NORTH SCOTTSDALE ENDODONTICS & IMPLANTOLOGY

VOLUME 2 ISSUE 3
AUGUST/SEPTEMBER 2010

SPECIAL POINTS OF INTEREST:

- Providing minimally invasive dentistry
- Advancements in technology in the past 30 years
- Adhesives, magnification, lighting, ultrasonics, and lasers.
- Embracing new ideas and change.

INSIDE THIS ISSUE:

Endodontic Diagnosis	2
Patient Comments	2
Dr. John Stropko	2
Just Dam It, Part 2	3
Patient Comfort	3
Insurance PPO's	4
AZ Sunshine Lemon Pie	4

MINIMALLY INVASIVE DENTISTRY

Most dentists that have been doing clinical dentistry for any length of time at some point come to the realization that the less we do to alter sound tooth structure the better. There are a number of things that have transpired over the last 30 plus years that allow modern day clinicians to practice what could be termed minimally invasive dentistry. Some of these innovations include but are not limited to dental adhesives, magnification, lighting, ultrasonics, as well as lasers.

Many restorative dentists no longer adhere to the principles of cavity preparation and design as outlined by G.V. Black unless of course we are taking a board exam, placing a Class II amalgam, or even a Class II cast gold restoration. Some of these same principles of cavity preparation are used in the preparation of posterior gold restorations especially if you have been exposed to the incredible longevity of gold restorations that have adhered to the principles outlined in the Richard Tucker gold study club techniques.

Better lighting and increased magnification has allowed restorative dentists and other clinical dental specialists to keep preparations of teeth more conservative. Because dentists can see better they can treat better and with more confidence. With proper magnification a dentist can be more selective about removing tooth structure that otherwise might be removed. Certainly the strongest part of the natural tooth is the enamel. Why should we remove it if we do not have to? Arguably the best dentistry is when no dentistry needs to be done.

Ultrasonics today in combination with lighting, magnification, and properly utilized adhesive resins allow us to predictably perform a very conservative class one restoration that potentially removes a fraction of the tooth structure that we would do with a high speed bur. What is better for the tooth? Is it stronger or weaker with less natural tooth structure removed?

Lasers have been a buzzword in dentistry for a number of years. While they only comprise 9-12% of annual dental sales globally there are a plethora of procedures that can now be done with lasers in the clinical setting. These procedures include modification of both hard and soft tissues. Some of these procedures once considered controversial are now being taught in some of our dental schools. Certainly they are less invasive. Can they legitimately be considered minimally invasive dentistry?

Mark Twain said, *"Be careful not to let your schooling interfere with your education".* Technology and numerous advancements have brought us monumental changes and innovations. In this age of rapid change I suggest we need to have an open mind. Many of the things that we were taught in dental school may not be applicable today.

Some of the more significant changes that I have experienced in my years of practice have necessitated a change in my thinking. In future issues of this newsletter I will reflect on some of these changes that have resulted in paradigm shifts in how I see and do dentistry and endodontics in 2010 and beyond.

Written by

Thomas V. McClammy, DMD,MS

We welcome your comments and experience with any of the above . Sharing ideas and technology makes us all better clinicians.

Endodontic diagnosis

Proper diagnosis is essential in all phases of dentistry. We have all had cases where a recent restorative procedure is done and the patient develops pulpal sensitivity. This can be frustrating for the restorative dentist as well as the patient, especially when a fixed restoration was recently cemented. Now the patient may have to have Root Canal Therapy completed via an access opening in the new crown.

These scenarios may be avoided by performing pulpal diagnostic testing prior to beginning major restorative work. Simply doing this before any cuspal coverage restorative may lead to diagnosis of necrotic teeth prior to restoring them. Many necrotic teeth may appear to be WNL radiographically, yet the pulp is not healthy. There are also indications in the amount of pulpal calcification present. If a pulp chamber appears greatly receded or a large pulp stone is present, chances are that the pulp may not be healthy enough to maintain vitality through the restorative process. It may be beneficial to consider prophylactic endodontics prior to restorative work or have the patient consult with an endodontist to determine the likelihood of a pulpal flare-up associated with the restorative procedure. This may prevent the need for RCT through a recently placed crown. *Written by Dr. Palermo*

"The Friendships of those we serve is the foundation of our Progress"
Author unknown

What our patients say about us

How can we make your visit less stressful?

"Serve Cocktails?" *Curt Wieden*

"Not stressful both my husband & I were so happy with our treatment." *Stell Hoemke*

"Everything was well explained. There was no reason to be stressed." *Raquel Chen*

"Other than not needing to have the procedure done, nothing could have been handled better." Ed Berman

"It was perfect" Pearl Wolfe

"If this had been my first dental experience I would not be the "dentaphobic" I am." *Bette Daetsch*

"Just a few breaks(short ones). The muscles in my jaw were so sore, I couldn't stand it. Other than that, I enjoyed the friendly bantor and humor."*Christa Evernham*

"Have a TV for mental distraction"

WELCOME

We are pleased to announce that Dr. Stropko has joined our practice!

Dr. John J. Stropko received his DDS from Indiana University in 1964. After spending two years in the Air Force, he practiced Restorative Dentistry until 1987. In 1989, he received a Certificate for Endodontics from Boston University and was in private practice, limited to MicroEndodontics. As a pioneer in his specialty, he spends time teaching, writing, and lecturing about MicroEndodontics. He is an internationally recognized authority on MicroEndodontics, has been a visiting clinical instructor at the Pacific Endodontic Research Foundation (PERF), an Adjunct Assistant Professor at Boston University and an Assistant Professor of Graduate Clinical Endodontics at Loma Linda University. He has performed numerous live MicroEndodontic and MicroSurgical demonstrations, has published in numerous endodontic journals, and was recently a member of the endodontic faculty at the Scottsdale Center for Dentistry, in charge of MicroSurgery. Dr. Stropko and his wife, Barbara, will be offering their combined years of experience and expertise at North Scottsdale Endodontics & Implantology.

Just Dam It! Part II

Rubber Dam Clamp Selection

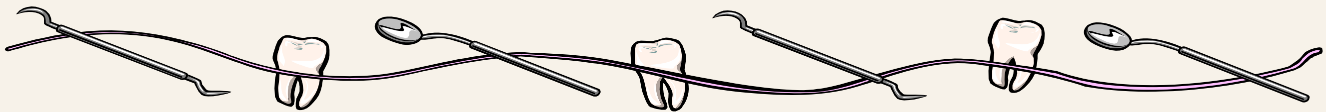
Our recent quarterly newsletter featured an article entitled *Just Dam It!*, which discussed the importance of rubber dam usage during Root Canal Therapy (RCT). To practice endodontics without the use of a rubber dam is practicing below the Standard of Care. We thought it might be helpful to share with you the types and brand of rubber dam clamps we use. Sometimes it is simply a matter of having them at your disposal and ready to go that allows you to efficiently use a rubber dam.

You and your staff will find treatment with the use of a rubber dam much more enjoyable and manageable as it serves to retract the soft tissues and give you an unimpeded view of your working field. It is possible to isolate roughly 99% of teeth with an armamentarium of only 5 clamps. In fact, probably 95% of teeth will only require the use of three different clamps. You will notice that 3rd molars are not included as they are difficult to isolate and often extraction is the best treatment option when 1st and 2nd molars are present in the same quadrant.

Clamps	12A	13A	2A	9	W8A
Teeth Isolated	UL, LR Molars	UR, LL Molars	U and L Pre-Molars	Anterior Teeth	Prepped or Broken Teeth

There are several brands to choose from and, as with all things in life, you get what you pay for. One of the best manufacturers of dental instruments and rubber dam clamps is Hu-Friedy. Hygienic and Ivory are other brands with good quality clamps. What it comes down to is your preference for vendors and a trial-and-error to see what works best in your hands.

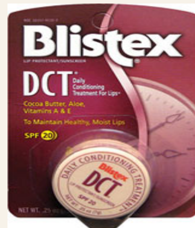
While this list is not a panacea of what is used all the time, it does cover 99% of the cases. There are times where, depending on the tooth or the status of the tooth, you may need to improvise your rubber dam isolation. If you have any questions, please don't hesitate to contact us. *Written by Dr. Palermo*



For Our patient's comfort

Dry and chapped lips can be uncomfortable and sometimes even painful! Taking into account the dry and hot weather here in Scottsdale, Arizona we at North Scottsdale Endodontics like to provide our patients with a lip moisturizer before each procedure. Not only does the hot dry weather play a part in dry lips, but using a rubber dam can also be very irritating to soft tissue. Taking the time to apply a generous amount of moisturizer can relieve chapping and cracking of the delicate skin which decreases the risk of inflammation, infection and burning. Sometimes patients may be mouth breathers or on medications which cause the lips to loose moisture. How much more comfortable they will be when provided with an application of a lip moisturizer!

Provided by Amanda



NEW TEAM MEMBER!

We would like to take this opportunity to introduce Deb, our new endodontic assistant. Deb brings to our team 20 years of dental assisting experience. With her reassuring smile and gentle chair side manner she easily puts the patients at ease during treatment.

WE'RE ON THE WEB!
NSENDODONTICS.COM

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WE SINCERELY THANK YOU FOR YOUR CONFIDENCE WHEN REFERRING YOUR PATIENTS TO OUR OFFICE!

NORTH SCOTTSDALE
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Met Life, Delta Dental, United Concordia, Cigna, Aetna PPO, Humana, Dentemax, EDS, American Dental Plan, International Teamsters, Premier Access, Principal, TDA, Guardian, Blue Cross Blue Shield of AZ
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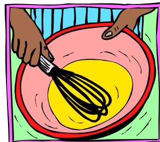
Arizona sunshine lemon pie

Here is a recipe for a lemon pie and a cute story attached to it.

"If you or your neighbors have a lemon tree, this would be a great time to pluck a nice big juicy one. If not, get to the store and look for the largest lemon in the bunch. This sensationally citrus pie is so simple that shopping for that lemon is going to be the hardest part of this recipe! The rest is easy as… , well you know! So, who doesn't love the idea that you can throw five ingredients into a blender and pour it into a pie shell and 40 minutes later you have the zestiest sweet-yet-tart lemon pie that tastes like you've worked on it for hours? I mean you don't even squeeze the juice

from the lemon. You just throw the whole lemon—peel and all—right into the blender! I mean you don't even squeeze the juice from the lemon. "



Ingredients

1 large lemon

4 eggs

1 stick (8 TBSP) melted butter

1 1/2 cups sugar

1 unbaked piecrust

Directions

Pre-heat oven to 350 degrees. Cut lemon in small chunks leaving the rind on. Remove seeds. In a blender or food processor, blend together lemon chunks, eggs, butter, vanilla and sugar until mixture is smooth and creamy. (It should be fairly runny) Pour into unbaked piecrust. Bake at 350 degrees for about 40 minutes. If the crust becomes too brown, cover gently with foil and finish baking. Serve with a dollop of fresh whip cream. ENJOY!

This recipe was brought in by a patient