The Adjudicator

Canadian Association of Dental Consultants

Synopsis of our 2017 September Symposium in Edmonton, AB

From Our President…

Dr. Sandy Tse

Many thanks to Dr. Wessner and the generosity of Alberta Blue Cross – our recent meeting in Edmonton was a huge success. The venue was perfectly chosen where all amenities were within easy reach. Personally, I took full advantage of the great Alberta sales tax discount, and bought myself a fancy cellular phone – something my office desperately needed. I only wish my son would come home soon to set up this glass tablet for me.

This year our speakers conveyed a concept that is painfully obvious yet largely forgotten in dentistry. **Prevention is the key.** Despite our clinical excellence and the explosive advances in techniques and materials, prevention of disease always translates to less morbidity, less time loss and fewer dollars being spent on treatment. Perhaps it is the instant gratification that we get when we manage to "fix" a diagnosed problem, or perhaps it is our remuneration system that encourages us to treat more; whatever the reason, we as clinicians, are often more focused on treatment modalities. What we tend to forget is that had we been successful in preventing and containing dental diseases in the first place our patients may never had needed to undergo invasive treatment procedures at all. Let's keep this in mind at our staff meetings or when designing the next insurance contract.

The 2018 CADC meeting will be held in Whistler next September. This world-renowned town offers plenty of activities for everyone. For those of you attending, do plan on a longer stay. Enjoy this privilege before our government takes away our travel expenses. I look forward to seeing you there!

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Enjoy the autumn colours!

Dr. Michael Eggert, Perio – avoidance of failures

Dr. Eggert supported his lecture with slides showing the results of studies and the meta-analysis of studies of periodontal disease.

It is clear from this presentation that the disease is well understood and standards of practice exist for the appropriate diagnosis and treatment of this disease.

Risk factors for periodontal disease (influence progress and response to treatment):

- Poorly controlled diabetes
- Smoking
- Pathogenic bacteria
- Furcation involvement
- Crown/root ratio
- Genetic pre-disposition
- Patient compliance (research now includes this as a factor)
- The risk factors are cumulative; 3 factors are greater than 1

Take-away points to assist when advising or adjudicating:

- The clinical evidence for periodontal disease is bone loss
- Gingivitis without bone loss is not periodontal disease
- Unlike dental caries, periodontal disease has intrinsic as well as extrinsic factors
- The periodontal probe has limitations when determining the degree of periodontal disease
- Clinical attachment loss is the standard measure for the disease
- Severe disease: >2 sites CAL => 6 mm
- Moderate disease: >2 sites CAL => 4 mm
- 75% of people attending dentists or hygienists do not have periodontal disease
- 8% have a genetic predisposition for the disease (this is the area of intensive research)
- Mono-therapy – one treatment modality for all is not appropriate
- The treatment objective is to assist patients to suppress microbes because they can't do it adequately themselves

Round Table Discussion Items

The informal discussion session was an effective way of asking questions and getting feedback from the CADC members present. Here is a list of some of the topics discussed:

- When it comes to ortho, should there be a lifetime maximum amount spent per tooth?
- How can plans offer a prevention instruction benefit without excessive abuse?
- Has anyone noticed a big increase in the use of periodontal appliances?
- What frustrations do people have with regulatory bodies?
- How much manual adjudication is being done?
- Does anyone have issues with restorative hygienists?
- Have any plan sponsors asked for radically different dental plans?

Dr. Liran Levin,

Perimplantitis – teeth vs implants

Dr. Levin began his lecture with the question – Tooth or implant, which do you prefer? He opined that treatment of a tooth problem by extraction should not be tied to the suitability of replacement by an implant. Dentists are not good at prognosis. Many compromised teeth last for years longer than dentists predict. The misleading public notion (sometimes supported by dentists) that implants last forever can encourage patients to choose extraction and replacement by implants.

1. Treating periodontal disease by extraction and implant placement is a false economy because patients with periodontal disease are more vulnerable to implant loss.
2. When implantitis occurs we don't know how to treat it.
3. The dental profession continues to spend too little time teaching patients plaque control.
4. Patient risk factors are the same as for periodontitis; inadequate plaque control, smoking, diabetes, intrinsic susceptibility.
5. Implants require more preventative maintenance than teeth.
6. If the rough part of an implant becomes exposed it is impossible to adequately clean.

You can read more about Dr. Levin's work at:
http://www.quintpub.com/journals/qi/abstract.php?article_id=12034

2018 Symposium, Whistler, BC

September 21 - 23

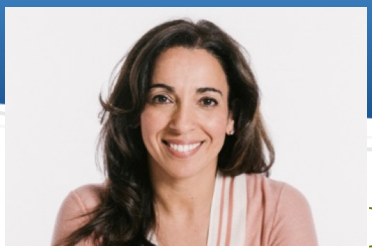
We want to hear from YOU!

All CADC members are invited to send their suggestions for speakers and topic ideas to Dr. Andrew Kay at a-skay@shaw.ca

We will be having a special session for dental plan administrators to share their "pain points" and hear how others are dealing with these issues and more.

Mark your 2018 calendar now and come to learn from dental consultants and dental plan administrators across Canada.

Learn. Connect. Share.



Dr. Reena Talwar

Implants and Bone Grafting

Dr. Talwar provided us with a lecture gleaned from her role as professor at the University of Alberta dental school.

She provided her standard of practice for predictable success when placing implants. She also provided advice on some of the contentious claim management issues.

- Full operatory and operator sterility
- Post-op, Amoxicillin or Clindamycin for 5 days
- Minimal flap
- Smokers and diabetics with caution
- Contraindications: bisphosphonates, compromised health, oral disease
- Immediate implant placement is technically difficult and sometimes ill-advised due to angulation issues

Minimal measurements for success:

- 6 mm between teeth for implant placement
- 1.5 mm from adjacent tooth
- 3 mm from adjacent implant
- Buccal bone thickness 1.5-2 mm in anterior, 4 mm in posterior
- 10 mm implant size needed for success

Grafting issues:

- Socket preservation – *Dehiscence is the only clinical indication*
- Bone grafting indicated to increase width
- Bone grafting will not achieve increased vertical height

Dental consulting take-away comments:

- Predetermination for bone grafting should be accompanied by a photo showing the defect
- Dental plans without implant coverage should allow the 3 unit bridge benefit towards a single tooth implant placement
- Guided Tissue Regeneration refers to both bone and soft tissue, in all cases only one procedure code is appropriate

Read more at:
http://www.contoursurgery.ca/meet-us/dr-reena-talwar/

We will be posting Dr. Talwar's presentation on our web site – www.dentalconsultants.ca

September Symposium 2017