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onlays, crowns, implants, cosmetics, etc. So, dentists will usually try to educate the patient by giving them enough information to make an intellectual decision about their treatment. In other words, a "Dentistry 101" type of approach.

The problem is that while you are communicating to them on an intellectual level, the patient's mind is processing this decision on an emotional level. This creates a "disconnect" in the patient's mind which often leads to the response... "I'll think about it."

Why wouldn't they want to think about it since you have been accessing the "thinking part" of their brain by trying to teach them dentistry? You don't want your patient thinking about their treatment plan; you want to get the patient feeling about their treatment plan.

So, how do we accomplish this with our patients? First of all, presenting needed dental treatment to our patients is a team event... not just the dentist's responsibility. In my practice I want the patient already wanting the dentistry they need before I even walk into the treatment room to do the exam.

My team has already pre-accessed needed treatment, connected with the patient on an emotional level, created urgency, and have moved the patient to the place where they emotionally want the treatment - as opposed to intellectually needing the treatment. Our job is to get our patients to want what they need. People will typically find a way to pay for what they want, but not necessarily for what they need.

How many times have you educated a patient about the need for a crown on their tooth, and when they get up to the front desk they don't make an appointment because they want to talk to their spouse about it first? This typically really means, "I may need it, but I don't want it."

There are several strategies we use to help our patients to the point of wanting what they need, like talking over-the-patient, hand-offs, creating urgency, maintaining urgency, treatment in stages, not presenting too much too soon, etc.

One strategy that you can do in your practice today, which will help you to connect emotionally with the patient, is to tell them what is going to happen if they don't fix the problem. After you tell the patient the treatment they need, immediately follow that by talking about how not fixing the problem is going to negatively impact their life... pain, more expense, inconvenience, more involved treatment, etc.

A really easy way for you to improve in this area is to keep things "short and sweet." Don't go into a long explanation about the problem. Just keep it to one sentence, "Mrs. Jones, your tooth on the upper right side has a big crack running through it."

Next, talk to Mrs. Jones about what is going to happen if she doesn't fix the cracked tooth... turn into a root canal... bad tooth ache... cost more to fix... need an implant... tooth split in half... etc. You may also want to talk about experiences you have had where a patient did not fix the problem and it got worse.

This is where you will want to take some time and talk for a while. Why? Because this part creates the emotional connection with the patient for the treatment they need. This also creates urgency to get this treatment done soon.

Lastly, talk about the solution. Keep this part extra short... "Your tooth needs a crown to strengthen it and keep it from breaking." That's it! Don't go into lots of details about margins, materials, crowns vs. onlays, etc., etc. Remember this part really turns you on, but not your patients. They usually just want you to fix it and spare them the details.

The reason dentists typically talk too much about how they are going to fix the problem is because this is the part they like to do, therefore the part they like to talk about. Too much detail is often boring and confusing to the patient. There is a basic sales principle: "confused minds don't buy." So, don't confuse your patients by going into lots of detail about the solution to their problem.

Getting your patients to say "yes" to the treatment they need is important for their health, and important for your practice profitability. No one wins if the patient doesn't do the treatment they need. Not the patient, not you and not your team. Everyone wins when you are able to help the patient say "yes" to the dental treatment they need.

Dr. Mike Kesner is a practicing dentist and author of Multi- MillionDollar Dental Practice. He is founder and CEO of Quantum Leap Success in Dentistry; a consulting company that help dentists build the practices of their dreams in 24 months or less... Guaranteed! Dr. Kesner speaks nationally on topics related to mastering the business of dentistry. 480-282-8989 www.QLSuccess.comdrkesner@QLSuccess.com.

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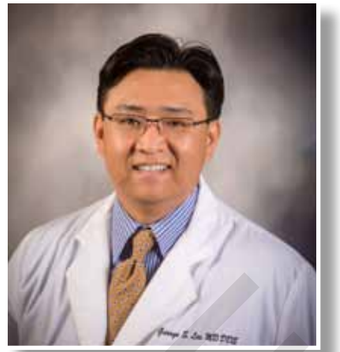

FROM THE DESK OF GEORGE S. LEE, MD, DDS:

DEDICATED DOCTOR EMERGENCY LINE:

Should you ever need to reach us for emergency care of your patients, we have a dedicated Doctor Line. This number is for our colleagues to reach us to discuss a patient care issue or refer a patient for emergency care. The number is (931) 472-9300. This line will be available during our normal business hours, 8:00am-4:30pm Monday - Friday. If Dr. DeFelice or I are not available, our nurse or office manager will relay the message to us immediately and we will respond as soon as we are available. After hours emergency assistance will continue to be via our answering service, who will promptly contact the on-call surgeon. This number is (931) 552-3292.

To keep the Doctor Line clear for emergencies only, we do ask that it not be used for staff members to schedule regular appointments or shared with patients for their personal use. All routine calls to schedule appointments, that are not emergent, will be directed to contact our primary office number for assistance. We want to keep this line dedicated to you, our valued professional colleagues.

NEED FOR CURRENT PANORAMIC X-RAYS

We are frequently asked by patients why we require a current panoramic x-rays for extraction of teeth. For evaluation of a patient for routine extraction of 3rd molars, non-emergent extraction of teeth, and extraction of teeth for placement of dentures we will accept a panoramic x-ray taken within the past 12 months that is of diagnostic quality. We are happy to review past x-rays and compare them to a current image, but x-rays that are not current or of diagnostic quality cannot be used to plan surgery.

For examination of patients with acute infections, dental pain, jaw fractures, or evaluation of a radiologic finding, we do require a panoramic x-ray taken either the day of the consultation or within 2-3 days prior. This is to allow us to adequately evaluate the surgical need of the patient.

All consultations for dental implants will require a panoramic x-ray taken by our office the day of the consultation appointment using our software that standardizes the measurements so we can appropriately evaluate the need for a bone graft and select the correct implant size.

The acceptable age of a panoramic x-ray for other conditions, such as an exposure and ligation, will be at the discretion of the surgeon based on the clinical examination of the patient.

We explain to our patients the need for current diagnostic images to correctly assess their condition and plan surgery. We use the example that they would not see an orthopedic surgeon for knee surgery and expect the surgeon to use an x-ray that is 2 years old. We hope this explanation will help you convey the importance of current radiologic images to your patients when a specialty referral is required.

THE INFLUENCE OF SMOKING ON THE SURVIVAL OF DENTAL IMPLANTS: *A 5-YEAR PRAGMATIC MULTICENTER RETROSPECTIVE COHORT STUDY OF 1727 PATIENTS**

The purpose of this study was to evaluate the influence of cigarette smoking on the survival of dental implants with a retrospective observational study of 5 years. A total of 1727 consecutively treated patients at four private practices were divided into non-smokers (NS group, 1178 patients) and smokers (S group; 549 patients) according to what they declared prior to implant placement. Non-smokers received 4460 implants and 2583 implant-supported prostheses, whereas smokers received 2260 implants and 1292 implant supported prostheses. Various implant systems and procedures were used. Outcome measures were prosthesis and implant survival.

Over the 5 years after loading, 159 (17%) non-smokers and 91 (13%) smokers were lost to follow-up; 20 (0.9%) prostheses could not be placed or failed in 15 non-smokers and 12 prostheses (1.2%) could not be placed or failed in 12 smokers. One hundred and twelve (2.9%) implants failed in 105 non-smokers and 107 (5.5%) implants failed in 75 smokers. Most of the implant failures (90%) occurred before implant loading. Examining the appropriate statistical analysis for early implant failures and total implant failures, taking into account the clustering of implants in patients, there were no statistically significant differences for prosthesis failures and early implant failures between the two groups. However, when considering all implant failures up to 5 years after loading, significantly more failures (5.5%) occurred in smokers compared with non-smokers (2.9%).

Due to the retrospective nature of this study, conclusions have to be interpreted with caution. Five years after loading, smokers experienced almost twice as many implant failures compared with non-smokers. Non-statistically significant trends in favor of non-smokers were observed for early implant failures and prosthesis failures.

** Cavalcanti R, Oreglia F, et al. Eur J Oral Implantol. 2013 Spring;4 (1):39-45*

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Pat's Pointers on Ultrasonics

by Patricia A. Worcester, RDH, BS[2]

In order to maximize the use of ultrasonic tips, you first need the ultrasonic gauge which is made by both Dentsply and Hu-Friedy. These devices check for wear and tip efficiency. With only a small amount of tip wear, your ultrasonic tip can easily have 50% power loss. With improper power, you will burnish the calculus instead of remove the calculus. Burnished calculus is very difficult to remove and can fool you because it will feel smooth. But since the calculus has not been removed, it acts as a reservoir to hold biofilm and rebuild calculus immediately.

Crystyline calculus protects the biofilm and acts as a foreign body for additional biofilm formation, so all calculus must be removed before the biofilm can be controlled. The biofilm causes inflammation and the long junctional epithelium will not attach resulting in the pocket not being reduced. In grooves and cracks of only a few micrometers, the first traces of bacterial re-colonization are visible less than 24 hours after biofilm removal, while the surrounding "smooth" surfaces reveal only sporadic, single-adhered bacteria. If you find you are not achieving pocket reduction and your patients are bleeding, there is planed or burnished calculus present holding the biofilm in place, thus, preventing healing.

Secondly, proper tip selection is crucial for successful calculus and biofilm removal. For heavy calculus, the Hu-Friedy 1000 Triple Bend or Dentsply THINsert on medium to high power setting should be used. For moderate and light calculus the Hu-Friedy #10 Universal or #100 Thin tip, or Dentsply FSI SLI-10 should be used on medium power setting. For smoothing root irregularities, biofilm removal, smear layer removal, pellicle removal, root debridement and sulcular decontamination the Hu-Friedy straight, right and left, slim line after 5, ultrasonic tips, or Dentsply FSI straight, right and left slim line tips should be used on low power setting.

Thirdly, I personally prefer the magno-restrictive ultrasonic tips because you can utilize all sides of the tip where as the piezo you can only use the lateral sides. When I was invited to Dentsply International, the engineers explained how the magno-restrictive tips will kill anaerobic bacteria 2mms past the tip. In deep pockets and fucation involvement, it is crucial to have this extra 2mm of anerobic bacterial decontamination. The piezo will not do this and if you are performing a lot of non-surgical periodontal therapy, you need to kill all the bacteria to achieve healing and re-attachment.

Lastly, do not use the ultrasonic tip because the tip has the most power and can gouge the cementum, especially softer infected cementum. When I teach my hands-on program, I often see hygienists unknowingly gouge the roots with the tip of the ultrasonic. This unintentional act will permanently damage the root surface. A gouge will also collect even more biofilm and calculus and prevent any long junctional epithelial reattachment and therefore, no pocket reduction. You can use the tip on supragingival heavy calculus as long as you are only using the tip on the calculus. But it is still easy while removing the calculus to inadvertently gouge the root. In periodontally diseased patients, the root surfaces are infected by pathogens that can soften the centum. Technique is most important to remove the diseased cementum and not cause damage by over instrumentation.

So if you notice your patients are not healing, look for burnished calculus and gouged root surfaces. When properly used, the ultrasonic is a wonderful piece of equipment that makes our jobs easier and our patients healthier. According to Dr. Sam Low and other experts, we should be using ultrasonics 75% of the time to remove the biofilm so that our patients heal quickly and completely.

Pat is an international speaker, published author, practiced full-time hygiene for over three decades, and is a trainer to dental practices across the United States, Canada and the United Kingdom. She is an Instrument and Product Analyst for DENTSPL Y International, and Thought Leader for Hu-Friedy Dental Instruments. Pat is founder and clinical director of Mission Possible... Best Hygiene seminars and clinical hands-on training programs. Combining working on your patients, your team and your practice for RESULTS! Healthy Patients = Healthy Profits. You may contact Pat at 954-536-0700 or patworcester@comcast.net, www.missionpossiblehygiene.com.

Case Presentation That Leads To

by Dr. Mike Kesner[1]

Have you ever worked up a comprehensive treatment plan for a patient only to have them say..."I'll think about it."? Of course you have. And how often have you taken the time to thoroughly explain the desperately needed treatment only to have the patient say, "I can only do what my insurance pays for," or "But Doc, nothing hurts," or to just simply recoil in "sticker shock" and run from your office, never to return?

Getting your patients to say "yes" to needed treatment should be a successful, systematic and non-stressful event for you, your team and your patient. You can easily make this happen every day, even in today's economy, once you and your team understand how patients make decisions regarding their treatment.

We have been taught in dental school and in CE courses that the key to case acceptance is patient education. In other words, give the patient enough information so they will be able to make an intelligent decision about their dental treatment. The only problem is that this approach kills case acceptance! It simply doesn't work.

Now, before you start throwing rocks... hear me out. I am not saying that we should withhold necessary information from the patient. And I am not saying that there is never a place for education. What I am saying is, if you want your case acceptance to go up, you must learn to present treatment to your patients in a way that appeals to their emotions instead of their intellect.

We find that most dentists have a case acceptance rate around 20-30%. This means that around 7 out of 10 new patients don't follow through and do their recommended dental treatment. What if you could increase your case acceptance rate to 60-70%? This would mean that your revenue essentially doubles with the same number of new patients!

So how do we present treatment to a patient that impacts them on an emotional level?

First, you must realize that a patient's decision to do dental treatment is an emotional decision, NOT an intellectual decision. In fact, most buying decisions are emotional. Dentists, on the other hand, usually present treatment to patients from an educational and analytical perspective. This is the way that we naturally think, and therefore communicate to our patients.
When we look into a patient's mouth and at their radiographs, we are analytically processing a lot of information to come up with the diagnosis and treatment plan. We are thinking about occlusion, vertical dimension, perio, endo, ortho,