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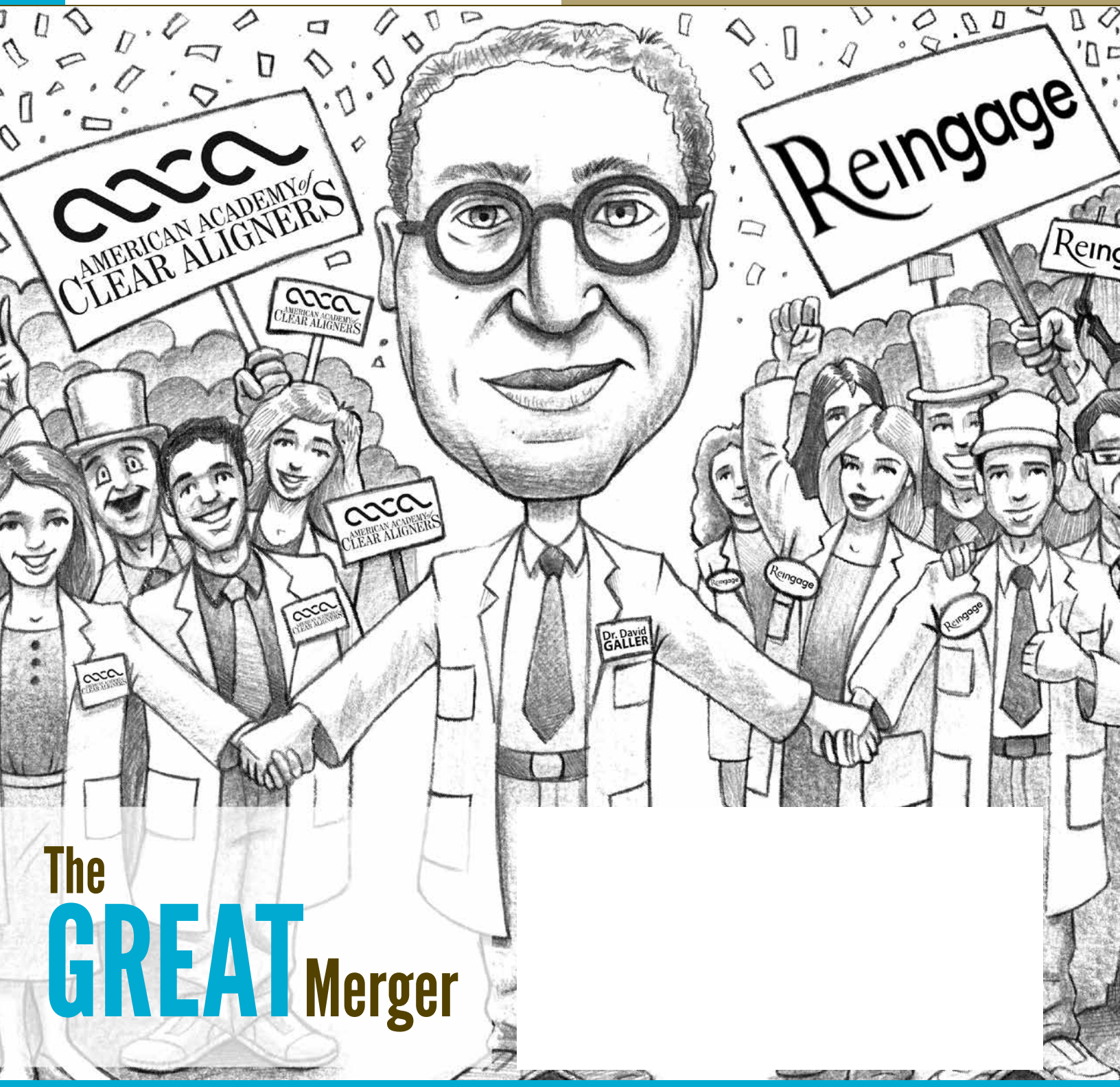
WINTER 2018

the Journal

American Academy of Clear Aligners

The Academy for Clear Aligner Therapy



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American Academy of Clear Aligners

Editorial

Attention Writers

We are delighted when we receive articles for inclusion in the *Journal of the American Academy of Clear Aligners*.

We especially welcome case studies, analytic articles, and viewpoints from readers who would like to share their expertise with our academy members.

I recently came across one of those anonymous Internet articles, containing excellent, tongue-in-cheek instructions for potential authors. I wish I knew who originated this piece, because it is clever and well written.

HOW TO WRITE GOOD

1. Avoid alliteration always.
2. Prepositions are not words to end sentences with.
3. The passive voice is to be avoided.
4. Avoid cliches like the plague. They're old hat.
5. It is wrong to ever split an infinitive.
6. Writers should never generalize.

Seven: be consistent.

8. Don't use more words than necessary. It's highly superfluous.
9. Be more or less specific.
10. Exaggeration is a billion times worse than understatement.

So, dear authors, with these instructions in mind, please continue to send us your submissions!

Dr. Jeffrey Galler
Editor

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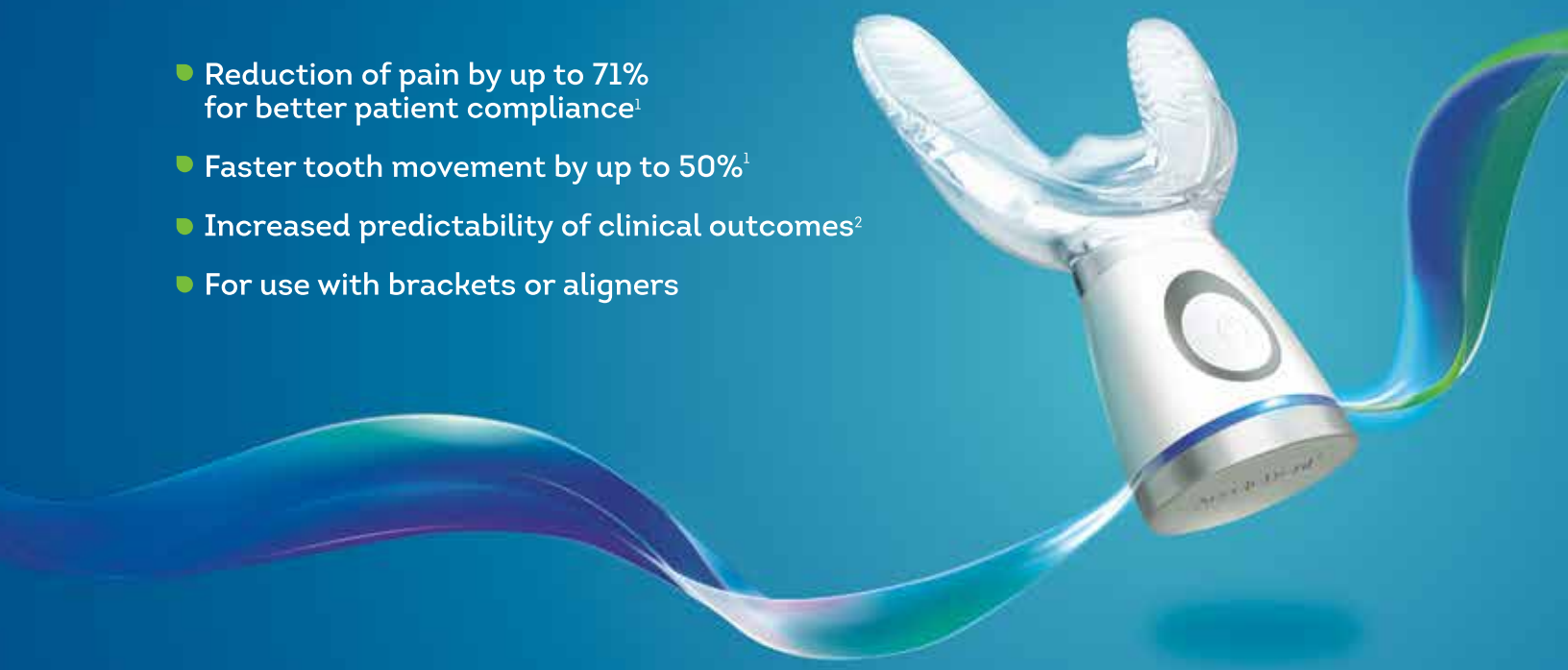

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Case Reports

A Simple, Open-and-Shut Case

by Perry E. Jones, DDS, MAGD, IADFE

Dr. Perry Jones is a graduate of Virginia Commonwealth University School of Dentistry, where he now serves as Director of Continuing Education and Faculty Development, as well as Adjunct Faculty, Associate Professor, Department of Oral Maxillofacial Surgery.

He is Director of the Virginia Academy of General Dentistry MasterTrack program, and is a Master of the Academy of General Dentistry. One of the very first GP Align Technology education speakers, Dr. Jones lectures extensively and has given some 300+ Invisalign and iTero presentations.

Currently, Dr. Jones serves as Director of Education for AACA, and maintains an active private practice in Richmond, Va.

Introduction

We treated this case some 10 years ago using Invisalign as the stand-alone force system. Although we are rapidly moving into the world of digital scanning, the majority of Invisalign providers are still using conventional PVS impressions, as we did in this case.[1]

The case was treated with 14 sets of aligners using the full Invisalign product. (In subsequent years, Align has brought out other products, such as the Invisalign Assist, Invisalign GO, and Invisalign Lite, which would also be capable of effecting the tooth movements of this case.) This case stands as an illustration of tooth movements that constitute strengths of the Invisalign force system.[2]

One of the benefits of tooth movement to a GP practice is that a practitioner can be more conservative with restorative applications. This case is a good example of a conservative approach. There are many options for a spaced case such as this one, with some restorative solutions more aggressive than others. Closing space with composite resin is a more conservative approach than the more aggressive approach of partial-veneer or full-crown enamel removal. But the most conservative approach entails neither enamel removal nor composite resin, but relies purely on tooth movement; this is the approach to follow if at all possible.

Published articles have made the case for the value of a more conservative approach, citing greater longevity of teeth where enamel is not removed. Objections to aggressive enamel reduction include concern to avoid pulpal damage, the irreversible nature of enamel reduction, and alteration of the mesiodistal (M-D) width proportion.[3] As always, the overall primary goal is to help the patient achieve improved esthetics and to deliver the very best fit and function for a lifetime of dental health.

Clinical examination

A healthy 21-year-old female with noncontributory medical history presented for dental examination. Her chief complaint was that "she did not like her smile" because of the large spaces. She further stated that she was very interested in closing the spaces, did not want "braces," and did not want to close the space with restorative materials.

We completed a comprehensive assessment and discussed the alternatives, benefits, and complications of treatment. The patient stated she was agreeable to tooth movement with Invisalign.

Diagnostic findings

Periodontal: The patient presented with moderate gingivitis, sub- and supragingival calculus, probing depths of 2-3 mm with areas of bleeding, and some slight loss of crestal bone density.

Dental: All teeth including third molars were present.

Restorative: No prior dental restorations.

Temporomandibular joint/muscles of mastication: Examination revealed an apparently healthy TMJ with no pain on palpation, full range of motion, and no joint pain or noise. The patient denied bruxing, clenching or grinding.

Figure 1: pre-treatment photo template.

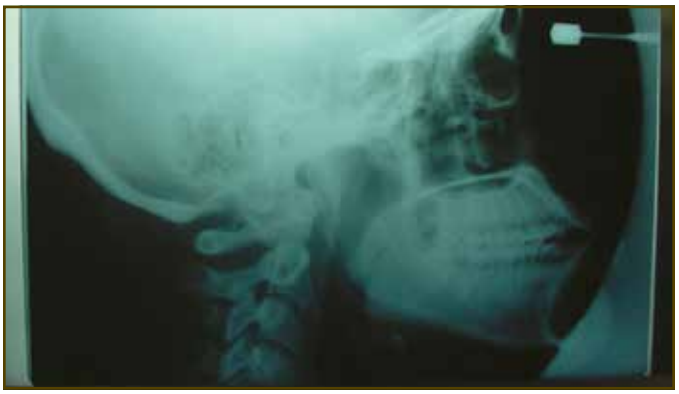


Figure 2: 2D cephalometric view.

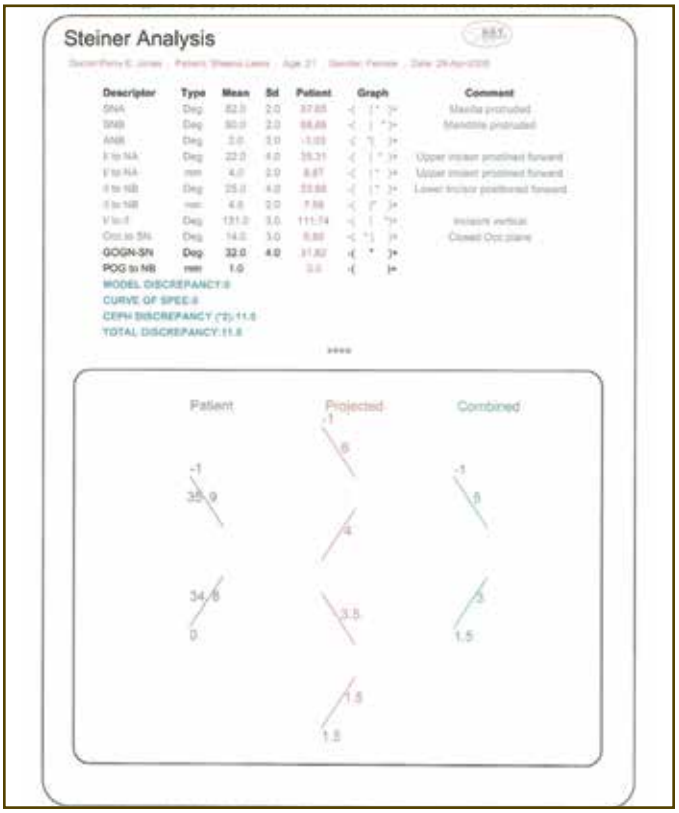


Figure 3: Steiner cephalometric analysis.

Occlusion: The patient had maxillary and mandibular spacing with a large maxillary central diastema. There was an anterior crossbite with anterior edge-to-edge occlusion. She had a Class I anterior-posterior (A-P) and posterior intercuspation.

Radiographs: Panoramic 2D imaging revealed a full dentition, including third molars. 2D cephalometric study findings included a diagnosis of bimaxillary protrusion.

Summary of orthodontic data:

- Study models
- Photo template (**Figure 1**)
- Cephalometric 2D radiograph (**Figure 2**)
- Panoramic 2D radiograph

Sagittal dimension:

- Cuspid: right and left side Class I
- Molar: right and left side Class I
- Overjet: Zero (edge to edge) with right and left anterior crossbite
- Incisor profile maxillary (Mx) flared
- Incisor profile mandibular (Md) flared
- Curve of Spee: concave
- Maxillary and mandibular bilateral protrusion

Vertical dimension:

- Overbite/deep bite: edge to edge
- Maxillary anterior leveling: Mx moderately high
- Mandibular anterior leveling: level

Horizontal dimension:

- Midline upper to facial: centered
- Midline lower to facial: centered
- Anterior crossbite: teeth #6 and #27
- Arch shape, upper: narrow tapered
- Arch shape, lower: narrow tapered
- Inclination of posterior teeth: upright

Arch length:

- Upper arch: spacing about 6 mm
- Lower arch: spacing about 6 mm
- Missing teeth: none
- Bicuspid/canine rotations >30 degrees: none

Cephlometric assessment: Steiner analysis (Figure 3):

- SNA maxilla protruded
- SNB mandible protruded
- ANB within normal range
- I/to NA upper incisor forward
- I/to NB upper incisor forward
- I/ to I/ more acute angle

Treatment objectives:

- Resolve maxillary and mandibular crowding
- Use relative extrusion to reduce labial flare and resolve anterior crossbite

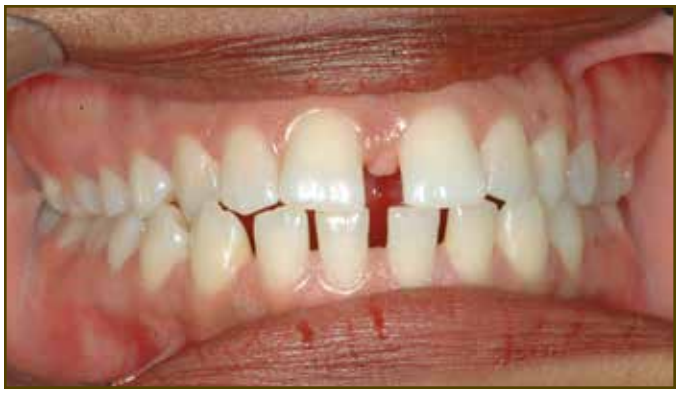


Figure 4: excellent clinical periodontal outcome. Ready for case submission!

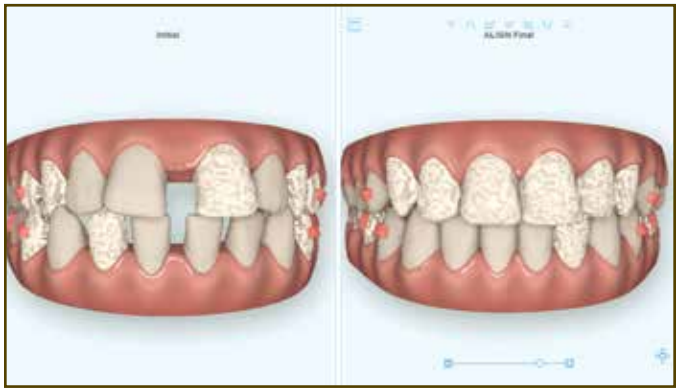


Figure 5: ClinCheck virtual tooth movement treatment plan anterior view: initial and final prediction.

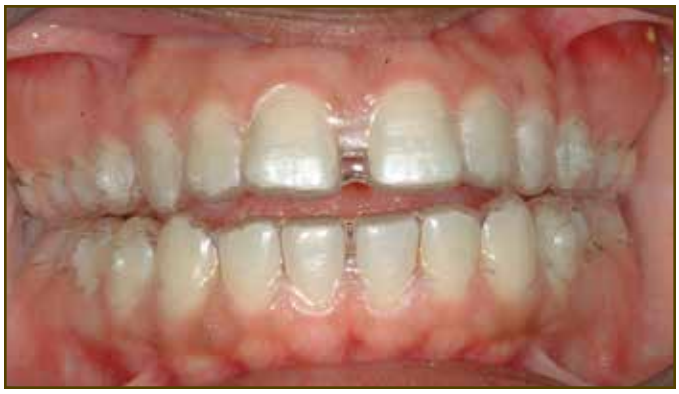


Figure 6: initial anterior view with aligner stage 1.

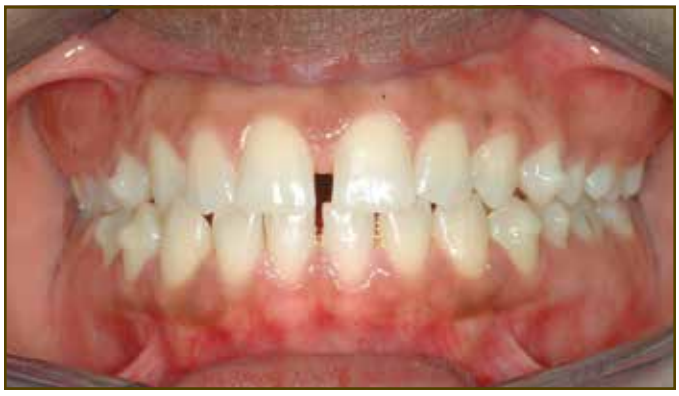


Figure 7: progress, stage 8: clinical anterior view.

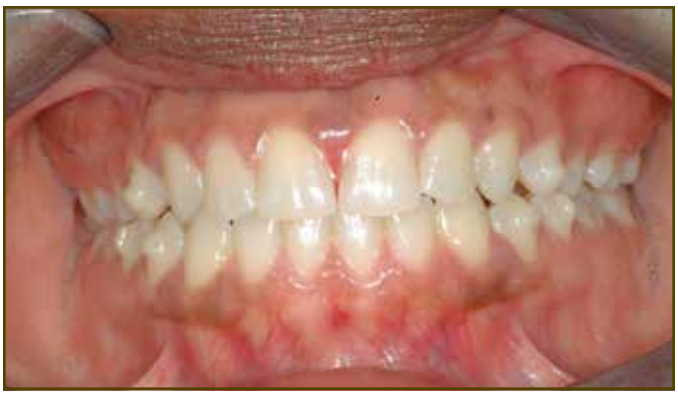


Figure 8: final clinical anterior view.

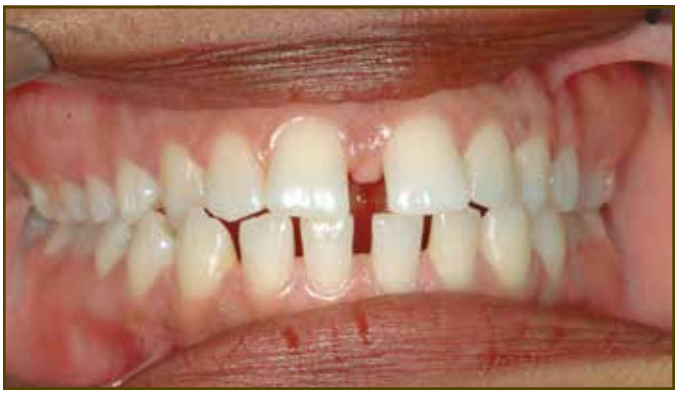


Figure 9: initial anterior view.

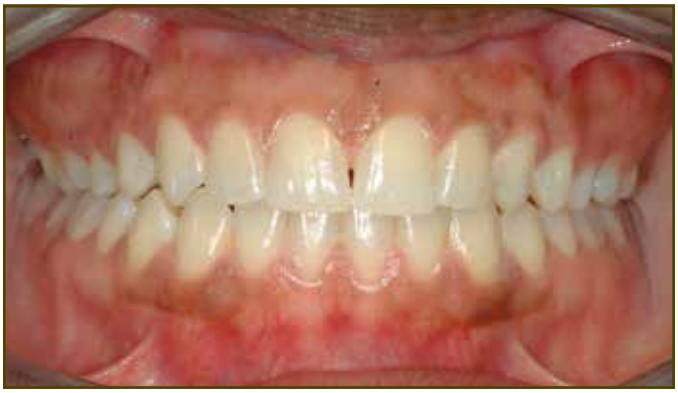


Figure 10: after 10 years, the treatment results remain stable.

Figure 11: initial and final full-face smile views. Happy patient!

- Anterior extrusion to create overbite/deep bite
- Resolve right side crossbite
- Optimize anterior esthetics with anterior leveling
- Maintain A-P relationships

Clinical treatment:
Prior to initiating Invisalign treatment, we performed periodontal therapy, consisting of scaling and root planing with removal of subgingival and supragingival calculus. The soft-tissue response was excellent (**Figure 4**).

We sent submission records (PVS impressions, photo template, and prescription form) to Align. A ClinCheck was generated, changes made, and a final treatment plan approved (**Figure 5**). The ClinCheck virtual prediction of tooth movements consisted of 14 aligner stages.

We placed attachments using the supplied template.

Sequential anterior views with and without aligners demonstrate the clinical treatment progress (**Figures 6-8**).

Following final aligner stage #14, we performed minor occlusal equilibration. For retention, the patient began wearing full-arch thermoplastic retainers.

Discussion

Treatment with Invisalign is most successful when the tooth movements are among the strengths of the movement system. Studies have shown that controlled crown movement (commonly referred to as crown tipping) is a strength of tooth movement with Invisalign.[4]

Closing anterior space using a series of clear plastic aligners is an example of crown-tipping movements. The single force that induces movement is easily applied to the crown of the tooth, creating a center of rotation in the apical third of the root. As in this case, the aligner gets slightly smaller in each stage, and this exerts a crown-tipping force that predictably closes the anterior space.

The skill set for the Invisalign treatment process in such cases is minimal. GPs are skilled at impression taking, photo taking is easily done, and placement of composite resin attachments using a plastic template is easy to master.

Figures 9 and **10** illustrate that the clinical outcome is excellent. The patient was extremely pleased with her new smile (**Figure 11**)! ■

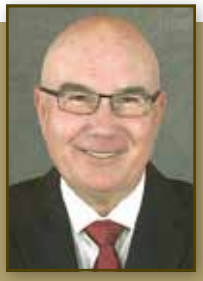
References:

1. Xu JQ, Murphy SL, Kochanek KD, Arias E. Mortality in the United States, 2015. 1. Kravitz ND, Groth C, Jones PE, Graham JW, Redmond WR. Intraoral digital scanners. *J Clin Orthod*. 2014 Jun;48(6):337-347.
2. Djeu G, Shelton C, Maganzini A. Outcome assessment of Invisalign and traditional orthodontic treatment compared with the American Board of Orthodontics objective grading system. *Am J Orthod Dentofacial Orthop*. 2005 Sep;128(3):291-298.
3. Christensen GJ. Are veneers conservative treatment? *J Am Dent Assoc*. 2006 Dec;137(12):1721-1723.
4. Kravitz ND, Kusnoto B, BeGole E, Obrez A, Agran B et al. How well does Invisalign work? A prospective clinical study evaluating the efficacy of tooth movement with Invisalign. *Am J Orthod Dentofacial Orthop*. 2009 Jan;135(1):27-35. doi: 10.1016/j.ajodo.2007.05.018.

Practice Management

What Do Patients Want From Their Dentist?

by Jim Du Molin



According to his website, Jim Du Molin "is a leading Internet marketing expert for dentists in North America. He has helped hundreds of doctors make more money in their practices using his proven Internet marketing techniques. He developed **TheWealthyDentist**® email newsletter as a way to share the 30-plus dental management and marketing strategies he has developed and tested over the last 20 years working with dentists."

I've run this survey over and over again, and it always comes up with pretty much the same things.

Greet them warmly.

The first thing people want when they go to a dentistry practice is to be greeted by name by a warm smiling face when they walk through the door.

"Good morning, Mrs. Jones, we're so happy to see you today!"

When people are greeted cheerfully and respectfully, they feel much better...and that makes a big difference in case presentation acceptance.

Don't keep them waiting.

Patients want to hear these words: "Step right this way, Mrs. Jones. The dentist is ready for you."

People just don't want to wait for their appointments. They want to be moved into that operatory almost immediately when they walk through the door, if at all possible.

This is an important part of the patient experience...and remember, a happy patient is someone who's preheated for case acceptance!

Write down those financial arrangements.

Patients also want written financial arrangements.

People are not so much concerned about the cost of their treatment as about how they can make it affordable.

So, it's very important to explain in writing how patients are going to pay for care and what their expenses are going to be. ■

How Many Rings Until You Answer

by Jim Du Molin

I've got some more advice for your front desk on effective call handling:

You want to be sure you answer your phone within 2 to 3 rings.

All the studies tell us that 2 to 3 rings works really well. People feel that they're getting immediate attention.

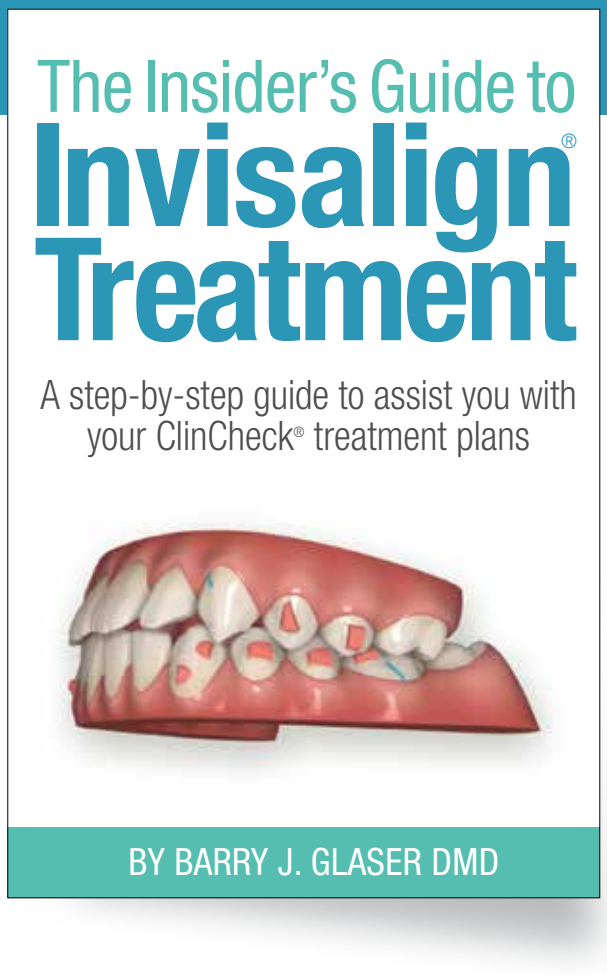
People really don't want to have to listen to it go for 6 rings and then get the machine.

Personally, I've even had it go 9 rings before it goes to voice mail. It drives me a little nuts. I don't know whether I've got the right office. I don't know whether I'm going to get a machine. If I'm going to get a machine, I don't want to have to wait for it.

So take a moment to ask yourself: How quickly does your phone get answered?

This is one area where seconds really do count!. ■

Groundbreaking Book on Invisalign® Treatment – *Think Force Systems, Not Teeth!*



THIS STEP-BY-STEP GUIDE TEACHES:

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- How to "over-engineer" your ClinCheck® plans to achieve excellent results
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- How to save valuable time with efficient, comprehensive virtual treatment planning
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Check out the **patient edition**, *The Insider's Guide for the Invisalign Patient.*

Financial Management

The Basics of Retirement Planning

by Ralph Adorno

Chartered Life Underwriter Ralph S. Adorno is an independent financial professional with more than 46 years of experience in financial services. He serves clients whose net worths range from $250,000 to $1.5 billion. Using his proprietary Income-Legacy Planning method, he works with clients to create, preserve, and maximize their wealth.

Mr. Adorno holds insurance licenses in 12 states and is a member of the Estate Planning Council and the National Association of Insurance and Financial Advisors. For more information about him, his firm, and the services they offer, visit: rsaretirement.com.

Year after year, having enough money for retirement consistently comes up as number one among Americans' long-term financial concerns. Consider:

- The Employee Benefits Research Institute reports that nearly half of all Americans (47%) aren't confident they'll be able to afford living comfortably in retirement, up from 29% in 2007.
- A survey by Allianz Life in 2012 found that 28% of Baby Boomers age 55 to 65 are worried they won't be able to cover their basic living expenses in retirement, and that 43% don't plan to focus on retirement planning until they're five years or less away from retirement.
- A Wells Fargo survey released in October 2012 found that 30% of middle-class Americans believe that to retire comfortably, they'll have to keep working until they're 80 years old.

Here are the basic steps involved in creating a retirement plan. The objective is to introduce you to the retirement planning process, so you can be confident that there is a way to map out your future.

Step 1: Set a goal

Everybody has dreams about retirement: beginning a life of leisure, traveling, dining out, visits with relatives and friends, or whiling away the hours. There's nothing wrong with dreaming; in fact, it's necessary to give your life direction. But in the world of financial planning, dreams aren't goals. The difference is that a financial goal is a measurable objective, with two components: a **precise amount of money** to be available at a **specific future date**.

For retirement, then, choose a date. It's okay if you're not actually sure if you can retire by that date. This is the one data point where you're encouraged to state your wish, because the realistic date will really be affected by the second part of the goal: the annual income you want to live on. And how do you decide that? Forget about inflation and use your current household income as a guide. A rule of thumb says that you can maintain the same lifestyle you currently enjoy at anywhere from 60% to 80% of your current income. You can also use current dollars and adjust later for future inflation.

Step 2: Determine your defined annual retirement benefits

For most people, defined annual retirement benefits include Social Security income and perhaps a company pension. You can get an estimate of your Social Security benefits by contacting the Social Security Administration or visiting its website. For your projected pension income, contact your employer's human resources department. You could also include in this sum any predictable income you may expect to receive.

Step 3: Calculate your income gap

Subtract your total defined retirement benefits in Step 2 from the retirement income you defined in Step 1. This is your income gap—the amount of annual income you're going to have to generate from your own savings or other investments.

Step 4: Determine the approximate size of the retirement fund you're going to need

Divide your income gap by the rate at which you plan to draw from your nest egg every year in retirement, expressed as a percentage. Many experts suggest a number between 3% and 4%—a rate that aims at keeping retirees from running out of money over the long run.

Step 5: Calculate how much your current savings balance needs to grow each year

First, tally up the current balances of all the accounts you intend to use to fund your retirement. Second, add into that sum any lump sums you can expect to receive between now and the day you retire. This can include inheritances, the sale of a business, or the sale of any other hard assets, like real estate.

Now subtract this total amount from the nest egg amount you calculated in Step 4 and divide by the number of years you will continue to work. The resulting number represents the average amount of growth your retirement accounts will need until you retire.

Step 6: Determine where the growth will come from

This is the point at which you can determine if you're on track to meet or exceed your goal, or if it's unrealistic and you need to change some of the variables. For a start, reduce the average annual growth amount you defined in Step 5 by the amount you are already saving per year. The remainder is the amount that you will have to earn from investment returns.

To get a very rough idea of the rate of return you'll need, divide that remainder by your current lump sum. The rate you actually need will be less, if it's in a tax-deferred account, because compounding will make the effective growth rate a bit higher. Finally, add in an estimated rate of inflation.

This has only been a rough sketch of retirement planning, and it leaves out the final parts: creating and executing an investment strategy, and monitoring it year by year. ■

Ralph S. Adorno, C.L.U. & Associates
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Pre-restorative Orthodontics

Restorative Challenge #2: Orthodontic Treatment Involving the Vertical Dimension of Occlusion

by Richard Schmidt, BSc, DDS

Dr. Richard Schmidt asserts that "Orthodontic treatment can enhance the long-term predictability of restorative dental treatment by positioning the teeth in their optimal location within the dental arches." In a poll of dentists, he identified the top 6 restorative challenges that dentists feel can be made easier with pre-restorative orthodontics. This is the second of his 6-part series of articles, discussing these challenges.

Dr. Richard Schmidt practices general dentistry in Brampton, Ontario. He has been in practice with his wife, Dr. Tamara Sosath, for 29 years. He has always had an interest in orthodontics and recently introduced Clear Aligner Therapy (Invisalign) as a treatment option for his patients to establish a sound occlusion. In addition to treating teens with Invisalign, he is utilizing it to align teeth conservatively for rehabilitative restorative treatment.

Introduction

For simplicity, the abbreviation VDO will be used here to denote vertical dimension of occlusion. There are many different opinions regarding VDO. The confusion stems from the differing views regarding how to treatment-plan a new VDO, whether it can be modified, and what complications the modification may engender.

A wide variety of opinions usually indicates that they are all correct—some of the time. It is nice to know, at least, that there is one common definition, as provided by the Academy of Prosthodontics: "VDO is the distance between two selected anatomic or marked points (usually one on the tip of the nose and the other on the chin) when in maximum intercuspation"[1] (**Figure 1**).

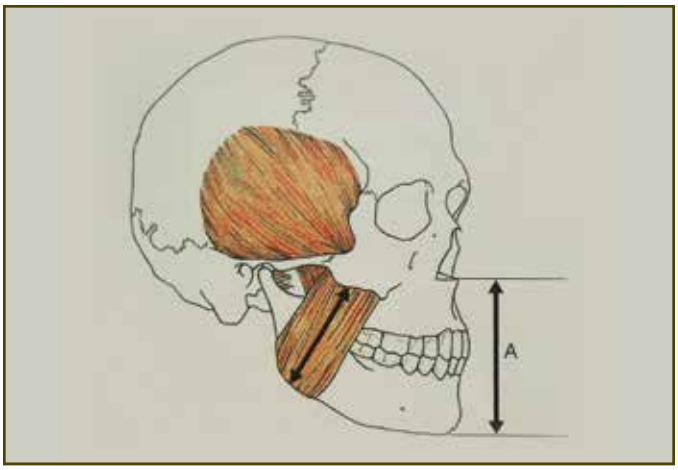


Figure 1: the measurement A represents the VDO. From Dawson; used by permission of the publisher.[2]

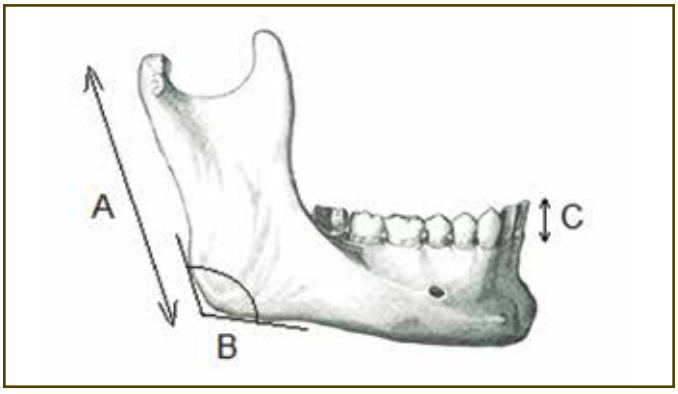


Figure 2: A = length of the ramus; B = mandibular gonial angle; C = tooth position.

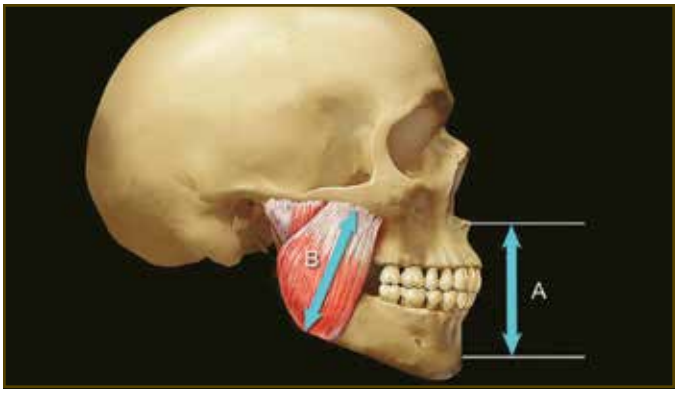


Figure 3: A = VDO; B = contracted length of the masseter muscle. From Dawson; used by permission of the publisher.[2]

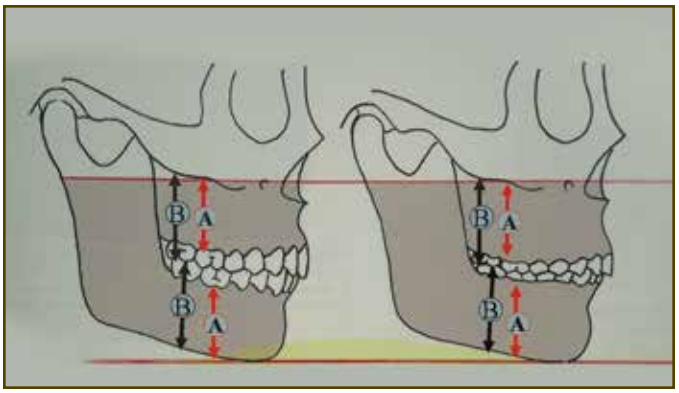


Figure 4: VDO remains constant with wear. The dimension (A) from a bony landmark to the CEJ increases with extensive wear, but the dimension from the same landmark to the occlusal surface remains the same. From Dawson; used by permission of the publisher.[2]

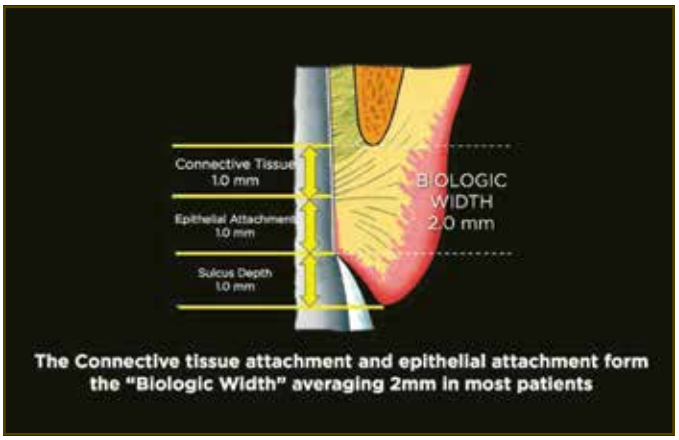


Figure 5: schematic representation of biological width. Used by permission of Dr. Frank Spear and Spear Education.

As with many issues dentists encounter in the oral cavity, nothing is as simple as it first appears. The determinants of VDO can be best understood if the concept is divided into hard and soft tissue components.

A) The hard tissue determinants (**Figure 2**) include
- The length of the ramus
- The magnitude of the mandibular gonial angle
- The eruption of the teeth during growth and development, and the degree of dentoalveolar eruption (DAE) in the non-growing patient

Figure 6: a 77-year-old patient with minimal wear and minimal DAE.

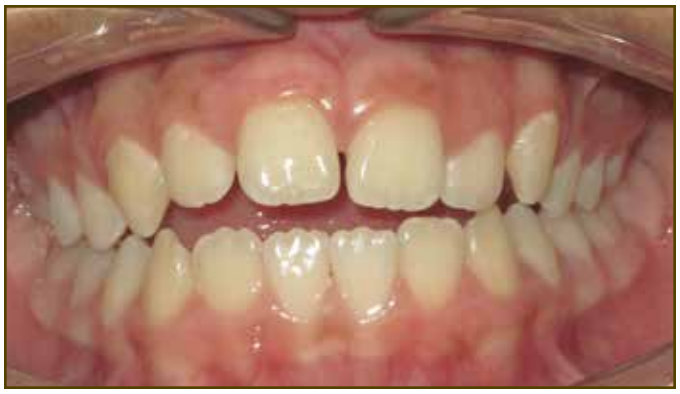


Figure 7: thumb-sucking habit obstructing DAE.

B) The soft tissue involvement is determined by the repetitive contracted length of the elevator muscles, the major muscle being the masseter muscle (**Figure 3**).

The relationship between the hard and soft tissue components determines the VDO. It is genetically influenced and therefore specific for every individual.

In a healthy mouth, free of extensive tooth breakdown and loss of posterior axial inclination, the VDO remains constant over time. However, an interesting phenomenon can be observed when extensive tooth wear is present. The VDO remains relatively constant in the worn dentition, owing to commensurate increase in alveolar bone height (**Figure 4**).

This author refers to this phenomenon as dentoalveolar eruption (DAE). As long as the rate of DAE is similar to the rate of loss of tooth structure, there is no reduction of the VDO.

To fully understand DAE, one must go back in time.

The clinical crown erupts out of the alveolus until the cementoenamel junction (CEJ) is approximately 2.0 mm exposed above the alveolar crest. At this point, the supracrestal biological width of the periodontium develops, composed of the connective tissue and epithelium attachments (**Figure 5**).

Any additional vertical movement of the clinical crown is the result of DAE. The evidence for DAE is discussed in the previous article in this series, in the Fall 2017 edition of the *AACA Journal*.

Teeth are very adaptive to the space around them mesially/distally and occlusally/incisally. In an otherwise "normal" oral environment, in the absence of wear, the eruptive force of the dentoalveolar complex is balanced by an opposing restrictive force, usually provided by an opposing tooth (**Figure 6**).

DAE is an active, ongoing vertical process responsible for teeth remaining in occlusal contact in the presence of wear. DAE can be interfered with by an obstructive force, such as that imposed by tongue, lips, a digit or thumb, a smoker's pipe, or an appliance covering the occlusal surfaces (**Figure 7**).

Skeletal disharmony of the arches also demonstrates the effects of this constant eruptive force, as seen in Class II and III malocclusions. In Class II, the opposing restrictive force is usually supplied by the palatal tissue of the maxillary incisors (**Figure 8**).

The maxillary lip can provide the opposing restrictive force in Class III malocclusion (**Figure 9**).

The scope of this article is to discuss the treatment of 3 patients with varying diagnosis and treatment plans involving VDO. The following will **not** be discussed:

- The varying theories on how VDO should be established
- The different scenarios on how growth and development influence VDO
- The suggested concerns of altering VDO

For additional detailed information, the author suggests reading the article written on this subject by Dr. Frank Spear[3] and the textbook by Dr. Peter Dawson.[2]

What causes reduced VDO?

- Collapse of the posterior segment due to tipping of teeth, loss of teeth, or occlusal wear
- Rate of tooth wear not compensated for by rate of DAE

The practitioner should be aware that in addition to the need to restore severely worn teeth, an underlying medical condition might be lurking. It has been shown that bruxism can be related to restricted airway issues, namely sleep apnea.[4]

Why would a dentist alter the VDO in the treatment plan?

- To provide space for restorative material to rehabilitate worn/structurally compromised teeth

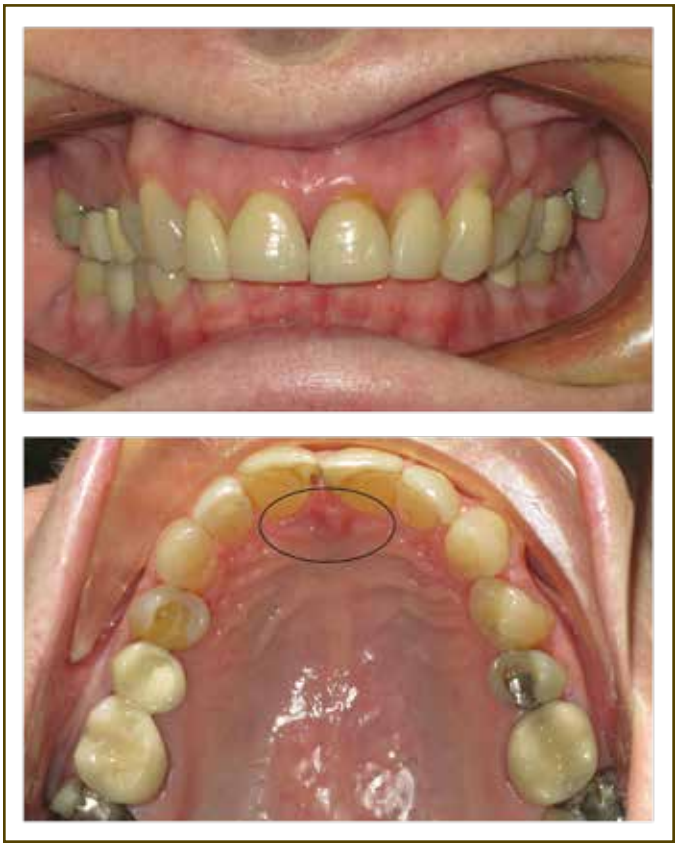


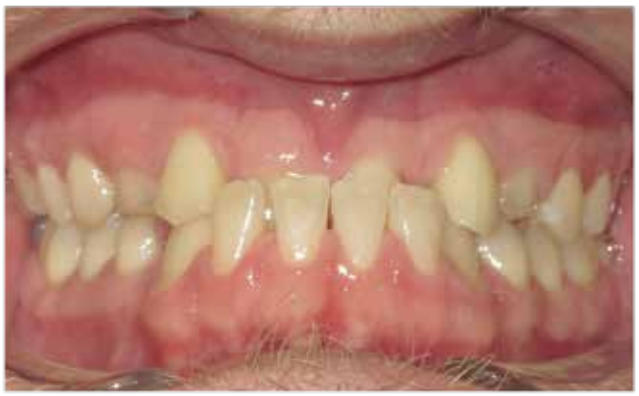
Figure 8: clinically, the palatal tissue demonstrates imprint from the opposing incisal edges (with black circle).

- To improve the occlusal relationship: e.g., in a patient with edge-to-edge anterior occlusion, the clinician can rotate the mandible down and back, thus improving overjet and the interincisal relationship, and providing the opportunity to improve anterior guidance
- To provide the environment to improve aesthetics by altering the incisal edge position, gingival display or facial form through jaw surgery

Will the patient benefit from altering the VDO? (Will altering the VDO improve the prognosis of the dentistry?)
This is the number one question which must be asked! According to Dr. Spear, the areas of concern most dentists have when contemplating altering the VDO are:

- Effects on the TMJ
- Degree of muscle pain
- Stability of new VDO
- Effects on muscle activity and bite force
- Effects on speech

Dr. Spear discusses the concerns in his article, and this author highly recommends seeking out the article for advanced learning.[3] All of these concerns have been shown to cause minimal long-term consequences in the majority of patients.



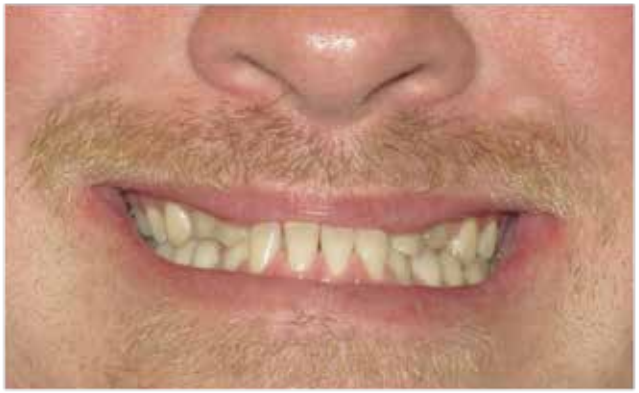
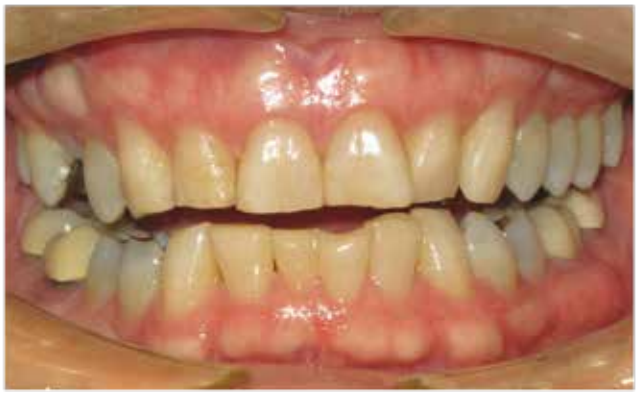


Figure 9: in Class III, the maxillary lip offers the obstructive force interfering with DAE of the incisors.

Figure 11: diagnostic wax-up used for additive resin restorations and increasing VDO (Case 2).



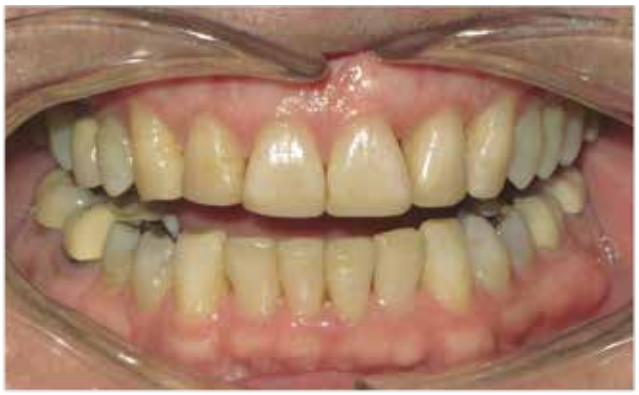


Figure 10: segmental anterior wear restored conservatively using an orthodontic/restorative approach without increasing the VDO.

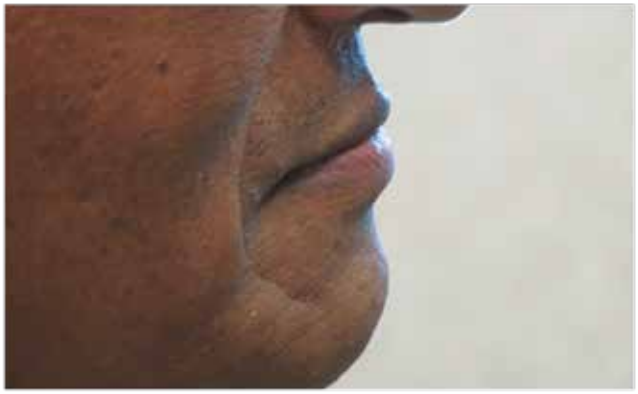


Figure 12: (top) at rest and (bottom) at maximum intercuspation: a soft tissue labial fold suggests decreased VDO (Case 1).

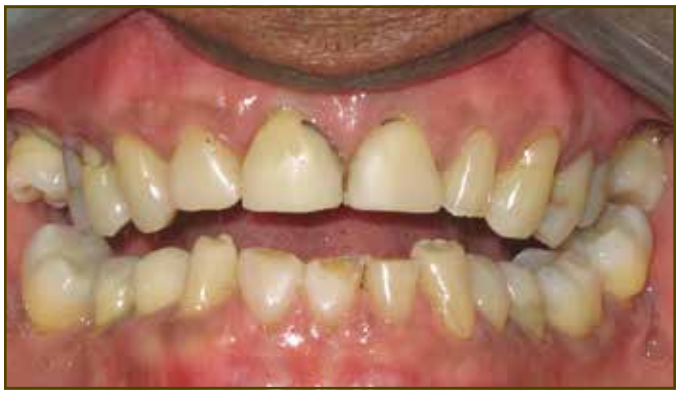


Figure 13: loss of VDO caused by mesial and distal tipping of posterior teeth and palatally inclined maxillary posterior segment; DAE did not compensate for reduced VDO. Note wear on incisal edges (Case 1).

How does one alter the VDO?

The common approaches are:

- Surgical treatment
- Orthodontic treatment
- Restorative treatment
- Placing the condyle in a fully seated position in the fossa
- Any combination of the above

Should the VDO be increased?—a common misconception

A question which often arises when a challenging case presents for treatment planning is "Should the VDO be increased?" This usually results when diagnosing a segmental anterior worn dentition, and the clinician commonly applies the phrase "loss of VDO" in the diagnosis. Yet in the presence of healthy, **unworn** posterior teeth, with an acceptable axial inclination, it is highly unlikely that a loss of VDO has actually occurred.

Most commonly, segmental wear involves the anterior teeth, and the posterior teeth are unworn. The treatment of choice for anterior segmental wear is an orthodontic/restorative combination approach which will not increase the VDO (**Figure 10**). The correct diagnosis is essential, to avoid unnecessary restorative treatment and iatrogenic removal of healthy tooth structure.

If generalized wear is present, involving most of the posterior and anterior teeth, the already worn and shortened crowns will require treatment. If the restorative treatment will involve extensive tooth reduction, possible pulpal involvement, and the need for surgical crown lengthening to expose additional clinical crown structure for retention form, then an additive restorative approach will be more conservative, but increasing the VDO will be inevitable (**Figure 11**).

The body's ability to adapt to reasonable modifications will provide a stable, long-term result.

Orthodontic treatment alone will not increase the VDO; however, the positioning of the teeth into a more optimal location will, in conjunction with restorative treatment, provide the best outcome. The following cases demonstrate how the

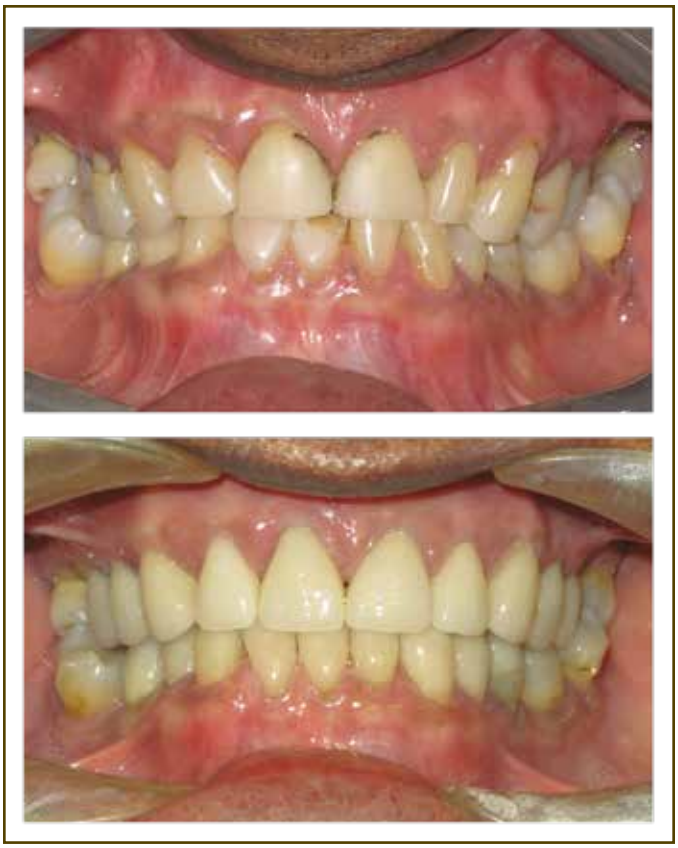


Figure 14: note the increase in distance from the gingival margins in the premolar areas, indicating an increase in VDO (Case 1).

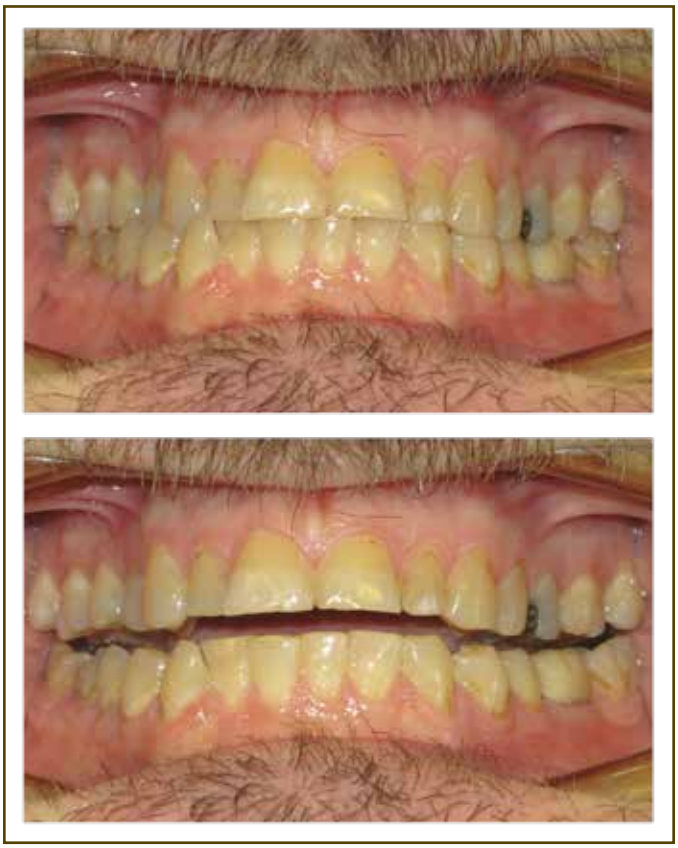


Figure 15: generalized wear and loss of tooth structure (Case 2).

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VDO can be altered using clear aligners, to provide the patient and clinician with a very satisfying result.

Case #1

A 67-year-old patient was referred by his wife, who had just completed a major orthodontic/restorative treatment plan. His chief complaint was "My front fillings keep breaking the next day after my dentist placed them." He presented with a Class III malocclusion, unfavourable axial inclination of the posterior segments, and an edge-to-edge anterior relationship (**Figure 12**). The tipped posterior teeth contributed to a collapse of occlusion and a decrease in VDO. In order to restore the incisors with a favourable and long-term prognosis, anterior space had to be developed.

A significant soft tissue labial fold, both in the maxilla and mandible, when in maximum intercuspation, evidenced a decrease in VDO (**Figure 13**).

Treatment involved an orthodontic/restorative approach. Initially, we used Invisalign clear aligners to upright posterior buccal segments, to improve axial inclination, and dentoalveolar intrusion (DAI) of the mandibular incisors to increase space for restorative material. As the VDO was increased, the mandible auto-rotated down and back, improving the overbite/overjet relationship (**Figure 14**). This allowed the improvement of the anterior occlusion, from edge-to-edge to a more favourable anterior guidance.

Case #2

John has been a patient in the practice for approximately 20 years. During this time, we had noted his erosion and wear (**Figure 15**) but never developed a definitive treatment plan, since the author lacked the knowledge and experience to diagnose and treatment-plan the situation. More recently, with a few years of clinical education under his belt, the author presented the necessary information to the patient, and he agreed to the treatment plan, albeit a phased one. It will involve Invisalign orthodontic treatment to improve the alignment of the teeth (**Figure 16**), followed by a full-mouth rehabilitation, initially using conservative resin restorations (**Figure 17**). When it is financially suitable, the patient will phase into stronger, ceramic restorations.

With the amount of occlusal/incisal loss of tooth structure, one would assume that a reduced VDO is present. However, according to Dr. Dawson's findings, DAE has acted to maintain tooth contact, and therefore, the patient has had no loss of VDO. An accurate assessment of VDO would involve comparing serial cephalometric radiographs by superimposing on some bony landmarks (e.g., the nasion and menton).

Case #3

Not all VDO treatment requires pre-orthodontic treatment. Ed was referred to our clinic for a consult regarding his worn dentition. It was the most severe case of a worn dentition the author has ever come across (**Figure 18**). He was 63 years old and had been a patient in his former dentist's care for almost 20

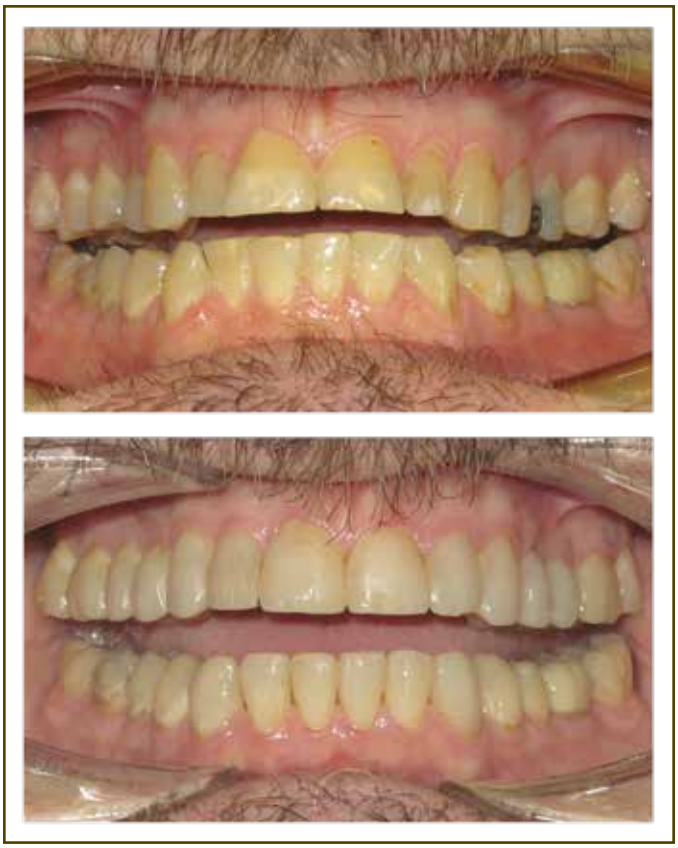

Figure 17: phased conservative resin restorations post–Invisalign treatment (Case 2).

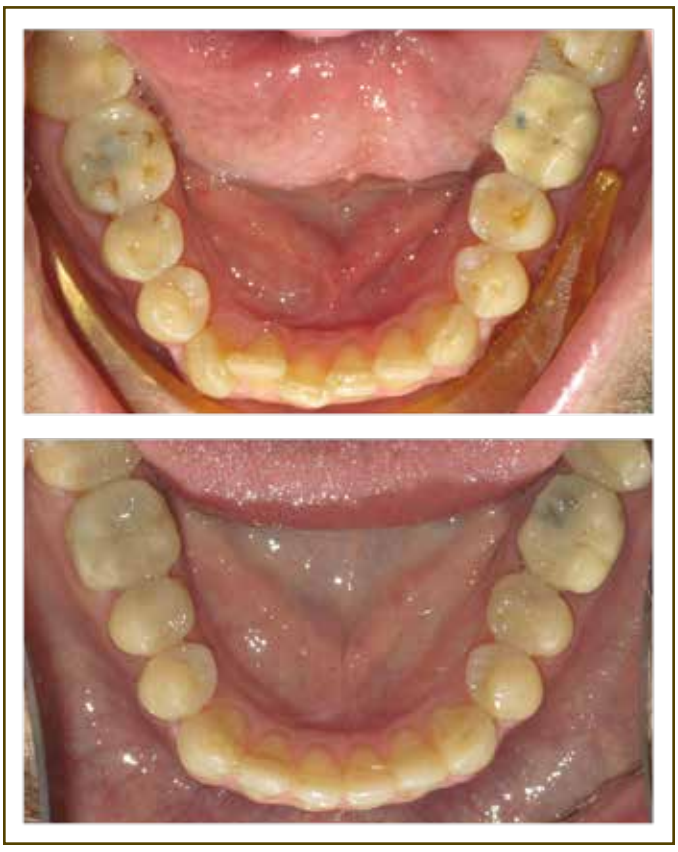

Figure 16: Invisalign orthodontic treatment to correct mandibular anterior crowding (Case 2).

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years. And as with the patient in case #2, the dentist was unsure how to proceed.

Ed's treatment involved 6 root canal treatments, followed by posts and cores, numerous resin buildups, and a fixed bridge. Again, for financial reasons, the treatment has been phased, and will continue when the patient is ready to proceed. In this case, the VDO was increased using restorative treatment alone **(Figure 19**).

Conclusion

When a patient has reduced VDO, the treatment of choice is the least amount of dentistry that will establish a VDO which fulfills the aesthetic and functional needs of the patient. When possible, one should always treatment-plan at the patient's current VDO. As always, a proper diagnosis is necessary to determine if the patient can benefit from increasing the VDO and from the subsequent restorative treatment. Clear Aligner orthodontic treatment can provide the framework to achieve the objectives. ■

References:

1. Academy of Prosthodontics. The Glossary of Prosthodontic Terms: 9th Edition. *J Prosthet Dent*. 2017 May;117(5S):e1-e105. doi: 10.1016/j.prosdent.2016.12.001.
2. Dawson PE. *Functional Occlusion: From TMJ to Smile Design*. Maryland Heights, Mo.: Mosby; 2007.
3. Spear FM. Approaches to Vertical Dimension. *Adv Esthet Interdiscip Dent*. 2006;2(3):2-6,8-12,14.
4. Attanasio R, Bailey D. Sleep Medicine and Dentistry. *Dent Clin North Am*. 2012 Apr;56(2):387-413.

Figure 18: severe generalized wear, with no benefits of orthodontic treatment (Case 3).

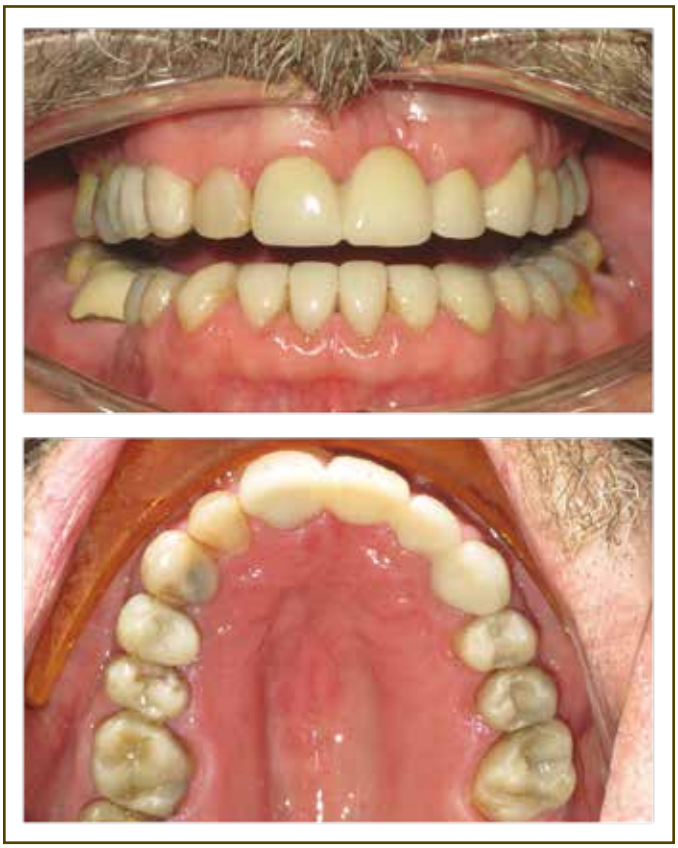

Figure 19: the VDO was increased using restorations only (Case 3).

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Viewpoint

It Is What It Is.

Being Honest With Your Patients Can Propel Your Career as Well as Their Oral Health

by Christopher Hart, DDS

Dr. Christopher Hart obtained his DDS degree at the Indiana University School of Dentistry and his BS in dental hygiene at the University of South Dakota.

Dr. Hart is the owner of Hart Dental, Center for Modern Dentistry in Mitchell, South Dakota, is active in his church and community, active in study groups, and enjoys helping others with Invisalign treatment. Dr. Hart is an Invisalign Premier Provider and devotes a significant amount of time to Invisalign treatment for the patients of the practice, focusing on adult orthodontic treatment and pre-prosthetic case preparation.

The answer was there in front of us. We stared, squinted, and turned our heads as if somehow the image would magically mutate into what we wanted. But nothing changed.

There it was: a black, ominous, oblong radiolucency creeping all the way up the mesial root of tooth #19. Root fracture. An extraction was the only reasonable next step.

At this point, my then employer and mentor looked at me and said, "Well, Dr. C, *it is what it is*." We proceeded to walk over and tell Mrs. Jones the news we were obligated to share.

Years later, that piece of wisdom plays in my head nearly every day: *It is what it is*.

Although we may not enjoy it, as dentists, we usually handle delivering diagnostic news with relative ease. Solving problems—and especially preventing bigger ones on the horizon—is a big part of what we do.

When patients come in with carious lesions, hurting or not, we make the diagnosis and tell them. When patients have issues that are painful, visibly broken, or ugly, we tell them. Whether they want it, or can afford it, we tell them. *It is what it is*.

One day, though, I made a subtle shift. I decided to give my patients *all* the information I could. Even if the problems didn't fit into the category of painful, visibly broken, or ugly. Even if I thought they might not want it or could not afford it.

That decision changed the way I practice forever.

Within months, the number of Clear Aligner cases I was treating jumped 1,000 percent. Within the year, I was an Invisalign Preferred Provider, and I soon became a Premier Preferred Provider, treating more Invisalign patients than any general dentist in my state.

You might be surprised to learn that my practice does not serve a metropolitan area. I live in a rural community of 15,000 in the middle of endless miles of farmland. Nine out of 10 of my patients are more interested in function than esthetics.

You might think I am the only Invisalign provider in my area. No, there are 12 other great dentists and 2 orthodontic offices in our town, and most also provide Invisalign treatment.

I do very little marketing and have no magical powers to persuade patients to treat their orthodontic needs. Like the no-nonsense people in my community, I just started calling it as I see it. And patients have benefited.

As dental professionals, we choose whether we offer what is best for our patients. Seventy percent of patients present with a malocclusion of some kind. Hence most of the time, we have an opportunity to call it as we see it and give our patients a choice.

So the next time Mr. Smith is sitting in your chair and it looks as if someone took a chainsaw to his lower anteriors, don't ask yourself if he wants orthodontic treatment, or if he can afford it. Remind yourself that he came to you with that bite—you may have even allowed some of the destruction to progress—but you now know how to prevent it from going any further. And watch how caring enough to be honest benefits not only your patient's health and his enjoyment of his smile, but your practice's health and your enjoyment of your career. ■

Post Invisalign Treatment of BlackTriangles Using the Bioclear Method

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Presented by:
Dr. David Galler, DDS,
Dr. David Clark, DDS,
and
Dr. Jihyon Kim, DDS

2018 Dates:
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Social Media & Technology

Getting the Word Out:

4 Simple Ways to Promote Your Practice Website

by Melody Gandy-Bohr

Exposure is everything, especially where your practice is concerned. It can be difficult to stand out with the increasing number of competitors in your area, so an effective online marketing strategy is vital. Your practice website can go a long way toward bringing new patients through your door, but they have to find your site first. Read on for 4 easy ways to promote your practice website, increase online traffic and earn new patients.

Get active on social media

The best way to bring eyes to your website is to be active on Facebook and Twitter. A study revealed that consumers from the ages of 35 to 48 spend the most time on social media, about 7 hours per week. You practice can tap into that demographic by creating interesting social media posts that encourage patients to visit your website for more information. Moreover, they may share your posts with their friends, expanding your target audience base.

Manage local listings

The majority of users who click on your practice website rely on the local listings such as Google+ and Yelp to make that decision. 91% of users will read an online review, so make sure that your listings are updated and that you respond to both positive and negative reviews.

Feature patient testimonials

Word-of-mouth recommendations carry a lot of weight, especially when it comes to health-care practices. Patient testimonials add authority to your practice by showing examples of real-life patients who recommend your practice and vouch for your services. Add links to your testimonials across your entire web presence, including your social media accounts and your practice blog. Curious users will want to visit your website to read more testimonials and learn more about your practice.

Start a video strategy

Video marketing is on the rise. In fact, adding a video to a landing page can increase conversion by an amazing 80%. Whether the videos you're creating directly promote your practice or provide educational content for your patients, videomarketing is an excellent way to drive users to your practice website.

Implementing these 4 tips into your online marketing strategy will help promote your practice website and potentially increase your patient base. Promoting your site is a continuous process. Make sure to keep updating your social media accounts, monitoring your listings, and above all else, regularly updating your website! ■

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Reingage News

Reingage Chapter Highlights

Years ago, I started with a vision to create an educational course that could teach dentists everything that they needed to know about Clear Aligner Therapy with Invisalign via a 2-day hands-on course. I wanted to call it "The Course That Changed Everything."

Fast-forward 4 years later, and it has become the largest force in the North American GP Invisalign market. Reingage doctors make up many of the top GP providers in North America. Combined, the group submitted almost 25,000 cases in 2017—making it the largest submitting group in the world. The group's hallmarks include a passion to provide the best Invisalign treatments in North America. There is a large emphasis on a family feeling, with kindness toward other members about things related to both their dental and their personal lives. We strive to be the most knowledgeable and effective Invisalign providers in the world.

As the class hit close to 1000 attendees from 30 classes, we decided to migrate into a nationally recognized, AGD-accredited academic institution. The one most closely aligned with our vision and goals is the American Academy of Clear Aligners. This issue marks the merger of 2 great educational institutions in North America.

We welcome all the Reingage Family and doctors into the American Academy of Clear Aligners. We hope to unite in our quest for knowledge about the best, most predictable and effective ways to treat the patients who entrust their care to us. We will never stop learning and never stop improving. I am proud to have led both groups for the past few years, and now, to have brought them together. —Dr. David Galler

ARCH MADNESS Reingage course

BAM! Arch Madness ended the year with a bang, with Dr. Anna Berik (Wicked Straight, Boston) teaching her accelerated method of treating Invisalign patients with Propel. On December 1, the St. Louis–based Gallerites met up for their second study club of the year following June's course with Dr. Danièle Larose (Montreal Wolfpack). We are looking forward to our next family reunion in Spring 2018!

BOTEX Reingage course

Following a successful Invisalign Summit in September, the second Reingage group ever, Botex, had a social meeting at Magiano's in Dallas on Friday, November 3rd. We also had three Reingage members from outside of Botex join us. It was a great opportunity for us to come together and enjoy each other's company without a formal program. We are looking forward to our planned CE event in Dallas in January.

The Capitaligners capped off a great year by winning the Galler Junior Cup at the GP Summit. Since then, we got to hear the amazing Dr. Anna Berik speak in Tysons Corner about Propel—a game changer for many of us! Our team has grown by 10 percent, and completed 208 cases from June through October this year, compared with 188 over the same period last year. We continue to grow both personally and professionally, and are looking forward to a great 2018.

Much has happened for the Chicago Style Deep Bite in the 18 months since our original meeting at Dr. Galler's Reingage course. We've had the opportunity to gather and learn both Dr. Anna Berik's BAM method for acceleration and the Bioclear system to close black triangles and enhance esthetics, and to visit the Align production facility in Costa Rica. Most recently, half of the class reunited in Washington, D.C., at the Invisalign summit, strengthening personal and professional bonds and rekindling our Reingage spirit!

After the best social event at the Reingage course in Miami, Florida, in 2015, the ClinCheck Cartel was born, with members from all over the USA and Canada. A few months later we met again in Costa Rica for more education and an incredible jungle zip line experience. Although a good number of our team were affected by Hurricane Irma this September, The Cartel still had a strong showing at the D.C. Summit. The Cartel continues to be a formidable force in producing Invisalign cases quarter after quarter.

The Corkscrewers found their stride this fall, hitting a team personal best of 97 case starts in October! Dr. Andrea Dernisky (Vancouver, Canada) presented her first lecture on eliminating barriers to help promote Invisalign growth and flow in the office, and Dr. Sonya Verma (Calgary, Canada) reinvented her social media presence. Dr. Verma shares posts with a unified flow of filters and simple imagery that is attractive to the younger, tech-savvy demographic. They learn about her clinic and enjoy her fun quotes, Invisalign tips, contests, and clinical photography.

After taking the Invisalign Summit by storm and winning the Galler Cup with the most cases, we have had the trophy on tour. Starting in Philly and moving on to Jersey, New York, Connecticut, Massachusetts, and then Toronto, it will make its way back just in time for the GoBIG Reingage Meeting, April 27–29 in Hoboken, N.J., for all to learn how to ramp up their own Invisalign production. All the members of our team will be contributing hard work, friendship, shared ideas, mutual goals, and Empire memories.

The Empire Too had our first reunion at the Invisalign Summit in September. We enjoyed our nights together at Dr. Galler's banquet, on our cocktail cruise followed by dinner, and at the Invisalign Gala. It was wonderful to reconnect with each other in person and celebrate our new successes as a group. We're looking forward to more chances to get together in Costa Rica in February and at our Go Big CE event in April.

Ghosts of POB was created during the Reingage course in August 2017 at LeMéridien Hotel in Tampa (one of the most haunted places in the United States). Unfortunately, in September, just after the class was created, two major hurricanes devastated the island of Puerto Rico, with one striking South Florida as well—areas where many of the Ghosts have their practices. Despite the limitations imposed on our fellow dentists by the lack of electricity, water, and logistics in the affected areas, all of these doctors kept an optimistic spirit during and after the tragedy, and most of them are getting back on their feet. Four months after our class started, Ghosts of POB has closed 363 cases (and still counting). Go Ghosts!

The Hells Aligners have had an incredible year: by August, our hardworking sophomore class was VERY narrowly edged out of a first-place victory by a mere four cases. Five of our class won medals at Summit for producing above-average numbers of cases. We look forward to helping to arrange some clear-aligner–supportive Continuing Education in the Bay Area in 2018, and hope that this can serve as a reunion for us and a Re-Reingage for many more!

We are the Hotlanta Stripperz—the Reingage class that includes members from 13 states, Puerto Rico, and Canada, all united with a common mission: to daily improve the lives of all patients that walk into our offices, while providing excellence and fun along the way. Little did we know how much our Reingage course in August 2016 would change our attitude toward dentistry, fuel and motivate us to expand the scope of our practices, and give us the skills and tools to be successful, while allowing us to become lifelong friends and colleagues with some of the best dentists in North America and beyond. We are improving our communities, cities, countries, and world every day. We are Hotlanta!

2017 was a successful year for the Houston Drillers. We grew together as a group and as providers, and received significant recognition at the GP summit for our efforts. We are excited to make 2018 even better. As we become a closer unit, we are now looking to support each other in all aspects of our practices beyond Clear Aligner Therapy. We are currently planning a mastermind panel in Austin, Texas, in early 2018 to begin the journey of enhancing our personal and practice lives through our collective experience and expertise.

Reingage's Los Aligners began in Los Angeles in June of 2015. Our American members come from North Carolina, Missouri, Oregon, and of course, Southern California. About half of Los Aligners call Canada home.

In November, Los Aligners accepted more than 100 ClinChecks for the first time ever; Dr. Sam Lee (from Canada) had a career month and was our leader in cases started. And our current overall production leader, Dr. Terri Pukanich from Slave Lake, Alberta, wrote an amazing piece about a book, a day, and an intention that transformed her already outstanding practice into a next-level powerhouse.

And finally, we were honored to stage the first-ever AACA-sponsored study club event in Pasadena, California. Docs Danièle Larose, Anna Berik, and The Wolf himself, David Galler, treated 60 Reingage doctors to a triple-header of awesome advanced training. We were joined by 50 more Align-referred dentists for an evening with the Wolf.

The MetroAligners are a group of friends who also happen to be dentists. We have all grown to be better people and dentists because of each other. During the 2017 Invisalign Summit, our own Brian Wilk hosted and organized a dinner cruise on the Potomac, featuring great food, great music, and over 300 great people. Since Summit, several of our members have truly excelled, including Jerry Matt (his best 2 months ever), Eric Seidel, Mariliza LaCap and Steven Liao. Congrats to Frank Visitini for making Premier Provider, and congrats to all for a good showing!

The Mile High Munchies had a great turnout for the GP Invisalign Summit in Washington, D.C., this September. October was a great month for our class, with 66 total cases. We are looking forward to a fantastic all-day event on January 26th in Dallas/Fort Worth. Finally, we would like to congratulate Dr. Katie Coniglio on the birth of her daughter on the first of December.

The Montreal Wolfpack, led by Dr. Danièle Larose, includes many bilingual and francophone doctors. In September, 20 of us reunited in Washington to further our education at the Invisalign Summit. One of our challenges is educating our mostly francophone teams. In order to rise above this hurdle in a world of anglophone CE, we are looking into offering a francophone team retreat in the coming year. Haooooooooowl!!!!

The Northern Bites gathered in Edmonton but have united from across Canada. Although distance separates us, our passion for learning has brought us into each other's lives. We will never stop. We will never slow down. We will never relent. We are The North!

The Northwest Aligners are a top-notch group of dentists situated in Washington, Oregon, Idaho, and Alaska, and throughout Canada. NWA was fortunate enough this autumn to reunite twice: at the Invisalign Summit in September, and again in November when Arvind, Olga, Thomas, Peter, Cindy, Aaron, and Jim audited Dr. Galler's Reingage course in Portland. Special mention to Olga and Cindy, who have amazing Invisalign practices in greater Portland, and Korey, who is one of the top Invisalign dentists in northern Idaho. The NWA docs continue to see their practices shine with Invisalign!

The last few months have been unbelievable for the Richmond Re-Aligners. Some of us attended Anna Berik's BAM Propel lecture at Chima in Tysons Corner. Dr. Jay Knight opened a new, larger practice in Charlottesville. Dr. Galler came to Richmond for Premier & Beyond's swan song. Several docs found their stride in the group and absolutely killed it. It's no wonder, then, that the group set a Gallerdom month record with over 200 cases started. Boom!

After onboarding in February, the Rockin Cavaligners were looking for something to give us a motivational boost heading into the end of the year. We organized a 2-month class case challenge for October and November. The October numbers came in showing we were right at 50% of our goal and had achieved our highest month case count ever as a class! Now we're applying what we've learned and pushing toward meeting our 2-month goal.

As one of the newest Gallerite classes (we came together only last May), we accepted our championship belt for Best 60 Day Results at the GP Summit. In Washington, D.C., 24 doctors in our group were able to get together and cheer on our star, Dr. Angel Zamora, during her keynote speech to kick off the conference. We're so proud! Also, our family continues to put our prayers together for Bill Brosky's son and Tony Bare's daughter, who have been bravely battling difficult medical issues.

For the Str8up Reingage group, the 2017 Invisalign GP Summit was a memorable event. We had a strong showing of 15 members, not too bad for a group put together over 3 years ago (the first Reingage class) and with a fair bit of geographic separation. Being awarded the Senior Galler cup was a proud accomplishment. Some more of our members finally took the digital step and added iTeros to their offices. Coming off the summit, several of our group members saw a boost in their case numbers, a bit of a trend for our group.

Straight Outta Brackets was formed after the Reingage course in July 2017. In the 60 days prior to our Reingage class we did 123 cases, but in the 60 days after the class, Straight Outta Brackets did 213 cases, making us the third-best class ever based on 60-day numbers. Many of us were able to attend the AACA course in Pasadena November 6th with Dr. Anna Berik, Dr. Danièle Larose, and Dr. David Galler. We are excited to continue this growth and learning into 2018!

2017 has been a super year for SuperCarlsBad. Big congratulations go out to Drs. Cherry, Ritzau, and Vondra, who welcomed new babies into their families, and to Dr. Browner, who opened her new practice in Las Vegas. Another 2017 highlight was having 22 of our Western-based classmates reunite in D.C. at the Invisalign Summit. Memories were made catching up with each other, supporting our mentor Dr. Galler, and enjoying an amazing night of dining and dancing out on the Potomac together!

This past fall was a time of both adversity and triumph for Sweet Caralign. After weeks without power in his home and office because of Hurricane Maria, our founding president Dr. Luis Camacho slowly got back in the swing of things, not only providing great dental care for the people in his area, but starting more Invisalign cases in one quarter than most orthodontists start in a year. In what has to be the marketing move of the year, Dr. Chris Angelopulos has purchased a fire truck and customized the exterior to add his practice logo. With his iTero Element in the back of the truck, he will be marching in several local Christmas parades, spreading the word of malocclusion to the masses and correcting many along the way. This diverse group of grizzled vets and young up-and-comers is becoming a force to be reckoned with in Galler Nation.

The Toronto Blue Trays are the only Gallerite study club that has members from the easternmost to the westernmost provinces of Canada. A special shout-out to Joan Chin for her gracious help on every case we post; also, a big thank-you to Janice Lo for negotiating for bulk order pricing with many of the companies we use regularly. At the Summit in Washington, we had a great team night on the boat cruise; we wore team tees listing the times we have been together, including Costa Rica, Dallas and Washington. This group is a ton of fun and loves to learn!

The last few months have been a wonderful opportunity for the members of VanWow to grow and learn from one another. In September, Summit was amazing! Since that time we have had Dr. David Galler, Dr. Anna Berik, and Dr. Danièle Larose speak in Vancouver. Dr. Bradley Gee also attended the Pasadena course on micro-osteoperforation and Dr. Berik's Berik Acceleration Method. In the future our goal will be to bring education to Alberta, where we have a lot of members.

Wicked hit the ground running in May of 2015 after our initial Reingage course with Dr. Galler. We won the Galler Cup! We have been driving forward and expanding our knowledge with top-notch continuing ed, hosting Dr. Ostreicher in 2016, and Dr. Larose and Bioclear in 2017. On February 8, we will host a tripleheader of Drs. Berik, McFarlane, and Galler. We congratulate Dr. Pless on opening her very own facility in 2018. We have found our strength in numbers this year by sharing our knowledge and expertise via our Whatsapp chat. 2018 will be our best year yet.

AMERICAN ACADEMY of CLEAR ALIGNERS

An Invitation

by John P. Bunkers

My name is John P. Bunkers, and I was recently asked to become Vice President of the American Academy of Clear Aligners.

It's an understatement to say this is something I never would have imagined happening at this stage of my career—or, probably, anytime in my career.

As a California dentist, every 2 years I must complete 50 hours of continuing education, and it was for that reason only that I went to San Francisco in April 2016 for what I thought would be "only" a 2-day CE course. It was called...

Reingage with David Galler

I walked into a life-changing experience.

After my first Invisalign course back in 2013, my Invisalign output ran:

- 2013: 8 cases
- 2014: 5 cases
- 2015: 5 cases
- 2016 through April: 6 cases

But since I attended the Reingage course, I've handled:

- 2016 May–December: 15 cases
- 2017: 83 cases

Yes, that's correct: 83 cases in 2017.

I'm sure I'm not the only one who's observed the decreased level of decay in the under-30 generation, and a few years ago, I wondered out loud what the general dentists of the future were going to do with themselves. Now I know the answer: with technology as a valued partner, the dentists of the future will be doing 90% of the procedures we used to refer out only a decade ago!

I invite you to join me on the journey, as Clear Aligner technologies increasingly dominate the field of orthodontic treatment in the coming decade. Being a member of the American Academy of Clear Aligners will keep you on top of the latest developments in both equipment and technique.

And don't forget to visit the Academy's website each month in 2018 and look in at the **Case of the Month**. All the cases you will see have been treated in my office in the last 18 months since this adventure began.

Thank you, Dr. David Galler!

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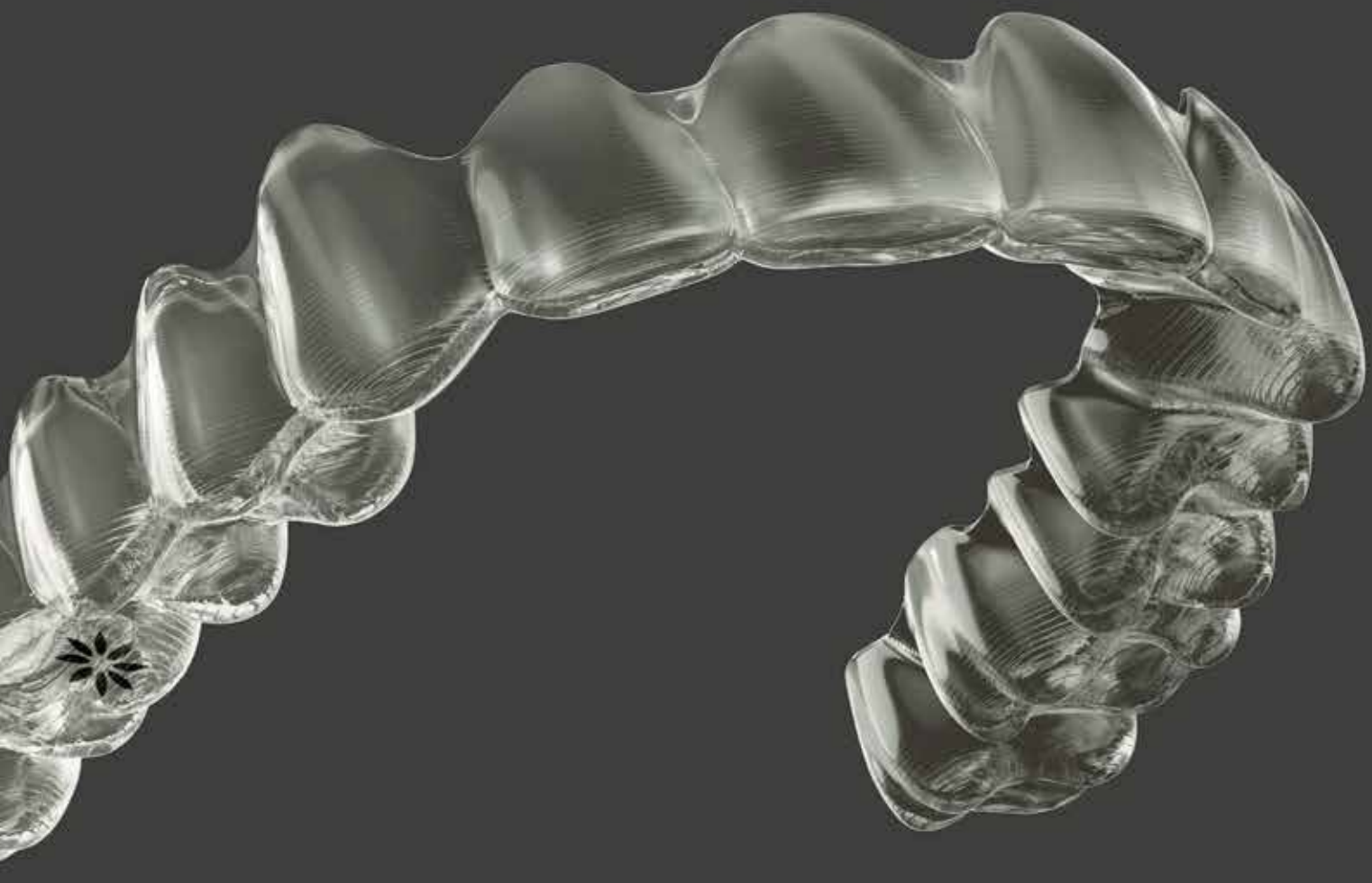

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