistance of GICs and composite restorations to secondary caries.[14] In other words, clinicians can use their full arsenal of restorative care, while SDF provides an added margin of safety for the patient. **DT**

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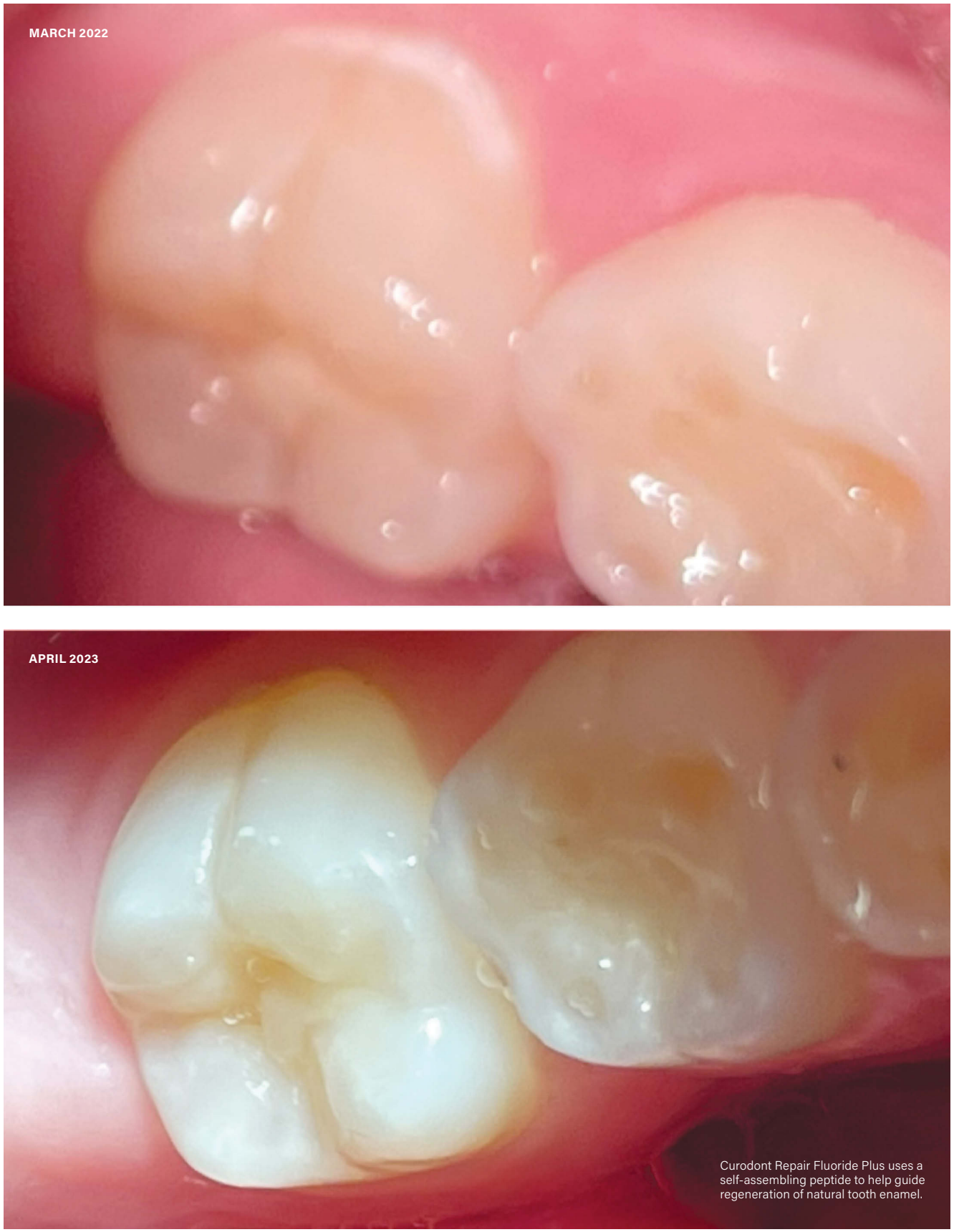
Dr. Marmar Mesgarzadeh is an assistant professor in the comprehensive care department at Tufts University School of Dental Medicine, where she has been teaching and mentoring dental students since 2011. Mesgarzadeh has been practicing general dentistry for more than 18 years, with a private practice in the Boston area.



Curodont Repair Fluoride Plus uses a self-assembling peptide to help guide regeneration of natural tooth enamel.

The Future Is Now

A close look at a new product that regenerates enamel

BY DR. JEANETTE MACLEAN

Dr. G.V. Black, one of the founders of modern dentistry, once said, "The day is surely coming—and perhaps within the lifetime of you young men before me—when we will be engaged in practicing preventive, rather than reparative, dentistry." Modern concepts for dentistry favor minimally invasive treatment approaches aimed at preserving natural tooth structure.[1] Curodont Repair Fluoride Plus stands to revolutionize dentistry with its first-of-its-kind treatment: biomimetic guided enamel regeneration using a self-assembling peptide, P_{11}-4.[2]

Innovation

Caries occur as a result of an imbalance in the dental biofilm, whereby decalcification exceeds remineralization, creating porosities in the enamel subsurface.[3] Various minimal interventions have been used to help manage caries. Diet and oral hygiene improvement are both important, but patient compliance can be a challenge. Topical fluorides are helpful for inhibiting demineralization; however, the enamel protection is limited to the outer ~30µm of the tooth.[4] Silver diamine fluoride (SDF) has gained popularity in recent years, but is refused by some patients because of the dark stain it creates on caries lesions.[5] Resin infiltration offers an aesthetic solution to noninvasive caries arrest, but by radiolucent, artificial means.[6] Unique in comparison to previous options, Curodont Repair Fluoride Plus penetrates to the depth of an initial caries lesion and stimulates de novo hydroxyapatite formation, thereby regenerating natural tooth structure.[4]

Mode of action

The enamel matrix proteins responsible for enamel formation during odontogenesis degrade during the final stage of maturation.[3] The self-assembling peptide in Curodont, P_{11}-4, mimics the ability of enamel matrix proteins to form a 3D scaffold that promotes hydroxyapatite crystal nucleation and mineral crystal growth.[7] P_{11}-4 fibers attract calcium from saliva, supporting hydroxyapatite formation within the porous caries lesion body, facilitating

Watch the product in action!

To watch Dr. Jeanette MacLean's video tutorial of how to apply Curodont, click the link inside the digital edition of this article at **dentaltown.com/magazine**.

Clinical case studies

Curodont can be applied to incipient caries lesions in a variety of clinical scenarios, such as these from Dr. MacLean's practice, to help patients remineralize their teeth, bridging the gap between "watch and wait" monitoring and conventional restorations.

Patient 1: Buccal use

Fig. 1: A 9-year-old boy with buccal gumline decalcification on his first permanent molar.

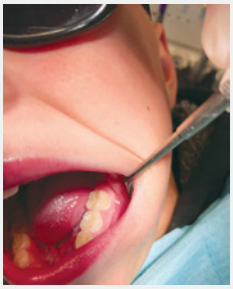


Fig. 2: After cleaning the tooth, 37% phosphoric etch was applied for 20 seconds, then rinsed with water and dried.

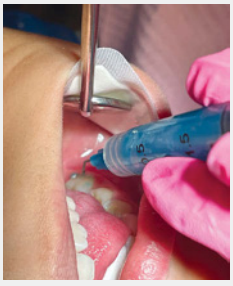


Fig. 3: Curodont was applied and allowed to absorb for five minutes.

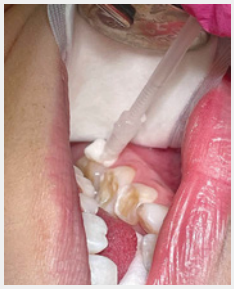
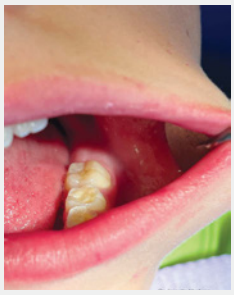


Fig. 4: A 16-month follow-up photo shows the buccal aspect of the tooth has not cavitated and the enamel translucency has improved.



Patient 2: Proximal use

Fig. 5: A 19-year-old male with incipient proximal caries lesion on the distal of the mandibular left first permanent molar.

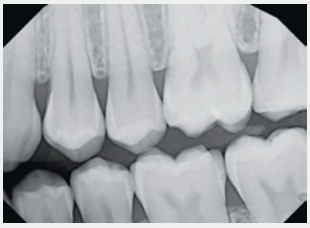


Fig. 6: Curodont was applied to the proximal contact using a plastic instrument to help push the liquid out of the sponge into the embrasure space.

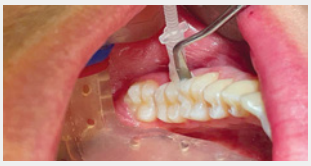
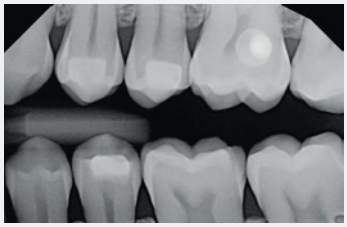


Fig. 7: A six-month follow-up bitewing shows the distal lesion on the mandibular left first permanent molar has not cavitated.



Patient 3: Around orthodontic brackets

Fig. 8: A 12-year-old girl in braces with white spot lesions above the brackets on her maxillary incisors. Curodont was applied to help prevent the lesions from getting worse because she would still be in braces for more than a year.

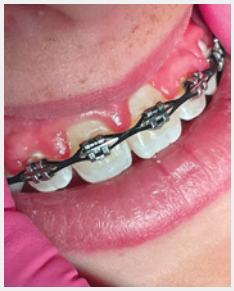
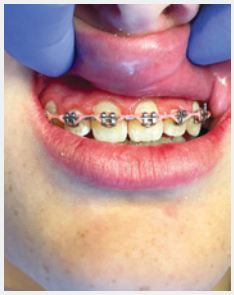


Fig. 9: A 12-month follow-up shows the teeth have not cavitated and some of the enamel translucency has returned.



hard-tissue regeneration. This biomimetic mineralization is analogous to the enamel matrix during enamel formation, effecting "natural" repair by regenerating the mineral itself.[8]

Efficacy

Numerous clinical studies support the safety and efficacy of Curodont, as well as its superior efficacy compared with fluoride varnish, placebo or saliva.[2,3,9–11] The Journal of the American Dental Association recently published a systematic review and meta-analysis, which found P_{11}-4 was capable of reducing cavitation in initial caries lesions.[12] A variety of clinical assessment tools evaluated the effect of Curodont, including microtomography, laser fluorescence, the Canary System, ICDAS-II Codes and Nyvad Caries Activity Criteria, in addition to conventional clinical and radiographic assessment.[1,7,9]

Teeth treated with Curodont have demonstrated greater remineralization, regression of caries and reduction of lesion size, with a highly significant change noted 30 days after

application.[8] The de novo hydroxyapatite crystals formed by Curodont have a fan-like shape, in comparison with the prismatic arrangement created by ameloblasts, which may explain why some lesions may not return to full translucency.[10,11]

Increased microhardness after Curodont treatment has been shown to reach a depth of 200µm; fluoride varnish, comparatively, exhibits a change in only the top 25µm.[1] The treatment is highly biocompatible, and clinical safety results show it does not pose any concerns and had no adverse events, medical complications or allergic reactions related to the treatment.[1,8]

Benefits

A paradigm shift in modern dentistry focuses on a noninvasive, medical model of care, in contrast to the traditional, surgical "drill and fill" model.[1,9–11] Early detection and minimal interventions such as biomimetic remineralization can help protect patients from unnecessary tissue loss or caries progression to expensive and invasive restorations. Preserving natural tooth structure for as long as possible and delaying or avoiding entry into the downward spiral of "redo dentistry" is a major advantage of Curodont.

Suggested uses

Regenerative procedures should be considered whenever possible and offered to patients. Curodont can be easily incorporated into everyday clinical practice. When incipient lesions are identified during an exam, clinicians can mention the option of remineralization to help reverse their enamel damage. Depending on your state dental practice act, the application of Curodont can often be delegated to a dental auxiliary. It can be applied in a matter of minutes in conjunction with their new-patient or periodic exam appointment, a stand-alone visit or along with a restorative visit. Clinical studies show efficacy on a variety of surfaces, including occlusal, buccal and proximal.

Application

1. Clean the treatment site with plain pumice. Five percent sodium hypochlorite may also be applied for 20 seconds to remove tooth pellicle. Isolate the treatment site with cotton rolls, Dri-Aids and/or an isolation suction system.
2. Apply 37% phosphoric acid etch for 20 seconds. Rinse off the etch with water, then dry the teeth.
3. Prepare the Curodont applicator by removing the safety clip and pushing the two cylinders together. Remove the applicator from the protective cover, then apply by squeezing the sponge onto the lesion(s)/proximal spaces. You can use a Hollenback or plastic instrument to help press the sponge against the teeth as well as twist and fold the applicator, like wringing out a mop, to help express the liquid out of the sponge.
4. Allow the solution to absorb for five minutes. The liquid must come from the sponge to deliver the peptide technology to the enamel.
5. After five minutes, it is optional to apply fluoride varnish. Instruct the patient not to rinse, eat or drink for 30 minutes. **DT**

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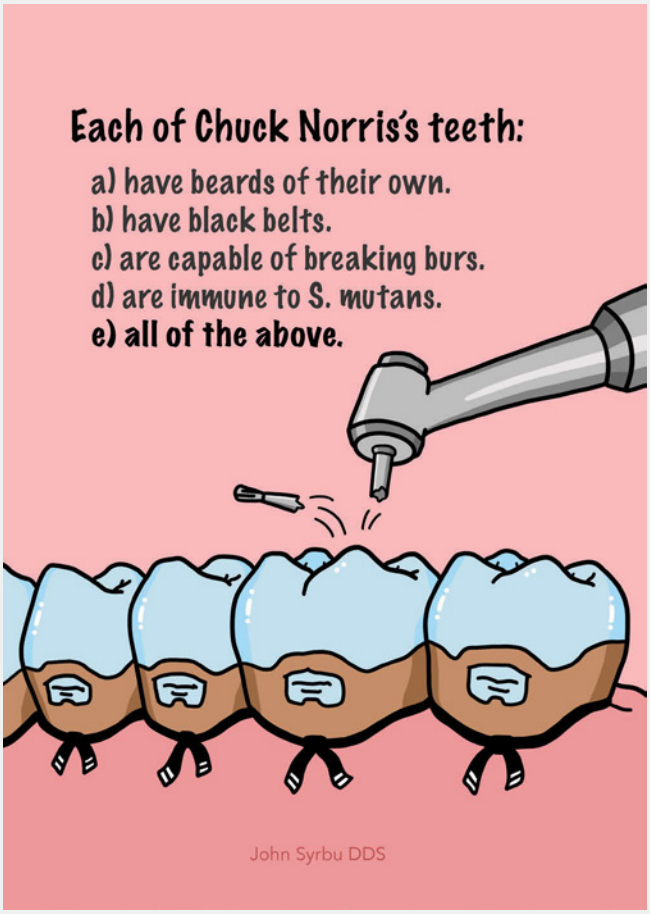
Same Old Year, Same Old Goals

My dear enduring associates,

Well, here we are again. The calendar insists on flipping. I sat down to pen this employee letter and had hoped some vague sense of optimism or excitement might take possession of my mind, or that the gummy I ate off the table in the break room would heighten my spirits, so to speak. Wish I could say yes, but I can't; I'm fairly confident it was just a watermelon Sour Patch Kid.

So, let's get on with it: It's 2024 and as we trudge into the haze of the next three hundred and some-odd days, the drills will whir and the chairs will creak, and this never-changing plotline of dentistry will refuse to further evolve. If this year is a good year (which I doubt), we might have a few things to look forward to.

HUMOR WITH BITE



And if not, we have a few things to reflect on that were, God willing, mere cosmic accidents outside of our control—though I did ask the local community college to send out one of their undergrad archeology students to see if maybe we just built this practice on an Indian burial mound like the one in Stephen King's *Pet Sematary*. That incident with the raccoon chasing Audra across the parking lot had to have been a fluke. She says she didn't have string cheese in her pocket, but come on—when has that ever been true? Ringo the Possibly Rabid Raccoon might still be out there, so if you use the side exit, go with a buddy or grab the stick leaning against the wall for protection.

The strip club opening up across the street was this past year's biggest obstacle to overcome, both in the fact that we lost half our front desk to it and that most of our patients with children abandoned us. But on the literal bright side, the lights at the Jiggle Joint are cheerful and sort of fun to look at.

Then there was that time in the break room when we were all watching the news report about a delivery truck going into the river. I said something like, "With our luck, that truck had all our upgrades to the employee bathroom." I've learned not to say things like that anymore. Update on that: The city sent out divers to make sure there was nothing hazardous in all those packages. Our new toilet is home to a family of catfish.

I watched a short video once on YouTube about how to better inspire employees and it said to always end on a positive note. I think the fish having a new house covers that.

Thanks for not quitting,

Dr. Smith

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