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From Trisha's Desk

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Creating Your Personal Oral Health Directive

by Trisha E. O'Hehir, RDH, MS, Hygienetown Editorial Director

No one wants to think about it, but you could end up in a nursing home one day due to either an accident or complex medical issues requiring others to care for you. Lawyers urge people to have a signed advanced health-care directive, consisting of two forms. One is a living will, specifying what health-care actions be taken if through illness or injury you become unable to make those decisions yourself. The other form is a power of attorney or health-care proxy specifying who will make your health-care decisions if you can't.

Missing from these directives is a specific oral health-care directive. In the five wishes document, a comprehensive living will from the Aging with Dignity Organization, oral health falls under general grooming, not health. But since oral health is so important and needs to be addressed every day through both oral hygiene and diet, a specific oral health directive should be in place as well. What specific directions would you like caregivers to follow to maintain your oral health? Or, as some Townies on Dentaltown suggested for nursing home patients, would you opt for full-mouth extractions? They weren't suggesting it for themselves, but did for nursing home residents. What if one day you become a nursing home resident? Do you think those Townies would still want full-mouth extractions for themselves?

In 1993, this became a reality for Irene Woodall, RDH, PhD, a leader and visionary in the dental hygiene profession. While skiing in Colorado she suffered an aneurysm. With speedy medical care, she was rushed to the hospital and underwent brain surgery that prevented a more intense stroke that would have taken her life. Instead, she suffered severe brain damage taking away her short-term memory and severely affecting her cognitive and physical abilities. Irene is now confined to a wheelchair and requires care around the clock.

In the midst of all the medical care needed to deal with the stroke and rehabilitation, her dental care was overlooked. Her daughters are overseeing her care at a long-term care facility in the Chicago area and were shocked to find that their mother, a consummate dental hygienist, now has severe dental disease! To cover the extensive dental costs ahead, they created the Irene R. Woodall Special Needs Trust from which donations will be used for Irene's oral health-care needs.

Had Irene had an oral health-care directive in place when she suffered the stroke and subsequently was moved to a long-term care facility, her oral health and diet would have been addressed the way she wanted, not overlooked because of other issues. Oral health will impact general health, so it shouldn't be overlooked in any situation.

What would you want done for your oral health on a daily basis if you suffered a stroke and were confined to wheelchair and unable to perform your own oral hygiene? I know what I would want – five exposures to xylitol every day, MI Paste morning and evening, twice-daily brushing with the 30 Second Smile toothbrush using baking soda to keep the pH of my saliva up, tongue scraping, interdental cleaning with either the Sunstar Soft Picks or flossing with water. I'd also specify the diet I want.

Write out your own oral health directive today just in case something unforeseen happens one day and write your directive with the hope that it will never be needed. n

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Perio Reports Vol. 23 No. 10

Perio Reports provides easy-to-read research summaries on topics of specific interest to clinicians.

Perio Reports research summaries will be included in each issue to keep you on the cutting edge of dental hygiene science.

Perio Pathogen Linked to Brain Abscess

Periodontitis is a bacterial infection that contributes to the overall inflammatory burden on the body. Periodontal pathogens are linked with several systemic diseases, including infectious bowel diseases, atherosclerosis, coronary heart diseases, stroke, diabetes and rheumatoid arthritis. *Aggregatibacter actinomycetemcomitans* (*Aa*) is a major periodontal pathogen, found most often in association with endocarditis.

A man, age 42, with a history of heavy smoking and alcohol abuse was admitted to a hospital in Leeuwarden, the Netherlands, complaining of confusion and reduced consciousness over the previous three days. Lab tests revealed an elevated white blood cell count and a moderately elevated C-reactive protein level. His oral health was poor. A CT scan of the brain revealed four lesions. No other lesions were found elsewhere in the body.

The patient was treated with dexamethasone and a follow-up CT scan showed no changes. Biopsy confirmed inflammation and abscess formation. *Aa* was the primary microorganism detected. IV antibiotics were begun. Nine days later, the patient's condition worsened, yet a new CT scan showed no change in the abscesses. It was decided to drain the abscesses and an oral surgeon extracted five teeth with advanced periodontitis. Antibiotics were continued for six weeks. At one year follow-up, he was doing fine.

Several other published case reports confirm the presence of *Aa* in a variety of infections in non-oral areas of the body.

Clinical Implications: Poor oral health can impact more than the teeth and gingiva, when oral pathogens travel to other parts of the body. Good oral health is necessary for good general health.

Rahamat-Langendoen, J., van Vonderen, M., Engström, L., Manson, W., van Winkelhoff, A., Mooi-Kokenberg, E.: Brain Abscess Associated with Aggregatibacter Actinomycetemcomitans: Case Report and Review of Literature. J Clin Perio 38: 702-706, 2011. n

Saving Questionable and Hopeless Teeth

The primary goals of periodontal therapy are to stop disease progression and save teeth. Treatment planning aggressive and chronic periodontal cases includes identifying teeth that are questionable or hopeless. Researchers have shown that with healthy gingiva (no gingivitis) the tooth survival rate is 99.5 percent. In the presence of gingivitis (gingival index score of 3) survival rate drops to 63.4 percent.

Researchers at the University of Greifswald in Greifswald, Germany, looked back at dental school charts for periodontal patients who had been treated and monitored with supportive periodontal therapy (SPT) for 15 years. Those who showed signs of bone loss (on at least two teeth) before age 34 were diagnosed with aggressive periodontitis (AgP). Those with bone loss (on at least two teeth) appearing after age 40 were diagnosed with chronic periodontitis (CP). Each group had 34 patients. Periodontal therapy consisted of scaling and root planing and in some cases, access flaps were needed to reach all subgingival deposits. Antibiotics were used only rarely. SPT intervals were individualized for each patient ranging from three to 12 months.

Teeth considered hopeless were those with 50 to 70 percent bone loss. Hopeless teeth were those with more than 70 percent bone loss. In the AgP group there were 262 questionable teeth and 63 hopeless teeth. After 15 years, 88 percent of questionable teeth and 60 percent of hopeless teeth survived. Tooth survival rates were similar for both the AgP and CP groups.

Clinical Implications: Many questionable and hopeless teeth can be saved with effective supportive periodontal therapy and good patient compliance.

Graetz, C., Dörfer, C., Kahl, M., Kocher, T., El-Sayed, K., Wiebe, J., Gomer, K., Rühling, A.: Retention of Questionable and Hopeless Teeth in Compliant Patients Treated for Aggressive Periodontitis. J Clin Perio 38: 707-714, 2011. n

Obesity and Dental Caries in Adolescents, No Direct Link

Dental caries and childhood obesity are growing problems worldwide. Changes in diet and lifestyle are impacting the health and nutritional status of many populations. Decreased fruit and vegetable consumption, decreased physical activity and increased snacking on highly processed foods contribute to these declining health levels globally.

Researchers at the University of Copenhagen in Copenhagen, Denmark wanted to know if there was a link between dental caries and childhood obesity or if there were lifestyle factors shared by both. The researchers evaluated 385 adolescents from eight municipalities in Denmark. The teens were all 15 years of age. Dental records were available and written questionnaires were mailed to the teens and their parents. The questionnaires provided basic demographic data and information on eating breakfast, daily fruit consumption, physical activity, smoking and alcohol consumption. BMI was calculated for each student from weight and height measurements.

There was no direct correlation between obesity and den-

tal caries in this group. Sixteen percent of the group was classified as obese and 62 percent of the group had no decayed, missing or filled teeth (DMFT). The average DMFT for the group was two. However, those who had no decay reported more healthful habits: eating breakfast, eating fruit, exercising and no smoking or drinking. Teenagers who did not eat breakfast were more likely to smoke and drink alcohol.

Bad habits begun as children are likely to follow these teenagers into adulthood, leading to more significant health problems. More must be done to address both obesity and dental caries earlier.

Clinical Implications: Dentists and physicians should work together to manage both obesity and dental caries.

Cinar, A., Christensen, L., Hede, B.: Clustering of Obesity and Dental Caries with Lifestyle Factors Among Danish Adolescents. Oral Health Prev Dent 9: 123-130, 2011. n

Toothbrush Age and Plaque Removal

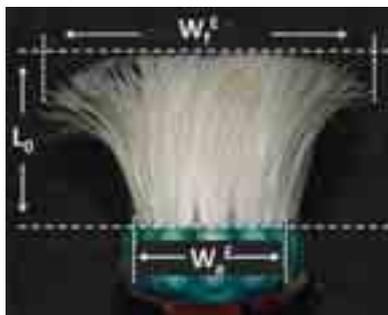
Many studies are published measuring plaque removal effects of both manual and power toothbrushes, but few are published on the impact of toothbrush wear on plaque removal. One reason might be the lack of a standard way to measure toothbrush wear. Toothbrush wear varies considerably between people and many use their toothbrushes for much longer than the recommended three months.

Researchers at Ponta Grossa State University in Brazil devised a method to determine toothbrush wear by measuring bristle splay from the brush head. They were able to categorize toothbrush wear into three categories: low, moderate and high wear. A total of 110 undergraduate, non-dental students were recruited from the university for this four-month study. Subjects were randomly assigned to one of four groups, having plaque and toothbrush wear measured at four weeks, eight weeks, 12 weeks and 16 weeks.

The students were all given a new manual toothbrush, plastic toothbrush cover, Colgate toothpaste and instructed to brush

and floss three times daily. Baseline plaque and gingivitis scores were recorded. Subjects returned at their assigned time.

No statistical difference in gingivitis scores was measured at any time point. There was more gingivitis on lingual surfaces than on facial surfaces. Plaque scores remained similar throughout the study, with more plaque found on lingual surfaces than on facial surfaces. Toothbrush wear increased over the 16-week study, but this wear didn't impact plaque or gingivitis scores.



Clinical Implications: Toothbrush age or wear might not be an important factor in effectively removing plaque. The toothbrushing method used and the time spent on lingual surfaces might be more important.

Pochapski, M., Canever, T., Wambier, D., Pilatti, G., Santos, F.: The Influence of Toothbrush Age on Plaque Control and Gingivitis. Oral Health Prev Dent 9:167-175, 2011. n

continued on page 4

Triple-headed Toothbrush

Children under the age of 10 usually need their parent's help to effectively brush their teeth. Children do not effectively remove bacterial biofilm due to lack of motivation and poor manual dexterity.

A triple-headed, manual toothbrush is available from DenTrust in Newport, Rhode Island and is designed to clean facial, lingual and occlusal surfaces with one motion. This design does not rely on manual dexterity to effectively reach all surfaces.

Researchers at the University of Sao Paulo in Brazil compared the triple-headed toothbrush to a conventional manual toothbrush. They asked two questions. First, was the new brush better at plaque removal and second, did it matter if the mother or the dentist did the toothbrushing. Four-year-old children were selected from two kindergarten classes for the study.

In this cross-over study, each child received toothbrushing with both brushes at different visits, one week apart. Disclosing solution was used to measure plaque scores both before and after brushing with the assigned toothbrush. The mothers and the dentist were instructed in the use of both toothbrushes and they practiced on a typodont until proficient.

The mothers were more efficient in removing plaque with the triple-headed toothbrush than with the conventional toothbrush. The dentist was more efficient with the manual brush than with the triple-headed toothbrush. Overall, the dentist removed 76 percent of plaque compared to 53 percent removed by the mothers.

Clinical Implications: The triple-headed toothbrush might be an option for parents who are not effectively removing all plaque from their children's teeth with a conventional brush.

Oliveira, L., Zardetto, C., Rocha, R., Rodrigues, C., Wanderly, M.: Effectiveness of Triple-Headed Toothbrushes and the Influence of the Person who Performs the Toothbrushing on Biofilm Removal. Oral Health Prev Dent 9: 137-141, 2011. n



Soft vs. Medium Toothbrushes

Researchers at Franciscan University in Santa Maria, Brazil wanted to know the difference between medium and soft toothbrushes for plaque removal and soft-tissue abrasion. A total of 25 undergraduate students participated in the study, all free of gingivitis. At baseline, the students were asked to refrain from all oral hygiene for 96 hours, to allow plaque to accumulate. Using disclosing solution, plaque scores for all facial surfaces were measured except central incisors and third molars.

For the experiment, students were randomly assigned to brush two contra-lateral quadrants with the medium brush and the other two quadrants with the soft toothbrush. This way, both right and left sides of the mouth were brushed with both the soft and medium brushes. The lower quadrants were brushed with Colgate Triple Action toothpaste and the upper quadrants were brushed without toothpaste. Upper quadrants were brushed first, before lower quadrants. Each quadrant was brushed for 30 seconds.

Both medium and soft toothbrushes removed significant amounts of plaque. There was no difference in plaque removal between brushing with or without toothpaste for the soft toothbrush. The medium toothbrush with toothpaste removed more plaque than without toothpaste. Both brushes removed more plaque from facial surfaces than from proximal surfaces. The medium toothbrush removed more plaque than the soft toothbrush in the premolar area. Both brushes removed more plaque in premolar areas than molar or anterior areas.

The medium toothbrush caused more cervical abrasions than the soft toothbrush and the medium toothbrush with toothpaste resulted in more tissue abrasion than without toothpaste.

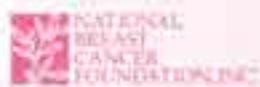
Clinical Implications: Soft toothbrushes with or without toothpaste should be recommended.

Zanatta, F., Bergoli, A., Werle, S., Antoniazzi, R.: Biofilm Removal and Gingival Abrasion with Medium and Soft Toothbrushes. Oral Health Prev Dent 9: 177-183, 2011. n



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Tongue Stud Damage - A Case Study

Oral piercings are becoming more common and so are the problems they create. Remind patients of the dangers of oral piercings.

periopeak

Posted: 7/16/2011

Post: 1 of 49



This female patient in her early 50s had a tongue stud for 10 years. Check out the damage it caused.

Class I mobility on 24 and 25, both are non-vital. Her periodontist recommended extraction of 24 and 25. Notice lack of attached gingiva. Endo was performed, then regenerative periodontal endoscopy (RPE) the same day with Emdogain. Limiting factor here will be the attached gingiva on the lingual. Buccal is all WNL with beautiful tissues.



Patient was prescribed metronidazole 500mg BID for eight days. DNA test revealed high level of *T. denticola*. She is PST negative, smokes half a pack daily and eats very well. Periogain was recommended, two caps twice daily for host modulated therapy. Do you think she has a chance of keeping these teeth? ■

lindadouglas

Posted: 7/16/2011

Post: 2 of 49



Judging by those periapical lesions I would have said the prognosis was hopeless, especially because she is a smoker, but I have seen your work before, so I would love to see the outcome after you work on this patient. I usually see tongue piercings on the young and foolish, but not on the middle-aged! I once read about someone who got a brain abscess after a tongue piercing. ■

JERSEY DEVIL

Posted: 7/17/2011

Post: 6 of 49



Unbelievable the damage she was doing and didn't even know it! ■

JGonzalesRDH

Posted: 7/17/2011

Post: 7 of 49



Absolutely savable! Expensive, but she could have these teeth for another 10 years I bet. If mobility remains after RPE, what are they considering for restorative options? Did they take #24/25 out of occlusion? Would be interesting to see a full arch photo as well if you have one... doesn't look like she has a lot of incisal wear, which is good. Great case study! Thanks for sharing. ■

Just for your general information, when considering treating this area with a CT graft I am mostly looking for the following:

drtoast
 Posted: 8/3/2011
 Post: 43 of 49

Is there adequate depth to the floor of the mouth? Does the remaining gingiva have some thickness to it so when I reflect it back I won't wind up perforating through the tissue? (When this happens, you are in really bad shape, and you have now most likely made things worse than they were before.) Will the patient's tongue allow me adequate access to do the surgery? And lastly, am I dealing with a highly compliant patient?

I know that recession on the lingual aspect of lower anterior teeth is an extremely prevalent problem, and many of these patients would benefit significantly if they could have soft tissue augmentation procedures. I am definitely very careful and cautious when I decide to treat one of these problems. I think a very appropriate area to treat is when a patient has only his lower six anterior teeth present and there is significant recession on the lingual of a canine, which happens so often as the lingual bar of the partial has settled. This can be a very nice service to a patient, helping her so she doesn't lose either the canine or worse still, the lower partial. (I am still a big believer in trying to preserve our own natural teeth where possible.) ■



periopeak
 Posted: 8/4/2011
 Post: 44 of 49

Here are some three-week post-op photos; nice tight tissue. ■



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Townies Doing Research

by Trisha E. O'Hehir, RDH, MS

Do you ever feel like a detective searching for the answers to clinical mysteries? Why can't patients effectively brush their teeth? Why don't pockets heal after they've been treated? If only you were a clinical researcher, you could answer those questions and solve those mysteries! As an active Townie, you can now become a Townie Researcher and participate in clinical research, gathering data to answer those questions.

Hygienetown and Dentaltown now offer Townies the opportunity to test new products in their own clinical practices. These are not randomized, controlled clinical trials. There is no calibration between clinicians. Extensive data collection is not needed. On the other hand, these studies are not simply product evaluations. These are real-life pilot studies to determine just how new products work in the hands of regular clinicians with regular patients. These studies bridge the gap between randomized, blinded, controlled, clinical trials and personal experience.

Top Townies, those who are active on the site, are invited to participate in the studies. If a particular project fits their schedule and their interest, they agree. Dentist and dental hygienist teams are invited to participate. The two most recent projects were directed toward hygienists, but since they work in practices owned by dentists, the dentist was informed about the study and agreed to the project as outlined.

The goal of Townie Research projects is to add something new to clinical practice that interests both patients and clinicians. Patients are impressed that their dentist/dental hygienists are researchers and they are excited to be part of studies testing new products that are already on the market. Data collection involves the usual clinical and photographic data already being collected in practice today. We want to know how these products work if you simply buy them and start using them. The indices used are plaque scores, probing depths and bleeding upon probing. Our

goal is not to add time to already busy appointments, but to make gathering the data useful in measuring the effectiveness of a new product.

Townie Researchers receive a copy of the complete research protocol explaining what the product is, what the research question to be answered is and step-by-step instructions on how to gather data, instruct or treat the patient and what follow-up data is needed. Test products are sent directly to the practice from the manufacturer. Telephone conference calls with the researchers on a particular project help answer questions, revise the protocol if we find an easier way to treat the patients and give the Townie Researchers an opportunity to compare notes with each other.

Reports from the latest two research projects are presented here. The Townie Researchers who participated enjoyed the experience and provided valuable information on the products they tested. Join them on the Townie Research message board to find out more about the studies and about becoming a Townie Researcher yourself!

Effects of the 30 Second Smile Power Toothbrush on Plaque Removal

A Clinical Practice Study

People brush an average of 38 seconds and brush in an erratic pattern that doesn't allow for equal brushing throughout the mouth. To overcome those difficulties, the 30 Second Smile power toothbrush was designed by Hydrabrush, Inc., located in Escondido, California, with a unique brush head that contacts maxillary, mandibular, facial, lingual and occlusal surfaces at one time, simply by biting into the brush and moving it gently around the arch. The 30 seconds that people now brush will reach all tooth surfaces equally.

Townie Researchers selected patients in their practices who showed high plaque levels despite repeated instructions in oral hygiene. Townie Researchers provided the 30 Second Smile power toothbrush to a total of 12 patients. Data collection included baseline plaque scores and intra-oral photographs. Plaque scores were repeated approximately two weeks later, and in some cases further follow-up visits were scheduled. Both children and adults were included in the study.

Before and after photos of the study reveal high baseline plaque levels. After using the 30 Second Smile toothbrush for two weeks, plaque levels were reduced. Plaque scores dropped from 58 percent to 25 percent (patient 1).

Patient 2 began with a plaque score of 82 percent and returned two weeks later with a 21 percent plaque score.

A null hypothesis was proposed for this study stating that no changes in plaque scores would be seen with the use of the 30 Second Smile toothbrush compared to previous brushing. Results demonstrated that a majority of patients in this study showed lower plaque scores after two weeks or more of using the new brush. Some showed no difference and none showed increased plaque scores using the 30 Second Smile toothbrush. Thus, the null hypothesis was disproved in this study.

Based on these findings, the 30 Second Smile power toothbrush provides better plaque removal when used instead of a manual toothbrush for

Patient 1: Before: 58 percent



Patient 1: After: 25 percent

Patient 2: Before: 82 percent



Patient 2: After: 21 percent

continued on page 10

These are real-life pilot studies to determine just how new products work in the hands of regular clinicians with regular patients. These studies bridge the gap between randomized, blinded, controlled, clinical trials and personal experience.

those who are ineffective with daily plaque removal. For patients who are not effectively removing plaque with a manual or power toothbrush, the 30 Second Smile brush promises to provide an effective alternative. The unique design and ability to reach all areas without depending on the manual dexterity of the user makes the 30 Second Smile ideal for those who need a new way to effectively clean their teeth.

A Clinical Practice Observation of the Effects of HybenX

Instrumentation on Non-Responding Periodontal Sites by Dental Hygienists in the European Union

Non-responding areas are common after completion of non-surgical periodontal therapy, due to remaining bacterial biofilm. These areas continue to show signs of disease with probing depths of 5mm or greater and bleeding upon probing. Bacterial biofilm is attached to root surfaces, floating within subgingival pockets and found within root surface calculus deposits. This subgingival bacterial biofilm can be disrupted with mechanical action or chemical desiccation causing the biofilm matrix to denature, precipitate and coagulate. This detaches the biofilm and allows it to be rinsed away.

HybenX Plaque Biofilm Remover is a concentrated sulfate solution that causes desiccation by absorbing water, making it an effective solution for breaking down bacterial biofilm. It is both selective and self-limiting, making it a safe plaque removal agent for subgingival areas. HybenX is made by Epien Medical in St. Paul, Minnesota, makers of Debacterol. HybenX is not yet available in the U.S., but is available in many countries outside the United States.

HybenX solution comes in pre-filled syringes for subgingival delivery prior to instrumentation. The HybenX will desiccate the bacterial biofilm and allow for effective subgingival calculus removal, resulting in reduced bleeding and reduced probing depths.

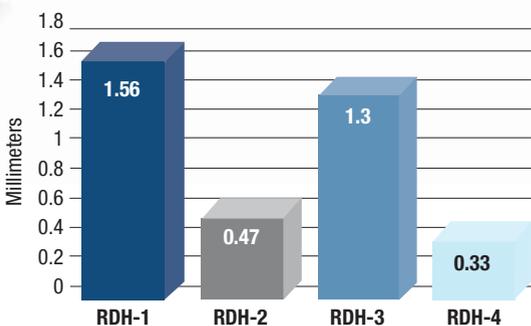
Four Townie Researchers were recruited, each active international Hygienetown members, from England (2), Scotland (1) and Italy (1). All Townie Researchers received a copy of the research protocol and the HybenX product. Each hygienist agreed to treat five patients with subgingival instrumentation plus the application of HybenX.

Data collection included baseline probing depths and bleeding scores on areas that did not respond to previous instrumentation (see chart).

Probing depth reductions were seen in 10 of the 13 patients treated. Three patients showed no reduction in probing depth after treatment. Comparing Townie Researchers, the mean probing depth reductions were 1.56mm for RDH-1, 0.4mm for RDH-2, 1.3mm for RDH-3 and 0.33mm for RDH-4. The overall mean reduction was 0.92mm.

Based on these preliminary findings, the use of HybenX in combination with subgingival instrumentation in sites that did not respond to initial scaling and root planing provided a benefit. Findings thus disproved the null hypothesis that no changes in probing depths and bleeding would be seen. Future studies will need to compare sites treated with instrumentation alone and sites treated with both instrumentation and HybenX to determine the impact of HybenX Plaque Biofilm Remover. □

Mean Pocket Depth Reduction





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FACING OUR FEARS

by Kathy L. Beard, RDH, BSDH

We are all aware of the common adage that *experience is the best teacher*. I would qualify this motto by adding... *if we use that experience for good.*

Communication is one of the most powerful instruments we utilize within our armamentarium. Words and their inflection, as well as actions can encompass both positive and negative consequences. We must ask ourselves, how are we being received? The answer to this question is somewhat contingent on whom might be the recipient of our dealings. What cannot be contested is that everyone needs care and understanding.

We all lead complicated lives and it is wise to remember this consideration while communicating with fellow staff members, other professionals and our patients. These principles have been profoundly illustrated to me during my personal struggle with obsessive compulsive disorder (OCD), and by the examples set by those caregivers who have encouraged me to face both my professional and personal fears. If it were not for the joint efforts of my physician, psychiatrist and clinical psychologist, I would not be where I am today. Everyone should have such personal care! I am also grateful for the skill and teamwork which I encountered at the Anxiety & Stress Reduction Center of Seattle (ASRC).¹

My primary objective in sharing this struggle is to provide hope for those who are openly or silently suffering with OCD, an anxiety disorder affecting 2.2 million Americans of both genders at the same rate.² OCD frequently becomes apparent during the teen and young adult years, and typically progresses slowly.³ In retrospect, I can see where this was true in my life as well, but it was not until 2006, that I began noticing my life spinning out of control after an emotional encounter. I was placed on Zoloft by my physician, but found it did not agree with me. I began seeing a social worker/counselor from May 2006 to October 2007. By May 2008, I realized that I could not continue in clinical hygiene. I was experiencing severe obsessions and compulsions which became very apparent to my employer as well as my fellow employees. I was the first person in the office in the morning, and the last one to leave at night, often returning home after 10 p.m. or so. I was fearful I would make a mistake and inadvertently hurt a patient somehow. I would continually question whether the operatory was clean enough, and wonder if I cleaned the tray of instruments properly. Were my chart notes understandable? Did they clearly represent the treatment I had rendered? When I would return home, I would shower for one to two hours, often using a full bar of soap each shower session.

These worries spilled over into my personal, everyday activities as well. I could no longer cook meals, and it became extremely difficult to touch our dirty laundry.

These illustrations introduce examples of the most frequent varieties of OCD. The debilitating trepidation that someone might be harmed by carelessness combined with the “rituals” performed trying to ease those fears for one, and “checking” items over and over again being another. The *obsessive* portion of OCD fears the worst, while the *compulsive* measures temporarily relieve those fears.⁴

As I saw my clinical future slipping, I tried to find other avenues to stay in the career I loved. I became founder/president of Premiere Hygiene Study Club from 2008-2009. I also earned my Bachelor of Science degree in Dental Hygiene from Eastern Washington University’s Dental Hygiene Degree Completion Program at Pierce College in 2009. Thankfully, there was no clinical component to this schooling.

In May 2010, I began the process of healing. I was referred to a psychiatrist who placed me on Prozac. I was referred to a clinical psychologist from the Anxiety & Stress Reduction Center of Seattle (ASRC). I was impressed by their confidence in evidence-based treatment:

“Both evidence-based medicine (EBM) and evidence-based practice (EBP) assert that making clinical decisions based on best evidence, either from the research literature or clinical expertise, improves quality of care and quality of life. EBP is unique because it includes the preferences and values of the client and family in the process.”⁵

My psychologist employed a method known as cognitive behavioral therapy (CBT), which assists individuals in recognizing actions which need to be modified.⁶ An example of this method used in my case is known as exposure and response prevention.³ “The following statements illustrate this principle...

1. You cannot always control your thoughts.
2. You cannot always control your feelings.
3. But you can always control your behavior.
4. As you change your behavior, your thoughts and feelings will also change.”⁴

Also, two books were recommended to me and gave me comfort as I went through the “recovery” process. They were *Getting Control: Overcoming Your Obsessions and Compulsions* by L. Baer⁴ and *Stop Obsessing! How to Overcome Your Obsessions and Compulsions* by E.B. Foa.⁷

In less than three months, and in approximately 13 sessions, I was done with treatment. I will always have to contend

with OCD, and take medication, but it will never take over my life again!

I have learned many lessons which I will bring back with me to the dental setting, such as the benefits of taking time to understand the individual in my chair. What works for one personality, might not work for another. Some might not know why they react in a certain way – I did not understand where my fears came from! They just might need to know that someone genuinely cares.

Providentially, experiences of these past few weeks have added to this journey. As I contemplate these events, I realize they will be extremely helpful in caring for future patients. A family member recently had surgery which went awry. There was much confusion and miscommunication between all of the different entities. It left me wonder-

ing, are we sending our patients home understanding services rendered? Are they confused about what treatment they are scheduled for, or how to care for a surgical site? Are we attentive, loving and kind? Do they feel cared for? There is much to ponder as we try and use our experiences for good. □

Some might not know why they react in a certain way – I did not understand where my fears came from! They just might need to know that someone genuinely cares.

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Author’s Bio

Kathy Beard, RDH, BSDH, has enjoyed the dynamics of a dental hygiene career for more than 25 years. Her duties as past president of Premiere Hygiene Study Club, as well as her responsibilities in implementing a safety program, have enriched her understanding of the importance of continued communication. She resides in Washington State with her husband, and has one daughter.



Increase Doctor's Production

Whether you're new in practice or just experiencing a slump in your schedule, there are many ways to increase production.

cln2th

Posted: 5/13/2010

Post: 1 of 36



Greetings all! I hope that you might have some suggestions for me. I work with a new, young dentist who purchased this established 30-year practice in a small, rural community. I worked with the previous dentist for 22 years. My schedule has remained full, even as much as being booked solid a month in advance. The issue is that the doctor's schedule has vacancies. How can I assist in increasing his production? Honestly, a majority of our patients do not need restorative care when they are examined during their care in my operatory. What should I be recommending? ■

timothyvives

Posted: 5/13/2010

Post: 2 of 36



I admire your loyalty to your employer. It sounds like he's a real preventive dentist with a minimal intervention approach. Has your dentist explored other avenues such as Invisalign? Tooth whitening is also a great way to bring in patients and is minimally invasive.

I am just beginning to realize the power of clinical photography. I'm finding that simply taking clinical photos, discussing them with patients and letting the patient have a copy has had a positive effect. These patients are starting to ask about orthodontics and aesthetic work, just by being presented with a photo – subtle marketing. ■

skr RDH

Posted: 5/13/2010

Post: 3 of 36



Be sure that the previously treatment-planned items are discussed at each subsequent visit if it is not booked yet. There are also plenty of courses and tools to introduce to the practice to boost treatment acceptance and production. ■

shazammer1

Posted: 5/13/2010

Post: 8 of 36



I like the idea of "before and after" photos hanging on the reception area walls. It gives patients something to ponder while waiting. Or a big photo album of before and after photos. I ask every patient if he or she has ever considered whitening. Not that they need it, but that they would have spectacular results if they decided to because of the beige undertone of their teeth. Once whitening is done, many patients are eager to continue with more treatment. Make sure every staff member has gorgeous dentistry in their own mouths for show and tell to the patient.

I make it a habit to talk over the patient. If I think some treatment would be good, say a crown or some cosmetic stuff, I will start to talk to the doc during the exam. Something like "George is not ready at this time to go ahead with that anterior crown on that discolored tooth, but when he is, what kind of time frame would he need for the appointment?" The doc and I discuss this without George so much as throwing in two words, but he is hearing it. ■

I own a laser company so that is obviously what I would suggest. You sound like an excellent hygienist and I'm sure you can spot all the things that your doctor could be doing with a little diode i.e., frenectomies, fibroma removal, operculectomies (tons of those to do), treating ulcers and of course, perio (decontamination and sulcular debridement)... just to name a few. ■ **Jim**

**jimking**

Posted: 9/6/2010

Post: 11 of 36

We're getting a laser in a week or so, and have many patients waiting for frenectomies already (our associate is trained and uses it elsewhere). Main reason we're getting it is for relieving tissue/hemostasis for crown impressions, minor crown lengthening and to have another technology to brag about on the Web site. ■

**skr RDH**

Posted: 9/6/2010

Post: 12 of 36

My office has struggled a bit with this also. Our patient population is a younger demographic, so their restorative needs are generally not extensive. We are currently working with a consulting firm. It's too soon to evaluate the outcome, but what I've learned so far is that having someone who is objective to look at things will bring many missed opportunities to light.

Hiring a consultant, of course, is a financial investment, but many have some type of guarantee. In other words, if they don't help you increase your profit by X amount they will refund the fees you paid. ■

I am also reminded of the fact that a regularly seen population of patients who have been in the practice for more than 30 years will not be providing you with opportunity for rehabs or even much more than naturally occurring repair work. You might need to start a program designed to bring in the new patients who are lingering out there and have not been seen by anyone for years or a lifetime. Ads touting laughing gas, sedation dentistry, comfort or painless anesthetic can fire up your phone calls. ■

**shazammer1**

Posted: 9/21/2010

Post: 18 of 36

My best advice is to use protocols and systems that you follow for consistency and thoroughness. Going over risk factors makes sure nothing is overlooked. This covers everything from gums, teeth, TMJ, smile characteristics and medical precautions. I feel good that I am being thorough and providing service that the patients need. ■

End-of-the-year letters can be sent out to patients who have unfinished treatment encouraging them to use their benefits. We typically do ours in the fall and they always generate a good response. ■

**toothbat2000**

Posted: 9/24/2010

Post: 30 of 36

dentmom

Posted: 9/24/2010

Post: 31 of 36

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