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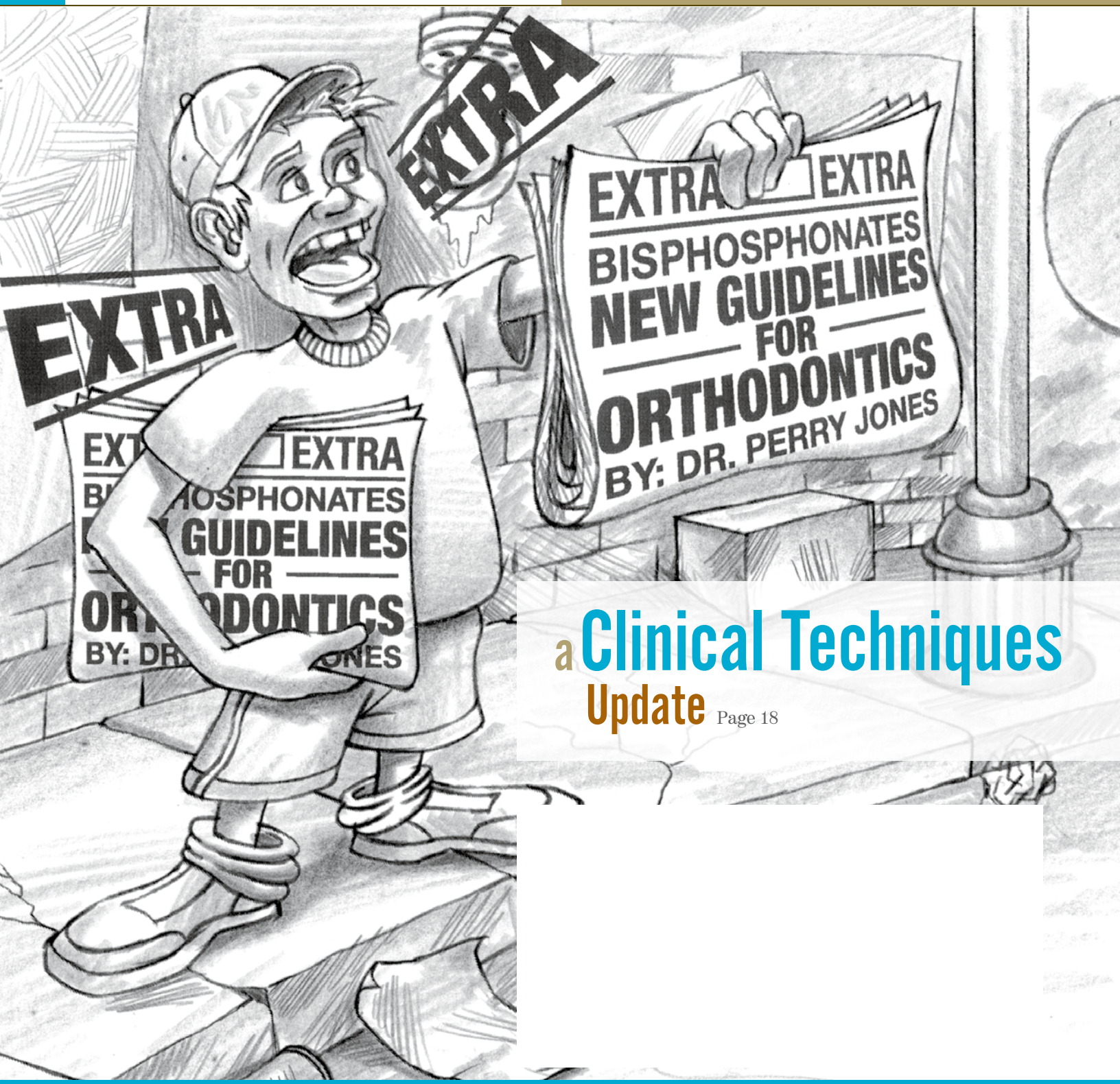
WINTER 2021

the Journal

American Academy of Clear Aligners

The Academy for Clear Aligner Therapy



a Clinical Techniques Update

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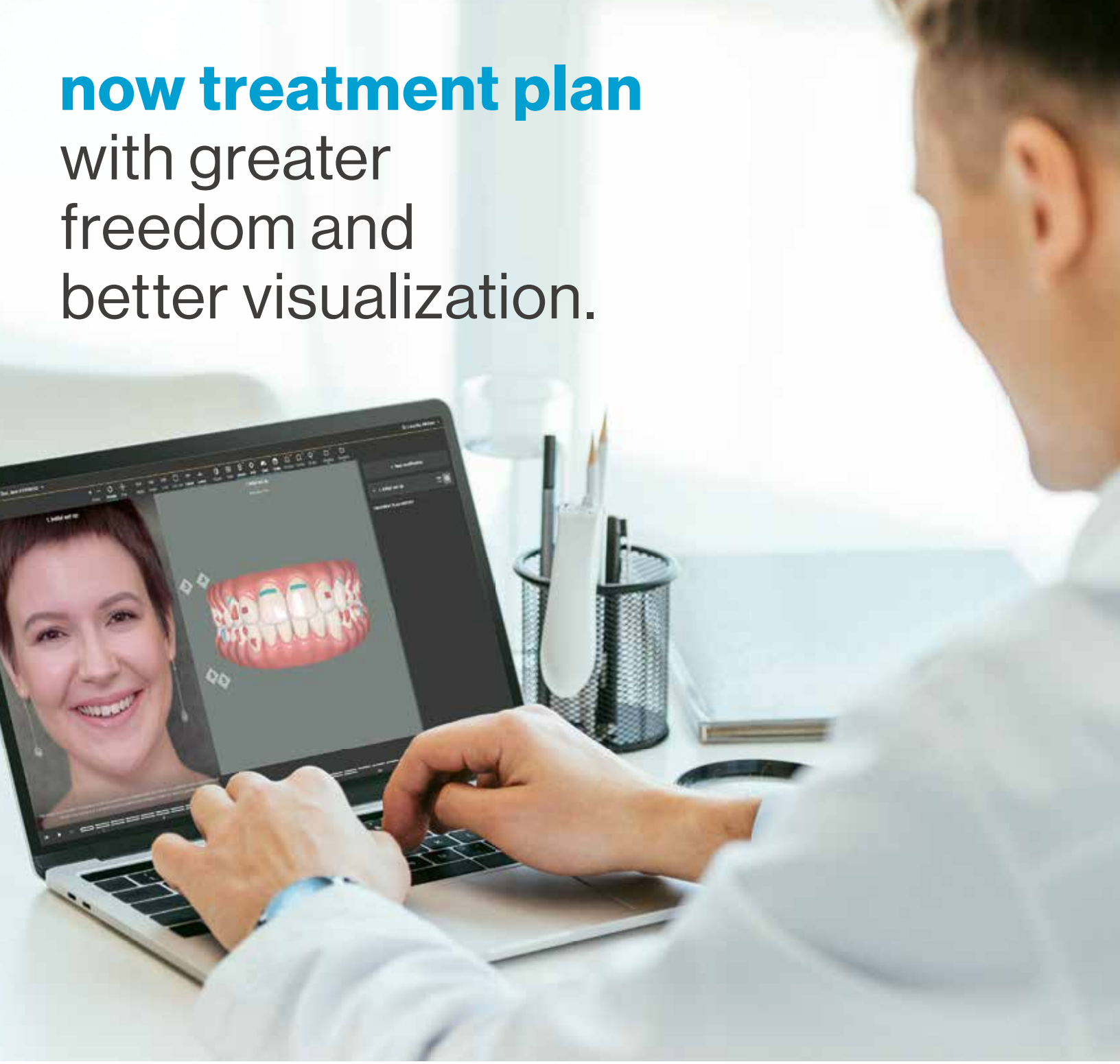

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American Academy of Clear Aligners

Editorial

Let's Eat Grandma

It was Thanksgiving dinner at the Galler homestead, and an exceptionally impatient and hungry grandchild declared, "Let's eat grandma."

After that unfortunate omission of an important comma, other family members competed to find other sentences and phrases rendered humorous through errors of punctuation.

Among the entries:

- SLOW KIDS AT PLAY
- Let's look for something to eat kids
- Learn how to cook and carve children

These quips reminded me of a lecture that I attended years ago, where the speaker advised that dental journals should avoid the kind of confusing information that he found on a popular magazine cover:

Rachael Ray | Finds inspiration | In cooking | Her family And her dog

Last summer, a local store window advertised:

GIFTS FOR THE FRIENDS YOU VALUE AT $19.99 OR LESS!

More recently, AACA copyeditor Marc Glasser returned the edited manuscript of a soon-to-be-published case study, with this comment:

"Here's the usual markup on Dr. D's article. Note that her degree is DMD and not DD, unless she's also been studying for the priesthood. (That might help her answer patients who ask, 'My God, how much is this going to cost?')"

Let's hope we are all able to express ourselves punctiliously.

Jeffrey Galler

Dr. Jeffrey Galler
Editor

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Case Reports

Eric Is 13 Turning 14

by Tracy Fadden, DDS

This case was one of the Golden Aligner Finalists at the 2019 Gallerite Reunion Convention.

Dr. Tracy Fadden's goal is to provide each patient with comfortable comprehensive care, incorporating health and function with a beautiful smile.

She achieved her degree at the University of Toronto in 1991 and is currently a member of the International Association for Orthodontics as well as a recognized key opinion leader for the American Academy of Clear Aligners.

Dr. Fadden has extensive training in smile design and rejuvenation, as well as advanced training in cosmetic tissue grafting and implants. She has been providing Invisalign orthodontics since 2008 and recently achieved Platinum status. Dr. Fadden has been a CAD/CAM instructor for other dentists as well as a speaker for various conferences and universities.

When not in the office, she enjoys spending time with her family, playing piano, and surfing.

Before and after treatment.

Eric was 13 turning 14: a perfect time for a Carriere appliance. With teens during a growth spurt, this appliance works extremely well.

When analyzing the first ClinCheck when using the Carriere Motion appliance, I basically ignore the upper arch. I just focus on the lower arch ClinCheck, which in Eric's case was straightforward.

We started Eric's treatment in September with a Carriere Motion appliance (**Figure 1**). Throughout the fall he came in at least 4 times with the Carriere disengaged: first off the front, then off the back, then off the right and left, and finally with the bracket off. Compliance was difficult, and it appeared that he was not wearing the elastics as directed.

Eric's parents became aggravated with the process and with the extra appointments. I explained that it is unusual for a motion appliance to debond. I had a conversation with Eric to review the protocol for wear, remind him to avoid certain hard foods, and reinforce the importance of wearing the elastics.

The breakages stopped, and Eric had great compliance. Two months later, Eric had gone from Class I to almost Class III, and we removed the Carriere appliance.

When the Carriere appliance comes off (**Figure 2**), it takes a real leap of faith to believe all is going well, because the bite

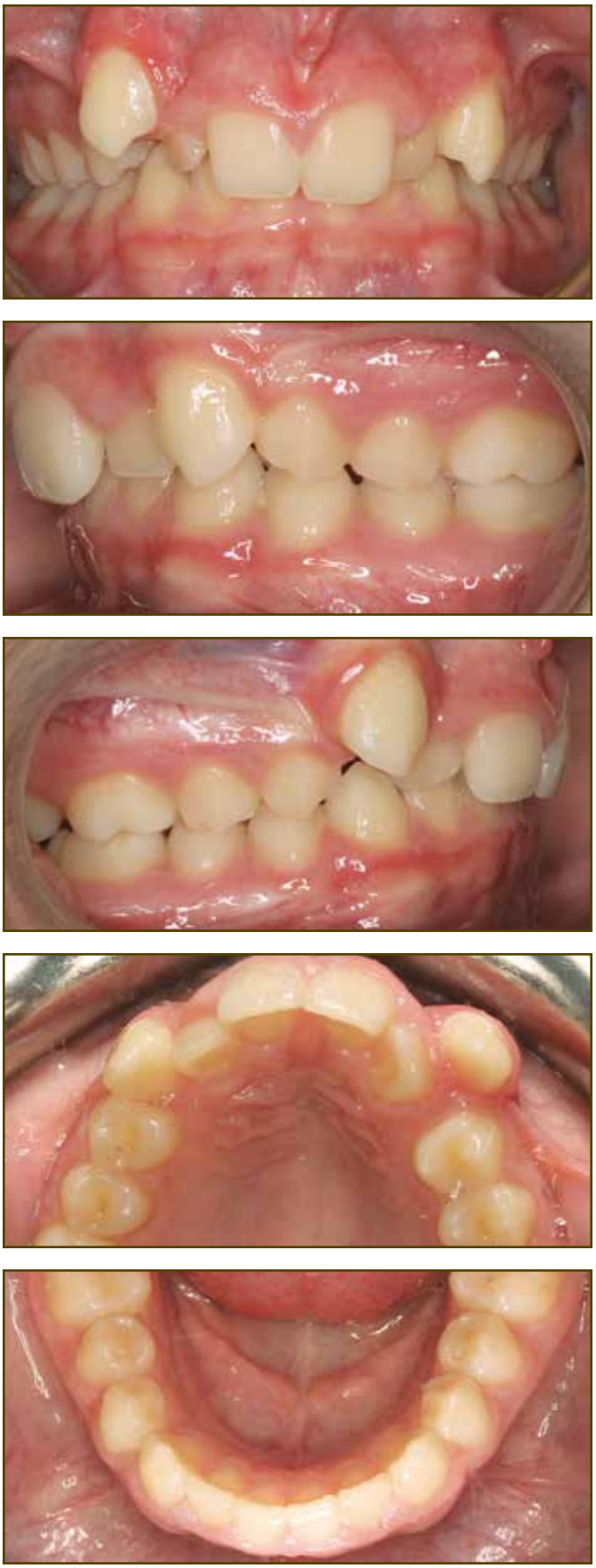

Figure 1: before treatment.

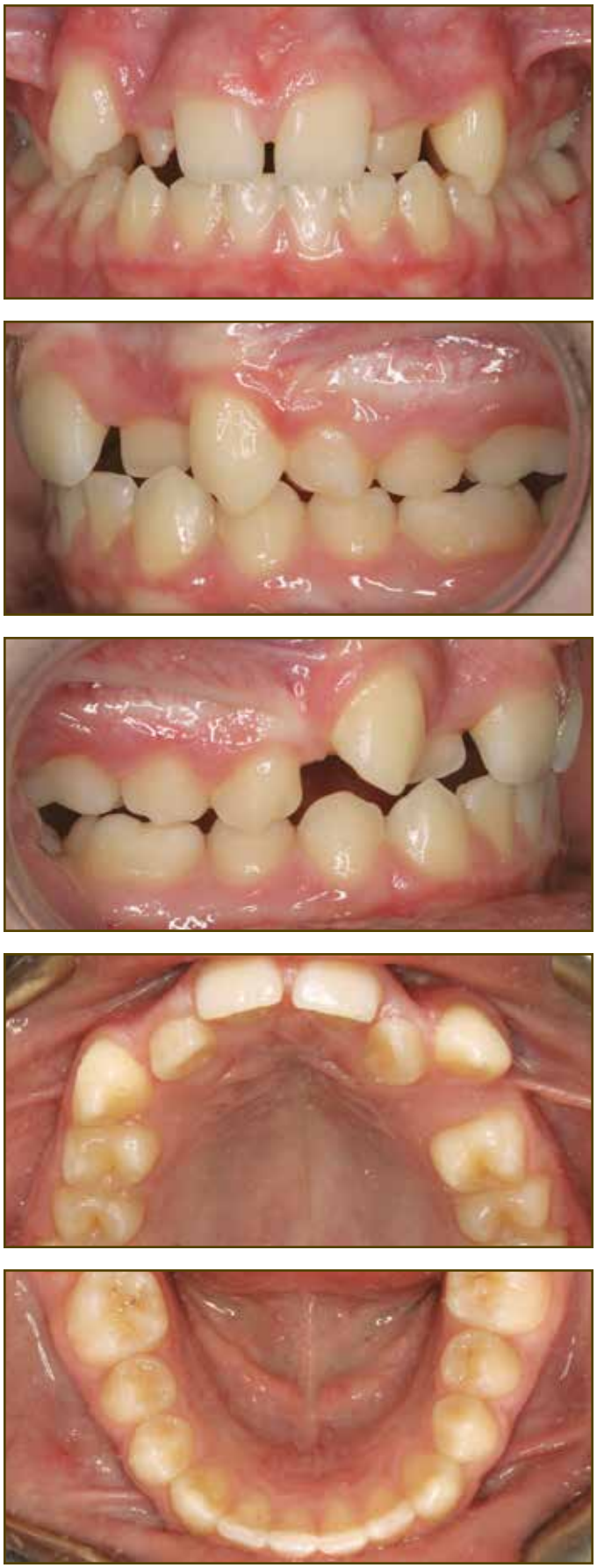

Figure 2: after Carriere removal.

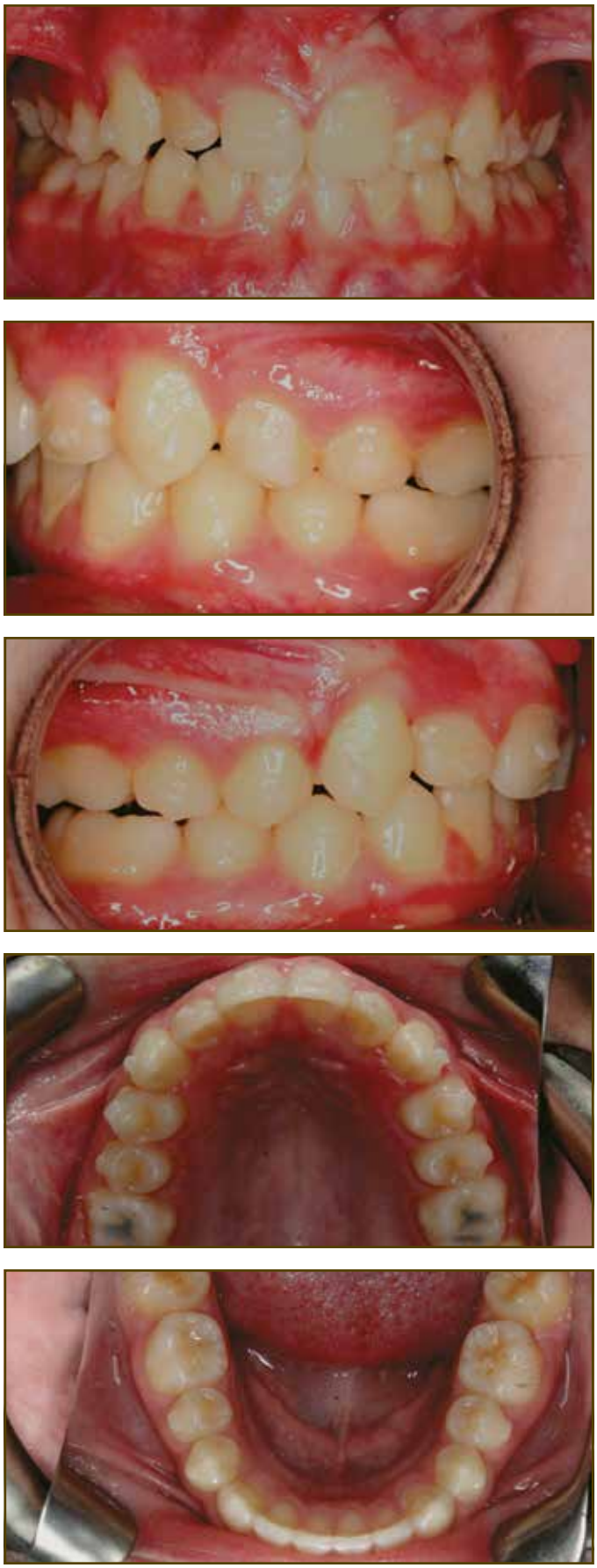

Figure 3: the home stretch.

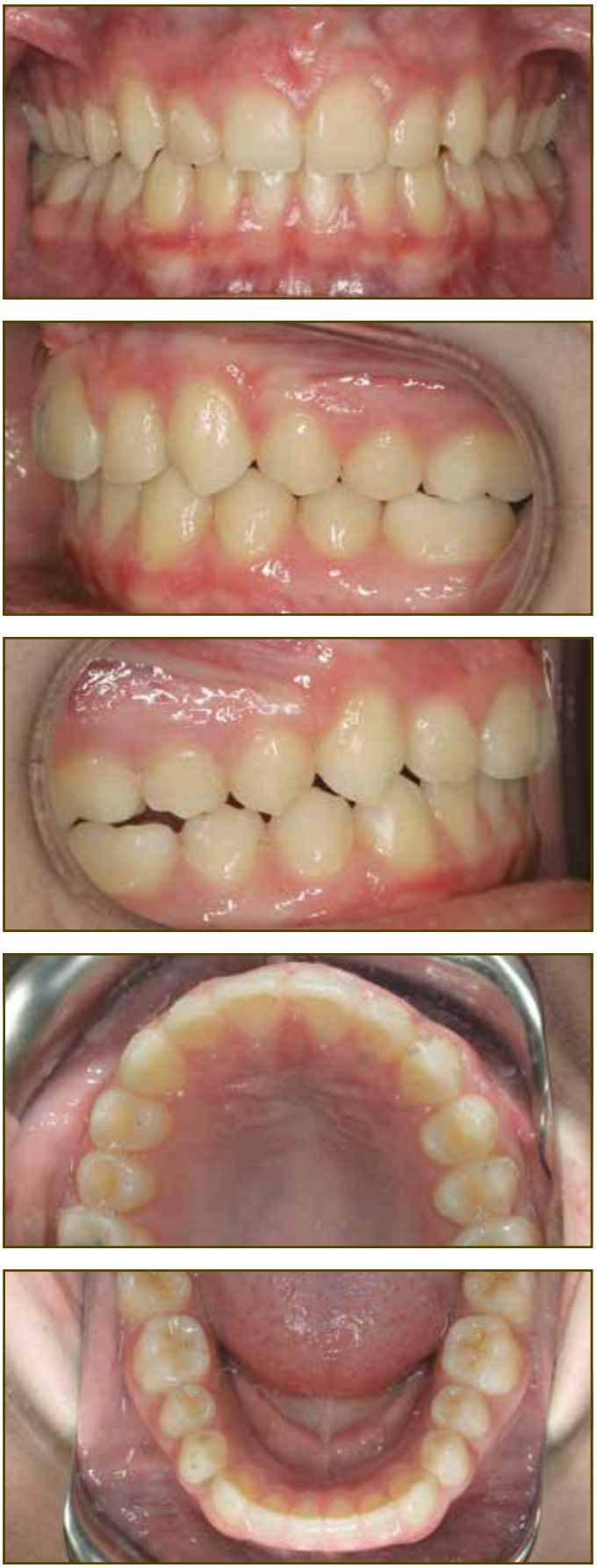

Figure 4: after treatment.

can look open or even end to end. Eric had no real posterior occlusion and was almost in Class III. But there was beautiful space opened up in the anterior, and the maxillary cuspids had a place to drop in. We had created a proper Class I molar platform, and now finishing up tooth alignment and correcting crowding and spacing were routine.

With the Carriere, as with most functional appliances, the mandible will settle and there can be a slight relapse into a normal position. We tend to finish the motion appliance with a Class III tendency or almost end-to-end bite.

Throughout the treatment (**Figure 3**) we had mixed compliance. Toward the end, I had another conversation with Eric. We agreed that we both wanted the treatment to finish. When treatment was complete, we placed Eric into Vivera retainers, with full-time wear at first, changing to nighttime only after 4 months' wear.

The beauty of dealing with growing teens is that if there is a minor posterior open bite, it will certainly settle as soon as the patient goes to nighttime wear with retainers.

The proudest part of this case for me is that I created a beautiful functional smile without the removal of any teeth. I set Eric up for proper growth and development. I did not constrict his arch or compromise his airway. I helped his mandible to shift forward into a more natural position, adding beauty to his face, instead of collapsing his face with extractions (**Figure 4**).

Cases such as this are challenging, but so rewarding. The Carriere Motion appliance combined with Invisalign is a predictable way to correct a Class II occlusion. The appliance allows the clinician to use functional orthodontics in a relatively short time, and the Invisalign finish is straightforward when the mandible settles. ■

Mind the Gap—Closing a Huge Diastema

by Jeremy Kurtz, DDS

Claire, a 42-year-old woman, presented to my office seeking advice. She wanted to "close the gaps" between her teeth. Specifically, she had quite a large diastema (**Figure 1**) between teeth #8 and #9, which she wanted to close.

In truth, this was the largest diastema I had ever seen. The space measured just over 10 mm and was about as large as teeth #24 and #25. Claire felt that the diastema was increasing over time, and said that even if it could not be fully closed, she would be happy if the space between the central incisors could be made smaller.

Dr. Jeremy Kurtz is a graduate of the University of Toronto School of Dentistry. He is a general dentist who maintains a unique private practice in Toronto that focuses exclusively on Invisalign and dental implant therapy. Dr. Kurtz is a guest lecturer at various Invisalign and implant study clubs in Toronto. He is a Diamond Plus (previously called Top 1%) Invisalign GP provider and enjoys making his patients smile with Clear Aligner Therapy.

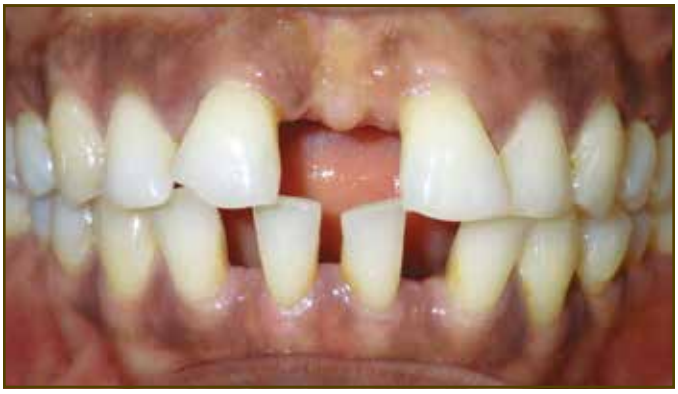

Figure 1: pre-treatment, with 10 mm diastema.

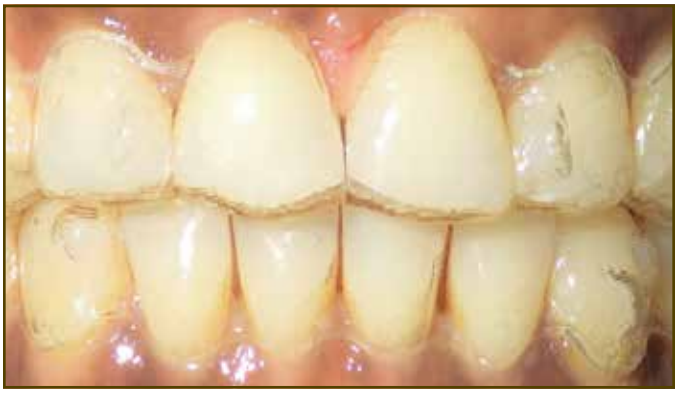

Figure 2: when closing a diastema leads to the aligner tray impinging on the gums, cutting a triangle out of the tray can relieve the pain and inflammation caused by the impingement.

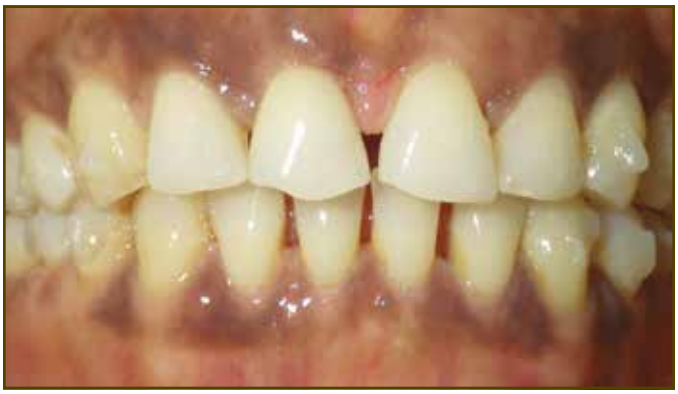

Figure 3: tray impingement in the present case. Rather than cutting a triangle out of the tray, we chose to do an early Refinement.

With these parameters and with somewhat reduced patient expectations, I felt that a reasonable result could be achieved. Even if we could not close the space fully, we could bring the teeth much closer together; potentially, we could add some bonding to further narrow the space. In the past I have had patients come to my office with much smaller spaces (6 mm to 8 mm) and report that they had been told they were not good candidates for Clear Aligner Therapy. I had proven the naysayers wrong in those cases, and was honestly curious and excited at the opportunity to extend my reach.

I estimated treatment time to be around 15 months. The initial ClinCheck called for 29 sets of trays, of which the patient only wore 24 prior to Refinement. These were switched at 14-day intervals.

Generally speaking, spaces are easier than crowding to treat with orthodontics, but this case (like other large-diastema cases) presented a few challenges that deserve attention.

1) **Root and crown tipping.** When incisors need to move a long distance bodily (crown and root) for diastema closures, there is a tendency for the roots to lag, so that the crowns then tip mesially. To remedy this, clinicians can place attachments (optimized double root-control attachments for maxillary incisors, and vertical rectangular attachments for mandibular incisors).

Interestingly, we used no incisor attachments in this case, and yet minimal crown tipping occurred. (This was even more surprising because teeth #8 and #9 were already parallel before we began treatment—a more challenging situation than when the incisors are flared and tipped distally to begin with.)

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Figure 4: first ClinCheck showing substantial black triangle.

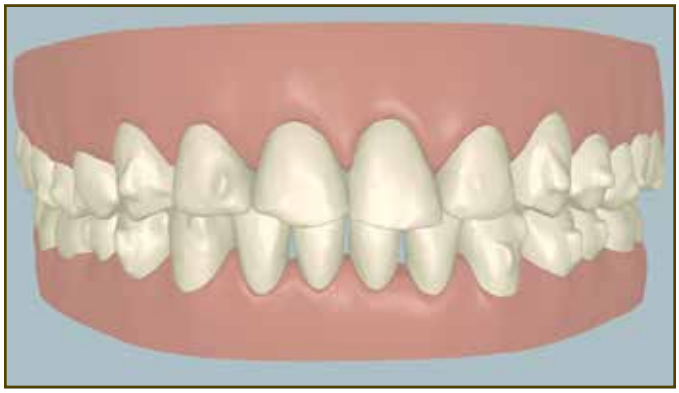

Figure 5: Refinement ClinCheck showing much-reduced black triangle.

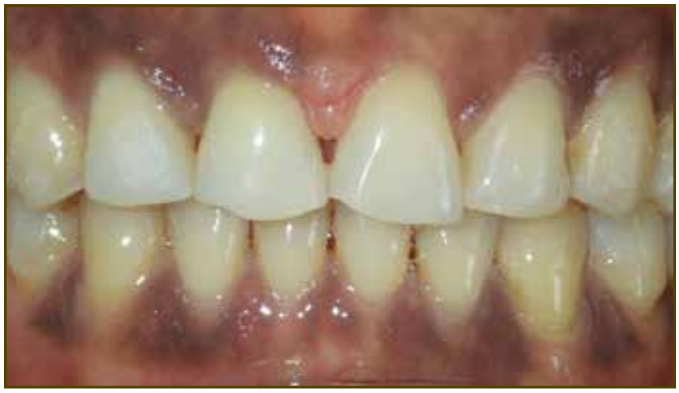

Figure 6: the patient was happy with the results and opted not to do any bonding.

2) **Tissue impingement.** I have found, when dealing with large diastemas, that the software cannot accurately predict how the tissue will appear as the space becomes progressively smaller. As a result, toward the end of the aligner series, the patient will call or present in our office with pain and/or inflamed gums due to the tray pushing on the buccal and lingual gum between teeth #8 and #9. We remedy this by cutting a triangle on the tray between the central incisors, following the contours of the teeth where the tray is impinging on the gum, usually on both the buccal and palatal sides. (**Figure 2**).

   As we might have expected, this started to occur around tray #24 (**Figure 3**). In this case, though, I felt that owing to the tissue impingement and contour of the tray, an early Refinement was warranted. (The actual fit of the tray on Claire's teeth was perfect; I chose to re-scan only to get a better fit around the gum tissue [compare **Figures 2 and 3**].)

Figure 7: similar diastema closure, pre-treatment and post-treatment. (Photos and treatment by Dr. Jeffrey Galler)

3) **Black triangles.** Because of the triangular shape of Claire's central incisors, the software showed a final result with a significant black triangle between teeth #8 and #9 (**Figure 4**). In this case, the tissue impingement of the tray actually helped in reducing the overall size of the black triangle. The Refinement ClinCheck reflected the new position of the gums, leading to quite a satisfactory result (**Figure 5**).

The Refinement consisted of an additional 14 sets of trays. Claire wore the first 8 trays for 7 days each and the final 6 trays for 5 days each.

At this point, Claire was very happy with the results and quite eager to phase into retainers (**Figure 6**). As a diligent and meticulous dentist, I felt that some bonding to reshape the anterior teeth and further reduce any black triangles would have further enhanced the results, but Claire reminded me that she would have been happy even without full space closure. Hence, after exactly 15 months, the case was completed with an ecstatic patient and an equally enthused dentist. So, the next time a patient comes into your office with a diastema as large as 7 mm, 8 mm, or even 10 mm, rest assured that this problem can be successfully treated with Clear Aligner Therapy.

(I showed these results to a dentist friend. He was inspired to also attempt closing an unusually large diastema. After 24 sets of aligners and tooth whitening, he, too, had excellent results [**Figure 7**].) ■

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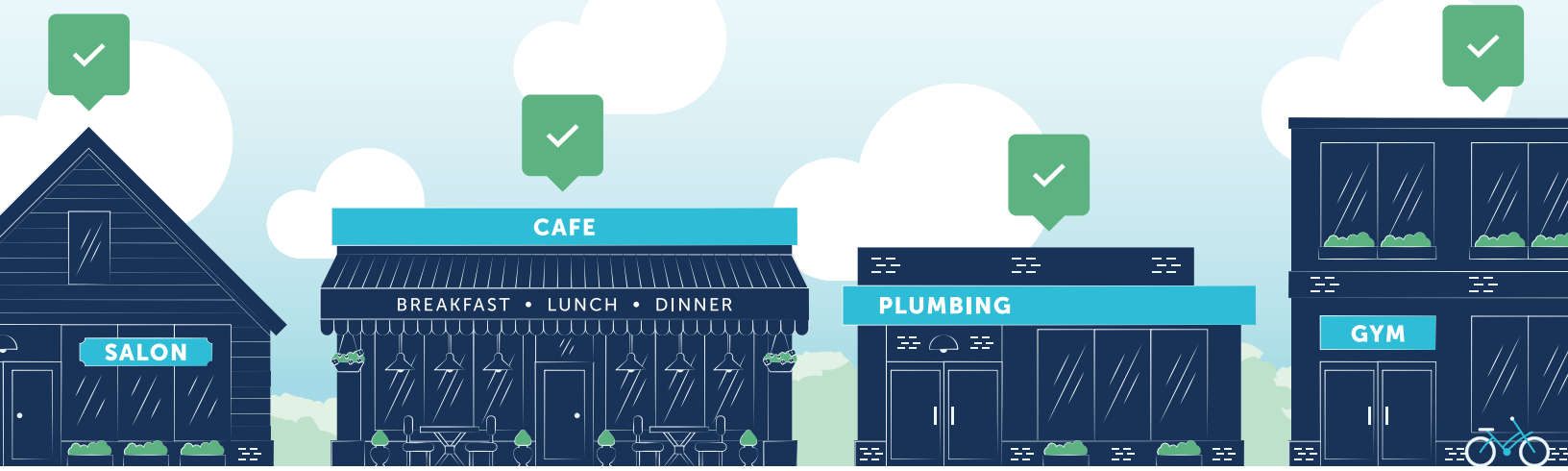

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A POB Nightmare Case

by Christina Blacher, DMD

Welp, it's happened to all of us. You just pop in for a quick Invisalign check, ask the patient to bite down—and BAM, find a huge posterior open bite.

I wish we could record some of the thoughts that go through our minds as dentists. In that moment, my thoughts included, "OMG, I just ruined this guy's life, I'm going to have to refer him to ortho, I'm going to get sued, I'm a horrible dentist, he's never going to be able to eat again…." I was in a panicked state. Luckily, the calm dentist inside me said to the patient, "There's a little area of your bite that I would like to correct. Let's scan and get you a few more trays."

Dr. Christina Blacher graduated from Indiana University in Bloomington with a BA in chemistry. She received her DMD from Midwestern University in Glendale, Arizona. She started in private practice in Manchester, Connecticut, while her husband completed an endodontic residency at UCONN Health, in Farmington. After 3 years in Connecticut, Dr. Blacher relocated to Dallas; she now has a private practice in Allen, Texas. She is most passionate about Invisalign and cosmetic treatments.

Dr. Blacher is a Platinum Invisalign provider, a faculty member for Align, and a board member of the American Academy of Clear Aligners. She has completed advanced courses in Invisalign and cosmetic dentistry, including Invisalign Pro, Invisalign Intermediate, Reingage with Dr. David Galler, and Botox and Dermal Fillers. She is also starting to implement Digital Smile Design and virtual consults. Dr. Blacher is a mentor to other dental offices, and has started an Instagram page @queenofinvisalign to share her insights into Invisalign as a general dentist.

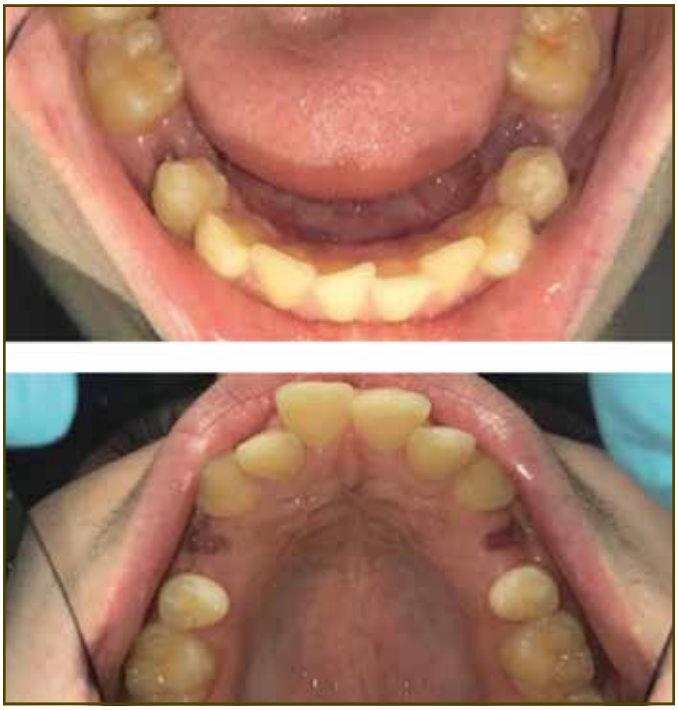

Figure 1: after extractions.

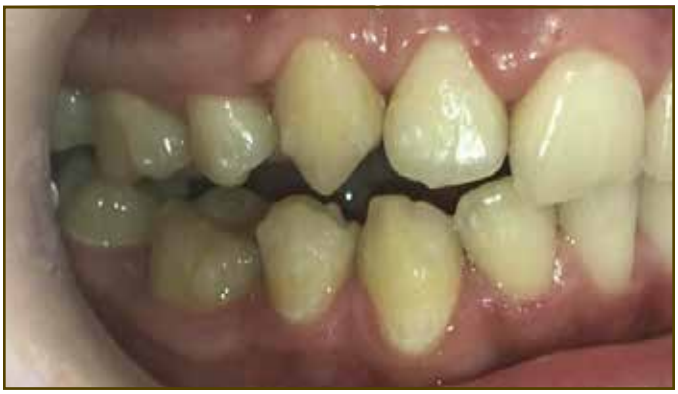

Figure 2: iatrogenic posterior open bite.

Off to a dubious start

So let's start from the beginning of this patient's story. It was day 1 in my new practice. I had just moved to Texas, and I had 3 years of Invisalign under my belt, so I wasn't a total amateur. The dentist that had sold the practice was staying on for a few weeks to have some overlap in case I had any questions. This patient was on my schedule that first day for extractions of 4 premolars before Invisalign.

I hadn't seen the patient yet, but I knew that we really didn't do a lot of premolar extractions anymore. That morning I even asked my office manager, "Are we sure these extractions are necessary?" When the patient came in, yes, he had significant crowding in the premolar area, but my gut told me not to do it. When I asked the previous doctor, he responded that "Those definitely need to come out." And so I listened. I didn't want to step on toes my very first day in the practice.

If you only take away one lesson reading this, take this one: *Always follow your gut feelings.*

Extractions went off without complications (**Figure 1**), and a few weeks later the patient came back to start Invisalign. Looking back now, I always deliver Invisalign the day we do any extractions, so this should also have been a red flag. And if the alarms weren't going off in my head enough, the day we delivered the case, the patient had 96 trays. Enormous red flag!

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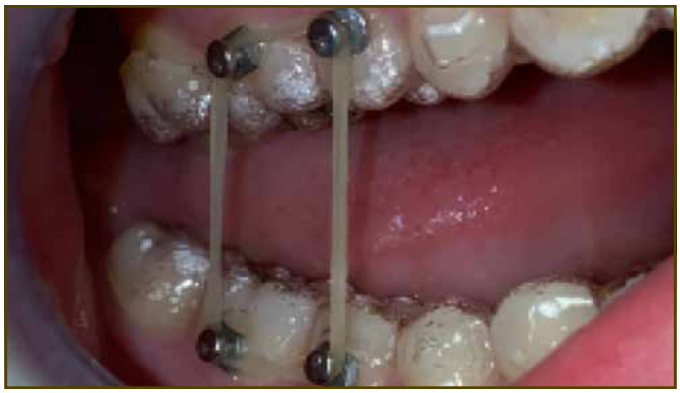

Figure 3: example of elastics and precision cuts (not the actual patient).

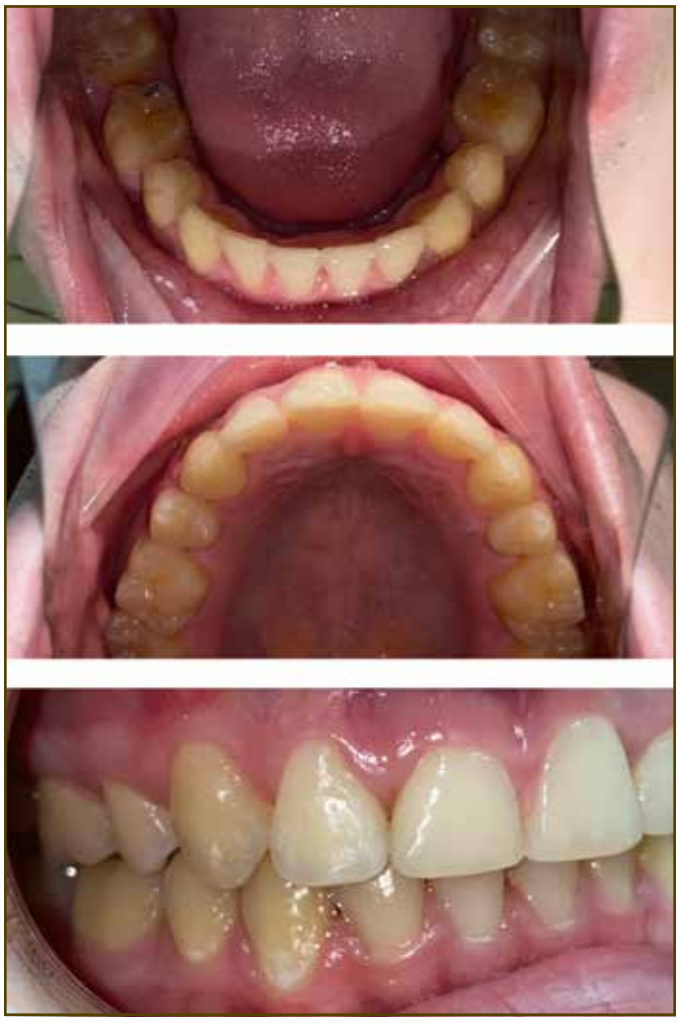

Figure 4: teeth are aligned properly, and posterior teeth are in occlusion.

Don't panic

The case started in August 2018, and in April 2019 came the day of the panic attack. Huge posterior open bite (**Figure 2**). One of the worst I've ever seen.

The Refinement came back with another 73 trays. Woof. We said our prayers and went ahead with our Refinement. Midway through, we decided to use some precision cuts and elastics (**Figure 3**).

Figure 5: successful conclusion.

Figure 6: before and after treatment.

The final Refinement was 9 trays, and we finished the case in October 2020—with all back teeth touching, I might add (**Figure 4**). I was so pumped for this case to be over that we were all excessively excited in the office. The patient must have thought he was one special case (**Figure 5**)!

What went wrong

So what exactly happened here? A few things. We were closing 4 large spaces, and this led to iatrogenic mesial drift. Basically, we were trying to retract the anterior teeth, but the posterior teeth wound up tipping forward, thus causing a posterior open bite. I'm sure we also had anterior interferences. Pretty much everything went wrong here. The only saving grace in this scenario was that our patient was a teenager, and he wore his trays.

Thankfully, with the help of some Refinements, elastics, and prayers, we were able to finish out the case with a good result (**Figure 6**). I was thrilled for the patient and proud of myself for sticking with it. This was my most humbling case, and I'm sharing it with all of you, first, so you know that if this happens to you, you are not alone! And second, hopefully, you can use my mistakes to help prevent this from happening in your cases.

The lessons I want to leave you with are these:

- Invisalign can do so much now without having to extract teeth.
- Too many trays and closing large spaces can put you at a higher likelihood of causing a posterior open bite.
- And most importantly, always follow your gut. ■

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Feature Article

Spotlight Oral Care: An Interview With Its Founders

Spotlight Oral Care was founded in 2016 in Galway, Ireland, by dentists and sisters Lisa and Vanessa Creaven. Their goal: to bring oral care products that are effective, ecologically friendly, sustainable, and free of potentially toxic additives to consumers worldwide. Dr. David Galler spoke with the duo about their philosophy, their products, and their newest initiative, which aims to reduce the impact of discarded Invisalign aligners on the environment.

Dr. Galler: Your tag line is "Harm-Free Oral Health." Tell me what's different about your products, and why we should care?
Drs. Creaven: First things first, David: all our products are clinically focused.

Dr. Galler: OK, great. So, you are believers in fluoride, et cetera.
Drs. Creaven: Yes, 100%. At the end of the day we are dentists first, and we understand that our patients need certain clinically proven active ingredients in their toothpastes and mouthwashes. We haven't reinvented the wheel here.

Dr. Galler: So, what have you done?
Drs. Creaven: Two things, really. First, we have removed all the other toxic ingredients found in over 95% of toothpastes. For example, propylene glycol—this is a very toxic ingredient that is found in 96% of all toothpastes, and it has been linked with central nervous system difficulties and thyroid cancer. We have removed every ingredient that is linked to any systemic health issues whatsoever and replaced them with clean alternatives.

Dr. Galler: So, sodium lauryl sulfate (SLS), triclosan, and such stuff have been taken out?
Drs. Creaven: Yes, and all palm oil–derived products have also been removed. As you're probably aware, David, the production of palm oil products is mired in controversy, both for the destruction of rainforests and for the widespread utilization of child labor. At Spotlight, we've found clinically proven, clean alternatives to this problem ingredient.

Dr. Galler: Great, so we can feel less guilty and ultimately safer when we recommend your toothpastes. What else?
Drs. Creaven: Well, did you know that the plastic in toothpaste tubes is 100% unrecyclable? This means that over the last 50 years, over 70 billion tubes of toothpaste have been dumped into landfill or, worse still, put into our oceans. So, when dentists recommend these products, we are actively promoting this destruction of the environment. Most dentists have never really thought about it that way; we certainly didn't, until we started Spotlight. That's why all our toothpaste tubes are made from sugarcane and are 100% recyclable.

Dr. Galler: Well, if I'm not compromising on the clinical efficacy, then I would be more than happy to do my bit to help save the planet.
Drs. Creaven: Ultimately, all we can do is our bit, and if there is no compromise, then why not?

Dr. Galler: And that brings us nicely along to your Invisalign recycling program...
Drs. Creaven: Yes. Invisalign aligners are very, very difficult to recycle. We are Invisalign providers ourselves, and have treated well over 2000 Invisalign patients over the last 5 years. A lot of our patients were asking about how to recycle the aligners after

use, and we had no answer. So, we engaged with a company called TerraCycle. Over a 6-month period, we sent them aligners from every dentist we knew that was using Invisalign and any aligners we could get hold of. Once they finished testing the material, they had a solution, and now Spotlight is bringing this solution to the profession.

Dr. Galler: Wow! OK, tell me about it.
Drs. Creaven: It's very simple, really, David. We know how busy dentists are, so you simply buy a very nicely designed recycling box from Spotlight and leave it in the waiting area of your office. Patients deposit their old aligners into the box when they come in for their new sets. When the box is full, you call us, and we come and pick it up and arrange for the aligners to be recycled.

Dr. Galler: I have one of these boxes at my office. It is indeed very nicely designed, and it's not small, so I'm guessing a lot of aligners can fit into one?
Drs. Creaven: Yes. We estimate it can comfortably take the aligners from 50 to 60 patients, so most practices will only need one box a year at most. As you mention, it is big enough to be free standing, so most clinics just have it standing against a wall in their waiting area.

Dr. Galler: Yep, that's where I put mine! I actually think it will provide for a lot more than 50 to 60 patients, as I don't think every patient will use it.

Drs. Creaven: No, you're probably right there. I'd say 60% of patients will use it. But you will be surprised, David, because patients become encouraged to do so and are happy to participate when it's easy.

Dr. Galler: I get you—the peer pressure from watching other patients doing it.
Drs. Creaven: Our box costs $299, so this is roughly $5 or $6 per patient, which is a small price to pay. From a marketing perspective, it is a total no-brainer. Actually, for Spotlight, this is a branding exercise: we don't make any money from this process, but rather we would like to be part of the good-news story that it encompasses. From the dentists' point of view, they can say to their patients that they have made the conscious decision to help reduce their environmental impact by paying for this additional service for their patients.

Dr. Galler: It makes tons of sense. Please tell our readers how they can get involved.
Drs. Creaven: Sure. Go to spotlightoralcare.com and look for tab marked "Recycling" and follow the prompts. You can talk to one of our sales team if you need more information, or you can simply pay the $299 fee, and free shipping and free pick up are included. We send you the box, and off you go. Once it is full, call us, and we come to collect it. Then, simply order another box—but as we said, it's going to take a long time for most dentists to fill one.

Dr. Galler: You say that the clinic registers to be in the program. Does this mean there is a list on your website of clinics that participate?
Drs. Creaven: There is, and this is a list we will be marketing. So, we will be encouraging patients to find a clinic near them that is engaging in the campaign. We will be announcing all new clinics on Instagram and giving a shout out to those getting involved.

Dr. Galler: I can see how a clinic could use this to find new patients...
Drs. Creaven: 100%. As we all know, David, marketing Invisalign is a difficult thing, so anything that gives you an edge over your competitors can only help!

Dr. Galler: And, of course, you would also be helping the environment, which is something we all need to be aware of. Ladies, I love the idea, and I wish you well with it. To me it seems like a complete no-brainer, so let's hope our readers agree.
Drs. Creaven: Thanks, David. ■

Dr. Lisa and Vanessa Creaven are both qualified, practicing cosmetic dentists and sisters from the West of Ireland. Their passion lies in clinically proven, clean, sustainable oral care products that work.

Dr. Lisa Creaven studied dentistry at Trinity College Dublin. In 2006 she founded the Quay Dental Clinic in Galway. She is now Spotlight's Director of Communications and a busy mum to 3 kids.

Dr. Vanessa Creaven studied dentistry at Trinity College Dublin and at King's College London. She worked with the Quay Dental Clinic prior to taking up a full-time role as Spotlight's Director of New Product Development. Dr. Vanessa is the proud owner of two doggies, Lola and Alfie.

Clinical Techniques UPDATE

Tooth Movement and Bisphosphonates: Revisited

by Perry E. Jones, DDS, MAGD, IADFE

Editor's Note: *Dr. Perry Jones, co-founder of the AACA, revisits an important issue, and concludes that bisphosphonates may slow down or reduce tooth movement, but are not contraindicated for tooth movement.*

Dr. Perry Jones is a graduate of Virginia Commonwealth University School of Dentistry, where he served as Director of Continuing Education/Faculty Development, as well as Adjunct Faculty, Associate Professor, in the Department of Oral Maxillofacial Surgery and the Department of General Dentistry. He is a Master of the Academy of General Dentistry and served as Director of the Virginia Academy of General Dentistry, Master-Track Program. One of the very first Align Technology GP education speakers, Dr. Jones has lectured extensively, having given some 300+ Invisalign and iTero presentations. He is the co-founder of the AACA. Currently, Dr Jones maintains a private practice in Richmond, VA.

Introduction:

In 2014, I published an article in the *Journal* of the AACO, titled "Tooth Movement and Bisphosphonates."[1] For most of us at that time, our knowledge of bisphosphonates was limited at best. The article was meant to introduce bisphosphonates and explore any potential adverse effects this class of drugs may have on orthodontic tooth movement. Although much has happened since 2014, many concepts have remained unchanged, and the passage of time has helped us observe clinically what risks and benefits this class of drugs truly presents. Hopefully, this article will help readers use the current data to best evaluate the risks and benefits of the bisphosphonate class of drugs. Different dental specialties will be impacted in different ways.[2] I will try to focus on the clinical aspects of bisphosphonates as they pertain to orthodontic tooth movement (OTM).

What is the controversy?

Bisphosphonates and similar drugs are common medications used in patients for the prevention and therapy of metabolic bone diseases such as osteoporosis, as well as tumor diseases and metastases to bone.[2] These types of drugs affect bone metabolism by interfering with bone resorption.[3] The unwanted side effect of bisphosphonate-related osteonecrosis of the jaw (BRONJ) is specifically found in patients using bisphosphonates and related drugs in either oral or intravenous forms.[4] The term medication-related osteonecrosis of the jaw (MRONJ) has been suggested as a replacement, to help include the increasing number of osteonecrosis cases involving the maxilla and mandible treated with other therapies such as antiresorptive (denosumab) and antiangiogenic therapies.[5]

Bisphosphonates work by targeting osteoclasts to inhibit their activity.[6] Orthodontic tooth movement relies on periodontal cells and the affinity between osteoblasts and osteoclasts.[7]

As with any other medication, bisphosphonates have side effects.[8] One such adverse side effect is osteonecrosis of the jaw (BRONJ/ MRONJ), which has important medical and dental implications.[9]

The question raising the controversy is: what, if any, evidence is there that OTM in patients taking bisphosphonates (and similar therapies) may be accompanied by side effects such as BRONJ/ MRONJ? We were taught that BRONJ was a rare occurrence but was a very serious side effect with bisphosphonate drugs. Now, after many years, we are told that bisphosphonate drugs can be used with orthodontic tooth movement without fear of BRONJ. What do we believe? How can we best help our patients?

Let's look at the scientific data for answers and help.

What were the past recommendations?

Early recommendations did not offer specific guidelines. Given the unknown future effects of bisphosphonates and OTM,

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by Dr. John Meis

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- **Why "bad news" about insurance coverage leads to 80-95% case acceptance** (pages 24-25)
- The simple roadmap to $326,400 in new revenue, without advertising (page 126)
- **How to boost your production to $225,000 a month** by doing new patient exams in just 8 minutes -- without sacrificing care (pages 50-62)
- The #1 secret to case acceptance is an "E---------- C-------- Exam" (pages 55-60)
- How to double your production starting tomorrow (yes, *tomorrow*) pages 15-18
- Why "nesting" is stopping you from tripling production (and how to fix it). See pages 71-72
- **How to reclaim $102,952 in new revenue per hygienist** by "framing" (see page 29)
- How to replace your salary with profits that multiply, *while you do other things* (pages 119-120)
- **How to create $440,000 a year in production.** Hint: no more meetings!? (pages 87-88)

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treatment was recommended with caution in low-risk patients. With most of the BRONJ cases seemingly originating from the "surgical" arena, more specific protocols have developed.[10] For example, the American Association of Oral and Maxillofacial Surgeons (AAOMS) published a series of position papers.[5,11] By contrast, guidance for orthodontic tooth movement and bisphosphonates has suffered from a lack of useful data, as so few cases existed. Below are a few examples of past recommendations from the orthodontic literature.

Zahrowski: recommends bisphosphonate medication screening, patient counseling, informed consent, and possible changes in treatment planning,[12] and additional patient counseling and modifying treatment according to specific needs.[13]

Krieger: regarding orthodontic aspects of bisphosphonates and tooth movement, "there are no guiding principles." In treatment of low-risk patients (low dose and short period of intake), OTM is possible. Treatment outcomes are still not predictable, especially in high-risk patients.[14]

Krishnan: "In orthodontics, the therapy usage of bisphosphonates should be handled with caution considering the pros and cons."[15]

What is the current state of scientific research regarding OTM and bisphosphonates' adverse effects?

Per current (2020) published data, "[T]here is a limited number of studies involving the effect of bisphosphonates on orthodontic tooth movement in humans. Currently, there is NO report of BRONJ inflicted by orthodontic tooth movement. However, bisphosphonates seem to have influenced factors such as tooth resorption and rate of movement due to their effects on osteoclasts and fibroblasts."[2]

Below are examples:

Kim: Each dental specialty must be aware of the risk of BRONJ, especially in patients with a history of bone-related therapy or tumor. No report of BRONJ as the result of orthodontic tooth movement.[2]

Ajwa: "No scientific proof illustrating that bisphosphonates are specifically included with ediopathogenic instruments of osteonecrosis and jaw osteomyelitis."[16]

What about the case example (Figures 1 and 2) in the 2014 AACO article?

As stated in the article, it is impossible to conclude that tooth movement with clear aligners caused the patient's osteonecrosis. Given the above current information, I suspect that there may have been some sort of soft-tissue trauma to the right-side molar area that may have initiated the stimulus for osteonecrosis to develop in this area. After confirmation of the diagnosis and no definitive treatment, the area spontaneously resolved to full health.

Figure 1: initial photos of right buccal area.

Figure 2: area of teeth #30-31 showing area of osteonecrosis.

I also reported in the 2014 article that even simple crown-tipping movements for this case were clinically slow to complete. This observation of slowed movements has been reported in the literature.[17] "Orthodontic anchorage" has been documented as a beneficial use of bisphosphonates.[18]

An interesting finding in the literature is a reference (Zahrowski) to retainers, as they may need to be trimmed to avoid gingival contact. Areas of gingival contact may produce a chronic soft-tissue irritant to initiate osteonecrosis. In the example, from the AACO 2014 article,[1] soft-tissue irritation from aligner soft-tissue impingement may have been another possible etiology that resulted in the osteonecrosis seen in **Figure 1**. The patient reported some 10-plus years of Fosamax therapy.

What should I do if I want to use orthodontic tooth movement with clear aligners, given a personal medical history of bisphosphonate therapy?

1. Take a good history that includes questions such as:
   a. Are you taking any medicine to strengthen your bones?
   b. Have you taken bisphosphonates or similar drugs in the past?
   c. Have you been diagnosed with osteopenia or osteoporosis?
   d. Do you have any bone tumor disease or bone metastasis?
2. Take good records to document the start of the case as well as progress and finish.

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3. Discuss the ABCs of tooth movement treatment with clear aligners: Alternatives/Benefits/Complications.
4. Complete a signed consent form such as the one provided by the American Academy of Clear Aligners (AACA).
5. Frequent progress visits are a good idea. Clinical outcome and movements may be slower.
6. It may help clinical outcome to increase activation time.
7. Be careful to trim aligners that may impinge upon soft tissue.

What are the most common osteonecrosis related drugs?

There are two types:

1. Antiresorptive, used to treat osteoporosis; these present a very low risk regardless of drug type (bisphosphonates, denosumab);
2. Antiangiogenic, used to treat various cancers.

Antiresorptive:

Alendronate (Fosamax) (Oral)

Risedronate (Actonel) (Oral)

Ibandronate (Boniva) (Oral/IV)

Pamidronate (Aredia) (IV)

Zoledronate (Zometa) (IV)
(Reclast) (IV)

Denosumab (Xgeva) (Subcutaneous)
(Prolia) (Subcutaneous)

Antiangiogenic:

Sunitinib (Sutent) (oral)

Sorafenib (Nexavar) (oral)

Bevacizumab (Avastin) (IV)

Sirolimus (Rapamune) (oral)

Conclusion

Bisphosphonate is becoming a more common drug therapy as the population ages. Taking a good medical history is a critical part of identifying patients commonly treated for metabolic disorders such as osteoporosis and osteopenia. Drugs such as bisphosphonates have a strong association with cells responsible for metabolism, such as osteoblast and osteoclast cells. Bisphosphonates have the potential to affect orthodontic tooth movement. It is therefore very important to understand what we may expect when treating patients taking inhibitors of bone resorption such as bisphosphonates and similar drugs. It is not uncommon to find that tooth movement may be slowed by bisphosphonates and similar drugs. The most recent published data confirm that although there has been a limited number of studies involving the effects of bisphosphonates and orthodontic tooth movement, there has as yet been no report of osteonecrosis (BRONJ) caused by orthodontic tooth movement! ■

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Marketing Tips

Ten Rules for Marketing

by Nathan Jeal, DMD, and Bao-Tran Nguyen, DMD

Dr. Nathan Jeal is a multi-practice dentist and entrepreneur. Clinically, his practice is focused on select procedures like Invisalign, veneers, and dental implants. He writes and speaks on the topics of authority marketing and prescriptive sales in dentistry. Dr. Jeal is the founder of Dental Authority Marketing and co-founder of Fast Growth Practice with his wife, Dr. Bao-Tran Nguyen. Through these platforms, he provides practice growth strategy and advises doctors on how to bridge the gap between their clinical training and actually "doing the dentistry." He was featured in the book *Titans of Dentistry* for his innovations in marketing. Dr. Jeal is a Key Opinion Leader for the AACA.

Dr. Bao-Tran Nguyen was born in Ho Chi Minh City, Vietnam. She escaped communism and spent time in a refugee camp before emigrating to Canada as a child. In her day-to-day practice she focuses on empowering patients to see new possibilities for themselves through life-changing cosmetic and rehabilitative dentistry. Dr. Nguyen and her husband Dr. Nathan Jeal have successfully grown and transitioned six dental practices while developing a highly engaged team that makes it possible for her to reserve time to grow her business. She is a mother, a dentist, a mentor to others, and a businesswoman, co-founding Fast Growth Practice to share what she has learned and mastered. Dr. Nguyen is a Key Opinion Leader for the AACA.

Abstract

Many dentists would agree that in order to achieve new revenue targets or to broaden their procedure mix, it is advisable to have a practice marketing plan in place. What's often overlooked is the importance of having a baseline understanding of what's true and timeless when it comes to market positioning, messaging, and conversion. Given that dental practices lose up to a fifth of their patient base each year, the following 10 simple rules for marketing are critical for dentists who want to maximize results while minimizing waste and frustration.

RULE #1: Don't follow the masses

Our first rule of marketing is to *not* follow the masses. If the majority knew what to do, then everyone would have a multimillion-dollar practice, and Platinum and Diamond Invisalign providers would be the norm rather than the exception. Unfortunately, that is not the case. Following the masses is simply the wrong thing to do, especially when it comes to marketing, which is all about standing out from the crowd, not melting into it.

If what you are putting out into the marketplace is indistinguishable from what most other dentists are also doing, then you are not going to get very far with your marketing efforts at all. Marketing that fails to differentiate one place of business from another or one provider of solutions from another is destined to fall short.

So rather than following the masses, instead find a way to distinguish yourself through your story. Stand out from the crowd with a unique and enticing offer directed to the right audience that makes those patients want to walk out their door and into yours.

RULE #2: Know your audience

As CEO of your dental business, you have got to know who your patients are. It is especially wise to know who your *most valuable* patients are. A worthy exercise involves describing your ideal patient, so that you know whom your message

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should be designed for before you ever start trying to market to that patient. How can you possibly market to someone successfully if you don't know to whom you are marketing?

Is your ideal patient a soccer mom with kids? Or an older adult with enough years behind him or her to have dental problems *and* enough disposable income to fix them? Or maybe you want to focus on cosmetic orthodontics using Invisalign. The point is that depending on whom you want to attract, both your message and your medium will change.

It's very difficult to reach the right people if you aren't sharing your message where those people spend their time. For example, it wouldn't make any sense to place ads relating to loose dentures on Instagram. On the other hand, it makes perfect sense to use Instagram for cosmetic orthodontic ads highlighting your solutions for crooked teeth. It's all about knowing whom you want to reach and paying to be visible where your prospects spend their time.

Dental practices lose up to a fifth of their patient base each year.

RULE #3: Use social media (but do it right)

Many doctors use social media to showcase clinical cases, share pictures of their staff, and post seasonal graphics. This is perhaps engaging to the small number of people who see it, but it's often not doing anything to actually market their practice. The cold hard truth is that "likes" on social media don't amount to much and have no intrinsic or extrinsic value.

If you are going to use social media as a tool for practice growth, identify who among your audience uses which platform before putting your efforts into it. Each platform tends to appeal to a different segment of the population. For example, if you wanted to reach teens, you wouldn't put your efforts into Facebook and Pinterest. Similarly, if you want to do more adult orthodontics, you shouldn't put effort into Snapchat or TikTok.

Beyond choosing the right platform, you have to be massively *consistent* to generate a return. A single post once in a while is fun, but it's not a strategy. Social media can be used to great effect when there's a clear vision, a consistent message, and a regular (near-daily) presence with distinct calls to action. You can use social media to build a following and solidify your credentials, but it's even more important to get your message right. Anything else might be cute, but it won't generate new patients or new business, except by accident.

RULE #4: Don't ignore traditional media

Everyone has seen some variation of the typical dental office postcard. You know, the one offering a free exam, free x-rays, and a discounted cleaning, maybe even free whitening for life. Combine that with a stock picture of a beautiful family or an attractive middle-aged couple, and it's...boring. Nothing new here! Sending this out in the mail may generate a few phone calls, but like most things that fail to inspire, these postcards end up in the recycling bin.

This is not to say that print media and postcards are dead. On the contrary! Direct mail is a smart, effective medium when it's used properly. Just remember Rule #1 and avoid the urge to follow the masses. A postcard that's like every other dental postcard isn't an investment; it's an expense. But using postcards, radio, TV, and even billboards can be very smart when it gives prospective patients a reason to take action and make an appointment with *you*.

RULE #5: Be careful what you offer

What you offer prospective patients to draw them in the door is as important as where you position it. The offer is what people will respond to and resonate with, and it should be sufficiently compelling that people don't want to miss out—which means there should be limits to participation. Most people know they should go to the dentist for a checkup and a cleaning twice a year. Your offer should be giving them a reason to choose you, now.

If you are violating Rule #1 and positioning your practice in the same way as every other dentist around, then don't be surprised to get very mediocre results. When your offer is based on low price, then it is likely to appeal to people who think you are cheap—which is one way to practice, but it's not the only way, nor is it the easiest way in many cases. Ever larger discounts and lower prices are a "race to the bottom" in which there are very few winners. If you make it about price, your patients will make it about price too.

RULE #6: Distinguish between branding and marketing

Branding refers to how you design the look and feel of your marketing materials, as well as some of the intangible elements of patient experience. While important, branding alone won't make or break your business. No one ever came to your office solely because they like your logo; there is always more at play. The elements of branding matter, but they are a complement to your external advertising, not a replacement for it.

A practice website is important. As a piece of internet real estate, it's a branding asset, but if you can generate visibility and convert website visitors into action-takers, then your website can also perform an important marketing function. The problem is that most dental websites lack visibility and have no offer or call to action. So why would someone pick up the phone? Nine out of 10 times, they don't.

In short, it's great to have a nice website and a cool logo. But it only makes a difference if there are people seeing it and if you are giving visitors a reason to take action. Pretty does not equate to profitable—which is exactly why traffic and visibility generated by marketing are needed.

RULE #7: Spend what you need to spend to achieve what you want to achieve

A common question about marketing relates to budget. This topic has been so misunderstood that we consider it critical to go on the record here in a meaningful way.

It is overly simplistic to suggest that one can determine a marketing budget based on a percentage of past revenue. If we correctly view marketing as a growth-focused activity, then using a lagging indicator to determine budget is inadequate.

What we must do instead is project forward using real numbers. First we need to state a revenue growth goal and establish the value of a new patient. Next we need to know what it costs to acquire a patient. When we have these numbers, then it's easy math to figure out the correct budget. You simply divide the desired revenue growth by the value of a patient to determine how many patients you need. Then you multiply the number of patients required by the cost to acquire a patient, and voila, you have a sensible marketing budget.

RULE #8: Be everywhere

When you really want to grow, you have to be everywhere that people look. We often have new patients who are unsure where they first heard about us, because they saw our billboard, received our postcard in the mail, were targeted by us on Facebook, follow us on Instagram, and heard us on the radio. At some point, we became the only sensible choice among all the dental offices they *could* call, precisely because of this perception of omnipresence.

Yes, it costs more to use more media. But when the message and offer are right and the audience is properly selected, then it's an appropriate investment. You don't have to start by jumping right into the deep end, however. Get one medium and one message right before adding additional media and offers. And out of respect for your hard-earned money, if something works, stick to it! Most marketing results come over time, not overnight.

RULE #9: Answer the !%&* phone

Answering the phone seems so simple, and yet it happens so inconsistently. Estimates based on real data from our friends at Call Tracker ROI tell us that 33% to 55% of new patient phone calls go unanswered.

And what about calls that are answered? Well, more than 60% of those are never converted into appointments. Putting this all together reveals a grim picture in which less than a third of the people who *want* to come into your office ever make it onto your schedule. And that's using the numbers at the top of the range, which are skewed up by top performers.

If that doesn't scare dentists, we don't know what will!

A few quick guidelines may help. First and foremost, we have to accept that the phone is not a tool for answering questions about treatment. That's what consultations are for. Second, phone calls should never last more than two or three minutes. If they do, it is a sure sign that your team members are going into dangerous territory, discussing things they know little about. Finally, Murphy's Law tells us that nonurgent enquiries (such as those related to billing) tend to come at the *exact moment* when a new patient is calling to book an appointment. So it makes perfect sense to divert nonurgent questions until a time when they can be given the attention they deserve.

Why? Because when it comes down to the basics of business in dentistry, *the phone is a tool for making appointments, and everything else can wait.*

RULE #10: Follow up with undecided patients

The majority of your most valuable patients require multiple touch points before they feel confident and ready to proceed with your recommendations for treatment. If we fail as dentists to maintain top-of-mind awareness during their decision-making, then many of them will simply leave and get their work done elsewhere. Worse, some will suffer in silence and never get their work done at all, incorrectly believing that their problem (along with your solution) isn't important.

In real life there are several categories of "buyer." Some will commit to recommended treatment right away. Others will buy later, after they gain confident answers to their questions and are able to dispel any lingering doubts. A final category of people includes those who will never buy, mostly because they don't care.

What we don't want to risk doing is missing the opportunity to help people in the as-yet-undecided category. In order to control for this, we have to practice follow-up, and that means we must ensure that people know that if they have questions, there are answers. We want people to know that we care and that we're going to stick with them. It's a proactive approach, as opposed to what most dentists do, namely not following up at all. They take one shot, one big swing at the pitch, and then drop the discussion with people who don't immediately pull out their wallets and pay.

This is just the wrong way to practice business, and it's an unfortunate way to practice dentistry. So, commit to consistent follow-up. Have a plan. Outline a schedule of correspondence and then assign it to someone on your team, with an accountability check to ensure it gets done.

Find a way to distinguish yourself through your story.

BONUS RULE: Follow a framework to improve conversion

The number one factor in whether your marketing will be a blessing or a total bust for your business is your ability to convert. Yes, that's correct. Only the practice owner is

ultimately responsible to ensure someone answers the phone and competently books appointments. It's also no one's responsibility other than the practice owner's to ensure that when patients come into the practice with a problem, they don't leave without a solution. Nor is it up to anyone other than the practice owner to have sufficiently flexible financial terms to allow average people with average salaries to afford quality dentistry.

Conclusion

Each of the rules for marketing described above is important, and most critically, they are all the responsibility of the practice CEO. The uncomfortable truth is that when marketing doesn't "work," the first place to look is in the mirror, because the answer to all return-on-investment (ROI) questions is entirely dependent on what the person asking the question is doing to ensure his or her own success. Having an understanding of how marketing works and what's important is a starting point for bigger discussions about practice growth and predictability.

If you would like to know more about marketing your dental practice, we can make recommendations. It's easy to get in touch. Just look us up in the AACA Marketing & Practice Growth chat rooms #1, 2, or 3, find us on Instagram @drnatejeal and @dr.baotran, or send us an email:

drnate@fastgrowthpractice.com

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References:

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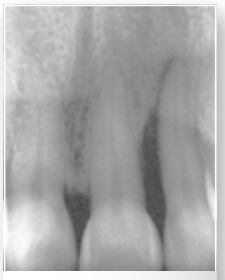
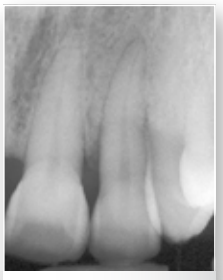
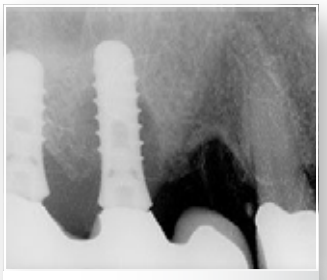


Before



After

Peri-Implantitis Treatment



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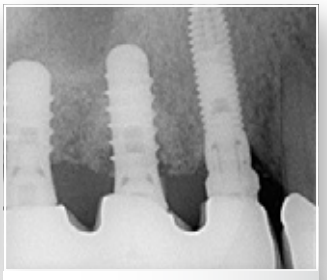

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Jack's Corner

by Jack Von Bulow, DDS

December 18

December 18, 2020, was our last day in the office after a problematic year.

On Thursday, March 12, we knew we weren't coming back for a while. Team leader Dani and scheduling coordinator Denise came into the office the next day and made numerous calls, rescheduling a week's worth of patients that would soon become a month's worth…and then more than three. We had In-N-Out for lunch.

We'd made it through 2019, a year that was way more than the usual challenge. We'd spent more than 12 months implementing an ill-fitting (for us) program that failed to consider our existing strengths and our areas in need of guidance and improvement. We were also missing 2 team members, and close to 40 years of Temple City Dental Care experience, for most of the journey. We'd been exposed to much of the training content before, though implementation and consistent application were often another story.

We finished 2019 with a record month, and as we were cruising along to begin 2020, I think we all felt that we could breathe and be ourselves again. Yet through the second half of 2019 and into the New Year, I couldn't help but notice some team divisiveness. Maybe our expansion in mid-2018 had created a kind of physical environment for disunity. Maybe it was simultaneous key life events with differing outcomes between friends.

Drifting apart

Two people I love as daughters became distant, cold with one another. I had thought that together, their complement of skills, personalities, and instincts, already obvious in the way they worked together as clinical assistants, could create a strong leadership. I committed to coaching both toward a conversation that would clean up the past and create a clean slate. But my effort to produce that conversation was a failure. Today, the divide is even greater. One dear friend doesn't feel like a fit in our practice anymore; her former best friend and mother of a beautiful year-old daughter mostly works remotely.

Family is more important to me than anything. I wouldn't trade my growing-up experience for the world. But my brother, dad, mom, and closest aunt have been leaving my life for the past 52 years. My co-workers of some 10 to 22 years never applied for the job, but they're my family now.

How could we protect our patients and ourselves from a virus transmitted by asymptomatic carriers?

Not what it used to be

When the COVID-19 pandemic first became known, and when it began taking lives in this country, I began feeling a sense of inevitability. How could we protect our patients and ourselves from a virus transmitted by asymptomatic carriers? Closing down, hopefully temporarily, seemed only a matter of time.

We were away from March 16 to June 22. We returned well rested, at least slightly paranoid, and determined to find a system or protocol that would retain our "making dentistry fun" purpose while maintaining safety for all who spent time within our four walls. Our much-needed recovery time had been tempered by the horrifying daily morning briefings from New York Governor Andrew Cuomo and the growing fear of an unseen viral disabler and killer.

We noticed, in spite of making our dental office one of the safest environments possible, that patients were more fearful, agitated, and generally behaving out of an altered state of character. If only we'd looked into a mirror. If only I'd looked into a mirror.

Staying motivated

We remained divided. Our commitment to coaching one another to be extraordinary seemed selective and incomplete. Listening and mutual respect became merely occasional behaviors. I began arriving to work 2 hours early, just to savor the time alone. I began searching out inspirational quotes to

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launch our morning huddle, on the pretext of energizing the team; I had to energize myself first.

I don't do anything for 45 years without finding joy, fulfillment, and family in the day-to-day experience. I generate endorphins from human interaction, not stationary bikes. I'm beyond grateful for all the advantages my families have given me. Yet these days, I walk away feeling disappointed in myself and sad. It's as if I'm on the verge of losing my family. Again.

Resigning yourself to loss without acting is quitting. Getting by with persistent complaints and excuses is quitting in slow motion. And I've used "sad" enough for one day. Maybe it's time to ask some questions, listen, and offer support; maybe even accept some advice or counsel? Communication creates possibility.

"Breakdowns access breakthroughs." "Winners never quit; quitters never win." I read those affirmations every day; they're posted at home. Maybe it's time to read them twice.

For sure, it's past time to suck it up and lead. ■

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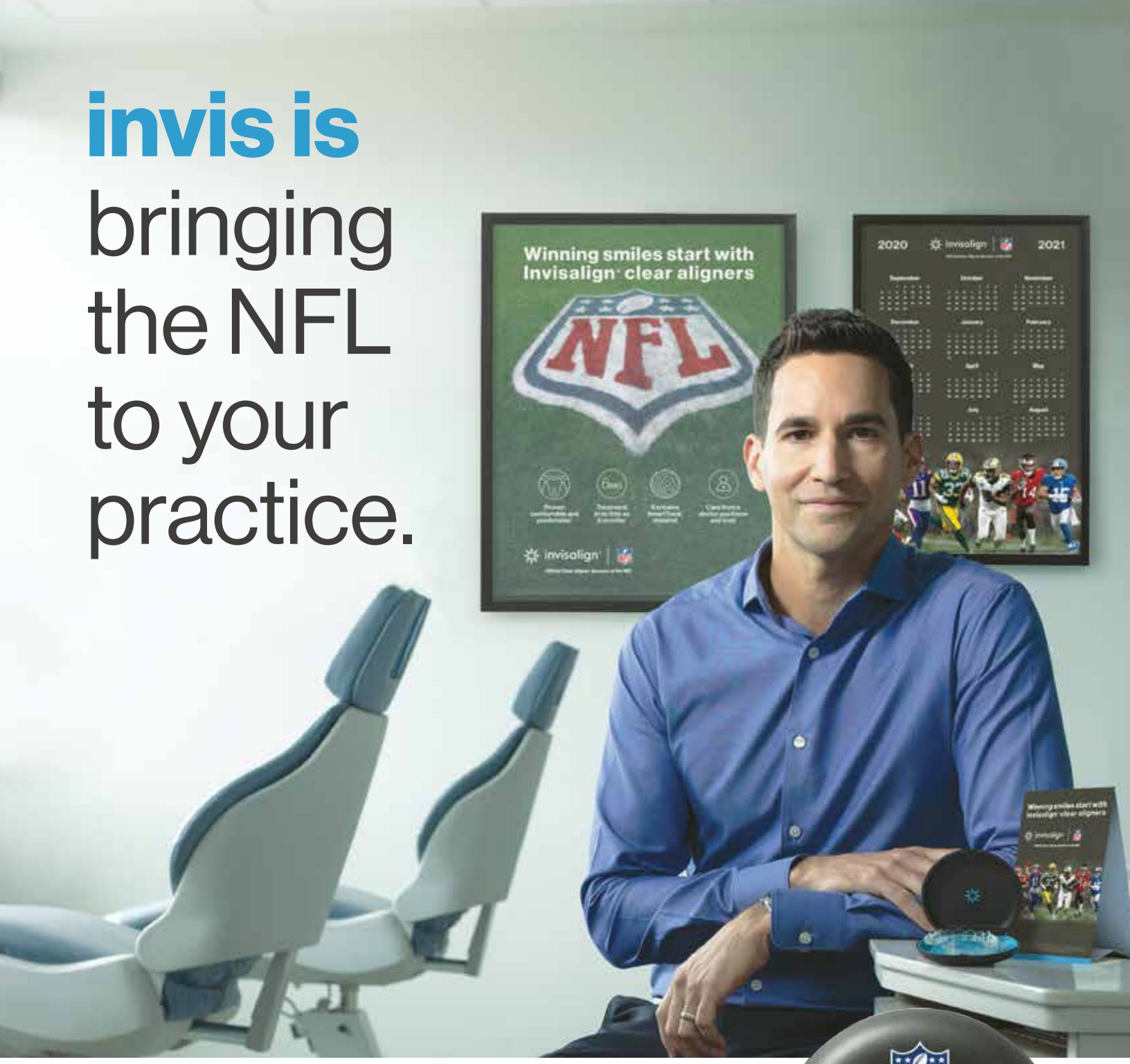

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