american academy of gold foil operators

Gold Leaf

March 2013

Minutes for AAGFO Board Meeting

October 24, 2012

Union League of Philadelphia at 2:30 p.m.

I. Call to Order- Rick Nash--

II. Minutes of Previous Board Meeting- Council approved previous meeting minutes

III. Secretary Report—The duties of the secretary are slowly being transferred to Dr. Tollefson over the next three years. The student awards program is already in his hands as well as meeting material preparations. The complete transfer should be done by the 2014 meeting in Portland when most of the remaining archive, duties and supplies will be relocated.

Membership Report—Current membership is 195 which includes all categories. There are currently 126 active and associate members. Two new memberships are pending: Dr George Bediot and Dr. Carol Klingensmith. Nine members have been dropped for no response, dues default or membership request. There are currently 40+ members requesting the Gold Leaf in hard copy form.

IV. Treasurer Report-Dr. Evans reports that our Academy is in very sound financial condition. Although our membership probably will continue to decline, but at a slower pace. We still have a core of committed members who believe in gold foil as a superior material which they continue to promote. The transferal of duties and account reconciliation is now complete under Dr. Evans.

V. Annual Meeting Reports- Dr. Keene stressed the importance of not committing to future room blocks with hotels because of the risky financial obligations and monetary hemorrhage. Rather we should pay for meeting rooms separately at our conventions and let members book their own rooms at the best rates available. Dr.Keene also stressed finding a new meeting coordinator for future meetings.

Scientific Sessions—Dr Tollefson reported that all the speakers have been lined up and confirmed. Our speakers are Dr Leonetti on managing implants, Dr. Trope on endodontic success, and Dr. Anderson on changing paradigms in healthcare.

Education & Clinical Seminars--Dr Zinter reported that for the clinical session we have 5 foil operators and 10 cast gold operators . Following the clinic, we will have a masters class followed by critiques of the various operations.

Literature & Research-It was decided to keep the present format for paying dues for the Journal of Operative Dentistry to remain the same and choose the option of requesting a hard copy in addition to the online version if so desired at an additional cost at time of dues payment. Dr. Henry reminded us that the AAGFO voted last year to subscribe to an online version. Dr. Nash moved that the dues format remain the same as before and this was passed by the council.
Nominating Committee—no report. We will hear their report in February 2013.

Constitution & Bylaws—Dr Evans reported that duties of Secretary and Treasurer have been split and the bylaws have been updated to reflect this change. Everything else is up to date.

Inter-Academy Liaison—no report

Distinguished Member—this year's member is Mark Ziemkowski.

Outstanding Clinician—no report. This year is Dr. Clyde Roggencamp.

Annual Meeting Facilitator—Dr. Keene reported that a search for a new meeting planner continues and that a Meeting Planner's Manual is in the making and should be completed by the Mid-Winter Chicago meeting.

VI. Report of the Journal—no report

VII. Web Page Report—no report

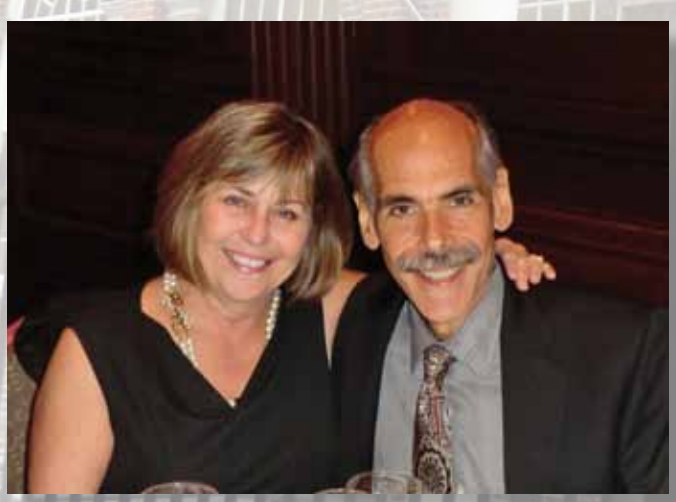
VIII. Gold Leaf Report—Dr. Brinker reported. The Sept. Gold Leaf has been sent by e-mail. Dr. Brinker respectfully requested a replacement editor be named as soon as possible. The Gold Leaf is now online with hardcopy by request.

IX. Old Business. Dr Henry reports we are not having a table clinic at the Operative Academy Convention in Feb. 2013 because of a mix up in the application process. All the table clinics are taken already. Dr. Keene is working on a new meeting planner. Plans are being made for our May 2014 meeting in Portland, Oregon and probably will also include the Ferrier Study Clubs. Wednesday to Sunday will be the time allotment. Student membership is now available and dental schools will be notified of this.

X. New Business: Dr Henry will investigate a possible meeting in Florida for 2015. Our new council member is Dr. Bruce Small. Dr. Nash will investigate better communication with our life members. As a matter of interest, we have 16 participating dental schools in the AAGFO student awards program and only 13 students were given awards and 3 schools responded they had no worthy candidates this year. The award is given to worthy students skilled in either direct gold or cast gold.

Council Members present:
Dr. Ted Ramage
Dr. Rick Nash
Dr. Dan Henry
Dr. Barry Evans
Dr. Marc Tollefson
Dr. Wendell Foltz
Dr. Rick Brinker
Dr. Clyde Roggencamp
Dr. Joe Newell
Dr. Janet Zinter
Dr. Bob Keene

Social photos courtesy of Robert Keene.



Background photo is Christ Church in Philadelphia, PA

Lecture Managing Implants

J. Leonetti, DMD

25 October 2012

At the outset, Dr. Leonetti pointed out that in spite of what you hear from sales reps, approximately 3% of offices have 3-D imaging and even less use them for more than diagnostic purposes. The future will see increased use of this technology in dentistry but the important point is that we understand and utilize the diagnostic capability of this technology in our treatment planning. One leader in the field, Dr. Scott Ganz, likes to say, "It's not the scan, it's the plan!"

The discussion reviewed an article by Dr. Carlo Tinti, MD, DDS on the Clinical Classification of Bone Defects: Understanding the anatomic nature of extraction site defects is one of the keys to choosing appropriate implant site development modalities to restore hard and soft tissue for implant supported restorations.

Extraction site defects were described and clinical cases were shown to illustrate a decision tree for implant site development.

Class I extraction wound: Envelope of bone intact, extraction walls intact. Consider immediate or delayed implant placement with particulate graft/membrane assisted GBR.

Class II: Envelope of bone not intact. Fenestration and dehiscence defects are included in this category. Immediate or delayed implant placement with particulate graft/membrane assisted GBR.

Horizontal ridge deficiency: Block graft with autogenous or allographic bone.

Vertical Ridge Deficiency: Block graft or sinus augmentation via lateral wall approach or osteotome assisted crestal technique
Key factor in anterior esthetic zone is horizontal bone width of buccal plate prior to implant placement in extraction site defects
Predictable stability of hard and soft tissue requires 2 mm or greater of buccal plate thickness. . It is better to graft and wait and let time be our ally in these cases.

The concept of Pink Esthetic Score (PES) was introduced.

The concept of the difficulty in obtaining excellent results with side by side implants in the esthetic zone was referenced. Clinical cases were shown and PES score assessed to evaluate results.

Attention to details: Frequent use of grafting materials, key is preservation of the buccal plate, polish on temporaries and adherence to Dennis Tarnow's 5 mm rule (contact point measured from crestal bone in preservation of the soft tissue papilla was stressed.

Strive for PES of 10+ with minimal soft tissue augmentation and again the concept of delayed implant placement (5 months) with the concept of 1 mm of bone growth monthly as it closes the diameter of the extraction site.

Class II extraction wound – extraction walls are not totally present 3-D imaging evolution: DICOM files from Cone Beam and Spiral Beam CT hard tissue can be merged with optical scans of stone models for soft tissue.

Beware of hour glass x-sectional profiles to prevent perforation of the lingual plate and access to the vascularized floor of the mouth… reference to morbidity and mortality issues

Horizontal Ridge Deficiency (HRD) – must use block grafting techniques
Type I > 50% of implant within the envelope of bone
Type II < 50% of implant within the envelope of bone

Block graft cases were shown utilizing both autogenous and allographic bone.

For technique leading into the hands-on workshop he mentioned making the pilot hole more to the palatal aspect rather than where the root had previously been located anatomically.

Vertical ridge deficiency (VRD) – a case was shown using autologous iliac crest.

The predictability of endosseous implants is excellent. Endodontic therapies are not the only option for otherwise helpless teeth.

Zimmer's Puros allograft was shown as a predictable grafting material for extraction site defects.

The Zimmer internal hex and good corporate product support were mentioned as important items of manufacturer reliability

Begin With The End in Mind!

Endo Notes

Success relies on the coronal restoration……

M. Trope, DMD

Endodontics defined – prevention or elimination of apical periodontitis without extracting the tooth

What is the Success rate?

Strict success vs. functionality

Strict – no detectable disease
Functional – tooth functions without clinical symptoms

- Without apical periodontitis in a university setting 85-97%
- With apical periodontitis 65-75%
- In private practice 50%

Ideally there should be cuspal protection from the premolar back

- With cuspal protection 6x less susceptible to loss (8 year study)
- With M-D contact 12x less susceptible to loss (8 year study)
- Tooth loss is usually due to fractures

On Retreatment: If you respect the apical morphology (apical 1/3), results can be as good as primary endo – otherwise success drops to 40%. With newer technologies, success is above 90% for apical surgery. Root canal filling materials are not very good overall, because we treat so it can be retreated.

Periapical stutus of endodontically treated teeth:

	Good Restoration	Poor Restoration
Good endo	91.4%	44.1
Poor endo	69.6%	18.1

Absence of RL = 61% success Ray and Trope 1995

Conclusion – It is the quality of the restoration rather than the quality of the endodontic procedure (NSRCT) that leads to long term success. The operator should do the root filling and the definitive restoration at the same visit ie do not wait.

If not should use 4 mm of cavit and chlorhexidene soaked cotton pellet for interim period. Fot optimum results should restore immediately and provide at least one contact point (two are better, M and D). One should avoid lone standing endodontically treated teeth whenever possible.

Orifice barriers: Study using IRM and composite in dogs. The barrier should extend below bone level to prevent periodontal contamination. Role of the endodontist in improving root filling:

Gutta percha – bonds to nothing (GP sandwich). Product developed by Dr. Trope is Resilon, bonded to resin sealer. Note: NaOCl interferes with bond by producing O2. Endores and bioceramic sealer produces a bond (Brasseler). This is still retrievable.

Self-etching materials are not as good as two part prime and bond more traditional strategies. Thick layer of cavit (.3.5 mm) gets the patient an extra 2-4 weeks. The core should be restored immediately.

Glass Ionomer – Vitrebond on pulpal floor results in 0% leakage at 60 days vs no vitrebond which results in 60% leakage at 60 days

Taper – Ideally, minimal taper should be used in endo (recommends .04). If you use a Brasseler (.04) fiber post there will be no additional preparation required thus conserving structurally important root dentin.

Posts – avoid if possible, place with a rubber dam, use Ca(OH)2 or CHX on cotton pellet between visits. Rinse with NaOCl + EDTA + CHX before cementing post. Although I said use NaOCl I think it is not a good idea. Sodium hypochlorite is the enemy of resin bonding so if we use a resin post avoid NaOCl also.

CHX (Chlorhexidene gluconate) – He recommends 2% from a compounding formulary vs. the 1.2% commercially available as Peridex. This is also the active agent in Hibiclens surgical scrub soap.

TEXT REVIEW

The Innovator's Prescription

C. Chistensen, J. Grossman, M.D., J. Hwang, M.D.

This well written and concise treatment of the future of health care includes segments on Big Pharma, Medical Education, Hospital management, medical devices, and private practice to name a few. The authors, including two M.D.'s, are forthcoming with strategies in their prognostications. The text was reviewed by Dr. Max Andersen.

The key measures I took from the book were the future of funding mechanisms for health care:

- High deductible insurance plans for catastrophic illness
- Personal tax advantaged savings plans for limited ongoing medical expenses

The authors explained their views as Precision Medicine and felt that by more accurately diagnosing disease states that we would be able to transfer patient management decisions to lower and lower echelons of care and training. They termed this usurping of decision making as a disruptive technology.

We are beginning to see this trend in a few states with the addition of mid-level dental providers.

They foresee a difference in hospital departmental strategies from a current one which is organ system based to one which is genomic based and targeting treatments toward an individual's personal medical profile. This book is an excellent treatise on the future of health care in general and I would recommend that our concerned members consider giving it a look.

-Ed

Background photo is Longwood Gardens

Good Germs Bad Germs Health and Survival in a Bacterial World

J.S. Sachs

Dr. Max Andersen reviewed this text for our group in Philadelphia and though certainly readable, it deals with the world of microbiology on a realm way past what was learned in your dental school curriculum. Unless you are a recent graduate, many of the immunotherapeutic references are a revelation. Keeping up with the basic sciences is certainly given a helping hand with this text. You will likely find yourself working hard to remember much of the more simple information referenced. As stated above, the author has taken a difficult subject and made it interesting. As to why we may not want to overprescribe antibiotics for instance, she points to a virtual protective shell of normal microflora that accompanies us from our birth both inside and out. In point of fact, due to the relative size of the microbiotic communities that our own human cells are outnumbered by bacterial ones… causing one to ponder whether we are more human or bacteria…

-Ed

Mark Ziemkowski: Distinguished Member ARVTSC/AAGFO 2012

Mark was born in 1953 in Missoula, Montana. He is the third oldest of nine children and had six sisters and two brothers. His mom stayed at home and his father was a State Farm Insurance agent. He attended school in Missoula including the University of Montana and remains a true "Griz" fan.

In 1972, following the 4th of July party at Tommy Thompson's home, he started his career with American Dental Manufacturing with a hangover. After working in the automotive side of the business, he was asked to attend a dental meeting in Minneapolis. He purchased his first suit, dress shoes and took his first airplane ride.

American Dental Manufacturing was the largest client of the local travel agency. For two years his contact person at the agency was a pleasant voice on the other end of the line. Eventually, he only asked to speak to Leslie. It became a friendship that later led to gentle ribbing and sarcasm from both parties. When he dished it out, SHE gave it right back. Many times she answered his calls with "what do you want now." Following a massive itinerary change to Japan, Tasmania, and Australia, which required that the refunds be done by hand, it was suggested that he treat "her" to lunch. After robbing his piggy bank, they went to a Royal Fork type restaurant for all you can eat. Now remember, this is the 70's. Mark showed up in his polyester shirt and fluffed up hair. Les later nicknamed him Bouffy Boufont.

The second trip to the beaches of Australia included Leslie and they started to plan "our" future.

They married in 1980 and at this time American Dental Manufacturing was experiencing an ownership and philosophical change and Mark decided to leave the company. After a short time off, they sought out Bo Suter in Chico, California. He became the lead sales person and their family would soon include three future employees. Their sons, Zachary, Kyle and Ross, have all worked in various positions at Suter Dental.

He continued his role as a sales rep and industry sponsor. Upon his return from one of his many "trips", Les was amazed to see "sparkles" all over his suit. Mark was unaware that Ann Pelegrini's banquet gown was shedding its glitter on anyone seated next to her. I'd hate to think what Les' first thoughts might have been.

One and a half years after his purchase of the company, changes in dental sterilization requirements altered his business and dentistry as a whole. Thankfully Mark had the foresight to also produce stainless steel instruments along with his line of carbon steel. But, as time passed the carbon/stainless steel issues continued with more and more pressure from many sides, which made the use of this metal more difficult. We all love Suter but in February of 2011, Mark made the difficult decision to close. Before doing so, he personally contacted a placement agency and provided the background on each of his 14 employees in hopes that future jobs would be available.

He currently is employed with Hu-Friedy. His 30 year respect for this company offered the assurance that new Carbon-like Steel in non-corrosive materials could be developed. He still travels extensively in sales, while Leslie maintains her own business, "Life Print Interiors." She stages homes to increase their sales appeal to potential home purchasers. She also consults homeowners on how to best "redecorate" their home with existing furnishings. Their 3 ½ year old grandson, Colin, provides plenty of entertainment and exercise.

We all call Mark "our friend." Les' aunt even calls him St. Mark because he has always been there for family. And he will continue to be there for the dental profession.

-Presented by Dr. Rich Nash & Dr. Andy McKibbin.