Academy News

Academy of Osseointegration
Advancing the Vision of Implant Dentistry

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In This Issue

New program to offer AO Certificate in Implant Dentistry

A new program will offer an **AO Certificate in Implant Dentistry** to provide an opportunity for AO members to demonstrate that they have attained a level of education and experience that verifies their core knowledge and competence in the field of implant dentistry.

The certificate program is being developed by a task force of the AO Board of Directors led by Dr. **Michael R. Norton**, London, England, UK. "The Academy has long seen the desirability of offering some kind of certification, but it has been difficult to achieve. We believe the new AO Certificate in Implant Dentistry will address an important need in distinguishing accomplished practitioners from those who may choose to depend only on what they have learned during a weekend seminar," Dr. Norton says.

To qualify for an AO Certificate in Implant Dentistry, applicants will be evaluated on four criteria:

- **Core Knowledge:** Applicants will be required to have attended a university or other postgraduate institutional-based course on implant dentistry or demonstrate training in any of the mono-specialties (with an integrated implant module), of at least one year duration or the equivalent. Clinicians who completed their dental education before 2005 will have this requirement waived under a three-year grandfathering provision. Nonetheless, any evidence of all and any training may help in obtaining a successful application.
- **Continuing Education:** Applicants must present evidence of verifiable CDEs (CERPS, CPD, etc.) over a three-year period, on implant-related material, totaling 200 hours.
- **Competence:** Each applicant will have to submit four case presentations, using the AO Case Presentation Template (CPT), covering the following categories: single tooth, fixed partial denture (fixed bridge), full arch fixed reconstruction, and overdenture. One of the cases presented should fulfill an immediate temporization/loading protocol. Each case presentation will require a signed statement of authenticity from the patient.
- **Commitment to AO:** The applicant must have been an AO member for three consecutive years and have attended at least two Annual Meetings during that time.

A non-refundable application fee of $350 will be required on submission of all documentation. The Certificate will be dated and valid for one year only but will be automatically renewed each time a successful applicant renews his or her AO membership.

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Dollars and Sense

Starting your practice from scratch can be a priceless experience

By Dr. Navid Rahmani, New York, NY, Academy News Editorial Consultant

These days, starting a specialty practice right after graduating is an approach not many graduates attempt. As a young professional, I always wanted to start my own practice in the heart of New York City. It's been five years since I started and I would like to share with you what has helped me build referrals and a great, wonderful practice.

Dr. Navid Rahmani

Right after receiving my degree in periodontics, I started working for two general dentists and a large group practice. Even though it was great to be out of school and making good money with few or no headaches, something was missing. The more I worked; the greater was my appreciation and respect for these doctors who built their practice from scratch. The amount of energy and enthusiasm that they put into building and continuing their already established practices was never ending. I also realized, however, that the loyalty to their specialists that the dentists had established was not as strong since I came on board. That worried me. I was very intrigued and curious to figure out a way to ensure that the connections I would build would not weaken.

I remember the day vividly. It was a Sunday, and I was reading the *New York Times* Real Estate section, when I came across an office for rent two days a week in the heart of NYC on Central Park South. I was there the next morning and loved the space. The same week I signed a two-year lease and left my deposit check. I was beyond happy. I had a great space, my PC (professional corporation) was established, and for the first time the emptiness I felt as an employee was starting to ebb.

It was time now to buy instruments and materials. Do I start with a paperless or a conventional charting system? My friends and colleagues were telling me to invest as little as possible, build your practice, then invest more, which made a lot of sense. However, I was looking at the situation differently. I knew I wanted to be paperless since it was a faster, more organized and efficient way of filing and sharing information with doctors. I decided to invest in paper free software, and be headache free. At this point I had everything I needed to treat patients; my staff was in place, website was up and running, and I was surgically equipped to render any treatment.

During this initial period, I was working 3 days a week in other offices and two days in my own office while meeting new doctors. I knew the practitioners around me were all established dentists and prominent specialists. My goal was to meet as many dentists within a two block radius and just let them know I had arrived. I am here!! I felt like a fish swimming with sharks but I didn't let it intimidate me. Everyone was very welcoming and promised to send patients; however, that did not happen.

I decided to go back to my notes on the doctors I met and see who I should reach out to again. My goal as a specialist was to provide my future referring dentists with current evidence-based knowledge in the field of periodontal regeneration and implant therapy. I began sharing cases and articles with groups of dentists and found that they were enjoying it. I was happily engaged in opening new doors for approaches that we had discussed. Most of the articles came from the I*nternational Journal of Oral & Maxillofacial Implants (IJOMI)* and the *Journal of Periodontology (JPerio)*.

A momentum was created, and the same referrers were sending more patients. Patients were referring their friends and family. The website was a great source for the patients to get to read about me and my credentials. I soon learned that getting a referral was hard but keeping a referral happy was harder. I believe the key to keeping my referring dentists happy is to grow together and to be on the same page with patient treatment through clear communication.

This past year, I invited one of my referring general dentists to the AO meeting in Seattle. His knowledge in implant dentistry and general dentistry was impressive. I knew that once he witnessed the great AO speakers from every specialty sharing their knowledge in a well organized fashion that we would both benefit significantly and grow together. After three days of lectures by wonderful speakers and amazing presentations with evidence-based approaches, a new light was sparked in his thinking. We would walk out of the presentations and talk about the cases shown and what we liked or what we might incorporate into our practices.

At the meeting, he also took a few restorative track courses, which he found very interesting. We discussed laboratory advancements and established relationships with a few new venders as well. He was so pleased with the format and speakers of AO that he decided to become a member. Since we came back, the quality of our treatment planning and numbers of new patients referred by this doctor has increased dramatically. Not only are we more excited about treatment planning, but we have become closer friends, as well.

Most dentists in this city have a few surgeons with whom they work and as a new periodontist in the community, my goal is to move up in the contact list and become the first, if not second, person for a particular practice. I now intend to take as many referring dentists as I can to AO meetings. If they are not members, I will inform them of the many advantages of

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Clinical Issues Feature

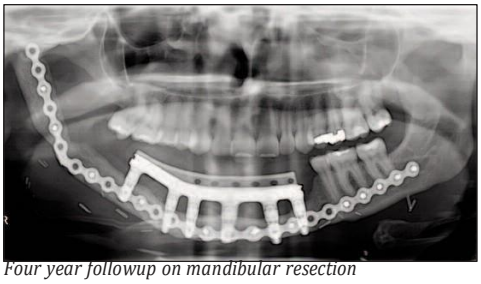
Head and neck cancer patients can enjoy enhanced outcomes with dental implants

By Dr. Robert L. Schneider, Iowa City, IA, Academy News Editorial Consultant

Treatment of the head and neck cancer patient after surgery can have an enormous effect on patients' ability to assume a relatively normal lifestyle, following rehabilitation. Multidisciplinary therapy related problems that are functional, esthetic, social and psychological in nature are challenges for many practitioners. Advances in diagnosis, microsurgical and grafting techniques, along with advancement in dental implant technology have allowed today's practitioner to provide much better functional and esthetic outcomes for these patients, even those that have been subjected to chemotherapy and radiation therapy following their ablative surgery.

Dr. Robert Schneider

In the U.S., it is estimated that 52,000 new cases of head and neck cancers are diagnosed each year. It is also estimated that these led to more than 11,000 deaths in 2012.[1] Many of these patients are treated with surgery and either radiotherapy or chemotherapy, frequently a combination of both. There have been significant advances in all treatment therapies; however, oral mucositis and xerostomia are prominent, limiting the patient's ability to wear conventional removable prostheses.



Four year followup on mandibular resection

Historically, in many institutions, it was a contraindication to place dental implants into irradiated bone due to the restricted healing capacity of the irradiated area. Fortunately, today that is not true for many of our patients. The use of microvascular grafting techniques and improvements in dental implant surface technology and prosthetic designs have made rehabilitation of these patients possible with very good and predictable long term results.[2]

Following ablative surgery and microvascular grafting for oral cancer, a major treatment challenge is the restoration of oral function and comfort. Generally, conventional dental prostheses are less than successful. Osseointegrated dental implants placed in microvascular bone grafts, such as the fibula or scapula, and restored with either fixed or occasionally removal prostheses have become the primary method for reconstructing the dentition of these patients. Survival rates of dental implants placed in the microvascular grafts and irradiated bone have been reported to be close to 90%; however, the success rate varied with the radiation dose, with decreasing survival rates after higher doses of radiation.[2] It has been reported that the time of radiation treatment to the treatment area, either before or after implant placement, has no significant effect on survival rate. However, the location of implant placement does, with better survival rates noted in the mandible than the maxilla. It has also been noted that doses up to 55 Gy do not significantly alter implant survival rates, neither did the use of adjunctive HBO therapy.[2]

The restorations have also progressed over time. Today many prostheses are CAD/CAM milled with a titanium substructure. This offers advantages over the traditional lost wax and cast restorations from improved fit, strength and variability of design options. With cancer ablation some of the defects are very atypical in their contours and do not totally replace the missing tissue. This is compensated for in the design of the prosthesis, which has been made much easier through the use of digital technology, CAD/CAM designed frameworks that provide support for materials in the area of the missing soft tissue, providing the patient with a near normal appearance and very good function to facilitate mastication, speech and swallowing.[3]

Organizations such as the AO strive to bring current information to its members to allow them to make informed decisions on treatment of their patients with complex medical and dental treatment issues. A multidisciplinary approach is required to provide our patients with the best possible treatment in these very difficult situations.

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Starting your practice from scratch

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membership. Access to *IJOMI* is a great source to stay up to date with evidence-based implant therapy. Educating and communicating with my dentists has been an essential in building my practice and making sure that loyalties remain solid. Currently, I have moved to a bigger office a few blocks away from where I had started. My referral network is growing and the hard work definitely has begun to pay off. It's one thing buying a practice or becoming an associate with a road to partnership, but starting your practice from the scratch is priceless.

Dollars and Sense is a quarterly column dedicated to implant practice management concepts. The editors of Academy News welcome reader comments and suggestions Please direct them to Dr. ***Bruce Barr*** *(barrperio@aol.com). Dr. Navid Rahmani is accepting patients at his practice in NYC Dental Implants Center.*