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This year it won't be holidays with the grandchildren. We're heading off to vacation with old college friends. It's been 40 years since we graduated, but we feel like we never left school! Thank goodness Jack found a prosthodontist ten years ago when we discovered he was about to lose all of his teeth. Thanks to his prosthodontist, Jack still has the same enchanting smile that I fell in love with in that cold university library.+
Over the past 50 years, there has been an explosion of technology related to restoring and replacing damaged, worn and missing teeth. The prosthodontic specialty is leading the expansive technological push that enables better and more beautiful tooth restoration. The discipline involving prosthodontic procedures is of course practiced by the majority of general dentists. So, it’s not surprising that over the past 50 years, many people have been treated for damaged, worn or missing teeth using dentures, crowns, bridges and dental implants. One of the most valuable lessons learned from the dental care provided over these past decades is that dentistry is not permanent. Today, patients with crowns, bridges, implants or dentures find themselves in need of having their outdated, worn or broken dental prostheses made again. These needs among the large and expanding aging population are likely to increase and will place an increasing demand for care on the prosthodontic specialty.

Retreatment is a growing reality for many dental patients. With this growing need for treatment comes increasing complexity of care.

Retreatment is a growing reality for many dental patients. With this growing need for treatment comes increasing complexity of care. This complexity often exceeds both the dentist’s and patient’s capacity to cope with the problems at hand. For many, the prosthodontist represents the last hope for solving such complex restorative needs. The American College of Prosthodontists seeks to inform the general public about the prosthodontist’s unique skills and abilities and works diligently with prosthodontic educators to assure that standards for education and related therapy meet the needs of our patients.

The focus of this issue of the ACP Messenger is retreatment and the prosthodontist’s role in providing assistance and comfort to the individuals with dental retreatment needs. The included features and case reports highlight the especially valuable role of the prosthodontist in providing retreatment. Retreatment implies failure, and that implies fault. Understanding the fault, imperfection or challenge that leads to dental prosthesis failure is critical to solving problems unique to each patient. The growing knowledge base of dental prosthesis outcomes is moving discussion of failure-induced retreatment from blame to the recognition of biologic, mechanical and clinical causes of failure. This is a hallmark of today’s prosthodontist. New techniques, improved materials, and better prevention of disease and dysfunction can be directed to providing a new and improved dental prosthesis.

“Again,” in the context of dental rehabilitation, could be a dreaded word. “Again”, that adverb inferring once more (the dreaded do-over), also infers the return to a previous position or condition. Today’s dental patients who need or desire replacement of outdated, worn or broken dental prostheses are fortunate that there is a specialist with experience and knowledge that can return patients to – and often improve – health, comfort and beauty. This issue of the Messenger embraces the challenge of “again.”

About the author

ACP Fellow Dr. Lyndon F. Cooper is the Chair and Stallings Distinguished Professor of Dentistry of the Department of Prosthodontics at the University of North Carolina at Chapel Hill. He is a Past President of the American College of Prosthodontists as well as the Editor-in-Chief of the ACP Messenger.
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Case Presentation

Treatment of the non-restorable dentition

Stephen M. Parel, D.D.S.

The loss of his teeth caused one patient physical, personal and social discomfort. After seeking prosthodontic care, he has a completely new smile – and outlook on life.

The unfortunate circumstance of the non-restorable dentition, a permanent dentition that presents without reasonable alternatives for tooth-supported restorations, was once an opportunity for immediate dentures. That period in evolving dental care provided the patient with a now well-documented lifetime of continued oral bone loss, denture complications and their management and reduced quality of life and associated co-morbid health issues. Today’s prosthodontist can offer the unfortunate individual facing the loss of all teeth an alternative to removable dentures. The following presentation illustrates the use of minimal numbers of dental implants to provide fixed dental prostheses (bridges) in both the upper and lower jaws to avoid the lifetime use of dentures.

A young man in his mid-twenties sought care of acknowledged advanced dental needs. The severity of decay and attrition offered both social and functional limitations, along with discomfort. Among solutions discussed with the patient was the removal of all teeth and their immediate replacement using dental implant supported fixed prostheses. The complexity of this procedure was managed by specialists with advanced training to accomplish the clinical work in a short period of time.

As is evident in the accompanying x-ray, four upper jaw and four lower jaw implants were placed at the surgical appointment. The implants were carefully aligned at specific angles to fully support the planned bridges and to...
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Case courtesy of Anthony LaVacca, DMD
Prosthodontist, Naperville, IL

TESTIMONIAL

“As a Chicago police officer for 40 years, I witnessed many difficult situations and hardships. I am now retired and ready to live my life to its fullest. My smile has been missing but I’ve found it again thanks to a wonderful dentist and laboratory. For me, circumstances have changed for the better – and it began with my smile!”
- Kathleen, actual patient of LSK121

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Please scan to be directed to another patient's implant case video.
Figure 3. An intraoral photograph reinforces the notion that this dentition is in need of complete rehabilitation and that many of the teeth may not be restorable.

Figure 4. Extraction of all teeth and strategic bone reduction was performed to permit the placement of four implants in the maxilla and four implants in the mandible. This image shows the immediate postsurgical result of implant placement in the maxillary arch.

Figure 5. A panoramic radiograph reveals the planning and achievement of implant placement. The angulation of these implants avoids the sinus in the upper jaw and the major nerve of the lower jaw. The use of tilted implants, a relatively new innovation in implant dentistry, is accompanied by the use of special abutments that permit the parallel orientation of the abutments.

Figure 6. After several months of healing, the implants are osseointegrated and a final impression can be made for construction of CAD/CAM milled frameworks that are revealed in this later panoramic radiograph. Note that the frameworks extend slightly beyond the tilted implants to support additional molar teeth.

avoid the upper jaw sinuses and the lower jaw nerves. After a morning of surgery, the upper implants were revealed through the palatal tissues. On these small but firmly anchored implant components, a complete set of upper teeth can be attached that day or often within 24 hours. Similarly, implant components in the lower jaw can be used to anchor a complete set of lower teeth. The need for grafting was avoided with this approach.

The upper and lower teeth are revealed just one week after surgery. This approach, called immediate loading, is one way to provide implant care when there is sufficient bone and the implants can be firmly anchored in that bone to permit healing termed ‘osseointegration’. The position of the teeth, how they blend with the artificial gum tissues and – most important – how the upper teeth and lower teeth contact – are critical details that are expertly managed by your prosthodontist. It is important that patients discuss the intended appearance and function of their teeth with the prosthodontist at the earliest possible time. Prosthodontists arrange these teeth and organize the occlusion (upper and lower tooth contacts) before implants are placed, and help to determine the location of implants so that the implant positions do not interfere with tooth arrangement and function.

Because of the great teamwork between the patient, the prosthodontist, the dental technician and surgical specialist, this young man has found a new smile to replace his non-restorable dentition.
The accompanying x-ray shows the metal supporting bars attached to the implants, but the resin teeth are invisible to the x-rays. These images of success at the biological level in our x-rays and revealed through the new smile are the result of careful planning and treatment.

Prepared for a new life with his new smile, new responsibilities for the care and management of these artificial teeth must be recognized. His commitment to a lifetime partnership with his prosthodontist will help to assure lifelong dental implant success and dental health.

About the author

Dr. Parel is a Diplomate of the American Board of Prosthodontics and the American and International College of Dentists, and a member of many professional organizations, including the American Dental Association, the Academy of Prosthodontics and the American College of Prosthodontists. He has been course director for osseointegration training at the University of Texas Health Science Center School of Dentistry in San Antonio, one of the four original Bränemark training centers in the United States. His literature contributions include over 45 scientific articles as principal author, and multiple textbook contributions. He was editor and co-author of Esthetics and Osseointegration, a landmark reference source for implant dentistry. He authored his second book, The SmiLine System in 1991, and recently completed a third book, Esthetic Implant Restorations. He was co-founder of Osseointegration Seminars, Incorporated, and has been president of The American Academy of Maxillofacial Prosthetics, The Academy of Osseointegration, and The Osseointegration Foundation. He has received the Andrew J. Ackerman Award for meritorious lifetime service in the field of Maxillofacial Prosthetics, the Distinguished Lecturer and Dan Gordon Awards from the American College of Prosthodontists, and presently serves as Immediate Past President of the American Board of Prosthodontics. Dr. Parel has served as a professor at Baylor College of Dentistry—Texas A&M University System Health Science Center and director of the Center of Oral Maxillofacial Prosthodontics in the Department of Oral and Maxillofacial Surgery/Pharmacology from 1998 until 2008. He presently is the director of Prosthodontics at a private Implant Specialty Clinic in Dallas, Texas.
In the Office

Why do crowns, fixed partial dentures, and complete dentures have complications and sometimes fail?

Charles J. Goodacre, D.D.S., M.S.D.

In prosthodontics, avoiding or minimizing failures requires a three-tiered process. First, we need to acknowledge the types of failures that occur. Secondly, we need to identify the reasons why each type of failure occurs. Thirdly, we need to avoid the factors associated with the reasons for failure as we provide care for our patients.

To illustrate the above discussion, the three most common complications associated with single crowns are the need for endodontic treatment, porcelain fracture with metal ceramic crowns, and loss of retention. With fixed partial dentures, the three most common complications are caries, need for endodontic treatment, and loss of retention. It is apparent that caries is much more common with microscopic flexion of a prosthesis compared to a single crown could produce more microleakage, thereby increasing the rate of caries over time.

Consider the causes of complete denture failure and a greater challenge emerges. To properly identify the most common causes of clinical failure, all of the potential factors that cause failure should be part of the items assessed in the same study. With complete dentures, we know they can fail due to psychologic/behavioral factors as well as comfort, function, esthetics, phonetics, and mechanical reasons. Multiple, appropriately designed clinical studies that evaluated all these factors in the same group of subjects are lacking and it would be an extremely daunting task to complete such comprehensive studies.

It is apparent that this foray into “why failures occur in prosthodontics”...
requires greater evidence than is currently available and, of necessity, must currently involve clinical experience with its naturally occurring speculation. During my career, scientific evidence has expanded substantially but is generally inadequate in addressing the reasons why failures occur in prosthodontics. Without complete evidence, the clinical experience of seasoned practitioners will continue to be an important part of the guidelines we use to avoid clinical complications and failures. After all, none of us will live long enough to have all the experiences and encounter all the complications and failures of those who have gone before us, necessitating us to pay attention to clinical experience until the undiscovered data emerges.

About the author

Dr. Charles J. Goodacre received his D.D.S. from Loma Linda University School of Dentistry in 1971. He completed a three year combined program in Prosthodontics and Dental Materials at Indiana University School of Dentistry and in 1974 earned his MSD degree. In 2011 he received Honorary Fellowship in the Faculty of Dentistry of the Royal College of Surgeons in Ireland and the Distinguished Service Award from the American College of Prosthodontists. He is currently Dean of Loma Linda University School of Dentistry. He is a Diplomate of the American Board of Prosthodontics, Past President of the American Board of Prosthodontics, Past-President of the American College of Prosthodontists, and Past-President of the Academy of Prosthodontists.
At the Chair

Retreatment …
or the second time around

Jonathan P. Wiens, D.D.S., M.S.D., F.A.C.P.

What brings a patient back to the prosthodontist’s chair? The return visit can have many causes…but it can also have a beneficial outcome.

From Frank Sinatra to Lady Gaga there have been more than two dozen singers who have recorded “The second time around.” Of course, that song title refers to falling in love the second time around … with your feet planted firmly on the ground. There is a similarity when dental treatment is needed the second time around, although the mood may not be as amorous. Hopefully, the retreatment is grounded with the full knowledge of what can realistically be achieved.

There is a perception that dental treatment will or should last a lifetime, revealed in our scientific literature. Despite the known timelines and reported favorable outcomes, they are not infinite and there are wide variations related to patients’ individual conditions. Some first-time treatments fail because biologically mediated processes remained uncontrolled while many others simply fail because of the lack of a proper diagnosis. Treatment that falls short of what our patient believes to be appropriate or fails to meet their esthetic, functional or comfort needs results in obvious dissatisfaction and remarkable feelings of loss. The impending psychological impact can be devastating and must be resolved first. The rapport and understanding between the patient and the doctor can be challenging.

“… the prosthodontic practitioner can envision or conceive the dynamics of the situation, illuminating both the depth of caring required and defining the proper scope and quality of treatment…”

which is simply not possible. Certainly, some treatment can last a lifetime. It may be better performed or cared for and perhaps the treatment outcome eclipses the lifespan of the patient. The frank reality is nothing will last forever. Dental procedures, including prosthodontic treatment, have a predictable lifespan that has been draining for all patients and also increases the demands upon the health care practitioner to not only retreat but to exceed what was previously achieved. Retreatment is challenging in scope and technology for both the patient and the dentist. Often strategic abutment teeth are lost or there are failing implants, infections and functional compromises – even underlying changes in patient systemic health – that require that an alternative, more elaborate approach to meet patient expectations. The formal education that includes comprehensive oral rehabilitation enables the prosthodontist to make observations from the failed treatment history, which usually provides some insight in planning future treatment choices. In the process, the prosthodontic practitioner can envision or conceive the dynamics of the situation, illuminating both the depth of caring required and defining the proper scope and quality of treatment that has little room for error.

Advanced prosthodontic specialty education addresses many of these concerns, as the fundamental knowledge learned prepares the
prosthodontic specialist to recognize the causes of failure, the various treatment options available and the attendant outcomes for each. When a correct diagnosis is made to retreat, often the patient’s expectations are met, resulting in a long-term positive and healthy outcome.

There is an adage that states, “You see … what you know.”

This observation reflects upon the learned achievements from a thorough prosthodontic education that mirrors the successful outcome of patient care. Retreatment needs of patients require a diagnosis of the cause of failure, the reestablishment of patient trust and remarkable attention to technical details, all of which define our prosthodontic specialty.

About the author

Dr. Jonathan P. Wiens received his D.D.S. from the University of Detroit. His advanced prosthodontic training and MS degree in fixed and removable prosthodontics and maxillofacial prosthetics was received at the Mayo Graduate School of Medicine. He is a diplomate and vice president of the American Board of Prosthodontics. He is a past president and fellow of the American College of Prosthodontists, the American Academy of Maxillofacial Prosthetics and the Academy of Prosthodontics, a fellow of the Greater New York Academy of Prosthodontics and a member of the Academy of Osseointegration and International College of Prosthodontists. He is a Clinical Professor at University of Detroit Mercy School of Dentistry. He also is the attending staff maxillofacial prosthodontist at Beaumont Hospital. He maintains a private practice limited to Prosthodontics in West Bloomfield, Michigan. Dr. Wiens is the recipient of the Andrew J. Ackerman Memorial Award for outstanding contributions to maxillofacial prosthetics.

Features of Retreatment

| Failed expectations and emotional loss |
| Mistrust and patient education |
| Financial burden |
| Compromised biological support |
| Technological challenges |

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Advances in prosthodontic technology have made an extraordinary level of patient care possible. In one patient’s case, a treatment failure opened the door for a dramatic transformation.

We retreat when a prosthesis has exceeded its useful life or when treatment has had a poor outcome. Rita’s treatment failure provides a brief look into the importance of managing process and leveraging technology.

Rita presented to our office in pain, depressed and defeated, one year following placement of two implants and an implant-assisted overdenture. In spite of the outcome she appreciated the effort and kindness of her general dentist who “freshened” the soft liner in the overdenture every two or three weeks making the prosthesis bearable for short periods. Dramatic improvements were required.

Clinical examination presented an atrophic mandible with two mal-positioned implants and ball attachments (Fig 1), assisting an overdenture with a framework and tissue conditioner (Fig 2).

A complete diagnosis of Rita’s problem involved imaging of the nerves in the lower jaw (Fig 3). Unfortunately for Rita, her nerves were exposed by the severe resorption of her lower jaw, allowing the denture to pinch these nerves when chewing occurred.

Rita’s Retreatment

Rita’s medical condition prevented retreatment solutions involving removal or addition of implants to support a more comfortable overdenture. Another

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solution was required. Fortunately, evolving technology permits better diagnoses as illustrated above with the CBCT imaging. Equally promising are the evolving technologies and clinical knowledge that ultimately provided the solution for Rita.

Rita’s need for comfort required an overdenture that did not rotate and ‘pinch’ her nerves. A solution was identified in parallel-sided abutments that can retain and help to stabilize the overdenture. The solution has been made practical because today’s dental laboratory technology utilizes computer aided design and manufacture (CAD/CAM). Here, the conus abutments were computer designed and manufactured to be parallel and to match the path of insertion of the denture. The frictional fit and height of the abutments provided retention and improved stability. The process soft liner allowed for resilience to avoid mechanical stress on the implants.

Two conus abutments (Atlantis Abutments, Dentsply Implants) were fabricated (Fig 4), along with a new complete lower denture with a processed soft liner (Fig 5).

Managing Rita illustrates:

- The importance of process
- The meaning of opportunity cost to a patient
- Leveraging open standards technology to improve outcomes and productivity
- Issues related to proprietary solutions and networks

The importance of process

Proper project management requires a CBCT to diagnose the existing condition, design the prosthesis, and provide the option of a surgical guide for any number of implant systems.

The meaning of opportunity cost to a patient

Your time is a resource that is not free: “it has an opportunity cost, which is the measure of value it could generate if put to productive use.” Details aside, the lost opportunity in time, productivity and outcomes stays with your patient forever. Rita’s opportunity loss has been the hope of a successful and comfortable lower prosthesis along with approximately 2 hours for every “freshening” of her soft liner.

Leverage open standards technology to improve outcomes and productivity

CBCT was critical in the diagnosis and plan for Rita. The technology could have reduced clinical and patient time by hours and could have provided a guide for a successful outcome. This is an example of how outcomes and productivity are directly related.

CAD/CAM technology elevated design and manufacturing standards by providing a cost effective, 2 degree taper abutment with perfect parallelism. The solution was not limited to a single implant system.

Issues related to proprietary solutions and networks

Proprietary file formats and networks limit our ability to acquire, store, share, and use information. Laboratory communications and file sharing for Rita’s treatment was accomplished with TransLab™ an open standards service that hosts all file formats and provides multipoint networking for individuals, groups, institutions, and dental labs.

Reference:

Harvard Reference to Business Terms.

About the author

Dr. Arnold Rosen has served as Director of Hospital Dentistry at New England Medical Center Hospital, co-founder and Director of the Dental Implant Center at Tufts University School of Dental Medicine, and founder of the Tufts Dental Implant Fellowship Program. His specialty from Boston University School of Graduate Dentistry and Sloan Kettering Memorial Cancer Institute was Prosthodontics and Maxillofacial Prosthetics and he has since added an MBA from Boston University School of Business Administration. Dr. Rosen has also worked as co-founder of the telemedicine company Global Telemedix and founder of Transcend, Inc. He has been an active consultant in the industry, setting up an implant center in Jeddah, Saudi Arabia; evaluating joint ventures in the Ukraine, Czech and Slovak republics; and designing and project managing, training and education centers.
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Our Community

Lifetime Achievement Award for ACP Past President

Nancy S. Arbree, D.D.S., F.A.C.P., M.S. received the inaugural Gustav O. Kruger Lifetime Achievement in Dentistry Award from the Georgetown University School of Dentistry at their 2012 Dental Alumni Reunion & Awards Dinner in Washington, D.C. The award is conferred upon an alumna/us of the school who has rendered outstanding and exemplary community or professional service in support of the profession of dentistry. It is named for Gustav O. Kruger, D.D.S., who was the chair of the Oral and Maxillofacial Surgery Division and director of the Hospital Dental Service from 1948 to 1982.

A Past President of the ACP, Dr. Arbree is currently a prosthodontist in private practice, a professor in the Department of Prosthodontics and Operative Dentistry and the Associate Dean of Academic Affairs at Tufts University School of Dental Medicine.

First Prosthodontist Elected CODA Chair

Kent L. Knoernschild, D.M.D., M.S., F.A.C.P. has become the first prosthodontist to be elected Chair of the Commission on Dental Accreditation. The Chair represents the Commission to the ADA, as well as the dental health care community and the public at large. The Chair also presides at all meetings of the Board of Commissioners, which reviews accreditation recommendations, makes accreditation decisions, and sets policy for the Commission.

“The Commission has broad representation from all areas of dentistry — general dentistry, advanced specialty education, dental allied and dental laboratory groups,” said Dr. Knoernschild. “I’ve gained valuable perspective from collaboration with the commissioners over the last three years, and I’m honored to have been elected by them to serve.”

The Chair is elected by all commissioners of CODA. The results of the election are forwarded to the ADA House of Delegates, who review the nomination and make final approval. Dr. Knoernschild’s term will last for one year, starting at the ADA Annual Meeting in October.

Prosthodontist Stands for the Troops

Robert C. Rawdin, D.D.S., F.A.C.P. has been appointed to the Medical Task Force of Stand For The Troops, a 501(c)(3) educational foundation dedicated to safeguarding the physical, mental and emotional well-being of America’s frontline serving and returning troops. As a prosthodontist, Dr. Rawdin provides important insight into traumatic brain injuries, which the organization considers one of the defining injuries of these conflicts.

To learn more about Stand For The Troops, visit www.SFTT.org.

ACP President Honored for Advocacy and Leadership

Lily T. Garcia, D.D.S., M.S., F.A.C.P. received the Award for Advocacy and Leadership from the Hispanic Dental Association at their 2012 Awards Luncheon in Boca Raton, Florida. Presented by the HDA Board of Trustees, the Women’s Leadership Award recognizes and honors women who have helped to advance the HDA mission, displayed exceptional character and distinguished themselves as outstanding role models in the field of dentistry through service, education, advocacy and leadership.

Dr. Garcia with Dr. Adriana Segura (left), HDA Board Member, and Dr. Lilia Larin (right), HDA President
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The mission of the American College of Prosthodontists Education Foundation is to secure and steward resources with the aim of advancing prosthodontics. The ACPEF provides funding to support education, research and advance of the specialty and discipline of prosthodontics.

In 2012, the ACPEF is addressing its mission in the following ways:

Support for Education

The ACPEF has continued funding the digital resource library, Prosthopedia®. This digital resource library serves as a critical resource for all ACP member practitioners and educators by providing educational programs, model content, and materials (digital photos, videos, presentations) critical to developing the best in educational programming from individual lectures, to courses and even entire curriculum. In addition, the ACPEF will host the meetings of pre-doctoral and post graduate prosthodontic educators during the ACP's Annual Session in Baltimore. The ACPEF continues to provide support for American Student Dental Association (ASDA) at their annual session as part of an on-going initiative to attract pre-doctoral dental students into the specialty of prosthodontics.

Support for Research

In 2012, the ACPEF has provided research scholarships, based on peer reviewed grant application mechanism, for graduate residents and faculty. We continued our support of the John J. Sharry Prosthodontics Research competition at the ACP Annual Session, and supported the Young Prosthodontic Innovator Annual Award.

Support for Advancement of the Specialty/Discipline:

The ACPEF will sponsor prosthodontic residents' attendance at the 2012 ACP Annual Scientific Session. We also supported the ACPEF Founders Society Award. This award was established in 2010 to recognize the founding members of the ACPEF Board of Directors and continues on to recognize individuals who have served the Foundation in exemplary ways. The 2012 award recipient is Dr. Tom McGarry.

Annual Appeal 2012:

The co-chairs of the 2011-12 Annual Appeal are Drs. Nadim Baba and Robert Humphries. All members are encouraged to donate to the Annual Appeal. We have secured 100% participation of both the ACPEF and ACP Board members again this year. Funds from the appeal help offset operational expenses of the Foundation.

Thank you for adding your support!

About the author

ACP Fellow Dr. David Felton, is Dean of West Virginia University’s School of Dentistry. He completed his D.D.S. and M.S. (prosthodontics) degrees at the University of North Carolina’s School of Dentistry where he later served as Chair of Graduate Prosthodontics. Dr. Felton is a Past President of the ACP and currently serves as the ACP Education Foundation Chair and Editor-in-Chief of the Journal of Prosthodontics.

ABP Expands Oral Exam Options

The American Board of Prosthodontics has expanded the oral examination options for 2013. This is due to the continuing increase in demand for the examinations and to prepare for an anticipated rapid increase in demand for 2013 and 2014 as the option to take the Section B oral exams under the old format expires at the end of 2014.

There will be an oral examination session given August 1-4, 2013 in Chicago in addition to the February and October examinations. The written Section A examination will be held at remote (Pearson) testing centers throughout the country on April 10, 2013. Candidates who have completed one or more parts of the Section B oral examinations are reminded that they must complete the examination process by the end of 2014 or forfeit the results of previous oral Section B examinations. As of the February 2015 examinations only new format Section B exams will be allowed.

Please review the Guidelines posted on the ABP website at www.abpros.org under Guidelines for Certification and Recertification for all details relative to the examination process.
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Since immediate load solutions for fully edentulous patients have become very popular in recent years, the SFI-Bar® is a great additional solution to current treatment modalities for immediately loaded implant supported overdenture. This chair side adjustable precision bar can be utilized by any average clinician on the day of implant placement. On the other hand traditionally there are two main challenges involved with precision custom made bars; a) high laboratory cost b) passive fit.

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Hamid Shafie, DDS, CAGS
Director, Postdoctoral Implant Training
Washington Hospital Center Department of Oral and Maxillofacial Surgery

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FROM THE ACP LEADERSHIP

The ACP preferred future

Your ACP Board of Directors has worked over the past three months gathering data directly from you, the members. The ACP conducted a member survey in which we received over 1300 responses...more than 1/3 of our membership and partners, exceeding all expectations! With the results from our membership survey, in addition to having a facilitated discussion, we, the members of the Board of Directors, adopted three strategic directions:

1. To improve patient care and outcomes,
2. To further the specialty of prosthodontics, and
3. To better serve our members.

This may sound straightforward, but three key directions have impact on the focus and future for the membership. This level of commitment is supported by the collective “we”, emphasizing and articulating clearly that the leadership, especially the Vice President, President-elect, and President, along with the entire Board of Directors, will focus and align College activities with our precious resources. This defines a clear strategic direction for the ACP as the ONLY organization that represents prosthodontists.

The directions set forth include increasing public awareness about the value of prosthodontics, developing a practice and evidence-based knowledge network to improve patient outcomes, and engaging other dental professionals and prosthodontic organizations in ways that benefit our patients. Using our strategic directions, Division Directors and staff conducted a critical review of the ACP core services to ensure activities and efforts are focused. The multiple steps in this comprehensive review revealed that many College activities are “core” due to the value for continued distinction as a specialty and value of membership.

By using the simple phrase “As a prosthodontist...” whenever you have the opportunity to speak on behalf of the specialty or your own practice, you are promoting a message of excellence in patient care provided by prosthodontists.”

The ACP volunteer leadership and members work diligently in their day-to-day responsibilities. By using the simple phrase “As a prosthodontist...” whenever you have the opportunity to speak on behalf of the specialty or your own practice, you are promoting a message of excellence in patient care provided by prosthodontists. As the recognized-specialty organization, the ACP raises the message of value at every national, regional and local opportunity possible to be the leader on behalf of our members.

In Memoriam

The College and Board of Directors remember the following colleagues:
Dr. Marvin Carmen (a charter member)
Dr. Robert L. Kenney
Dr. Robert B. Lytle (a charter member)
Dr. George E. Monasky
Dr. Daniel Y. Sullivan, Sr.
Transforming Lives is what prosthodontists do. At the ACP’s 42nd Annual Session, through a mix of traditional prosthodontics and contemporary ideas, our goal is to advance the specialty by giving attendees the knowledge and expertise to transform their work – and make a positive impact on the well-being of their patients.

In the last issue, we looked at the Thursday sessions: Generations of Smiles and Transformative Materials. The program continues on Friday morning with What Every Prosthodontist Needs to Know, which promises to provide a state-of-the-art update on a variety of areas in dentistry, from histologic review of bone grafting materials to implant-abutment geometry, surgical orthodontics and the relation of “micromotion” to interfacial stresses and strains.

On Friday afternoon comes Implant Complications, Compromises and Solutions, a session that includes surgical and restorative treatment sequencing concepts as well as immediate load protocols. Topics will include critical treatment planning and sequencing decisions for the clinician, new options for patients with extreme maxillary atrophy, case-based presentations on failure rates of single stage treatment methods, and more.

Please consider joining us for the ACP’s 2012 Annual Session in Baltimore. For practitioners, researchers, educators, technicians, general dentists and more, we’ve designed a program to match your passion for planning and delivering positive outcomes in patients’ lives.
Research Luminaries

Science remains the antidote

George A. Zarb, BChD, M.S., D.D.S., M.S., F.R.C.D.(C)

As both a practitioner and a professor, Dr. George Zarb has received enough honors and awards to fill an article on their own. Here, he describes some of the advances he has seen over the course of his long and distinguished career.

The traditional twin solitudes of prosthodontics – removable and fixed – plus an emerging maxillofacial sub-discipline as a third therapeutic initiative, defined US graduate prosthodontic studies in the 60s. I was then a very grateful and privileged recipient of a Fulbright Scholarship that enabled me to study with Richard Kingerey at the U of M during its extraordinary era of academic leadership; and subsequently with Carl Boucher at OSU who became the most significant influence of my academic career. Boucher’s remarkable clinical scholarship, especially in the predicament of edentulism, coupled with his open-minded and rigorous approach to recognizing the challenge that time was ‘not a healer but a destroyer’ where edentulous ridges were concerned, dramatically underscored the significance of the periodontal ligament’s contribution to alveolar bone maintenance. It also catalyzed the conviction that a dentist-induced interfacial alternative to the PL’s naturally evolved biological interface could eventually catalyze the necessary unity for the specialty’s sub-disciplines. Hence my early interest in dental implants.

My U of T appointment enabled me to acquire research and graduate student support for preliminary experiments in the cementation with polymethylmethacrylate of alloplastic tooth implants into canine mandibles. The work led to a borrowed hypothesis from John Charnley’s dramatic orthopedic patient results with hip prosthesis cementation (an inarguable revolutionary treatment with significant public health implications). Additional government funding was sought for a formal beagle dog study where healed partially edentulous posterior mandibular ridges were managed with cemented blade implants that were left out of occlusal contact and virtually unloaded via a soft diet. The proposed 3 year-long project was aborted within a shorter time frame since all of the implants were eventually surrounded by severe bone loss, plus a knee-jerk conclusion that the induced interface was inevitably vulnerable to the presence of pathogenic flora and resultant localized osteomyelitis.

Personal enlightenment came in the form of PI Brånemark’s original research report (also with beagle dogs) that provided compelling evidence that a healed interfacial response could be induced to provide an ankylotic-like outcome for commercially pure titanium tooth root analogues; and the assertion that an immobile healed interface precluded the sorts of failures commonly encountered in dental implant therapy at the time. It was a ‘eureka’ event for me as my perception of the hoped-for interfacial induction mechanism changed.

“It was a ‘eureka’ event for me as my perception of the hoped-for interfacial induction mechanism changed.”

I first visited Brånemark in the mid-seventies when he had just described his applied Osseointegration protocol in humans and demonstrated the feasibility of providing prognostically reliable replacements for tooth roots without inherent associated risks – caries or periodontal disease – in his published data from a selected Scandinavian population group. I returned to Toronto convinced that if an independent replication study were to verify Brånemark’s results, routine and safe pre-prosthetic surgery permit implant treatment for most forms of complete and partial edentulism.
In 1977, I sought and obtained Brånemark's approval to carry out an independent Canadian Provincial-government supported research grant for such a replication study on specifically maladaptive edentulous patients. Our two universities’ joint efforts culminated in the May 1982 Toronto Symposium on Tissue Integrated Prostheses when Osseointegration research and protocols were introduced to the North American continent, indeed the world of academic prosthodontists and oromaxillofacial surgeons. The leading educators in both disciplines came to observe and criticize and then stayed on to share the enthusiasm for the clinical breakthrough. The first North American courses for surgical, periodontics and prosthodontic specialists quickly followed, together with specific treatment outcome research projects in the management of anterior and posterior zones partial edentulism, missing anterior and posterior single teeth and implant supported overdentures. The world of oral rehabilitation had entered a new era of accomplishment.

In retrospect, it is tempting to assert the obvious – that science remains the antidote to clinical anarchy. Osseointegration ushered into our professional lives more than a new technique (albeit one with extraordinary potential). It also provided a yardstick of scientific rigor that has been refined and expanded in the ensuing 30 years. The bar for evaluating treatment outcomes in the context of both patient and dentist-mediated therapeutic concerns has been raised; and we are all better off for it.

About the author

Dr. George A. Zarb recently retired as Professor and Head of Prosthodontics at the Faculty of Dentistry, University of Toronto following a distinguished forty year academic career. He is the recipient of numerous awards and honors including 6 honorary doctorates, the International Association for Dental Research Award in Prosthodontics and Implant Dentistry in 1993, the Thaddeus W. Clew Honorary Fellowship from Academy of General Dentistry in 2001, the Elmer S. Best Award from the Pierre Fauchard Academy in 2005, and the Goldhaber Science Award from Harvard University in 2006. He was awarded an Honorary Fellowship from the Royal College of Dental Surgeons of England as well as Honorary Fellowship in the Royal College of Surgeons in Ireland, on the occasion of his 69th birthday. He is also the recipient of the Order of Malta and the Order of Canada - both countries' highest civilian award.

In the past 5 years he completed 2 new books: “Osseointegration: Ongoing Synergies in Prosthodontics, Surgery and Biomaterials”, for the Quintessence Publishing Company in 2009, and earlier this year, the 13th edition of “Prostodontic Treatment for Edentulous Patients”, published by Elsevier in April 2012. He continues to serve the profession as the current Editor-in-Chief of the International Journal of Prosthodontics and by organizing biennial international workshops for Young Prosthodontic Educators.

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Innovation and cooperation

Robert Gottlander, D.D.S.

When I graduated from dental school at the University of Gothenburg in 1980, the profession was at a turning point, and Sweden was an exciting place to be. Based on decades of conscientious research, Professor Per-Ingvar Brånemark was about to revolutionize restorative dentistry with the commercial introduction of osseointegrated dental implants, and I wanted to be a part of it. On September 1, 1984, I joined Nobelpharma (now Nobel Biocare) not long after the path-breaking Brånemark System launch in North America. I started working with education programs, research, product development and later on sales and marketing. I was initially based in Boston, and later in Chicago.

By the end of the decade, it became clear that the prosthetic aspects of implant dentistry were going to be decisive for the long-term acceptance of this innovative form of treatment. Good surgery remained a cornerstone of clinical success, of course, but well-designed prosthetics—from both an engineering and esthetic point of view—would convince both patients and dentists alike about the advantages of bone-anchored solutions.

Returning to my native Sweden in the early 90s, I took on overall business responsibility for Procera, the first widely accepted CAD/CAM system in dentistry. Much of its success was based on open lines of communication between our R&D and marketing staff, and dental professionals around the world. Mats Andersson, who originally developed Procera, was enthusiastic about doing much of the early testing and clinical development at Professor Brien Lang’s Center of Excellence at the University of Michigan. It was a good call. The results of this groundbreaking work were transferred in short order to clinics and dental laboratories around the globe.

Prosthodontists provided us with the impetus we needed to make progress. Feedback on what was necessary for clinical success translated, for us, into commercial success. There is a tendency in an industry like ours to be fixated on technology for its own sake. To lead in the field, we needed — and continue to need — access to unbiased clinical experience in order to choose the most appropriate initiatives to pursue. As much as I love technology, I quickly learned that the design, quality and longevity of the clinical restoration are the decisive factors for success in our business — and a key stakeholder in this process is the prosthodontist.

“\(I\) quickly learned that the design, quality and longevity of the clinical restoration are the decisive factors for success in our business — and a key stakeholder in this process is the prosthodontist.”

Business leadership today remains closely associated with innovation and close cooperation with the clinical community — and you only ignore education and information at your peril. Our experience at Henry Schein in marketing, education and product development demonstrates that informing the dental community about
innovation is as important for the future of dentistry as the inventions you bring to market.

Dental school curricula, continuing education programs, large conferences and such new online options as iTunes University all provide forums for the dissemination of essential knowledge and knowhow. Together with professional leaders such as Dr. Jonathan Ferencz and Dr. Roman Cibirka I’ve had the pleasure of engaging in all these endeavors. In almost all of these venues, visionaries lead the way, showing how new technology can best be put to use in daily practice. In the business — as well as the practice — of modern dentistry, enthusiastic restorative dentists are the gatekeepers and trendsetters we turn to, and for good reason.

At Henry Schein, where I’m responsible for Global Prosthetic Solutions, we work mainly with new technology in the field of prosthetic reconstruction. We turn to prosthodontists for approval and acceptance of almost everything we have to offer. Currently, we’re in the midst of a dialogue concerning CAD/CAM solutions, which are intensely interesting as intra-oral scanning, in-office milling, powerful (yet easy-to-use) design software and new dental materials are entering the mix of products and services that make advanced oral rehabilitation possible.

All this new technology provides us with new opportunities that will inevitably change parts of dentistry. There is so much happening now, that information overload is a legitimate concern for many, as they make choices about which technologies and techniques to adopt for the future. At Henry Schein, it is our job to deliver proven products and then listen closely to what the prosthodontist has to say. We provide the tools. The professional provides the solutions. Together we forge the techniques that ensure the long-term success of new treatment modalities, all for the benefit of the patient.

About the author

Robert Gottlander joined Henry Schein in Melville, NY, last year as Vice President, Global Prosthetic Solutions. He came to Henry Schein from Nobel Biocare AG where he had previously served as Executive Vice President of Global Marketing and Products. Throughout his career, Robert has been a pioneer in the introduction of modern dental implantology and CAD/CAM globally.
### Announcements

**Welcome New Members** (Approved by the Board of Directors during the August conference call.)

<table>
<thead>
<tr>
<th>Reinstated Members</th>
<th>Gabriel F. Sader</th>
<th>Charles W. Puryear</th>
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<tr>
<td>Dr. Victoria Chokshi</td>
<td>Alicia M. Toro</td>
<td>Nathan E. Robison</td>
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<td>Reinstated Fellow</td>
<td>Sarah A.A.M. Amin</td>
<td>Michelle Ahn</td>
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<td>Stephen M. Schmitt</td>
<td>Hussain A. Hussain</td>
<td>Jacqueline A. Clary</td>
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<td>Reinstated International Member</td>
<td>Damian L. Black</td>
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<td>Winston U. Sy</td>
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<td>Honorary Members</td>
<td>Keri P. Lincoln</td>
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<td>Dr. Baldwin W. Marchak</td>
<td>Ashley J. Reyes</td>
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<td>Dr. Joseph J. Massad</td>
<td>Fatmirka Angkasith</td>
<td>Ioannis Bitsis</td>
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<td>Dr. Cherilyn G. Sheets</td>
<td>Celin Arce</td>
<td>Nuno M. Guilherme</td>
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<td>Student Members</td>
<td>Daniel Montero</td>
<td>William R. Trevor</td>
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<td>Edward A. Palos</td>
<td>Antigoni Stylianou</td>
<td>Christopher H. Wine</td>
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<td>Paul Jones, Jr.</td>
<td>David B. Burnham</td>
<td>Ghassan Al-Ayoub</td>
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<td>Darya Luchinskaya</td>
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<td>Han W. Lyu</td>
<td>Joshua E. Perry</td>
<td>Elizabeta Cokovska</td>
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**Predoctoral Student Alliance**

Rajesh Swamidas

Anthony P. Gragg

Michael Saba

Elizabeth Kallath

Nathaniel Dancykier

Mark S. Andrawis

Jane T. Frenz

Joshua N. Prentice

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California (Sacramento) – Exceptional opportunity for enthusiastic outgoing prosthodontists to replace retired partner in multi-specialty, multi-doctor, multi-location, dental group. Associate leading to equity partnership. Contact Dr. Brock Hinton at 916-454-0855 or BHinton@prosthogroup.com.

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Missouri (Kansas City) – University of Missouri-Kansas City School of Dentistry is seeking applications for a full time, 100% FTE, benefit eligible position of Chair, Restorative Sciences (Position 00037173). The Chair provides leadership in meeting UMKC School of Dentistry’s educational, research, patient care and service missions. The Restorative Sciences Department provides classroom and clinical instruction for pre-doctoral dental students in the areas of operative dentistry, fixed and removable prosthodontics, esthetic dentistry and implants. The Chair will work collaboratively with the school’s advanced education and dental hygiene programs and other departments in a comprehensive care environment. The Chair will be expected to embrace a contemporary vision of practice and innovation, and to envision the future of dental practice.

Qualified candidates should hold a D.D.S. or D.M.D. and preference will be given to candidates with Board certification in Prosthodontics or who have completed a General Practice Residency or Advanced Education in General Dentistry certificate. Experience in educational innovation, use of technology in education and leadership is expected with preference given to those with previous leadership, teaching, and research experience. Salary and rank will be commensurate with experience. Opportunities for clinical practice may be available for the qualified candidate. Interviews of qualified candidates will begin immediately and continue until the position is filled.

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New York (New York) – Great opportunity for motivated, ethical, skilled prosthodontist to join a FFS, expanding practice in Manhattan. Part-time leading to full-time - long-term only - please email your current CV to prosthoptnens@gmail.com.

Pennsylvania (Pittsburgh) – Prosthodontic practice available for sale in East Pittsburgh, collections are $400,000. Please contact United Dental Brokers of America at bob@ubba.biz or (412) 760-7112, or visit us on the web at ubba.biz.

Tennessee (Memphis) – The Dental Implant Aesthetic Center of Memphis, TN is expanding and looking for a full time Prosthodontist with experience in implant dentistry to grow with the Center. An opportunity for an equity partnership is available. If you are interested in applying for a position at the Center, please contact our office at 901-682-5001 or email info@dentalimplantac.com. Our web page can give you additional information about our office and staff.

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