

Inside this issue

Coming soon ...

Want a chance to “meet with” other orthodontists without leaving the comfort of your own home? What about being able to interact with respected opinion leaders and hear their thoughts on new products and technology? Well, soon you can, when Ortho Tribune launches its OT Study Club this July. You can get have a sneak peek of it though.

Page 3

Going paperless?

Transitioning your office from paper to digital can be a great thing — as long as you can keep the standards of quality up to the same level of excellence. AAO presenter Pat Rosenzweig has some advice. Read what she has to say, then go listen to her in Boston.

Page 14

Guide to the AAO



There are a lot of exhibitors at the AAO this year. How do you know where to start? We're here to help. We have plenty of info on products you will see, prizes you can win and companies you're going to want to check out.

Pages 18–28

3 places you must go

All work and no play is just no fun. So when in Boston, be sure to take in a little of the city as well, especially these three sights.

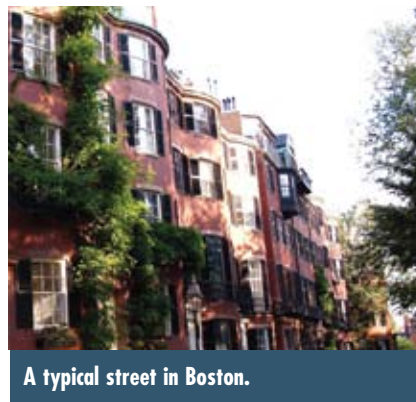
Page 30

Beantown bound

This year's AAO Annual Session in Boston offers plenty to see, learn and do

From facial aesthetics through the ages to the discussion of early childhood treatment to the merits of cone-beam computer tomography, the 109th Annual Session of the American Association of Orthodontists, being held May 1–5 at the Boston Convention & Exhibition Center, promises no shortage of topics to debate, discuss and detail.

This year's meeting, built on the theme “Orthodontics Heard 'Round the World,” features an array of leading clinicians and research-



A typical street in Boston.

ers — from Germany, Italy, Australia, Canada and the United States, among others — presenting their latest findings, along with an exhibit hall full of the newest technologies and products.

A few of the highlights include Dr. Anthony A. Gianelly on “Evidence-based Orthodontics” and Dr. Ravindra Nanda on “Achieving Treatment

Boston

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The age of digital imaging

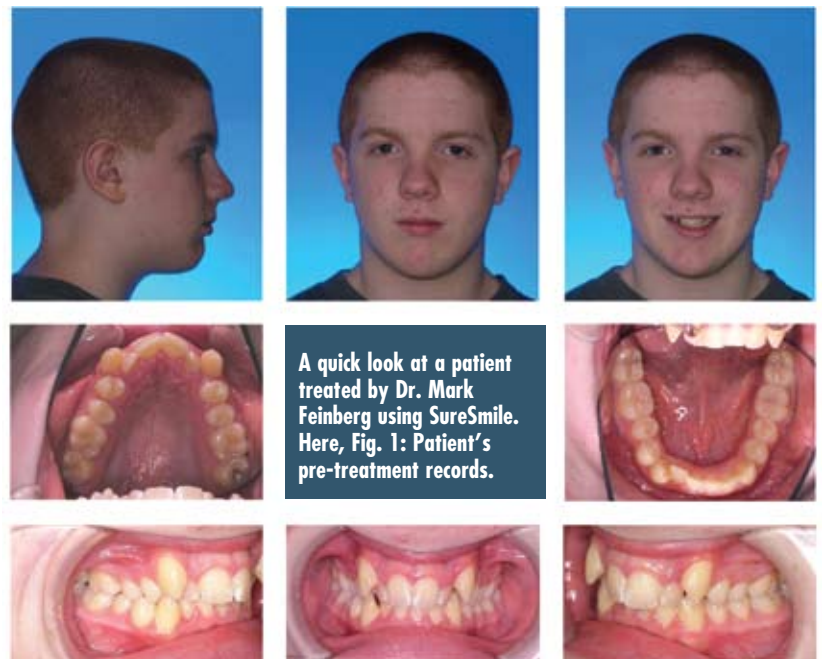
Why you should choose SureSmile to lead the way into the 21st century

By Adam Weiss, DMD

Part 1 of 3

Orthodontics is moving into the 21st century with digital and 3-D imaging. However, advancing one's mindset and practice into the 21st century can be a daunting process.

Selecting a technology to incorporate into your practice and decid-



ing when and how to implement it are not simple decisions. One must select a company that can bring these new technologies to patients in useful, meaningful ways. Choosing the right provider is similar to choosing the right financial planner — it can be extremely rewarding or financially devastating.

This orthodontic practitioner of 18 years who has not yet placed a TAD, exposed a canine or gone completely paperless wanted to move toward the future.

In October 2006, SureSmile was chosen to lead the practice into the 21st century and thus, as the first orthodontist in Pennsylvania to do

so, instantly created a cutting-edge practice persona for our patients and community. Part I of this article will elucidate the reasons for making this choice.

Dr. Mark Feinberg, an early user and pioneer of SureSmile, will present Part II of this article, in which he will present more in-depth technical aspects of the SureSmile software.

Along with the two parts of the article, cases treated with SureSmile will be presented (Figs. 1–17).

Imaging

OT see page 6

Ethical and moral scenario planning for orthodontics

By Dennis J. Tartakow, DMD, MEd, PhD, Editor in Chief



Part 1 of 3

Wouldn't it be nice to have a crystal ball so that when we look into it the future would appear? Well, this can be done, but it is a little time consuming and thought provoking. It is called scenario planning, which is also known as scenario thinking or scenario analysis.

Scenario planning is a strategic planning method that some organizations use to make flexible long-term plans. So let us begin to explore such dimensions by explaining the background and reasoning.

It is in part a generalization and adaptation of classic methods, which has been used by military intelligence for many years. In recent times, large corporations generate simulation games for policy making and organizational mapping. These games combine known facts about the future, such as politics, demographics, geography, industrial information and mineral reserves.

Thus, plausible alternatives for economic, social, technical, environmental, educational, political and aesthetic trends are created with key factors and driving forces.

The emphasis for business application depends on gaming the behavior of opponents by incorporating systems thinking, which recognizes that many factors may combine in complex ways in order to create guesstimates for the future. This can include such factors as (a) insights about the future, (b) shifts in values and (c) anticipation of unprecedented directives and regulations.

Used in conjunction with scenario planning, systems thinking leads to plausible scenario story logics with causal relationships that exist between the factors that can be demonstrated.

An organization's scenario plan consists of identifying possible outcomes by exploring several key factors and driving forces that might impact that business or organization, with matrices for looking into the future for years to come.

The factors are plotted in the matrices with x- and y-graphic coordinates to view various possibilities

and to gaze into this "graphic crystal ball" for presenting scenarios that might materialize in the future.

When scenario planning is integrated with a systems-thinking approach to scenario development, it is known as structural dynamics. Sustainable business growth strategies that are necessary to achieve top-draw growth and bottom-line results include: (a) developing a continuous improvement culture with an ethical and moral effort to improving organizational climate and productivity in response to never-ending changes in the marketplace; and (b) producing a stable corporate venture strategy with investments in new services, product development, new business creations and external venture investments in emerging markets from informational technologies.

Critical factors and social justice trends

Global economy, or the restriction thereof, will have a tremendous impact on the quality of our life, especially with technological development at every level. It is through creativity, distribution and modernization that all mankind will benefit and be observed in every aspect of life, including health care, welfare, transportation and, especially, education.

The ability to make educated choices about our future and to increase our extensive knowledge base addresses such issues as responsibility, authentic leadership, and ethical and moral social justice principles, the power of which will hopefully be utilized constructively.

The relative positioning of the global economy and education are the most important critical factors and forces associated with plausible backdrops for the future of orthodontics; from rising to falling and from death to a renaissance, the future depends on today's decision.

The major social justice trends that challenge all of us include an explosion of new knowledge and pervasive change in our community's local needs as well as public demand for scientific evidence-based health care and accountability. Issues such as energy resources, global economy, the credit crisis, unemployment, sociodemographic analyses and health-care delivery are meticulously reviewed.

By understanding (a) the rapidly changing environment, (b) the need for greater education and (c) improved oral health care, new research and extended community services became vital to the formulation of a contemporary strategic plan for improving the critical health-care needs of all people.

As such, we must work to remove all ethnic, racial, gender and cultural barriers with regard to education and community service.

Today, more than ever before, it is important for all of us to recognize these facts of life as they affect all of us.

Reaching social justice goals

Social justice in education requires powerful societal support that concerns the values, mission and authentic leadership for transforming society. Educational leadership requires ethical, moral and transformative attitudes and direction.

Some of these objectives have been realized while others have not yet been achieved. However, to reach such goals, we must demonstrate (a) authentic leadership, by questioning policies that shape institutions as a result of social inequities (ethnic, racial, gender and cultural barriers); (b) moral transformation, by addressing the use and misuse of power, advancing education and supporting activities that bring about revitalization of society and health care; and (c) social justice praxis, by encouraging research, scholarship and pedagogical methods to articulate a broader discourse for ethical and moral transformative leadership, which links the principles of democracy and the practice of equality.

Next month we will explore scenario planning, its intricacies, and how it works.

OT Corrections

Ortho Tribune strives to maintain the utmost accuracy in its news and clinical reports. If you find a factual error or content that requires clarification, please report the details to Managing Editor Kristine Colker at k.colker@dtamerica.com.

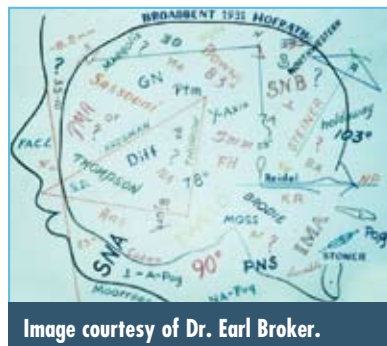


Image courtesy of Dr. Earl Broker.

Member Publication
AADE
 American Association
 of Dental Editors

ORTHO TRIBUNE

The World's Orthodontic Newspaper - U.S. Edition

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Published by Dental Tribune America

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Ortho study clubs help increase interaction, providing orthodontists with the opportunity to gain knowledge about products through their colleagues' experimentation and analysis and to hear from respected opinion leaders directly. Focused study clubs provide an unparalleled opportunity for orthodontists to "meet with" other like-minded individuals and their team members and to learn in a friendly, non-threatening environment.

Ortho Tribune is taking this concept to the next level by bringing the study club online, extending the realm of interaction to a worldwide arena. This allows for a variety of fresh perspectives from different cultures to further enhance the educational mix, inspiring new possibilities and creating higher expectations in online learning.

OTStudyClub.com is solely focused on today's orthodontist and offers an exciting mix of possibilities, including:

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- Contests with chances to win free tuition for ADA/CERP C.E. accredited Webinars; and much more!

Ortho Tribune is very excited about officially launching this initiative and would like to invite you to join us in breaking new ground in e-learning. On July 11, from 9 a.m.–5 p.m., Ortho Tribune will introduce the Ortho Tribune Study Club via a full-day online symposium.

The OTSC Online C.E. Festival — V.I.P. Launch Party will feature five one-hour Webinars in succession, followed by a 20-minute live Q&A session between the online audience and each speaker.

Participants will receive seven ADA/CERP C.E. credits, and attendance is free for the first 100 registrants. After the first 100 spaces are filled, the cost of the full-day symposium is only \$49, a mere fraction of what one would pay if traveling to an event. Live attendees also have 30-day access to the recorded Webinars to review at their convenience. Further details and registration can be found at www.OTStudyClub.com.



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Registering as a Study Club member is free and provides access to accredited C.E. Webinars and other beneficial tools catering directly to orthodontics. For example, in today's world of orthodontics, new products, concepts and techniques

are brought to light with amazing speed, so it's not surprising that many orthodontists are finding it difficult to stay up to date.


In an effort to make the most of practitioners' time, www.OTStudyClub.com will feature "First Impres-

sions," a series of five-minute video vignettes. These will present various ortho products with support of demo videos and will be archived in an online product library to be viewed at any time.

Please keep in mind that the site will be officially launched on July 11! Register early and mark the date on your calendar!

Please contact Julia for full details and for the OTSC launch registration by phone at (416) 907-9836 or by e-mail at j.wehkamp@otstudyclub.com.

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Consider the 'extras' of cone beam

By Edward Y. Lin, DDS, MS;
Richard L. Bridgham, DDS;
& William (Bill) Harrell, Jr., DMD

Cone beam technology has changed the face of dental treatment, literally adding depth to the art of diagnosis. Benefits to both the doctor and the patient include detailed 3-D images of patients' entire jaw and skull structures, shorter scan and appointment times and less radiation exposure than traditional CT scans. For orthodontists, the 3-D scans improve diagnostic accuracy, treatment precision and patient satisfaction — right in the office.

While most of cone beam's diagnostic and treatment-planning capabilities are apparent, three orthodontists share their insights into some additional benefits.

Adding to the toolbox

— Edward Y. Lin, DDS, MS

Using cone beam imaging, orthodontists can add more high-tech tools that streamline efficiency and increase productivity. For example, SureSmile® technology, an original method of orthodontic movement, has become an integral part of our practice. Because the i-CAT® is the only cone beam unit that is certified by SureSmile, we were able to integrate its technology with our existing cone beam 3-D system.

To be able to combine these two technologies means that we can utilize the second active therapeutic application developed in dentistry thus far (the first being surgical guides).

Orthodontists use SureSmile software to determine the teeth's final position and treatment plan, combining tools such as 3-D imaging and CAD/CAM. This process can cut treatment time from 24 months to about 14 months.

One method of using SureSmile involves a handheld digital intraoral camera, which takes hundreds of images of a patient's teeth and renders them into a 3-D model on a computer screen. We use our i-CAT scans instead of the camera (Fig. 1) to compile the image in the SureSmile software (Fig. 2). Digital lab technicians then use this software to virtually move teeth according to the doctor's prescription (Fig. 3). This information is then used to direct a small robotic arm to bend shape-memory alloy archwires (Fig. 4). When placed (Fig. 5), these unique wires produce precise and controlled tooth movement to achieve faster, more effective results.

Currently, the i-CAT creates the required 3-D CAD model, shortening scan time from 30 minutes (with the camera) to around 20 seconds. Because the scan offers full anatomical details, we can see the roots in addition to the crowns

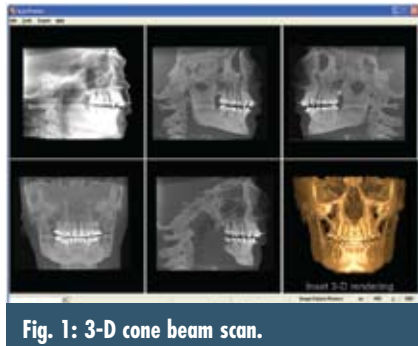


Fig. 1: 3-D cone beam scan.

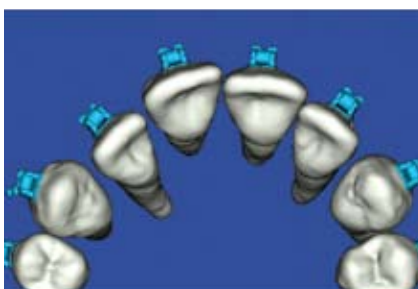


Fig. 3: SureSmile movement.



Fig. 5: Wires in place. (Image acquisition of Figs. 1–5 facilitated by Angela Berna.)

of the teeth and gain more accurate SureSmile setups. Plus, the radiographic scan also can be used for diagnostic applications.

The advantage is more than just clinical. Time savings is a big part of our return on investment. We've calculated the value of each clinical minute at our practice at approximately \$5. With i-CAT scans instead of camera images, we typically shorten an appointment time by at least 30 minutes, saving about \$150 in the process. Multiplied by 1,000 possible new appointments for braces yearly, that means up to \$150,000 in savings.

Shorter appointments have resulted in higher productivity. Using Cone Beam 3-D scans, we see the same number of patients, about 75 to 125 per day, depending on my clinical schedule, in a three-day clinical week rather than in four days, which reduces our staff requirements. It's definitely a tool that benefits our patients and our practice.

Clinical and captivating

— Richard L. Bridgham, DDS

Our investment in a cone beam machine keeps us ahead of the curve in treatment applications and



Fig. 2: 3-D X-ray in SureSmile.



Fig. 4: Robot making wires.



Fig. 6: i-CAT in office.

builds our reputation as technology leaders. While the clinical implications of having 3-D technology in our office were obvious, before we chose a system we reflected on how it would blend into our total design and aesthetic considerations, how it would be perceived by our patients and how it fit in to our space requirements.

While the trend in dental design leans toward opulent reception rooms, many of us still prefer to evoke a calming ambiance in our treatment areas. In design and equipment choice, we wanted to consider the patient's view with a broader perspective than just color and style.

While the main determinant for this investment was improving my practice's diagnostic and treatment capabilities, appearance did enter into my rationale for choosing my particular machine, the i-CAT by Imaging Sciences International. Its design is not imposing, and it performs scan functions quickly.

By contemplating both the functionality and the looks of this unit, we can retain our high-tech advantage yet offer equipment with a pleasant non-threatening appearance and streamlined non-intimidating function for our patients (Fig. 6). Lower-

ing the patients' stress also means reduced stress for practitioners and their teams.

Size constitutes another consideration for 3-D cone beam systems and other large-scale units. Because each square foot of our offices is valuable real estate, choosing a system with a small footprint makes for better use of this space. My i-CAT fits into a 4-foot by 4-foot area. It's a true 3-D system with a traditional 2-D pan option that additionally allows dentists to trade out their 2-D pan units while still preserving this lower-radiation option along with 3-D scans.

For practitioners who are considering adding 3-D technology, I recommend the following: The new unit should be a good fit in many ways — with the clinical needs of your particular practice, with your financial considerations and with the size and physical blueprint of your office. For those with tight budgets, check with your local dealer on pan trade-in options as this may let you make this practice-changing investment sooner, so you can begin to gain the benefits of this technology.

Building patient trust and case cooperation

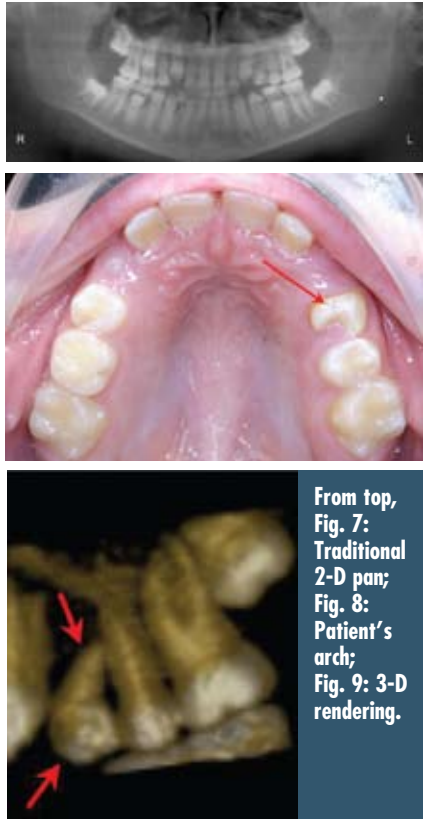
— William (Bill) Harrell, Jr., DMD

The benefits of obtaining 3-D images from the i-CAT are clear — the virtual, rotating model replicates the human jaw and face for greater accuracy, precision and efficiency. These scans expose pathologies that were previously undetectable with traditional methods; we all appreciate discovering the unexpected well in advance of a procedure. Thanks to the insights we gain from cone beam imaging, we also achieve better patient understanding of our diagnosis and build trust in our treatment plans.

The more precise we are during diagnosis and treatment planning, the more direct and efficient the process can become — which has the potential to eliminate costly or dangerous errors and reduce adjustments. Three-dimensional imaging has revealed anatomically true conditions that are indiscernible with traditional 2-D X-rays.

For example, in one case, a traditional panoramic projection showed mal-alignment and malformation of the patient's maxillary left first bicuspid (Figs. 7, 8); the most obvious treatment seemed to entail uprighting the crown mesially.

However, an i-CAT scan revealed that the tooth's root was dilacerated and actually positioned 90 degrees to the crown. After viewing the i-CATVision software's cross-sections and 3-D rendered views (Fig. 9), it became apparent that uprighting this tooth's crown to the mesial would move the root into the



From top, Fig. 7: Traditional 2-D pan; Fig. 8: Patient's arch; Fig. 9: 3-D rendering.

ods. While the dentist's decision is important, patient cooperation is a huge factor. You can devise the greatest treatment plan, but unless the patient understands and is ready to cooperate with what you are trying to accomplish, you may not have the success you're trying to attain. If patients can better visualize their problems and truly understand the reasons for the treatment because of the 3-D scan, they will be ready and willing and, best of all, cooperative.

The more complete diagnostic information and knowledge you gain from your imaging, the better you can relay that information to the patient. A patient's trust and confidence in your decisions can make or break case acceptance. Three-dimensional radiography gives the orthodontist another avenue on which to build a more successful practice.

adjacent second bicuspid root.

The 3-D view changed my treatment plan and allowed me to create a more sound treatment option to upright the crown more distally to place the root correctly into the alveolar bone. In the future, if the tooth is eventually lost, the alveolar bone will be preserved for a possible dental implant.

In yet another case, an i-CAT scan showed some suspicious calcifications around a patient's neck. While this doesn't affect our treatment, we were able to refer the patient to a radiologist and cardiologist for evaluation.

These areas turned out to be carotid artery calcifications and required treatment, even though the patient was not experiencing any symptoms.

Other areas such as airway problems or TMJ degenerative changes may affect our overall treatment plan. Some of these issues are not discernable on traditional panoramic or cephalometric imaging. In such cases, it is more advantageous for us to recognize such issues as clearly as possible and be a part of the solution.

This technology builds patient trust, improving the doctor-patient relationship. With 3-D scans, patients and parents can reach a new level of understanding their treatment because I can point out the details of the situation.

When I show them the rendered volume, and I am able to rotate and cross-section the model, it helps them to understand the impact of their condition — that we can predict problems in repositioning the teeth, impactions, thin alveolar bone and other conditions. Besides the clear case presented by the 3-D image, they are aware that we are ahead of the curve in taking care of their oral health.

Cone beam technology increases patient trust because we are able to predict treatment outcomes better than with other imaging meth-

OT About the authors



Dr. Edward Lin graduated with a bachelor of arts degree from the University of Chicago and continued his dental education and orthodontic residency at Northwestern University Dental School. He maintains a full-time private group practice in Green Bay, Wis. He has lectured extensively nationally and has taught at both Marquette University and the University of Minnesota Orthodontic Residency Programs.

he completed an orthodontic residency and became certified in orthodontics at the Albert Einstein Medical Center in Philadelphia. He is board certified as a diplomate of the American Board of Orthodontics and is a member of the World Federation of Orthodontists.



Dr. William (Bill) Harrell, Jr., graduated from the University of Alabama dental school in Birmingham in 1975 and completed his orthodontic



Dr. Richard Bridgham received his bachelor's from the State University of New York at Stony Brook and his DDS from Loyola University at Chicago. After a general practice residency,

residency at the University of Pennsylvania in 1977. He was board certified by the ABO in 1989. His private orthodontic practice is in Alexander City, Ala., and he conducts research in 3-D imaging and TMJ disorders as well as speaks internationally on 3-D imaging.

AD

HOW

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Imaging

OT from page 1

What is SureSmile?

SureSmile is the first and only system to integrate digital imaging, computer modeling, robotic technology and high-tech materials into a start-to-finish orthodontic treatment process. This new system is the brainchild of Rohit C. L. Sachdeva, BDS, M Dent Sc, who serves as the chief clinical officer at OraMetrix, the company that provides SureSmile technology and the accompanying services. Dr. Sachdeva is a pioneer in copper NiTi (Ormco) alloys, and it is his vision that has made SureSmile what it has become today.

SureSmile patients begin orthodontic therapy with a routine full banding procedure. After three to

four months of leveling and aligning, the patient's mouth is scanned using an OraScanner.

The OraScanner uses non-invasive white light to capture images of the teeth to create a 3-D model of them. This step is the only patient appointment that differs from conventionally treated patients and takes 20 to 30 minutes in the office. An orthodontic assistant trained by OraMetrix staff performs the scan.

From this 3-D model, the occlusion is treated in the virtual world (on the computer). The software developed by OraMetrix to simulate comprehensive orthodontic treatment is a marvel and will be presented in greater detail by Dr. Feinberg.

While the setup of the occlusion is performed in conjunction with the company's digital lab technicians, the orthodontist has total control of

the final result. The teeth are moved in the virtual world on the computer screen to completion. This information drives the SureSmile robot located in Richardson, Texas. This robot bends wires made of CuNiTi shape memory alloy to a level of precision well beyond human abilities.

The prescribed robotically bent wire is sent back to the orthodontist's office for placement in the patient's mouth as in a standard archwire change appointment. The gentle forces of the CuNiTi wire move the teeth precisely into the desired final position. This precision adds efficiency to the treatment, which, in most cases, results in shorter treatment time — typically by 30–40 percent.

My attraction to SureSmile

I was first introduced to SureSmile

at a national meeting six or seven years ago. The intricate bends in the robotically bent wires appeared to be technically accurate. Few cases are ever completed in pure straight wire form, and it is not humanly possible to bend a wire as demonstrated — especially a NiTi wire.

Initially, the technology was fantastic, but I did not know any orthodontists who were using it. In the summer of 2006, OraMetrix invited me to visit its headquarters in Richardson. The company was in full operation with its digital lab, staff and orthodontist training facilities and fully operational robots. It was proved to me that OraMetrix planned to be around for a long time and was completely committed to the future of our profession.

Imaging

OT see page 8

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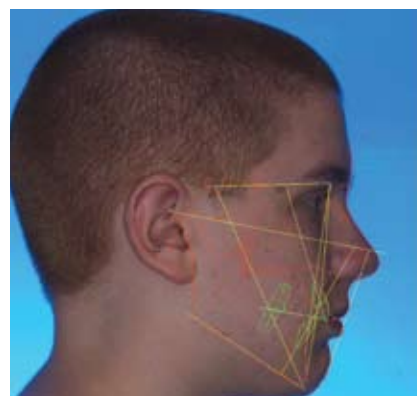


Fig. 2: Cephalometric view, pre-treatment.



Fig. 3: Panoramic view, pre-treatment.

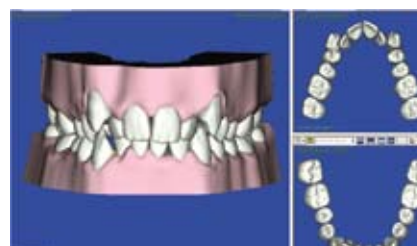


Fig. 4: Patient presents with a Class II division 1 malocclusion, moderate overbite, severe upper and moderate lower arch length deficiency. Upper lateral incisors demonstrated significant internal root resorption. The treatment strategy formulated involved extraction of the upper first premolar teeth as well as the upper lateral incisor teeth. Single tooth replacement implants were planned to replace the upper lateral incisor teeth.

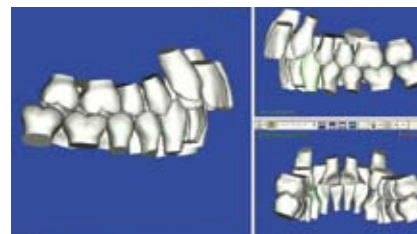


Fig. 5: More pre-treatment records showing Class II division 1 severe overjet and moderate overbite, severe upper and moderate lower ALD and internal resorption of upper lateral incisors.



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Imaging

OT from page 6

This high-tech system was consistent with my long-time belief that moving teeth was not about the bracket but about the wire. This does not imply that the technology is not an excellent choice for practitioners using modern self-ligating brackets because it is. For me, however, the bracket has always been a handle for the tooth, so the fact that SureSmile works with any bracket system was very appealing.

The idea of incorporating technology that can complete the treatment process in a shorter period of time also was very appealing to me. Shorter treatment time can translate into less oral hygiene risks, less overall discomfort for the patient



Fig. 6: A virtual simulation is performed to assess arch length needs and to assess the final occlusion. Module shows the right buccal view of simulated extraction of UR4.

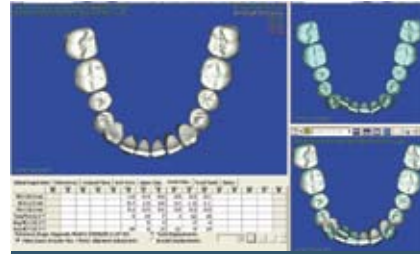


Fig. 7: An arch length analysis is performed on both arches. The lower arch as displayed reveals a deficiency of 3.0 mm. Based on the virtual diagnostic model setups performed, a determination was made to perform a non-extraction approach in the lower arch that would necessitate 3.0 mm of IPR based on maintenance of the lower incisor position.

and fewer visits to the office.

Another valuable selling point was the ability of the software to quality score my treatment decisions with a virtual grading system. Instead of wondering whether treatment would meet quality standards after completion, I could now order a robotically bent wire designed to finish the case with high quality at

the beginning of treatment. While this has not been put to the test to date, I plan on using SureSmile-treated cases during my personal recertification process.

Another factor in my decision

to choose this technology was that I needed new challenges in my career, and this software fulfilled that desire. While there was a learning curve, the staff at OraMetrix was readily available in the training process. In partnering with SureSmile, I have the support of a company who has as a vested interest in my success with its product.

The staff and management team at OraMetrix are committed to the success of this technology. Dr. Sachdeva is inspirational and a true visionary in our profession. He is currently crossing the country offering free C.E.-qualified lectures on SureSmile technology. I encourage everyone to take advantage of spending a day with Dr. Sachdeva. My interaction with him and the

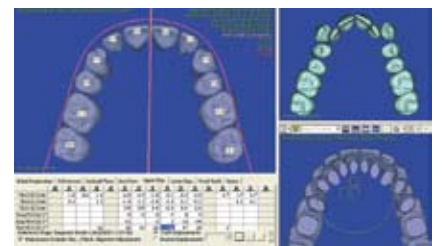


Fig. 8: Tooth size measurement and implant space.

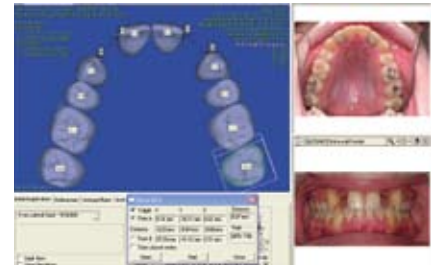


Fig. 9: A Bolton as well as a tooth-size analysis is displayed automatically and does not require the manual determination of these values.



Fig. 10: June 9, 2006 — therapeutic scan six months from initial wire insertion.



Fig. 11: Therapeutic scan timepoint.



Fig. 12: Comparison of the diagnostic vs. therapeutic timepoints reveals the degree of leveling of the curve of spee to date. Additional leveling was strategized in the setup plan stage, ultimately being designed into the SureSmile wire.

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Fig. 13: A therapeutic scan is performed as a prelude to SureSmile wire creation, and additional higher level treatment planning is performed. The blue teeth represent the patient's progress to date, and the white teeth represent the changes that will be necessary to achieve planned treatment endpoints. In this instance, the highlighted numbers represent tweaking of the arch form and provide the necessary transverse modifications.

input and shared experiences of other SureSmile users made my decision to implement SureSmile into my practice an easy one.

What about cost?

This seems to be a big hurdle for many colleagues if they only consider the costs — the expense of the equipment, a three-year commitment, the cost per patient, patients' willingness to spend more. SureSmile is an investment, not an expense.

The cost of a dental education is staggering today; the cost of the

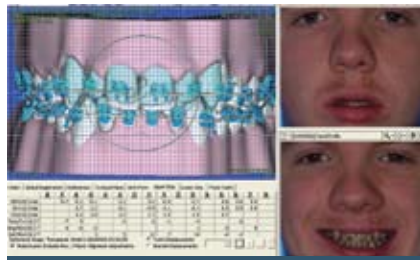


Fig. 14: The software grid calibrated in 0.1 mm increments is a valuable tool in planning the position of the anterior occlusal plane. In this case, more incisal show would be cosmetically preferable and, therefore, superior positioning of the upper anterior occlusal plane is planned.



Fig. 15: Nov. 9, 2006 (11 months from initial wire insertion).

three-year commitment to OraMetrix is less than one year of tuition in some orthodontic programs. Learning to treat patients in the digital world with this system will serve an orthodontist for the remainder of his or her clinical orthodontic career, making the investment in SureSmile a bargain investment.

The cost of the equipment includes



Fig. 16: Final records on Aug. 7, 2007.

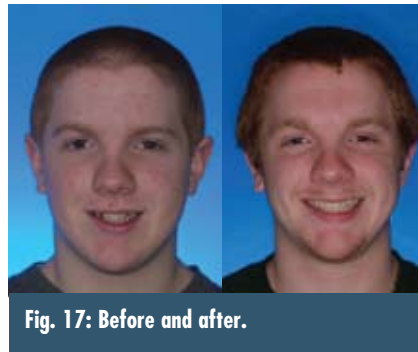


Fig. 17: Before and after.

installation and training; the cost per patient can be passed on in the treatment fee. Many patients understand that new technology costs more. Plus, partnering with OraMetrix will keep you current with the latest and best technology in our profession. The latest upgrade of the SureSmile software introduced CBCT integra-

OT About the author



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¹Sharma NC et al. *Am J Ortho Dentofacial Orthop* 2008; 133(4): 565-571.

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