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Implants displaced into the maxillary sinus

By Dov M. Almog, DMD, Kenneth Cheng, DDS & Mohammad Rabah, DMD

As some have predicted,[1] the growth in dental implant-based procedures increased considerably in recent years. As a result, there has been a rapid increase in the number of practitioners involved in implant placement, including specialists and generalists, with different levels of expertise.

At the same time, although at a low frequency, we are witnessing a diversity of unusual complications associated with these procedures, some of which are displaced implants into the maxillary sinus.

A literature search revealed several published reports of displaced foreign bodies into the maxillary sinus.[2–6] Generally speaking, foreign bodies in the maxillary sinus include multiple displaced objects. These include teeth, roots, impression materials, dental instruments, broken burs and, more recently, dental implants.

Although foreign bodies in the maxillary sinus are not common, it behooves us to familiarize ourselves with such an unusual complication and its management. Displacement of such foreign bodies into the maxillary sinus occurs following dental procedures that create an unplanned oroantral perforation.

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PND Conference: Where education meets beauty!

The 122nd annual Pacific Northwest Dental Conference (PNDC) offers two days of continuing education in one of the most picturesque and family-friendly settings. (Photo/Beverly Sparks) →*PND Conference, page 10A*

Washington cracks down on tobacco, and ADA approves

By Fred Michmershuizen, Online Editor

The American Dental Association (ADA) is applauding new legislation to regulate tobacco. The Family Smoking Prevention and Tobacco Control Act gives the U.S. Food and Drug Administration (FDA) the express authority to regulate the manufacture, marketing and distribution of tobacco products.

The ADA has a long-standing policy that nicotine is a drug and that cigarettes and other tobacco products are nicotine delivery devices and, therefore, should be regulated.

"Dentists are the first line of defense in the war against oral cancer and many other tobacco-related diseases," said ADA President Dr. John S. Findley. "About nine out of 10 people who will die from oral and throat cancers use tobacco."

"Tobacco products are also associated with higher rates of gum disease, one of the leading causes of tooth loss in adults," Findley said. DT

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Orange juice bad for teeth, scientists say

By Fred Michmershuizen, Online Editor

Scientists at the University of Rochester Medical Center who were recently studying the effects of whitening agents on human teeth discovered something alarming: acidic fruit juices markedly decreased hardness and increased roughness of tooth enamel. No significant change in hardness or surface enamel was found from whitening.

"Orange juice decreased enamel hardness by 84 percent," said YanFang Ren, DDS, PhD, of the university's Eastman Institute for Oral Health.

In the study, "Effects of tooth whitening and orange juice on surface properties of dental enamel," published in the Journal of Dentistry (Volume 37, Issue 6, June 2009), Ren and his team determined that the effects of 6 percent hydrogen peroxide, the common ingredient in professional and over-the-counter whitening products, are insignificant compared to acidic fruit juices.

Weakened and eroded enamel may speed up the wear of the tooth and increase the risk for tooth decay to quickly develop and spread.

"Most soft drinks, including sodas and fruit juices, are acidic in nature," Ren said. "Our studies demonstrated that orange juice, as an example, can potentially cause significant erosion of teeth."

It's long been known that juice and sodas have high acid content and can negatively affect enamel hardness.

"There are also some studies that showed whitening can affect the hardness of dental enamel, but until now, nobody had compared the two," Ren explained. "This study allowed us to understand the effect of whitening on enamel relative to the effect of a daily dietary activity, such as drinking juices."

"It's potentially a very serious problem for people who drink sodas and fruit juices daily," said Ren, who added that dental researchers nationwide are increasingly studying tooth erosion and are investing significant resources into possible preventions and treatments.

"We do not yet have an effective tool to avert the erosive effects, although there are early indications that higher levels of fluoride may help slow down the erosion," he said. DT

(Source: University of Rochester Medical Center)

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The procedure associated with the removal of foreign bodies from the maxillary sinuses is considered very invasive. In this case report, the authors describe a systematic approach to the removal of two implants displaced into the right and left maxillary sinuses.

Currently, there are two accepted methods for removing foreign bodies displaced into the maxillary sinus. One method is the endoscopic transnasal maxillary sinus surgery.[7-10] Access to the maxillary sinus is achieved through the nose via the ostium. The foreign body is captured and removed using an urological retrieval basket through the endoscopic working channel port. The advent of endoscopic techniques has made it the preferable choice, especially for patients with chronic sinusitis.

The most commonly used technique for retrieval of foreign bodies displaced into the maxillary sinus is the Caldwell-Luc procedure. In contrast to the endoscopic technique, which involves accessing the maxillary sinus via the nose, the Caldwell-Luc procedure involves gaining access to the maxillary sinus by the fenestration of the anterior lateral wall of the maxillary sinus or canine fossa.[11,12]

The Caldwell-Luc procedure offers better direct visual access to the maxillary sinus as compared to the endoscopic approach, but is considered more aggressive with potentially more serious complications. Some of the possible complications are dysesthesia of the infraorbital nerve, numbness of the maxillary teeth, injury to the floor of the orbit and facial edema. This older and perhaps less conservative technique for accessing the maxillary sinus was first introduced by two otolaryngologists (American and French) in 1893.[11]

Case report

A 50-year-old African-American male Vietnam veteran presented to the VA New Jersey Health Care System Dental Service at East Orange seeking dental care.

A comprehensive oral and maxillofacial examination included an intraoral and extraoral exam, including cancer screening, full-mouth X-rays, and a cone-beam CT (i-CAT™ 3D CBCT Imaging Sciences International, Hatfield, Pa.) revealing, among other things, two implants displaced into the right and left maxillary sinuses.

Ultimately, the exam revealed a diversity of oral and maxillofacial problems, such as retained roots, decay and missing teeth, to name a few. Nevertheless, the chief complaint noted by the patient, and most profound clinical finding, was "two implants displaced into the right and left maxillary sinuses" (Figs. 1–3). The medical history was non-contributory.

Proceeding with careful assessment of all the available diagnostic information, and upon further discussion with the patient, several treatment options were developed in association with his retained roots, caries and missing teeth. As far as the patient's chief

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DENTAL TRIBUNE
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Publisher
Torsten Oemus
t.oemus@dtamerica.com

President & CEO
Peter Witteczek
p.witteczek@dtamerica.com

Chief Operating Officer
Eric Seid
e.seid@dtamerica.com

Group Editor & Designer
Robin Goodman
r.goodman@dtamerica.com

Editor in Chief Dental Tribune
Dr. David L. Hoexter
d.hoexter@dtamerica.com

Managing Editor/Designer Implant & Endo Tribune
Sierra Rendon
s.rendon@dtamerica.com

Managing Editor/Designer Ortho Tribune & Show Dailies
Kristine Colker
k.colker@dtamerica.com

Online Editor
Fred Michmershuizen
f.michmershuizen@dtamerica.com

Product & Account Manager
Mark Eisen
m.eisen@dtamerica.com

Marketing Manager
Anna Wlodarczyk
a.wlodarczyk@dtamerica.com

Sales & Marketing Assistant
Lorrie Young
l.young@dtamerica.com

C.E. Manager
Julia E. Wehkamp
E-mail: j.wehkamp@dtamerica.com

Dental Tribune America, LLC
213 West 35th Street, Suite 801
New York, NY 10001
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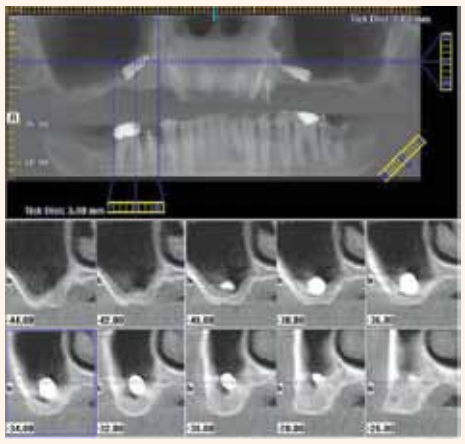

Fig. 1: Pre-operative diagnostic cone-beam CT revealing, among other things, two implants displaced into the right and left maxillary sinuses. By utilizing the i-CAT™ 3D CBCT (Imaging Sciences International, Hatfield, Pa.), which includes clear-cut panoramic and cross-sectional slices of any desired location, one obtains precise anatomical information.

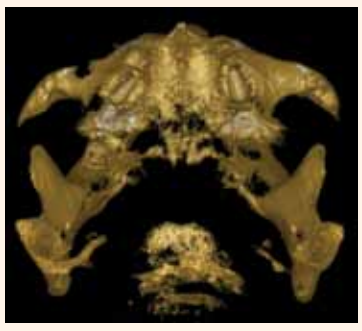

Fig. 3: Three-dimensional virtual rendering (3-DVR) of the displaced implants provides the surgeon feedback as to the surgical approach. In this case, a Caldwell-Luc procedure was performed using a bur to create an access window through the lateral wall of the maxilla, thereby gaining direct access to the displaced implant.

complaint, one treatment option was offered to him, that is, the Caldwell-Luc procedure to remove both displaced implants in his maxillary sinuses. After careful consideration, the patient chose to proceed with the proposed treatment plan.

A Caldwell-Luc procedure was performed bilaterally under general anesthesia. Specifically, the Caldwell-Luc procedure involved making an incision in the bucco-gingival sulcus in the area of the maxillary canine and bicuspid teeth, exposing the anterior lateral wall of the maxilla. Care was taken to avoid injury to the infraorbital nerve as it exits in the infraorbital foramen.

Using a bur and Kerrison's rongeurs, a window was made through the anterior lateral wall of the maxilla, thereby gaining access to the maxillary sinus. Antral currettes and a hemostat were used to retrieve the displaced implants (Fig. 4). The sinuses were then irrigated and packed with iodoform gauze, which was later removed. The incision was closed. Postoperatively, the patient did well and no complications were reported.

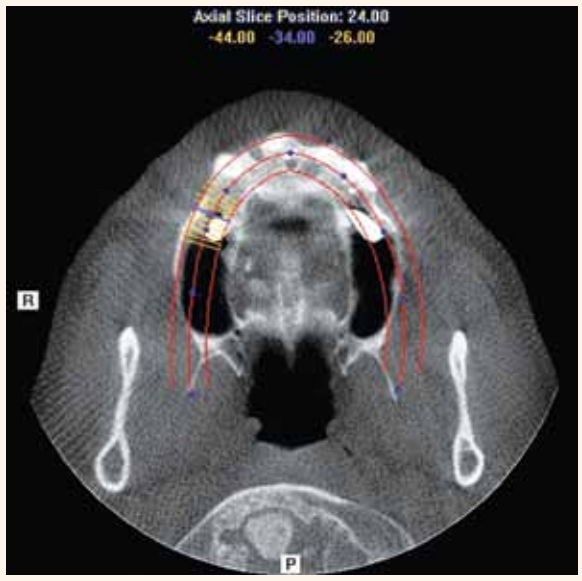

Fig. 2: Axial slice is useful for revealing the two displaced implants from a different angle.

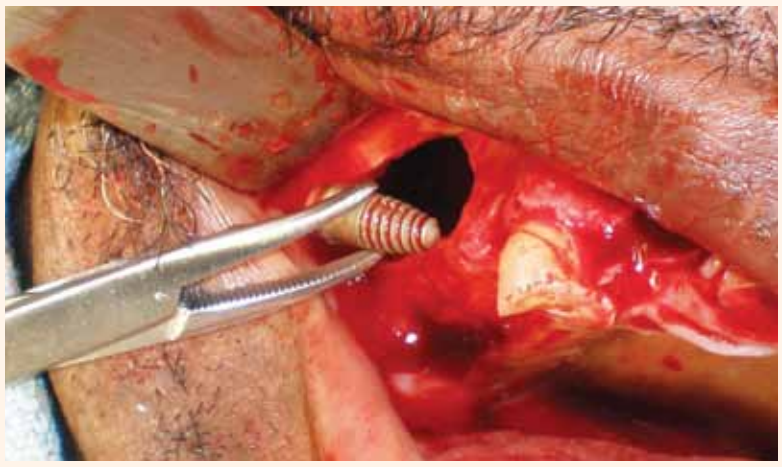

Fig. 4: Caldwell-Luc procedure is useful in gaining access to the maxillary sinus by the fenestration of the anterior lateral wall of the maxillary sinus. Note successful retrieval of implant from the maxillary right sinus through the access window.

Conclusions

As described in this case report, the clinical management associated with the removal of dental implants displaced into the maxillary sinuses is considered very invasive.

While numerous dental reports described patients treated for displaced implants into the maxillary sinuses, none illustrated those from a preventive standpoint, that is, the use of CBCT-based dental imaging before placing dental implants.

While the quantitative relationship between successful outcomes in dental implant treatment and CBCT-based dental imaging is unknown and awaits discovery through large prospective clinical trials, the authors strongly believe that using CBCT-based dental imaging is becoming a reliable procedure from a precautionary standpoint based on a series of recent preliminary clinical studies and case reports.

Therefore, the authors strongly believe that by making a CBCT-based study prior to placing dental implants, displacement of dental implants into the maxillary sinus can be avoided. DT

(A complete list of references is available from the publisher.)

About the authors

Dov M. Almog, DMD, Chief of the Dental Service, VA New Jersey Health Care System (VANJHCS)

Kenneth Cheng, DDS, Oral and Maxillofacial Surgeon, VANJHCS

Mohammad Rabah, DMD, Oral and Maxillofacial Surgery Resident, VANJHCS

For reprints:
Dov M. Almog
Chief, Dental Service (160)
VA New Jersey Health Care System
385 Tremont Avenue
East Orange, N.J. 07018
Tel.: (973)-676-1000, ext. 1234
Fax: (973) 395-7019
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Five of the top 10 reasons why associateships fail

By Eugene W. Heller, DDS

The "American Dream" is still to own a home. The "Dentist's Dream" continues to be the ownership of a practice. Thirty years ago, the dream was to graduate from dental school, buy equipment, hang out a shingle and start practicing. Today the road to ownership is a little different.

Due to extensive debt, most new graduates enter practice as associates to improve their clinical skills, increase their speed and proficiency and learn more about the business aspects of dentistry.

Most hope the newfound associateship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host dentist's practice, only to be forced to leave. This forced departure is the result of a non-compete agreement when the promised buy-in/buy-out doesn't occur.

The following reveal the first five of the top 10 reasons many associateships fail to result in ownership or partnership.

Reason No. 1: purchase price

If the purchase price has not been determined before the commencement of employment, the parties find themselves on different ends of the spectrum as to what the practice is worth and what the buy-in price should be.

When purchase price is established before the commencement of employment, three out of four associateships lead to the intended equity position.

Conversely, if the purchase price has not been determined, nine out of 10 associateships lead to termination without achieving the ownership intended or promised.

Reason No. 2: the details

The more items discussed and agreed to in writing beforehand, the better the chance of a successful equity ownership occurring as planned.

The written instruments should be two specific documents — an Employment Agreement detailing the responsibilities of each party for employment, and a Letter of Intent detailing the proposed equity acquisition.

Reason No. 3: insufficient patient base

Approximately 1,000–1,200 active patients are required per dentist in a dental practice. If the senior dentist does not intend to restrict or cut back his/her number of available clinical treatment hours, then the conversion from a one-dentist to a two-dentist practice requires an active patient base of approximately 1,400–1,800 patients and a new patient flow of 25 or more new patients per month.

Many senior dentists count their number of active patients by counting the number of patient charts on a wall. However, the best way to estimate the active number of patients involves utilizing the hygiene recall count.

Most hope the newfound associateship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host dentist's practice, only to be forced to leave.

Insufficient numbers of patients and/or an insufficient new patient flow signals that all expenses relating to the new dentist are coming directly out of the bottom line. The practice then begins to experience financial pressure.

Creation and maintenance of a sufficient patient base is an extremely important aspect of the business. If the senior dentist is nearing retirement with the intent that, within one to two years, the senior dentist will turn over total ownership of the practice and intends to cut back shortly after the beginning of the second dentist's employment, this problem is

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not as critical.

Often the senior dentist brings in an associate dentist as the answer to increasing business. A practice with insufficient new patient flow that experiences the addition of a new practitioner may result in termination of employment for the associate.

Reason No. 4: incompatible skills

The incompatibility in clinical skills between practitioners may include the possibility of one practitioner's skill level being below standard, but it may also include different practice philosophies. On the surface, it would appear that having different skill levels and philosophies might be desirable. In reality, the patient base that is available to the younger practitioner may not lend itself to various types of dentistry.

Reason No. 5: timeframe

The failure to identify when the buy-in or buy-out is to occur and when to execute it can result in failure to achieve an ownership status.

The Letter of Intent may have stated that the buy-in was to occur in one to two years, but certain behaviors and signs during the continuing employment relationship might give an indication that the senior doctor is having difficulty honoring the intended buy-out or that the associate does not feel ready to consummate the transaction within the original timeframe outlined.

Either position might result in the demise of the buy-in as involved parties lose patience over such delays.

identify the potential pitfalls at the beginning of the relationship

Summary

This article has been aimed primarily at a one-dentist practice evolving to a two-dentist practice; however, the issues apply equally to larger group practices.

One-to-two-year associateships with the senior dentist retiring at the end of the associateship and a three-to-five-year partnership ending with the new dentist purchasing the remaining equity position of the senior dentist at the end of five years can also benefit from the insights provided in this article.

Unfortunately, nothing can guarantee a successful outcome will occur. However, by identifying the potential pitfalls at the beginning of the relationship, chances of success can be greatly improved. DT

Look for the remaining five reasons in the next edition of Dental Tribune.

About the author

Dr. Eugene W. Heller is a 1976 graduate of the Marquette University School of Dentistry. He has been involved in transition consulting since 1985 and left private practice in 1990 to pursue practice management and practice transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental schools. Heller is presently the national director of Transition Services for Henry Schein Professional Practice Transitions. For further information, please call (800) 730-8883 or send an e-mail to *hsfs@henryschein.com.*

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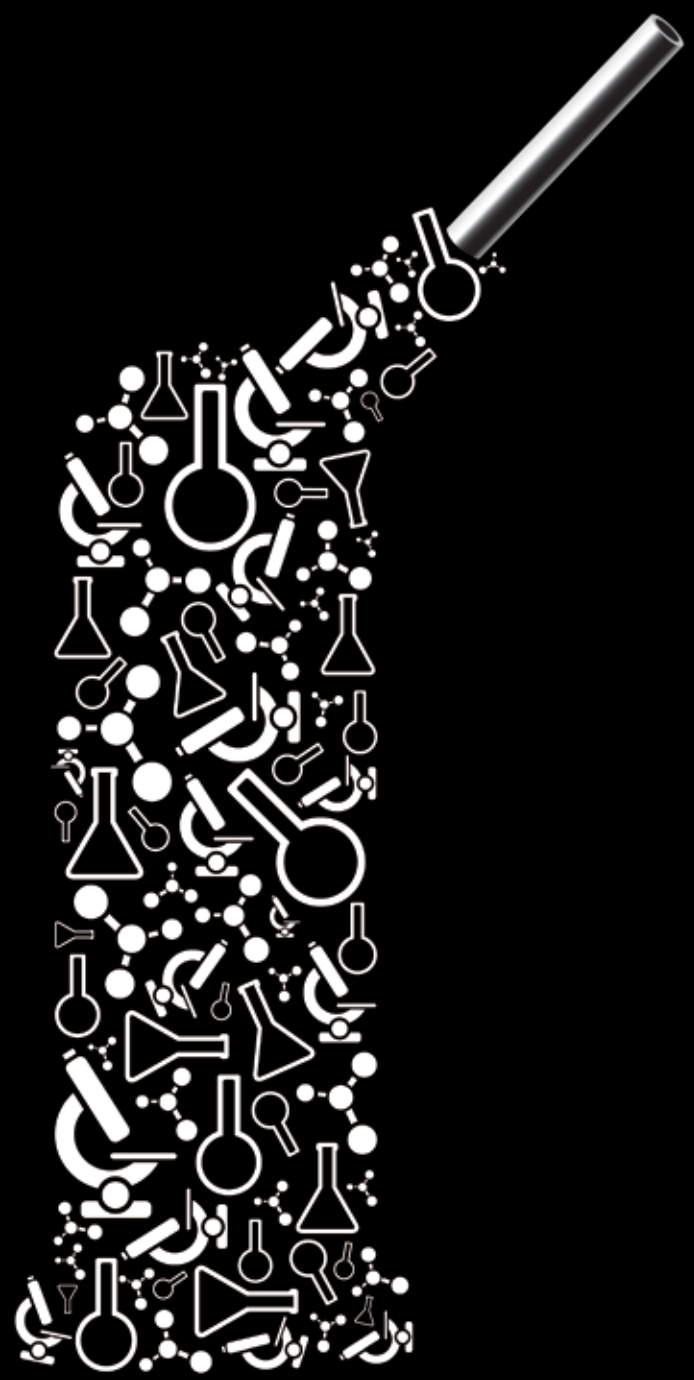

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