



*Periodontal Implant Center*

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# Periodontal News



A Recurring Publication from the Periodontal Implant Center ♦ Jacob Hager, DDS, MS

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## About Dr. Hager

Hometown: Cherokee, OK  
Undergrad: Oklahoma State  
Dental School: OU  
Perio Residency: OU

I met my wife, Kelly, while attending Oklahoma State.

We were married the summer before entering dental school and now have two boys, Grant and Landon, with another boy on the way.



Go Pokes!

## Contact Us

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## STOP!

Before you commit to tossing this newsletter in the nearest trash receptacle, realize that our office is a fresh option for the periodontal and implant needs of your patients. Our office is located near crossroads off of I-240 in south Oklahoma City, and we would appreciate the opportunity to become part of your comprehensive dental team.

## Our Mission

The primary purpose of our office is to provide superior periodontal and implant services for your office - enhancing the quality of comprehensive care you offer your patients. In doing so, we hope to increase your productivity by streamlining and assisting in the care of your patients, while also serving as a source of continuing education for you and your staff.

We hope to offer your patients unparalleled periodontal and implant therapies targeted at maintaining and/or replacing compromised dentitions while facilitating their education and understanding of dental diseases and recommended treatments. As a part of our services, we will focus on developing your patient's ability to care for and maintain their dentition and to improve their quality of life.

We feel that our ability to succeed in fulfilling these goals lies in our unwavering commitment to provide consistent care and communication for you and your patients each and every day.

## Black Hole of Perio?

It seems to be the mantra for many general dentists, "*patients sent to the periodontist never return to my practice*".

Not so at the Periodontal Implant Center. If accused of anything, I would like to be known for sending more than enough correspondence and keeping fewer patients for in-house recall.

You can expect written updates after each patient's initial examination, periodontal re-evaluation/maintenance, and surgical procedures. If patients stop treatment at any time, you will be updated of their status in our office immediately.

Additionally, any patients that are recommended for ongoing recall in our office will nearly always be on an alternating basis. My receptionist will coordinate these appointments with your office, and recommendations for the patient's next visit will be included in every maintenance report.

My goal is to get patients back to your office as quickly as possible. The only reason for patients to remain with us for recall is if they have persistent areas of periodontal concern that need close attention.



## Free Lunch CE

Call or email us to set up a lunch and learn for your office. I'll provide lunch and give an hour of free CE for you and your staff. Pick your topic:

- 1) General Periodontal Care – When to refer and how to get the most out of a relationship with a periodontal office.
- 2) Esthetic Periodontal Procedures and Soft Tissue Grafting – What Patients are Candidates?
- 3) Dental Implants - General Principles and Case Planning.
- 4) Implants in the Esthetic Zone – A Simplified Approach to Custom Abutments.
- 5) Topic of your choice.

To reserve a date, ask for Amanda at 405-636-1411, or email at [okperioimplantcenter@yahoo.com](mailto:okperioimplantcenter@yahoo.com)

## Easy Implants

Ever left in the dark to finish your implant cases? Not sure what pieces to order or torque wrench to use?

Our office will supply all the needed materials to help finish your referred implant cases. We seat the final abutment in our clinic and forward all the needed impression copings and lab parts and pieces to your office. Need more help – I'll come to your office and assist with the impression and delivery.

## Clinical Pearl

Save your cement! Be careful that your assistants aren't filling your implant crowns to the brim with cement prior to delivery.

Remember, most implant crowns are fabricated on an analog that has very little distortion relative to the abutment in the patient's mouth – giving a very precise fit. Therefore, a very thin film of cement to line the restoration is all that is needed. Try having your assistant use a microbrush to transfer a minimal amount of cement to the restoration.

Another trick is to quickly seat the restoration on the analog in the master cast prior to seating it in the patient's mouth. This will express all but a very thin residual film of cement inside the crown – all that you need.

Most importantly, too much cement will lead to heavy extrusion, which is very difficult to clean and retrieve around the subgingival implant collar. Any cement that is accidentally left behind can be deadly to the implant. I have had to flap many ailing implants only to find a chunk of cement that had caused significant inflammation and subsequent bone loss – easily avoided by following the tips above.

## Materials Tip

We all have certain instruments or materials that we would feel lost without. *Karl Schumacher* apical retention forceps are one such item for me. These extraction forceps are not going to be the cheapest you'll find, but they are amazing! Due to their design, you can engage much further up the root making extractions much easier. There is a lot of science behind their design. I would hate to extract a tooth without them. ([www.karlschumacher.com](http://www.karlschumacher.com))

## Featured Article

Cavallaro, J., and Tarnow, D. **Unsplinted Implants Retaining Maxillary Overdentures with Partial Palatal Coverage: Report of 5 Consecutive Cases.** *International Journal of Oral and Maxillofacial Implants.* Vol 22, No. 5, 2007.

This article showcases the advancements that surface technology has made in the success of dental implants placed in maxillary bone and the predictability of utilizing unsplinted implants with locator attachments to retain a palateless maxillary denture.

Historically, to support a denture, maxillary implants required splinting with a cast or milled bar. Most of the research that supported this view came from early work with machined implant surfaces – very different than current micro-roughened surfaces.

In the present case report, 5 consecutive patients were selected with sufficient maxillary bone to place a minimum of 4 implants at least 10mm in length and 3.75mm in diameter and were allowed to heal for a minimum of 12 weeks after placement.

Locator abutments were then placed on the integrated implants and final restorations were fabricated as palateless overdentures with a metal (cobalt-chromium) horseshoe framework. To date, with follow up times of 12-48 months, all implants remain in healthy function.

This type of restoration offers significant advantages to both the patient and restorative clinician versus a traditional denture or bar-overdenture:

- **Enhanced Esthetics:** Bar restorations require more room and often require setting of denture teeth much wider around

## *Medicine Update* *-Diabetes-*

the arch than is required for a locator overdenture.

- **Enhanced Phonetics:** The overall palatal bulk can be reduced compared to a bar overdenture and completely eliminated versus a conventional denture
- **Decreased Cost:** Significant cost decrease versus bar overdenture components and lab fees.
- **Ease of Attachment Placement:** Locator abutments can take as little as 60 seconds to seat and torque to place – a very different story versus the process of seating a bar that many times has casting discrepancies that require sectioning and soldering.
- **Simpler Impression Techniques:** Unwieldy open tray impressions are unnecessary.
- **Enhanced Prosthesis Durability:** Low-profile locator attachments require less space, thereby leaving more room for the overdenture resin base.
- **Easier Prosthesis Maintenance and Repair:** Individual attachments can be removed and replaced with ease.
- **Simpler for Patients Hygiene:** Plaque control is much simpler than around and under a fixed bar.
- **Bone preservation:** The bone preserving effect of implants is utilized versus continued ridge atrophy under a conventional denture.

Current data suggests that >7% of the U.S. population is affected by diabetes and up to one-third of these individuals may not be aware of the diagnosis. Amazingly, a child born in the year 2000 has a 33% chance of developing diabetes in their lifetime.

As dental clinicians, it is imperative that we understand the impact that this disease can have on our patients' oral health and the potential hazards it may pose during their treatment.

For review, Type II diabetes occurs when the body's tissues slowly develop a resistance to the action of insulin, which overtime will cause a decrease in insulin secretion by pancreatic beta cells. This decrease in the secretion/action of insulin leads to a marked increase in serum glucose levels (>126mg/dl after an overnight fast) that will eventually lead to the micro- and macro-vascular changes responsible for the major effects of the disease (stroke, retinopathy, neuropathy, nephropathy, myocardial ischemia, and amputation).

Diabetics are also at increased risk for severe periodontal disease, xerostomia, abscess formation, poor wound healing, and burning mouth syndrome.

There are two main ways for dentists to monitor the diabetic control of their patients: 1) capillary blood glucose levels via a finger stick and 2) serum glycated hemoglobin levels (HbA1c).

The HbA1c level is currently the only way to assess the long term glycemic control of the patient over the past 60 to 90 days. It is given as a percentage score, with <6% being considered normal. As a patient's glycemic control becomes poor, the

percentage of circulating glycated hemoglobin molecules will increase. A score of >8% suggests needed intervention by the patient's physician to gain better glycemic control. A medical consult is necessary to request a patient's most recent HbA1c level.

As newer diabetic drugs become available and patient compliance increases, serum glucose levels are able to be maintained at a much lower constant level. This, however, puts patients at higher risk for periodic hypoglycemic events if their strict regimen of controlled diet and medicines are not followed precisely – a very important note for dentists to understand.

Hypoglycemia, or insulin shock, is a result of decreased serum glucose levels below 60mg/dl and manifests itself with signs of mental confusion, dizziness, hunger, pallor, and sweating.

If pre-treatment blood glucose levels via a finger stick (*patient brings their glucometer to their appointment*) are less than 100mg/dl, have the patient drink 4 oz. of fruit juice. This should raise serum glucose levels 30-40mg/dl.

For patients that show signs of hypoglycemia during treatment, the procedure should be terminated and oral carbohydrates administered (juice, soft drink, cake icing). Emergency services should be contacted if there is no resolution of symptoms after 15 minutes or if loss of consciousness occurs.

Make sure patients have eaten and taken their diabetic meds prior to dental treatment in your office. Morning appointments are best.

As dental clinicians, it is imperative that we take an active role in the care of our diabetic patients with assisted monitoring of glycemic control, preparedness for possible diabetic emergencies, and careful attention to their oral health status over time.

