June 2019

FLORIDA FOCUS

The publication exclusively for the general practitioner

FLORIDA
ACADEMY of
GENERAL DENTISTRY

Legislative Affairs
Great things are happening in general dentistry

How Gum Shortening can Improve your Aesthetic Restorative Results
by Dr. James Kohner

Blast from the Past
Drs Marc & Barrett Tindell

General Assembly Meeting
June 28, 2019 - Gaylord Palms

June 2019

CONGRATULATIONS

AGD STUDENTS CHAPTERS!

D.M.D Class of 2019

LECOM School of Dental Medicine - May 26, 2019
NOVA SOUTHEASTERN UNIVERSITY - May 17, 2019
UNIVERSITY OF FLORIDA - Friday, May 17, 2019

RSVP TODAY

FREE General Assembly Luncheon @ FDC

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EXECUTIVE DIRECTOR
Patricia Jenkins

Farewell from our President... Dr. Merlin Ohmer, DDS, MAGD

I cannot believe how fast this year flew by. In June we install a new slate of officers. Dr. Andrew Martin will assume the leadership of our wonderful organization and carry it to new heights.

First, I want to thank the members of the Florida Academy of General Dentistry for your support and confidence. Secondly, the Florida Academy Board of Directors who provided the "heavy lifting" in accomplishing our goals. Without everyone's assistance, we could not have made progress to forward the specialty of General Dentistry. I truly value their hard work, dedication, and collegiality.

The Florida Academy of General Dentistry continues to take a major role in advocacy for our profession and specialty. In conjunction with the FDA, we have been at the forefront of efforts to again defeat Dental Therapist legislation in Florida. This took many hours of hard work and "sticktuitiveness". The bill was again defeated and our voices were heard. Additionally, our advocacy efforts paid off with a loan repayment bill that will help new dentists who agree to practice in underserved areas of Florida.

With constant work and the dedication of organized dentistry, we will be able to keep oral health care safe for our citizens.

Dentist's Day on the Hill was a success again this year. We had a strong presence led by Dr. Laurence Grayhills and Dr. Mel Kessler. Our efforts through constant liaison with the state representatives and senators paid off again. Our congressmen must be educated with real facts regarding ethical and quality healthcare. I urge each one of you to attend this annual summit. Membership is stagnant. We see very modest gains, mostly due to recruiting student members. While they are our future, we are losing too many members through non-renewal. We need each member to recruit at least two other general dentists. Not only will they enjoy the benefits of membership and cutting-edge CE, but each will also each get $50, courtesy of the AGD. What's not to like about that deal!

In closing, I could not have done this without YOU! The leadership and guidance I received were invaluable. Please, with me, thank Drs. Bob Gehrig, Harvey Gordon, Laurence Grayhills and Tony Menendez. They served as the "brain trust" to help me make sound decisions and provide leadership to our members.

Our organization is strong and will continue to succeed and make advances in the coming years. Thanks again for all your efforts and best wishes to the incoming leadership team.

"Dr. Ohmer's leadership has really helped the FLAGD navigate new obstacles and become more proactive in delivering value to our members. His presidency raised the bar, and I am both excited and nervous to take the reins and continue the momentum he created."

Dr. Andrew Martin, President-elect

With Dr. Ohmer's departure as the 2018-2019 FL AGD President, I thought I'd say a few words about his hard work and dedication to our organization. Our friendship began in the Comprehensive Dentistry Program at the University of Florida College of Dentistry while Dr. Ohmer was pursuing his Mastership. Our friendship has persisted to this day.

The Florida Academy underwent a metamorphosis when our long time Executive Director departed. The "rebuilding years" were challenging as we approached a new organizational era of work and responsibility for Board Members. As he rose in the ranks of the Executive Board he was perhaps the most loyal, reliable and stalwart supporter of the Academy. Besides expressing his opinions and leadership suggestions (which were always welcome and needed), he kept our coffers "in the black" with years of High-quality continuing education as the Florida Academy's Director of CE.

As you depart your role as President, thanks for your years of service! In Navy terms, Capt. Merlin Ohmer deserves a "bravo zulu," meaning "thank you for a job well done." But don't get too comfortable in your "retirement." There are bigger issues facing the Academy of General Dentistry. Your next mission awaits your talent and expertise! Dr. Laurence Grayhills, Region 20 Director

Editor's Note

The Florida Focus is one of your sources of Information within organized general dentistry. It is our way to communicate to one another. Our primary objectives of the Focus is to present education from various areas (i.e. Clinical updates, political and governmental mandates, etc.). Another of our primary objectives to initiate retention and growth of AGD membership. On our component level, our constituent level and ultimately the national level, retention of existing members and attraction of new members of the AGD are the life blood of a vital connection to the evolving role of dentistry and overall healthcare. At a recent national Leadership Development Symposium in April this was one many of topics that was discussed.

Only with the strength of organized membership can we adequately face the trends that are occurring within healthcare. So, we reach out to you, to help the AGD grow. Reach out to your colleagues from the various timelines of their career journey to encourage participation in the AGD. The Academy of General Dentistry is our connection and our voice.

Within this summer edition of your Focus, we call you to action. Just as the name of your newsletter implies, Focus.

We hope to reset your focus on what is real and valuable. The AGD offers us so many things to enable us to grow professionally and personally.

In this edition we present Dr. James Kohner's insight on the benefits of crown lengthening and/or gum shortening. The political aspects of general dentistry are discussed and the successes of rebuilding of AGD membership in Puerto Rico are outlined.

We hope that we all acknowledge that the strength of our AGD is in numbers. This is a "Call to Action." Get involved. Stay involved. Invite your colleagues to join the Academy of General Dentistry.

Randall Weisel, DDS, MPS, FAGD

Social media usage by dental practices is increasing

According to the Levin Group Data Center, 73 percent of practices have a Facebook account, 20 percent are active on LinkedIn, and 17 percent are on Instagram. Four in five practices today have a social media presence, which is a 20 percent increase over the last 12 months.

Action step: All dental practices should have a strong marketing program based on the number of new patients that are required for the practice to hit annual production goals. And, while social media is a key element of internal and external marketing programs, it's important that dentists know that a social media campaign will not fulfill all of their marketing needs.

While there are exceptions, social media is only one component of marketing, and there are other considerations that need to be made on an annual basis to help keep a practice strong.

Summary

The dental profession is changing in big ways, and it's important to take a big-picture look at what's happening with your peers and in the industry in general. Every dentist should stay abreast of current data and trends so they can take advantage of options that will help them build and maintain a highly successful practice.

Roger P. Levin, DDS, is the founder and CEO of Levin Group, a dental management consulting firm. To comment on this article, email impact@agd.org

FLORIDA ACADEMY of GENERAL DENTISTRY

GENERAL ASSEMBLY MEETING 2019

Date: Friday, June 28, 2019
Time: 1:00 - 2:00 p.m.
Location: Gaylord Palms Resort
Orange Blossom Ballroom

In conjunction with the FDC
Reservations must be made in advance

Registration options:
Email: Patricia Jenkins-flagd@flagd.org
Call or text: 386-503-0228
Please include your full name, AGD # and any dietary restrictions.
A $75 no-show fee will be applied.

FREE LUNCHEON FOR AGD MEMBERS!!!

AGENDA for GENERAL ASSEMBLY

i. Introduction of Board of Directors and Special Guests
ii. Pledge of Allegiance and Invocation
iii. Approve Minutes of 2018 General Assembly
iv. State of the FLAGD Report from the President
v. Unfinished business from 2018
vi. New Business

Election of Board and Officers for 2019/2021
(18-month appointment)
President, Andrew Martin, DMD, MAGD
Vice President, Naresh Kalra, DDS
Secretary, Ray Morse, DMD, MAGD
Treasurer, Harvey Gordon, DDS, MAGD
Editor, Randall Weisel, DDS, FAGD
Immediate Past-President, Merlin Ohmer, DDS, MAGD
Directors At-Large
Tomas Ballesteros, DMD, MAGD, Board of Dentistry
Olivier Broutin, DMD, MAGD, At-Large Member
John Gammichia, DMD, FAGD, Public Information Officer
Toni-Anne Gordon, DMD, Membership Chair
Mel Kessler, DDS, MAGD, Legislative Affairs
Douglas Massingill, DDS, MAGD, At- Large Member
Mohammed Mujeeb, DDS, MAGD, At-Large Member
Bipin Sheth, DDS, MAGD, PACE Chair
Marissa Whitehead, DMD, At-Large Member

Awards to be Presented

- Dr. Frank J Collins Life-time achievement award
- Distinguished Service Award
- Humanitarian Award
- Most Continuing Education Award

****PLEASE NOTE****
OUR NEXT GENERAL ASSEMBLY MEETING WILL NOT BE IN CONJUNCTION WITH THE FDC AND WILL BE HELD IN JANUARY 2021

How Gum Shortening can Improve your Aesthetic Restorative Results.. Part 1 of 2

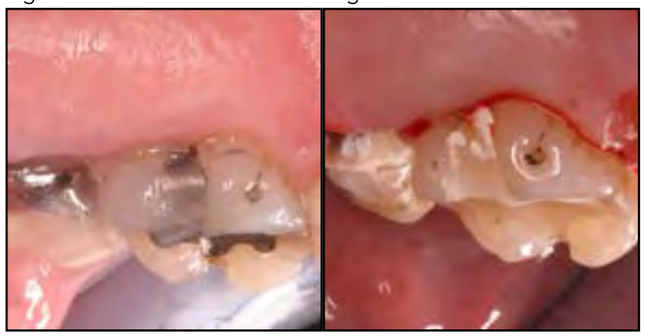
By Dr. James Kohner

Have you ever been frustrated when your beautiful aesthetic work is compromised by an existing display of excessive or uneven gingival tissue in the aesthetic zone? Have you been tempted by advertisements to remove the excess tissue by gingivectomy using a laser or electro-surgery unit, or blade? You are not alone.

But…..STOP! Do not proceed until you read further.

Dentistry in the 21st century has changed quite dramatically from the 20th century. Today both aesthetics, as well as use of technology, are higher priorities, and both have revolutionized what we do. From more successes with implants to highly aesthetic veneers and stronger bonding materials, we have powerful tools today that were not available even 10 years ago. But while utilizing these exciting technologies, it is essential to remember the basics. Today every complication or restorative challenge does not automatically need to become a titanium implant or a laser opportunity!

Fig 1.1 Fig 1.2



One basic procedure that many clinicians overlook, is Crown Lengthening. This procedure has remained essentially unchanged throughout the past 30+ years and remains as useful now as then. It has applications in all parts of the mouth. For posterior teeth often there is not enough tooth structure for retention, (Fig 1.1 and 1.2).
This can occur as a result of excessive gingiva, caries or fractures, and when teeth are prepared in a subgingival fashion problem can occur from impingement on the soft tissue. Crown lengthening can help create an abutment tooth that not only has better retention but allows for a crown margin that will not impinge on the soft tissues by creating enough mechanical tooth structure for retentiveness while keeping the restorative margin safely outside of the soft tissue dimension.

Fig 1.3

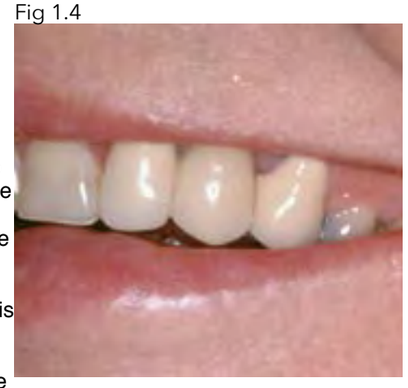
But instead of being pushed aside and forgotten, this “old standard” should make its way into every contemporary clinician’s armamentarium. In the anterior esthetic zone errors of margin, placement can be even more noticeable when inflammation occurs.
Placing crown margins too close to the bone, and impinging on the soft tissues of the Biologic Width has long been known to cause inflammatory complications. 1 Crown Lengthening can allow for restorations being placed and to avoid those known complications. This article is making a case for learning to manage the bone to restorative margin interface, which is the key to successful crown margin placements.

Of course, each tooth with restorative/soft tissue problems is not automatically an indication for crown lengthening! Extraction leading to an implant, a fixed or removable appliance, always needs to be in the differential diagnosis. Orthodontic extrusion, as well, should be considered as it is sometimes a viable option, but that is a topic for another entire paper and has been covered by others.
In the authors experience as a specialist, patients usually come on referral from their general dentist. It is interesting how many of those patients come in for consultation even though they have no idea what a “crown lengthening” actually is! At the same time, 40% of dentists surveyed by the author reported frustration in gaining acceptance of their referrals for crown lengthening procedures. Why are some so successful and others not?

Potentially the frustrated dentists might gain more acceptance of their referrals if the patients understood what benefit the procedure meant for them and if they could actually picture those benefits. For starters, consider using the term mentioned in the title, namely Gum Shortening, instead of Crown Lengthening. This term is more easily understood by patients. A useful tool is to describe crown lengthening as the “shortening” of gum tissue to expose more tooth structure and refer to the tissue as a “turtle neck” in an effort to use non-dental terms.

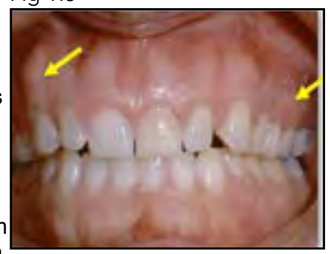
While patients demand higher and higher levels of aesthetics, it remains our responsibility to provide a high level of evidence-based, scientifically sound care. While implants and bridges have that evidence, so does Crown Lengthening. There also are many resources covering the biologic characteristics of human gingival tissues. 2 3 4 5 6 Despite the availability of this information, patients still have crowns placed that impinge on the gingival tissues in an apparent effort to obtain mechanical retention where there was a structurally insufficient clinical crown. Crown Lengthening is a way to avoid these complications by creating sound tooth structure for a restorative margin, and manage the key bone to restorative margin interface.

Fig 1.4



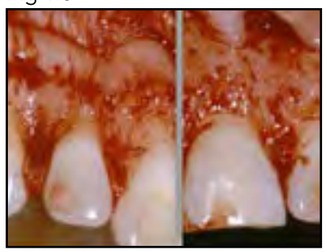
Besides this impingement scenario, there are instances where dentists overlooked basic biology when they performed gingivectomy to remove excessive or uneven tissues then place restorations in the space formerly occupied by the soft tissues. For example, picture 1.4 shows an example of excess tissue. Whether the tissue is removed with a laser, blade, or electro-surgery unit, this can be risky5. It is not the choice of an instrument that causes the problems, but a technique that fails to respect the dimension of the gingival soft tissue to the bone relationship or Biologic Width. Without removing the same amount of bone, a violation of the Biologic Width will be created and a predictable chain of events will follow when restorative margins are placed where soft tissues were, and then the soft tissue regrows. Published reports show that the gingiva will grow back to its original dimension. While this process sometimes takes up to 12 months, the tissues will regrow.7
This resulting “violation” of the Biologic Width leads to red, sore, or edematous tissues which occur as the tissue heals, re-establishing the original dimensions of the gingiva. While a different case, Picture1.3 illustrates that resultant redness when the restorative margins are too close to the bone after gingivectomy and the soft tissues re-establish the normal dimensions of the gingival complex. While some would refer to that phenomenon of regrowth as “Rebound”, many reports explain the phenomenon as the normal redevelopment of Biologic Width. 7, 7a, 7b
Thick ledges of bone, resulting in excess gingival height and small clinical crowns, leave potentially limited retention as often seen around 2nd molars, as illustrated earlier. (Pictures 1.1 and 1.2), This thick bone is common in both maxillary and mandibular molars, but is common also in the anterior, and knowing where the bone is located becomes the key to avoiding the embarrassing red gingiva in Picture 1.3. When this thick soft tissue is observed, the question becomes what makes it so thick?

Fig 1.5



Typically, bone is thick under the tissue, requiring removal of bone and not just soft tissue. Pictures 1.5 and 1.6 illustrate that thick tissue biotype associated with thick bone. Predictable healing results only when the bone is properly managed. 4, 7, 7a, 7b. When the healing and maturation of the soft tissues is complete, predictable results will be achieved only by removing enough bone and locating it correctly at 2.5 - 3.0 mm from the expected restorative margin, and not just from apically positioning the soft tissue or by doing a soft tissue gingivectomy7a, 7b. Bone, then, becomes the key parameter. While some concern for the crown to root ratio must be acknowledged, it is unlikely that with a periodontally sound tooth, that bone removal as describe here would result in mobility issues as so little supporting bone is removed.

Fig 1.6



So in summary, indications for Crown Lengthening include

- Excessive Gingival Display in anterior- often associated with thick bone
- Short posterior teeth with excess gingiva and thick bone
- Uneven Gingival Levels
- Fracture under gum margin
- Previous crowns and finish lines too close to soft tissue attachment

Fig 1.7

This article (and Part Two), shows the potential for creating beautiful smiles, and predictable posterior restorations, while respecting tissue biology and avoiding complications such as Biologic Width Violation. Keep the following principle in mind until next time when it will be explained further: It is generally sound advice to avoid removal of soft tissue without planning to remove a commensurate amount of matching bone as well. If you follow this advice, you will be one step closer to achieving predictable and aesthetically pleasing results. (Pictures 1.7)

Part 2 of 2 continued on page 10

James Kohner, DDS, is a Periodontist living in Denver, Colorado. He has over 35 years clinical experience and more than 25 years teaching and lecturing, with presentations all over the US and 8 foreign countries. He currently teaches Hands-on Surgical Training Workshops on Crown Lengthening, Soft Tissue Grafting, and Periodontal Surgery for the Perio Institute (www.Perio.com), dental school CE programs, and at multiple state association meetings. He can be reached at JamesKohnerDDS@gmail.com.

Legislative Report

Melvin “Mel” Kessler, DMD, FAGD

Advocacy. At. Work.

On March 11 -12, your FLAGD was very involved in defeating Dental Therapy bills HB 649 & SB 684. These were bills sponsored by Sen. Jeff Brandes and Reps. Rene Plasensia, Juan Frenandez-Barquin, Pew & Kellogg Foundations and Dr. Frank Catalanotto.

FLAGD Board members attending were Drs. Trotter, Gammichia, Grayhills, Kessler, from SEFAGD were CarvaJal, Morales, Maderal, Perez and in addition were members Past-pres. Eggnatz and FDA Trustee Sabates. I am also sure there were other FLAGD members in attendance. Overall there were ~ 180 doctors and students, which was a very good showing. (But we have over 14,000 licensed dentists, where were you?).

Major key to defeat of the DT bills was the messaging at DDOH and then the many letters to the members of the two committees hearing the bills. Neither the House nor Senate bills were even able to come to a vote in the very first committees they were heard. Overall the bills were not limited in their scope of only treating the most needy in rural communities and therapists would be doing irreversible surgical procedures under only general supervision.

Here again, we brought up the point that the dental student loan approach is much better, as we can have REAL doctors treating patients in rural areas within 6 months. This was a major victory in that we do not feel the DT legislation would benefit the patients they claimed it would.
In Minnesota, which has had a DT program since 2009, it has shown that the great majority wound up working in urban areas, where there is not a shortage of providers.

After the defeat of the DT legislation, bills SB 716 and HB 465, the Dental Student Loan Repayment Program, became our prime focus.

Meanwhile the student loan bills had not been passed by all the required committees, and there are only 2 weeks left. HB 465 only passed out of one committee, while SB 716 passed out of two. Three were needed. Since the legislature would adjourn on May 3, time became an issue. The language for earlier SB 716 was then inserted into another bill, SB 7078.On 4/17/19, the FDA GAO and FLAGD sent out a Call to Action regarding SB 7078. It ultimately became HR 843 and came before the two Houses as they prepared for budget conference negotiations. Yes, it is complicated, BUT without the proper response to these alerts and the help of enough members we would not succeed.
On 4/29/19, HR 843 passed both the Senate and House with unanimous votes, and is awaiting Governor Ron DeSantis’ signature. The bill would create the Dental Student Loan Repayment Program, which would provide up to $50,000 in funds for new dentists who commit to practicing in underserved areas. Thanks to all those involved and to all others, please see that your FLAGD is hard at work in advocacy for the best interests of all, for doctors and patients alike.

AGD Members Travel to Capitol Hill to Advocate for General Dentistry

On April 29-30th, AGD advocacy leaders gathered in Washington, DC for the AGD’s annual Hill Day Conference. Representing the FLAGD were Drs. Gerry Botko and Mel Kessler. As part of the event, attendees heard from high-level officials, members of Congress, Representatives Dr. Drew Ferguson Dr. Paul Gosarand a variety of subject experts on the issues facing oral health and general dentistry.
The event culminated in a day of meetings with lawmakers to urge their support for AGD’s top advocacy priorities, including Oral Health Literacy (OHL).
The event culminated in a day of meetings with lawmakers to urge their support for AGD’s top advocacy priorities, including Oral Health Literacy (OHL).
We personally visited the offices of Senators Rubio & Scott, and Representatives Bilirakis, Castor, Deutch, Frankel and Shalala. We stressed the importance of OHL, as prevention is the key to solving the dental needs of the public. In addition we stressed the following legislation:

- H.R. 1418 / S. 350 , the Competitive Health Insurance Reform Act - legislation that repeals the provisions in the McCarran-Ferguson Act that exempt the health insurance industry from federal antitrust laws.
- H.R. 1554 , the Resident Education Deferred Interest Act - legislation that would allow new dentists toqualify for interest-free deferment on their student loans while serving in a dental internship or residency program.

I want to add more info on the importance of repealing the McCarran-Ferguson Act, passed 3/9/45. This act exempted only two industries from having to comply with federal anti-trust actions: Baseball and Insurance. We want to repeal the only exemption on the health insurance industry. It is no longer a fledgling new benefit that the government must protect from colluding among themselves.
It is a behemoth of currently five major companies that control the health industry. They do not have to compete for business and do not have to be transparent in their actions. Just imagine what might change over time if they had to compete among each other. We could have reduced fees to the public and new choices in our health care insurance – time for changes. The AGD submitted a request to appropriators this year to increase funding for HRSA’s Oral Health Training Programs such as General Dentistry Residency program and the Dental Faculty Loan Repaymentprogram and ask that they include language supporting Oral Health Literacy and the CMS Head Start Program.
The AGD also presented its 2019 Congressional Appreciation Awards to Congressman and dentist Paul Gosar (R-AZ) and Senator Steve Daines (R-MT), sponsors of the Competitive Health Insurance Reform Act. We are fortunate to currently have 5 dentists in the House, they are : Brian Babin, R - TX,; Jeff Drew, D - NJ; Drew Ferguson, R - GA; Paul Gosar, R – AZ; Mike Simpson, R – IO. This has been extremely helpful and hopefully we can now get more support for dental issues.

Part 2 of 2 continued from page 7

How Gum Shortening can Improve your Aesthetic

Restorative Results

In the first part of this series you learned to resist the temptation of removing soft tissue in the aesthetic zone without also planning for an appropriate amount of bone removal. As described in Part 1, managing the bone is essential in obtaining predictable soft tissue results, and the distance between bone and crown margin (or CEJ in an anterior esthetic case) becomes the key component. Research has shown that the typical space from the gingival margin to bone on the labial or lingual is 3mm. 8 9 10 11. This basic rule applies to 85% of mouths, 8 10 13 thus most of the time the biologic with will be similar but must be verified by bone sounding under local anesthetic.
It is an exception when the gingival soft tissue dimension varies from that normal 3mm biologic width.
8 In those situations where the dimension of soft tissue to bone crest exceeds 3mm, this represents the single indication for soft tissue crown lengthening. The tissue exceeding the 3mm dimension, but not more, can be removed.
8 13 To take more tissue would leave less than the 3mm soft tissue dimension, and could result in margins being too close to the bone as described in Part 1 of this article Thus, it is evident that other than when the biologic width exceeds 3 mm, both aesthetic and functional crown lengthening will require bone management.

1. Sulcus depth: .69mm
2. Epithelial attachment width: .97mm
3. Connective tissue attachment width: 1.07mm

Conversely, there are some instances where the distance of gingival margin to bone crest is smaller than the “normal” 3mm. In these cases, as described by Kois, 8 the smaller biologic with MUST be identified ahead of tooth preparation time, and is a warning to avoid even the smallest amount of subgingival tooth preparation, or a biologic width violation might result. With those thoughts in mind, this second installment will address all those issues, and will look at the scientific rationale, treatment planning goals, and clinical benefits of Crown Lengthening, or Gum Shortening, which is what patients might understand better it as.
You will see a clear example that demonstrates how the removal of bone is used to create the predictability of the aesthetic results you and your patients want.

The research that offers guidance is the 1961 study by Gargiulo, Wentz, and Orban. 9 They measured and documented the dimensions of human gingiva and found the following average dimensions based on examining from 30 human cadaver jaws:

These numbers were their findings of an averaged soft tissue dimension across all specimens and all levels of gingival recession. Interestingly enough, these measurements were consistent even as passive eruption, or recession and its associated bone loss was
taking place. Consistency to the point that the 1.07mm for connective tissue attachment was almost identical at any phase of passive eruption or recession associated with either aging or disease.

Conventional wisdom, and many clinicians, now consider these dimensions of human
gingiva, or the “Biologic Width", to be a combination of three 1mm measurements 12 ,
resulting in a more easily understood total of 3mm from the labial/lingual bone crests to
the gingival margin.

There are slight variances inter proximally. 8 12 It is this soft tissue dimension that must be respected when locating a restorative margin.

To avoid a mechanical impingement of the soft tissues, which is the classic “Biologic Width Violation”, margin placement must remain outside the soft tissue attachment to the tooth. Thus, in the anterior where aesthetics is important, attention to limiting subgingival margin placement to no more than .5mm under the tissue is vital. Also, in the anterior the high rise of the inter-proximal CEJ must be accommodated or inter-proximal violations will occur there with all the sequelae discussed. Since we cannot feel or probe the exact spot where the delicate epithelial attachment begins, measuring apically from the gingival margin serves as our only reference point, and staying within that .5mm dimension is the parameter that guides proper margin placement. While we respect the research finding of .69mm as the approximate sulcus dimension, there is no way to probe the exact dimension of that sulcus. How is the end of the sulcus identified? Is it when patients jump from the pain of a probe?

The author contends that we really cannot feel it, so that is why the safe margin placement is typically no more than that .5mm distance below the marginal tissue. Yes, that is a small playing field for margin location, yet by understanding the normal dimensions of human gingiva, it is clear that is all the space available. Many anterior gum shortening procedures are done in conjunction with restorations. The prosthetic requirements must be determined during the initial stages of diagnostic workup so the restorations will be biologically sound, aesthetically pleasing, properly functional and non-traumatic to the tissue. The following is a summary of what should be determined as early as possible:

1. The eventual incisal edge position. Will it be the same or different from existing location?
2. The desired size of the clinical crown, and will the gingiva need to be relocated to accommodate this size?
This can be decided by reviewing a diagnostic wax up with the patient, using trial temporaries, a trial overlay, or Chu’s Esthetic Gauges to help approximate the Golden Proportion ratio of 75-80% width to height in the maxillary anterior.
3. The patient’s pre-operative biologic width. While most people have a 3mm distance from the gingival margin to the labial/lingual bone crest, there are exceptions and variations. 8 These exceptions must be recognized before beginning the tooth preparation. The location of the osseous crest on the labial or lingual can be determined
by bone sounding through the sulcus under local anesthetic.
4. If it is determined that the biologic width is LESS than the normal of 3 mm, then extra caution is needed since going even a small amount sub-gingivally with margin preparation might be too much. In these cases of biologic width being less than the normal 3 mm, something John Kois calls a “high crest,” there is danger of having margin placement too close to the bone even if we think we are safe withthe .5mm sub-gingival location.
5. If biologic width is more than the 3 mm “normal,” then some soft tissue removal can be considered. Only the dimension of soft tissue exceeding the “normal,” 3 mm of Biologic Width can be removed. It has been shown that following surgery these dimensions heal to the “normal” 3 mm dimensions.

Once these decisions have been made, and the amount of soft tissue removal to accomplish the objectives is determined, it can now be decided how much bone removal is needed to create the desired tooth size. Removing comparable bone will then allow space for biologic width, and restorative dimensions, without the complication of impingement or gingival regrowth. Just shortening gum and not the bone has been demonstrated to allow for regrowth of soft tissue. 15, 16 This regrowth, sometimes called rebound, is the normal re-development of the body’s 3mm biologic width that occurs when gingiva is shortened, and or surgically positioned, too close to bone level. If flaps are elevated, tissues shortened, and replaced at bone crest, the biologic width does redevelop, or “rebound” 11, 15, 16 If restorative margins are placed on the newly exposed tooth after the soft tissue alone is shortened, the restorative margins will be in the way when the tissue regrows. Impingement will often result. It is not a matter of if the gingiva will rebound, but a matter of when. The process may take a year, but the soft tissue will regrow. 11, 15, 16 Observing this skull specimen in Picture 2.1, the absence of the soft tissues gives solid evidence that the body knows the 3mm dimension of human gingiva. Clinical procedures must accommodate it, as well in choosing
the location of final crown margins.

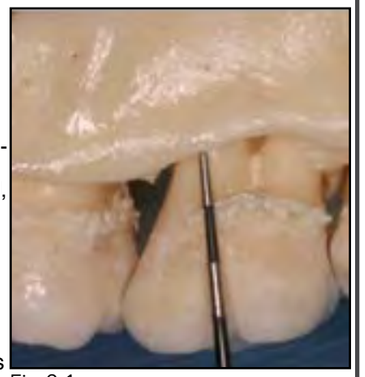


Fig 2.1

Fig 2.2

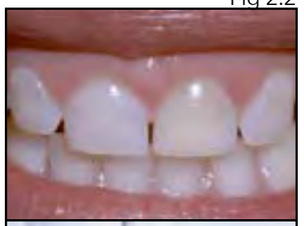
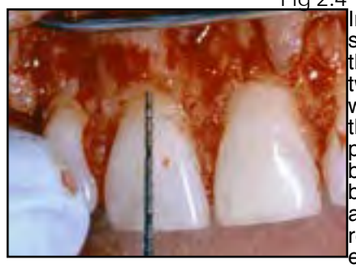


Fig 2.3

As the above five diagnostic decisions are made, the need for bone removal becomes clearer. Note in Picture 2.2 that the patient has 7.5mm of clinical crown showing. She requested longer teeth, and after workup with her general dentist (Picture 2.3), they decided on 11mm long central incisors. She understood that gum shortening would expose cementum, and agreed that veneers would be an acceptable solution. After those parameters were reviewed, the surgical goals were defined. If she starts with 7.5 mm long teeth and 11mm is desired, it becomes clear that 3.5 mm of soft tissue, and the associated 3.5 mm of bone, need to be removed (on the central incisors). Clinical situations like this develop when there is an altered pattern of bone development, such as thick bone biotypes, or tooth eruption resulting in relationships of bone crest to CEJ levels that depart this “normal” 3mm. In the “High crest,”scenario, the CEJ and bone are, by definition, closer together than in the typical 3mm biologic width 8 . In this situation, there is no room between bone crest and CEJ for the 2mm of soft tissue attachment, plus 1 mm of sulcus, found in the average anatomy, yet the body knows that the soft tissue dimension should be 3.0 mm, as illustrated by the skull example, (Picture 2.1), so the gingival margin ends up more coronally. This is what causes shorter clinical crowns with the gingiva on enamel.

Fig 2.4



Interdisciplinary teamwork can be very satisfying in solving these problems and giving patients the aesthetic result they want. When working as a restorative dentist / periodontist team, the two clinicians can develop ways to communicate clearly about diagnostic workups and patient goals in order for the periodontist to accurately relocate the bone to its correct position. 14 Relocating bone to the correct biologic position will not only allow for achieving a predictable size of clinical crown, but will also avoid crown margin impingement on the soft tissues via rebound. 15, 16 Clinical crown length gained has been shown to last as little as just six months if inadequate bone is removed. 16 Thus in the case illustrated here, the photos in Pictures 2.4 and 2.5 illustrate this correct bone removal with the original bone to incisal edge distance at 10.5mm. That 10.5 mm dimension, Picture 2.4, is a combination of the 7.5mm of the clinical crown plus the 3mm dimension of the biologic width which results in the expected 10.5mm dimension from incisal edge to bone crest. This is quite logical and follows what is expected of the gingival dimensions. To create an 11mm central incisor, the crestal level has to be relocated to 14mm from the chosen incisal edge position, namely 11mm plus the 3 mm biologic width as discussed above. In this case, the final incisal edge position will replicate the original incisal edge.

Fig 2.5

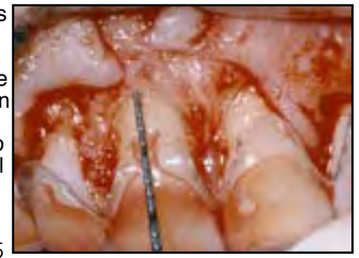


Fig 2.6

In the authors experience it is found that using a periodontal probe, Picture 2.5, during this surgical bone removal is an essential reference point, as it is impossible to judge dimensions only by visual observation. Making an eyeball judgment will often result in too little bone removal, as without measurement references it looks like an extreme amount of bone removal is taking place, when in fact that is not the case. (Picture 2.5). While the result looks like extreme amounts of bone were removed, it is the reliance on the known dimensions of human gingiva that guides success. The scope of this article is not intended as a detailed technique dissertation. Rather it is meant to be a guide for a restorative/periodontal team, or as in incentive for further learning. Keeping these parameters in mind, carefully studying and learning the dimensions of human gingiva, developing a periodontal / restorative team, and applying these principles will help you to create predictable aesthetics, satisfied patients and pleasant results. (Picture 2.6, 2.7)

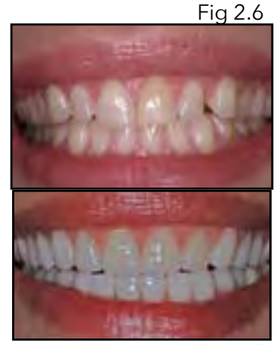


Fig 2.7

See page 14 for references

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Blast from the Past

Catching up with a former past-president, Dr. Marc Tindell, DMD, FAGD

This year has brought much excitement with a hint of sadness as a new era has begun at North Pointe Dental Associates (NPDA) in Tampa. Dr. Barrett Tindell has taken on a new position as a partner in the practice, while his father Dr. Marc Tindell has decided to retire, leaving the dental profession after an impressive 40-year career. Dr. Marc Tindell graduated from the University of Pennsylvania School of Dental Medicine in 1979. He then completed a GPR at Sinai Hospital in Baltimore, Maryland before joining Drs. Ron Pross and Richard Kanter (former past Tampa AGD President) at NPDA in 1981. Dr. Marc Tindell served on various boards as well as President of the Florida AGD from 2003-2004. He spent much of his time with the AGD advocating on behalf of General Dentists around the state.

In addition to his leadership roles, Dr. Tindell spent many years volunteering at the Judeo-Christian clinic serving the indigent population of Tampa.

Dr. Barrett Tindell credits growing up in a dental home and spending time at NPDA as his motivation to becoming a dentist. He saw how three partners were able to run a successful practice while always keeping the focus on patient care and continuing education.

A Tampa native, Dr. Barrett Tindell attended Jesuit High School and completed his undergraduate degree from the University of Florida. He then moved to New York City where he obtained his DDS degree from the NYU College of Dentistry. While in dental school, he married his now wife of 7 years, Cristy. With his sights set on moving back to Tampa and joining the partners at NPDA, Dr. Barrett Tindell understood the value of extending his post-doctorate education by completing a GPR at Monmouth Medical Center in New Jersey.

Christy, (Dr. Barrett Tindell's wife), Dr. Barrett Tindell and their daughter Naomi.

Dr. Richard Kanter, (top left) Dr. Barrett Tindell, (top center) Dr. Marc Tindell, (top right) Dr. Ronald Pross (Front)

During his associateship at NPDA, Dr. Barrett Tindell completed a year-long implant course as well as hundreds of hours of CE courses as he continues to work towards his AGD Fellowship. In 2017, he and his wife welcomed their daughter Naomi.

Surrounded by additional family members including his mother Diane, and sister Julie (along with her husband and 3 children), Dr. Barrett Tindell sees Tampa as his forever home. When he is away from the office, Dr. Barrett Tindell enjoys the outdoors and spending time with his family.
Entering one of its first major transitions in almost 40 years, NPDA is excited to write a new chapter as Dr. Barrett Tindell looks to help lead the practice to another 40 years of serving the Tampa Bay Area. If you're looking for Dr. Marc Tindell, as of May 1st, you can find him catching up on his reading as he enjoys the breeze along Tampa Bay, cruising and sightseeing in an RV throughout the US.

Julie Blacker (Dr. Barrett Tindell's sister), Dr. Marc Tindell, Dr. Barrett Tindell

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