59th Meeting of the

AMERICAN ACADEMY OF MAXILLOFACIAL PROSTHETICS

October 29 - November 1, 2011

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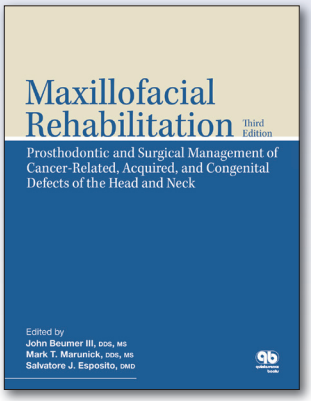

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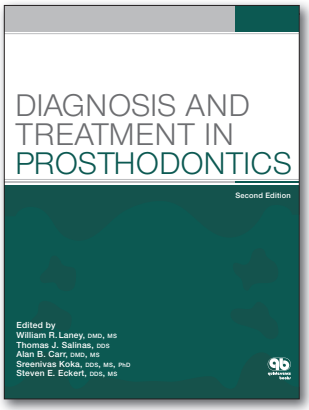

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AAMP Mission Statement

We are an association of prosthodontists who are engaged in the art and science of maxillofacial prosthetics. Our mission is to accumulate and disseminate knowledge and experience; and, to promote and maintain research programs involving methods, techniques and devices used in maxillofacial prosthetics.

The Academy is devoted to the study and practice of methods used to habilitate esthetics and function of patients with acquired, congenital and developmental defects of the head and neck; and of methods used to maintain the oral health of patients exposed to cancer-cidal doses of radiation or cytotoxic drugs.

MEMBERSHIP INFORMATION

How to Become a Member

If you are interested in becoming a member, attending our Annual Meeting is the best way to become familiar with the membership and educational process. There are three primary membership tracks for the AAMP:

• ***Affiliate • Associate • Honorary Fellow***

Application Process and Membership Categories

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• licensed dentists in good standing in the country in which they practice and retain citizenship

• persons licensed, registered or otherwise permitted by law to practice as dental or maxillofacial prosthetic technicians who are involved in only non independent or indirect patient care as directed or prescribed by a licensed dentist

• Student Membership is also available. Please see the AAMP web site to view the qualifications and to apply.

For more information, please navigate to our website: **www.maxillofacialprosth.org** and click **membership** tab

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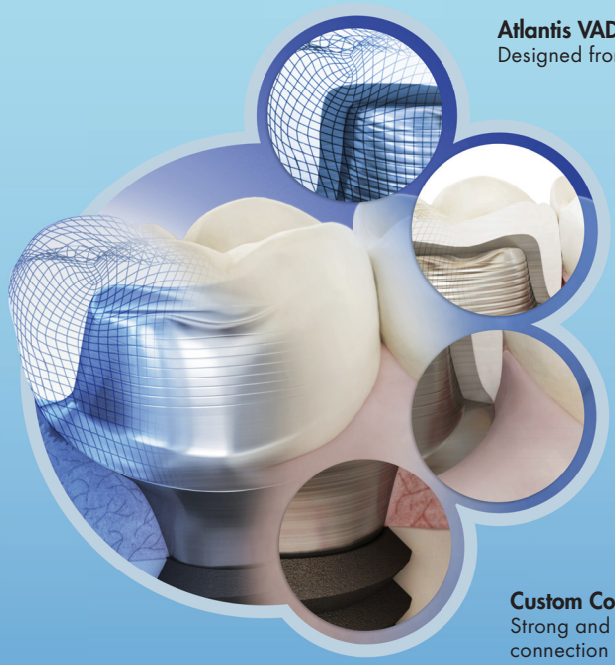

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ROBERT M. TAFT, D.D.S.

Welcome Message

Welcome and thank you for joining me for the 59th Annual Meeting of the American Academy of Maxillofacial Prosthetics. Our program chair, Dr. Larry Brecht, has assembled a world renowned list of speakers that challenge us to confront the changing dynamics of our specialty and to maintain our leadership role in the future.

The Program Theme for this year's meeting is "**Defining the Future - Delivering it *Today***" and includes three days of lectures, Sunday-Tuesday (October 30th - November 1st). Our optional CE program is outstanding this year. October 30th: Nobel Biocare will be supporting a workshop titled: *Treatment Planning the Edentulous Patient; The Immediate Load Concept*. This will be presented by Dr. Edmond Bedrossian. October 31st: 3dMD will provide excellent hands on opportunity to enhance your capabilities in diagnosis and treatment planning titled: *3D Surface Imaging in Maxillofacial Prosthetics*. November 1st: Cochlear Americas will present a hands-on implant placement and restorative seminar titled: *Osseointegrated Implants & Facial Prosthetics*.

As leaders in dentistry, it is imperative that we take an active role in shaping the future to advance the quality of patient care. This year's program is dedicated to that concept.

Take some time to enjoy the beautiful surroundings and special events that have been thoughtfully organized. We look forward to your active participation in this year's academic and social venue.

Robert M. Taft, DDS
President, American Academy of Maxillofacial Prosthetics

Dr. Taft's Biography

Captain Taft was born and grew up in Little Neck, Long Island, NY. He received his D.D.S. degree from Emory University School of Dentistry in 1983. He entered the Navy in 1983 following graduation and was commissioned a Lieutenant in the U. S. Navy Dental Corps. Following graduation, Captain Taft's first duty station was a one-year general practice residency at Portsmouth Naval Hospital, Portsmouth, VA. In July of 1984 he reported to Naval Station San Miguel in the Philippines as Department Head for Dental Services. His next duty station was at Naval Air Station Brunswick, ME where he served as the Prosthodontic and Division Officer.

In 1988, Captain Taft entered the Prosthodontic residency program at the Naval Postgraduate School in Bethesda, MD and two years later received his certificate. He stayed on staff in the Prosthodontic Department as the Laboratory Officer and Head of Fixed Prosthdontics. Captain Taft then continued in a fellowship in Maxillofacial Prosthetics at Wilford Hall USAF Medical Center, San Antonio, TX receiving a certificate in 1992. Following his specialty training, Captain Taft served in various positions at Naval Medical Center San Diego, CA. Captain Taft next served as Chairman and Program Director for the Maxillofacial Fellowship Officer program, Naval Postgraduate Dental School from 1997 – 2001 and later as professor in the Naval Postgraduate Prosthodontics Residency Program, 2002. He then took assignment at the Navy Medicine Education and Training Command, Bethesda, MD, as Director, Graduate programs and was the Medical Joint-Service Education Director, for the 2005 BRAC process. Captain Taft served as Dean of the Naval Postgraduate Dental School and Specialty Leader to the Surgeon General for Postgraduate Dental Education from June 2006 to June 2011 and is currently Deputy Chief, United States Navy Dental Corps.

Captain Taft is a Diplomate and Board Examiner of the American Board of Prosthodontics, Fellow of the American College of Prothodontists, President of the American Academy of Maxillofacial Prosthetics and past Specialty Leader to the Surgeon General for Maxillofacial Prosthetics and Implant Dentistry. His personal awards include the Legion of Merit, 3 Meritorious Service medals, two Navy Commendation medals and two Navy and Marine Corps Achievement medals.

WELCOME FROM AAMP 2011
CONFERENCE PROGRAM CHAIR

Defining the Future…Delivering it TODAY!

Welcome to Scottsdale and the 59th Annual Scientific Session of the American Academy of Maxillofacial Prosthetics! Perhaps no other discipline in dentistry so thoroughly embraces technology to the degree that Maxillofacial Prosthetics does. We as a subspecialty sit at the crossroads of dentistry, medicine and surgery and as a result, we define and develop the technologies that help *all three* healing arts and sciences to optimize our working together as a team. In our subspecialty area, we put into daily practice the dreamed of innovations of years ago and help develop the innovations of the future. Maxillofacial prosthodontists continue to be the developers of new technology and early adopters of these innovations.

From basic science, to imaging, to scanning, to planning, to milling, to surgery, to aftercare – this year, the 2011 AAMP Program Committee has put together an information-packed 3 day meeting. In addition, academy fellow Steve Alfano has organized 3 cutting–edge, hands-on workshops that will broaden your planning and clinical skills. In honoring our President, Capt. Robert Taft, the first active duty military AAMP president in over 40 years, we have included a session to highlight the advances developed by our members caring for those who serve our country.

Ideas are contagious! The fellowship of the AAMP is reinforced and friendships are made only when you are in the presence of others. Enjoy your stay in Scottsdale-share your ideas with your friends and colleagues, spend time with our generous corporate sponsors and take the time to wonder and think for the future!

For the Program Committee,

Lawrence E. Brecht, DDS
AAMP 2011 Program Chair

For the third time at an annual session, we are going to designate the membership status of all participants by having various colored lanyards being worn with the name badge.

The goal is to promote our various membership categories and make it easier for our student members to identify the diversity of specialists in our Academy.

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Past Presidents

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Associates and Affiliates

Yellow Lanyards
Student Members

Green Lanyards
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60th Annual Meeting of the AAMP & 10th Biennial Meeting of the ISMR

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- Maxillofacial Prosthetics
- Facial Prosthetics
- Implant Care
- Rehabilitation Medicine
- Chemotherapy and Radiation Therapy
- Digital Technology
- Functional Outcomes
- Nanotechnology and Biomaterials
- Tissue Engineering and Regenerative Medicine
- Psychosocial Considerations

Call for Papers

Delegates are encouraged to submit abstracts for oral and/or poster presentations. Due to limited time allotments, oral presentations will be selected based on abstract content and submission date. Submit your paper early!

Submission Deadline: April 1, 2012

Abstracts must be submitted via our conference web site: **www.res-inc.com/AAMP-ISMR-Meeting**

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**Denotes Deceased*

We thank all past AAMP Presidents for their dedication and service

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(front)

divider
(back)

Social Events

Saturday, October 29th

08:00 - 17:00	AAMP Board of Directors Meeting
17:30 - 20:00	Table Clinics / Poster Session & Welcome / Exhibit Reception *Table Clinics and Welcome Reception Sponsored by Quintessence*

Sunday, October 30th

06:00-06:55	Guest/Spouse Outing: Yoga Session (elective) *Located in the Lawn Court*
07:00-08:15	Breakfast in Exhibit Room *Located in the AZ Ballroom*
08:15-08:30	Opening Show & Welome *Located in the AZ Ballroom*
08:30-13:00	General Session
10:30-12:30	Art Walk & Lunch (elective)
13:05-14:25	AAMP Luncheon & Business Meeting *Located in Vaquero AB*
14:30-16:45	Workshop One- *Treatment Planning the Edentulous Patient; the Immediate Load Concept* *Located in Sonoran AB*
17:30-21:00	**AAMP Social Outing** Get Together at the Gainey Ranch Private Golf Club (elective) *Meet in Main Hotel Lobby*

Monday, October 31st

07:00-08:15	Breakfast in Exhibit Room *Located in the AZ Ballroom*
08:15-13:15	General Session *Located in the AZ Ballroom*
10:00-11:00	Crepe Cooking Class (elective) *Located in Arroyo E*
14:00-17:00	Workshop Two- *3D Surface Imaging in Maxillofacial Prosthetics* *Located in Sonoran AB*
19:00-22:00	**AAMP Presidential Reception & Banquet** (elective) *Located in* Vaquero Ballroom

Tuesday, November 1st

07:00-08:15	Breakfast in Exhibit Room *Located in the AZ Ballroom*
07:00-08:15	Student/New Member Breakfast *Sponsored by TopDentists.com* *Located in the Terrace Court*
08:15-12:45	General Session *Located in the AZ Ballroom*
14:00-17:00	Workshop Three - *Cochlear VistafixTM Osseointegrated Implants & Facial Prosthetics* *Located in the AZ Ballroom*

Wednesday, November 2nd

07:00-21:00	Post-Conference Elective: Grand Canyon Tour *Meet in main lobby*

SCIENTIFIC PROGRAM OVERVIEW

Saturday, October 29th

08:00 - 17:00	**AAMP Board Meeting**- *Board Members only*
17:30 - 20:00	**Table Clinics / Poster Session & Welcome / Exhibit Reception** *Table Clinics and Welcome Reception* *Sponsored by Quintessence*

Sunday, October 30th

07:00-08:15	***Breakfast in Exhibit Room***
08:15-08:30	**Opening Show and Welcome**
Moderator:	**Peter Gerngross DMD, MS**
08:30-09:00	John Wolfaardt, BDS, Mdent, PhD *Maxillofacial Prosthetics: Acting Today to Define the Future*
09:00-10:00	Rhonda F. Jacob, DDS, MS & Roman Skoracki, MD *Complex Maxillofacial Surgery & Reconstruction*
10:00-10:45	Edmond Bedrossian, DDS *Graftless Solutions in Maxillofacial Reconstruction*
10:45-11:30	***AM Break*** *Sponsored by Conexão*
11:30-12:00	Arun B. Sharma, BDS, MSc *The Zygomaticus Implant-Experience at UCSF*
Moderator:	**Larry Brecht, DMD**
12:00-13:00	**Treatment Planning Panel** *Treatment Planning The Maxillofacial Patient*
13:00	***Session Adjourns***
13:05-14:25	**AAMP Business Meeting & Luncheon**

14:30-16:45	**Nobel Biocare Workshop** *Treatment Planning the Edentulous Patient; The Immediate Load Concept*
17:30	**AAMP Social Outing:** *Gainey Ranch Private Golf Club*

Monday, October 31st

07:00-08:15	***Breakfast in Exhibit Room***
Moderator:	**Mark Chambers, DMD, MS**
08:15-09:00	Sreenivas Koka, DDS, MS, PhD *Bisphosphonate Related Osteonecrosis- Where are We?*
09:00-09:45	Brian L. Schmidt, DDS, MD, PhD *Oral Cancer Genomics*
09:45-10:30	Joel B. Epstein, DMD, MSD *Oral Co-morbidities from Chemotherapy and Radiation Therapy*
10:30-11:15	***AM Break*** *Sponsored by Conexão*
11:15-12:00	Clark M. Stanford, DDS, PhD *Management of the Ectodermal Dysplasia Patient*
12:00-12:30	John L. Ricci, PhD *Bioengineered Scaffolds*
12:30-13:00	James Kelly, DDS *PENTO/CLO and HBO: An Ounce of Prevention, or a Ton of Cure?*
13:15	***Session Adjourns***
14:00-17:00	**3dMD Workshop** *3D Surface Imaging in Maxillofacial Prosthetics*
19:00-22:30	**AAMP President's Reception & Banquet**

Tuesday, November 1st

07:00-08:15 ***Breakfast in Exhibit Room***

07:00-08:15 ***Student/New Member Breakfast***
Sponsored by TopDentists.com

Session Title: The Victor J. Niiranen Memorial Session
Moderator: Gerald T. Grant, DMD, MS

08:15-08:45 Gerald T. Grant, DMD, MS, CAPT. USN
Advancement and Use of Digital Techniques in Treatment of Wounded Warriors

08:45-09:15 Daniel D. Dunham, DDS, LTC, DC, USN
Use of Angulated Platform Implants in Restoration of the Mandibular Defect

09:15-09:45 William O. Wilson, DDS, MS, LCDR, DC, USN
3D Imaging and Fabrication of a Silicone Nasal Prosthesis

09:45-10:15 Alan J. Sutton, DDS, MS, COL, USAF, DC
Use of Digital Methods for Prosthetic Rehabilitation of Maxillofacial Burn Patients

10:15-11:00 ***AM Break*** *Sponsored by Conexão*

Moderator: Betsy Davis, DMD, MS

11:00-11:30 Todd Kubon, BA, MAMS, CCA
Improving Quality Assessment:Establishing A Custom Breast Prosthesis Program

11:30-12:00 Michael W. Klotz, DMD, MDentSc
A Universal Maxillectomy Classification System

12:00-12:30 David J. Reisberg, DDS
The Surgical Guide - Friend or Foe?

12:45 ***Session Adjourns***

14:00-17:00 **Cochlear Workshop**
Osseointegrated Implants & Facial Prosthetic

Sunday, October 30th

AAMP 2011 Conference Title:
Defining the Future, Delivering it TODAY!

08:15-08:30 Opening Show and Welcome

Moderator: Peter Gerngross, DMD, MS

08:30 John Wolfaardt, BDS, MDent, PhD

Institute for Reconstructive Sciences in Medicine (iRSM), Division of Otolaryngology Head & Neck Surgery, Faculty of Medicine and Dentistry, University of Alberta, Edmonton, Alberta, Canada

Maxillofacial Prosthetics: Acting Today to Define the Future

Maxillofacial Prosthetics has a long history as a subspecialty of Prosthodontics. In this role, Maxillofacial Prosthetics occupies a unique space between dentistry and multiple surgical as well as medical disciplines. As this role continues to evolve, it has also meant that Maxillofacial Prosthetics increasingly functions in a surgical/medical environment as opposed to a dental environment. This provides great opportunity for Dentistry and Prosthodontics but it also implies that this aspect of Prosthodontics is also subject to the considerable change that related areas of surgery and medicine are undergoing in First World environments. The rate of change of societal attitudes to heath care, the increased range of surgical and medical disciplines with which Maxillofacial Prosthetics interacts and advances in technology engagement in care are subjecting Maxillofacial Prosthetics to considerable strain. Adding to the complexity is that Maxillofacial Prosthetics must also be seen in the context of Second and Third World economies where it plays an increasingly important role. Maxillofacial Prosthetics in the Second and Third World, is advancing and expanding considerably and looks to the First World for leadership and guidance. This rate of expansion of Maxillofacial Prosthetics provides tremendous opportunity to contribute and advance

improvement in patient care. The rate of expansion and engagement provides challenging questions to Medicine, Dentistry, Prosthodontics and Maxillofacial Prosthetics if this subspecialty of Dentistry is to be allowed to contribute globally at the level demanded. In this change, it is Maxillofacial Prosthetics that will need to show particular transformative capacity. Central to this capacity will be the ability of Maxillofacial Prosthetics to bring clarity to the definition of an innovative future identity and role. Along with this will be the capacity of governments as well as organized medicine and dentistry to recognize and champion this role.

The presentation will consider the potential of Maxillofacial Prosthetics to serve as a transformative force to achieve the remarkable opportunity that exists to contribute globally to enhancement of head and neck related health care and knowledge creation.

Learning Objectives:

1. The present role of Maxillofacial Prosthetics in First as well as Second and Third World economies.
2. The future definition and role of Maxillofacial Prosthetics
3. How Maxillofacial Prosthetics needs to engage organized Medicine and Dentistry to support the transformation of Maxillofacial Prosthetics

09:00 **Rhonda F. Jacob, DDS, MS**
Professor and Maxillofacial Prosthodontist in the
Department of Head and Neck Surgery
University of Texas M.D. Anderson Cancer Center
Houston, TX USA

& Roman Skoracki, MD
Associate Professor of Plastic Surgery at the University
of Texas MD Anderson Cancer Center
Houston, TX USA

Complex Maxillofacial Surgery & Reconstruction

The use of microvascular surgery has revolutionized the form and function that can be achieved in head and neck reconstruction. However the decisions as to the integration of prostheses and surgical reconstruction are often determined by the skill and resources of the treating team, the expectations of morbidity from the treatment, and the level of form and function that can be achieved with the treatment. Specific discussion and patient presentations of head and neck cancer patients will highlight reconstructive and prosthetic treatment planning.

10:00 **Edmond Bedrossian, DDS**
Diplomate, American Board of Oral &
Maxillofacial Surgeons
San Francisco, CA USA

Graftless Solutions for Maxillofacial Reconstruction

Many potential candidates for implant restoration of the fully edentulous maxilla and or mandible are primarily interested in a fixed restoration as opposed to a bar/clip overdenture. While there are many factors to consider in the pre-treatment work-up, there is an advantage of being able to determine early in the consultation process the feasibility of a fixed restoration before significant time is invested in diagnostic procedures. This presentation examines three critical factors necessary to provide a fixed restoration that are able to be used as a screening mechanism to determine the possibility of a fixed implant restoration and likelihood of necessary bone grafting procedures to achieve the desired outcome.

Learning Objectives:

1. Pre-treatment evaluation & determination of the final type of fixed prosthesis.
2. Surgical considerations for the "tilted" vs. the "Zygoma" treatment concept.
3. Protocol for the fabrication of the immediate load prosthesis.
4. Management of early as well as late complications.

10:45-11:30 ***AM Break*** *Sponsored by Conexão*

11:30 **Arun B. Sharma, BDS, MSc**
Diplomate American Board of Prosthodontics
Clinical Professor – UCSF
San Francisco, CA USA

The UCSF Experience with Zygomatic Implants for Maxillary Defects

Obturation of congenital and acquired maxillary defects in edentulous patients poses significant challenges for prosthodontists. Osseointegrated implants provide an alternative to surgical reconstruction. However, not all patients have adequate native bone for the placement of conventional implants. The zygomatic implant was introduced by P-I Branemark in 1988 and has been used with success for the appropriate patient. In 1999 an edentulous patient with an anterior maxillary defect presented to the maxillofacial prosthetic clinic at UCSF unsatisfied with the functional outcome from her conventional obturator. She had insufficient bone for placement of conventional implants and was not a candidate for extensive reconstructive surgery. She was offered the zygomatic implant as an alternative and was successfully treated. We proceeded to treat other patients with similar defects and published our initial findings from 9 patients in 2004. This presentation will highlight updates on our success and failures with the zygomatic implant for edentulous patients with congenital and acquired maxillary defects.

Learning Objectives:

1. Identify patients with maxillary defects who will benefit from treatment with zygoma implants as an alternative.
2. Will appreciate complications and maintenance for patients with maxillary defects who have been treated with zygoma implants.
3. Success and failures will be discussed.

Moderator: Larry Brecht, DMD

12:00-13:00 Treatment Planning Panel

Presenters:

John Beumer DDS, MS
Chair of the UCLA Division of Advanced Prosthodontics, Biomaterials and Hospital Dentistry
Los Angeles, CA USA

Rhonda F. Jacob, DDS, MS
Professor & Maxillofacial Prosthodontist in the Department of Head and Neck Surgery
University of Texas M.D. Anderson Cancer Center, Houston, TX USA

Panelists:

David J.Reisberg, DDS
Diplomate of American Board of Prosthodontics
The Craniofacial Center at the University of Illinois
Medical Center in Chicago
Chicago, IL USA

Harry Reintsema, DDS, PhD
University Medical Center Groningen University of Groningen, Department of Oral Maxillofacial Surgery and Maxillofacial Prosthetics, Groningen, The Netherlands

Brian L. Schmidt, DDS, MD, PhD
Professor, Departments of Oral & Maxillofacial Surgery and Physiology and Neuroscience
NYU College of Dentistry, Director, Bluestone Center for Clinical Research
New York, NY USA

Arun B. Sharma, BDS, MSc.
Diplomate of the American Board of Prosthodontics
Clinical Professor – UCSF
San Francisco, CA USA

Roman Skoracki, MD
Associate Professor of Plastic Surgery
University of Texas M.D. Anderson Cancer Center
Houston, TX USA

Treatment Planning the Maxillofacial Patient –
Patient Presentations with A Panel of Experts

All too often, when confronted with a challenging patient treatment situation we find ourselves asking, *"What should I do for this patient?"*

Even the most experienced of clinicians often struggle with developing the *best treatment plan* among many options for a particular patient. In age of evidence-based medicine and dentistry, clinicians still realize that the "evidence" in the literature does not always apply to the patient in front of them.

In this session, it is our goal to present two actual patient treatment situations and see how a panel of experienced maxillofacial prosthodontists and surgeons would approach each particular scenario and then compare the recommendations to the actual treatment provided. We hope to develop the treatment planning skill set among our attendees and to explore how treatment algorithms and options are developed, enhanced and implemented. While there may not be any one particular "right" definitive plan, we hope it will be instructive to see how our colleagues approach treatment planning dilemmas!

13:00	***Session Adjourns***
13:05-14:25	**AAMP Business Meeting & Luncheon**
14:30-16:45	**Workshop 1-Sponsored by Nobel Biocare**
17:30	**Social Outing at Gainey Ranch Golf Club**

Monday, October 31st

07:00-08:15 ***Breakfast in Exhibit Room***

Moderator: **Mark Chambers, DMD, MS**

08:15 **Sreenivas Koka, DDS, MS, PhD**
Professor of Dentistry and Chair of the Department of Dental Specialties at the Mayo Clinic
Rochester, MN USA

Bisphosphonate Related Osteonecrosis-Where are We?

ONJ continues to crop up in a seemingly unpredictable manner and with frustrating irregularity. This presentation will provide an update on the latest information pertaining to the three big questions that most practitioners have to deal with: what is the risk of my patient getting ONJ; if my patient is at risk for ONJ, what should I do to manage this risk; and if my patient already has ONJ, how should I manage it? In addition, a new class of drug may also put patients at risk of ONJ, and preliminary findings from clinical trials, and the implications, will be discussed.

Learning Objectives:

1. List two classes of drugs that are associated with ONJ
2. Describe the risk factors for ONJ
3. Describe management strategies for prevention and treatment of ONJ

09:00 **Brian L. Schmidt, DDS, MD, PhD, FACS**
Professor, Departments of Oral & Maxillofacial Surgery and Physiology and Neuroscience
NYU College of Dentistry, Director,
Bluestone Center for Clinical Research
New York, NY USA

Oral Cancer Genomics

The human genome project has now been complete for a decade. However, the use of genomics has not significantly changed our management of oral cancer. The genetic abnormalities present within many cancers are more complex than we had anticipated.

This is especially true for oral cancer. In this talk I will review the impact of genomics on our understanding of oral carcinogenesis. I will use examples from published studies on other cancers to highlight what we know about the genetic alterations present in cancers. I will review the underlying genetic component associated with the primary problems faced by oral cancer patients and surgeons: local recurrence, second primaries and metastasis. Finally, I will outline the future direction of genomics research for better management of oral cancer.

Learning Objectives:

1. Understand the information resulting from the human genome project
2. Appreciate the richness of the genetic abnormalities present in cancer, including oral cancer
3. Recognize how genomics research might change management of oral cancer

Benefits:

At the completion of the course practitioners will have gained knowledge and familiarity with genomics and oral cancer. Practitioners will be familiar with genetic changes that comprise oral cancer and cancer in general. Participants will learn about the potential value that genomics research will have in the future for the management of oral cancer.

09:45 **Joel B. Epstein, DMD, MSD, FRCD(C), FDS RCSE**

Adjunct Professor of Oral Medicine
City of Hope, Duarte CA
Medical-Dental Staff at Cedars-Sinai Health System
Los Angeles, CA USA

Cancer Survivorship and Oral Care

We are all touched by cancer, in friends, families and in professional practice. Currently, it is estimated that approximately 4% of the population are cancer survivors.
The epidemiology and etiology of head and neck cancer has implications for dental care and cancer management. Patients

with solid cancers at other body sites and leukemia and lymphoma require expert oral care. Prevention and management of oral complications are required from diagnosis to survivorship. Late oral changes affect function, increase risk and severity of a variety of oral complications may affect overall health and are under-recognized. Cancer survivors have increased need for oral care, which requires knowledge of the cancer therapy and status, and the nature of the oral complications in order to provide appropriate preventive and interventional care in coordination with their medical status. As cancer survivorship increases the impact of chronic oral and dental symptoms and conditions continue to increase.

This course will review the cancer path in cancer survivors, with emphasis on head and neck cancer.

Learning Objectives:

1. Identify the oral impact of cancer therapy
2. Support diagnosis, and management of the oral/dental complications in cancer patients
3. Promote appropriate oral care as part of the multi-disciplinary oncology team

10:30-11:15 ***AM Break*** *Sponsored by Conexão*

11:15 **Clark M. Stanford DDS, Ph.D.**
Associate Dean for Research and
Centennial Fund Professor for Clinical Research
University of Iowa
Iowa City, IA USA

Management of the Ectodermal Dysplasia Patient

Patients often present with congenital and acquired tooth loss and it is incumbent on the Prosthodontics team to diagnosis, educate and provide care plans that address the range of issues concerning the young adult needing tooth replacement therapy. The diagnostic phase is critical and involves an interdisciplinary team. This will lead to progressive care plans that engage removable, fixed and implant Prosthodontics. This presentation will review the critical points of assessment, key points to

outline in the process of informed consent and then provide clinical examples of care planes for the transitional adult in your practice.

Learing Objectives:

1. The diagnostic issues needed in addressing the issues of tooth loss in the young adult,
2. The range of treatment options for tooth replacement including advantages and challenges,
3. The outcomes of care when electing to perform tooth replacement in this population

12:00 **John L. Ricci, PhD**

Associate Professor
Department of Biomaterials and Biomimetics
NYU College of Dentistry
New York, NY USA

Bioengineered Scaffolds: Present and Future Clinical Applications

Two advances in materials science technology, laser micromachining and 3-D printing, now allow fabrication of controlled surface micro-scaffolding on metallic implants as well as complex tissue engineered scaffolds on a larger scale. Using current knowledge of tissue healing and cell and tissue response to extracellular matrix, and concepts such as cellular contact guidance, we are using these technologies to create surfaces and scaffolds that predictably control cell and tissue response at the tissue/biomaterial interface.

For more than 10 years we have successfully clinically used laser micromachining to produce 3-D microchanneling on dental implant collars. These surface microscaffolds, with controlled microstructures in the range of 8-12μm in size, have been shown to control the behavior of cells at the implant surface. These surfaces retain crestal bone, attach fibrous connective tissue and epithelium, and establish an effective seal between dental implants and the oral environment. This surface (Laser-Lok,

BioHorizons, Inc.) is now used on multiple implant designs, has an extensive clinical history, and is being investigated for use outside of the oral cavity, where implants require an effective transdermal seal to prevent inflammation and infection.

We are currently developing 3-D printed scaffolds, produced using a technique called direct write (DW) technology, for use in regeneration of complex bone structures. DW printing allows layer-by-layer production of scaffolds with complex lattice internal structures as well as solid barrier layers, from osteoconductive and permanent or resorbable ceramics. We have used these scaffolds to regenerate cranial bone, by eight weeks, bridging 11mm critical sized defects in animals. The DW technology allows fabrication of off-the-shelf as well as custom devices using patient CT or MRI data. These devices have the potential to be used for adult and pediatric applications such as cleft palate repair. These devices may be ready for human use within 2 years.

Together, these examples show the potential for new materials science technologies to be applied in clinical tissue engineering applications.

Learning Objectives

1. How cells and tissue respond to microstructured scaffolds during healing and tissue formation.
2. How we are currently using this knowledge to develop controlled microscaffold surfaces for transdermal implants and 3-D scaffolds for bone repair.
3. How these surfaces have been and will be used clinically and what this means for the clinician.

12:30 **James Kelly, DDS**
Director of Maxillofacial Prosthetics
University of California, Los Angeles (UCLA)
Los Angeles, CA USA

PENTO/CLO and HBO: An Ounce of Prevention or a Ton of Cure?

This presentation will focus on the wide scope of treatment for osteoradionecrosis (ORN) as it applies to patients who have undergone cancer therapy for the head and neck. A historic perspective in regards to treatment of this disease process through different modalities including non-surgical and surgical treatment will be examined. A current literature review will be discussed looking at the Pentoxifylline, Tocopherol, and Clodronate (PENTO/CLO) protocol and its relative indications for patients with osteoradionecrosis. As well as discussing current literature, the patient population that is undergoing this treatment protocol under UCLA's ORN team will be discussed.

Learning Objectives:

1. The different treatment protocols available for osteoradionecrosis (ORN) through a historic perspective.
2. The current literature discussing the recent trend for treatment of ORN conservatively with Pentoxifylline and Tocopherol.
3. Clinical outcomes of patients following Pentoxifylline and Tocopherol treatment protocol at UCLA.

13:15 ***Session Adjourns***

14:00-17:00 **Workshop 2- Sponsored by 3dMD**
3D Surface Imaging in Maxillofacial Prosthetics

19:00-22:00 **AAMP Presidential Reception & Banquet**

Tuesday, November 1st

07:00-08:15 ***Breakfast in Exhibit Room***

07:00-08:15 ***New Member Breakfast***
Sponsored by TopDentist.com

Session Title: The Victor J. Niiranen Memorial Session

Moderators: Larry Brecht, DMD &
Gerald T. Grant, DMD, MS

08:15 **Gerald T. Grant DMD, MS**
Director of Craniofacial Imaging Research at the Naval Postgraduate Dental School (NPDS)
Service Chief of the 3D Medical Applications Center, Department of Radiology, Walter Reed National Military Medical Center
Bethesda, MD USA

Advancement and Use of Digital Techniques in Treatment of Wounded Warriors

Advances in digital information, imaging, and the use of additive and subtractive manufacturing techniques have produced software and techniques that have been applied in the routine reconstruction of our Wounded Warriors. All branches of the services have recognized the contribution of the use of 3D images and computer assisted additive and subtractive manufacturing for treatment planning, fabrication of positioning and cutting guides, and custom implants provides our patients. This presentation will serve to outline the Military's role in the research and advancement of this technology, as an introduction to following presentations by each of the armed services.

Learning Objectives:

1. Introduction to digital formats
2. Review of digital technologies in medicine and dentistry
3. Stimulate the viewer to think beyond the present technologies.

08:45 **Daniel D. Dunham, DDS, LTC, DC, USN**
U.S. Army Dental Corps
Diplomate of the American Board of Prosthodontics
Fellow in the American College of Prosthodontists
Bethesda, MD USA

Use of Angulated Platform Implants in Restoration of the Mandibular Defect

The use of dental implants in the mandibular defect frequently requires an off-axis surgical placement in order to maximally utilize existing or grafted bone dimensions. Anatomic limitations of bone in this region often result in a variety of implant angulations creating additional challenges for the restoring prosthodontist in terms of access, path of draw, biomechanical support, available space, and esthetic outcomes. Similar to, but shorter than long zygoma implants, angled platform endosseous implants are available in regular and wide diameters, 8.5 to 18 mm in length, and 12 to 36 degree angled platforms. These unique implants allow for a "one-piece" platform angle correction, obviating the need for a severe prosthetic correction. This presentation will focus on the use of angled platform implants to restore certain kinds of mandibular defects. Advantages and disadvantages of angled platform implant placement and restoration will be discussed as well as several clinical case presentations which have successfully employed their use.

Learning Objectives

1. To evaluate necessity and criteria for placement of angled implants in the mandibular defect based on existing morphology.
2. To understand the advantages and disadvantages of placing and restoring angled platform implants.
3. To discuss several clinical case presentations utilizing angled platform implants placed in different types of defects and the lessons learned from their restorative outcomes.

09:15 **William O. Wilson, DDS, MS, LCDR, DC, USN**

Lieutenant Commander in the United States Navy Dental Corps, Department Chairman and Program Director for the Maxillofacial Prosthetics Fellowship at the Naval Postgraduate Dental School
Bethesda, MD USA

3D Imaging and Fabrication of a Silicone Nasal Prosthesis

Advances in digital imaging have proven useful in the application of maxillofacial prosthetics. 3D digital technologies present an opportunity for a paradigm shift in the planning and fabrication of maxillofacial prostheses. 3D imaging techniques coupled with the use of rapid prototype design and fabrication can significantly improve the patient's comfort during treatment by elimination of the need for a facial moulage impression.

This presentation will demonstrate the process utilized to fabricate a silicone nasal prosthesis utilizing the convergence of these 3D digital imaging technologies with traditional silicone packing techniques. A brief discussion of the current limitations as well as possible future advancements will make.

Learning Objectives:

1. Familiarization with current 3D digital imaging technologies to capture facial surface contours.
2. Exposure to a technique for fabrication of a silicone facial prosthesis utilizing 3D digital imaging and rapid prototyping.
3. Understanding of the current limitations and exposure to areas in need of further research and development.

09:45 **Alan J. Sutton, DDS, MS, COL, USAF, DC**
Director of Maxillofacial Prosthetics
Wilford Hall Medical Center
Lackland AFB, TX USA

Use of Digital Methods for Prosthetic Rehabilitation of Maxillofacial Burn Patients

In every war conflict to date, dental facial trauma occurs. The US Navy-Marine Corp Combat Trauma Registry reveals that almost 61 percent of all patients wounded during Operation Iraqi Freedom (OIF) have a head and neck wound and 65 percent of all head and neck facial injuries are to the face. Therefore, many of our war-fighters are returning with facial burn injuries resulting in the loss of their ears, eyes and noses. Often, these patients have challenging reconstructions attempted by plastic surgery. However, when plastic surgery is not possible, then maxillofacial prosthetics are necessary to complete their rehabilitation. This presentation will discuss various burn categories, as well as past, present and future burn therapies. The presentation will also focus on digital methods use to enhance diagnosis and treatment of these patients. Additionally, methods of prosthesis attachment, surgical considerations for cranial implants, auricular, ocular and facial prostheses will be described. Lastly, an overview soft tissue care and maintenance protocols will be presented.

Learning Objectives:

1. To provide an overview of facial burns and injuries encountered
2. To describe current burn therapies
3. To show digital equipment and methods used to assist prosthetic rehabilitation procedures provided at Wilford Hall Ambulatory Surgical Center and Brook Army Medical Center.

10:15-11:00 ***AM Break*** *Sponsored by Conexão*

Moderator: **Betsy Davis, DMD, MS**

11:00 **Todd Kubon, BA, MAMS, CCA**
Sunnybrook Odelte Cancer Center
Toronto, Ontario, Canada

Improving Quality Assessment: Establishing a Custom Breast Prosthesis Program

Purpose: Ninety percent of mastectomy patients will use an external prosthesis where the standard of care employs a stock prosthesis that is purchased from "off-the-shelf". Our objectives were to determine patient demand for custom breast prostheses and collect qualitative information that could be used to influence future research and program direction.

Method: Sixty-five women with lumpectomy or mastectomy were asked to participate prior to exploring rehabilitation options. The quantitative outcome measures were EORTC QLQ-C30 and BR-23 general and breast-specific quality of life questionnaires and the Ambulatory Oncology Patients Satisfaction Tool. QOL tools were analyzed using Mann-Whitney U test. Comparison of satisfaction analysis was completed using Fishers Exact Test/Chi-Square Test. A descriptive qualitative approach making use of in-depth interviews exploring the experiences of women was used to establish patient perceived value of services. The analysis of the interview transcripts was based on a standardized content method to describe the experiences of the women.

Results: All women had had previous experience with a conventional prosthesis and reported wearing the custom-designed prosthesis was more satisfying for them. They reported comfort and ease in wearing it coupled with a sense of feeling less like a victim. Comparison of the quality of life and patient satisfaction scores showed no significant difference between the women wearing the conventional prosthesis or the custom-designed prosthesis ($P \leq 0.05$).

Conclusion: The qualitative data provided a strong case in

support of the new device. Patient demand, perceived benefit, and experience wearing the prosthesis were documented. Suggestions for improvements in the device and the program operations were gathered and will influence the future development of this service.

Discussion: Evaluation plays a major role in the delivery and monitoring of high quality products and services, whereas research and development is requisite for professional advancement. The health care community employs structured evaluation and objective research in order to first establish standards of care and practice and second to serve as the foundation for quality improvement initiatives. This presentation will use a problem based learning scenario related to prosthetic services to introduce a structured process for evaluation and demonstrate how to develop an objective research project to address quality improvements in products and services.

11:30 **Michael W. Klotz, DMD, MDentSc**
Diplomate of the American Board of Prosthodontics and Fellow of the American College of Prosthodontists
Ho-Ho Kus, NY USA

Development of a Universal Maxillectomy Classification System: Retrospective Analysis and System Description

Purpose: Multiple publications have discussed proposed systems to classify maxillectomy defects from both surgical and prosthodontic perspectives. Classification systems enable colleagues to accurately describe treatment rendered to patients and prepare them for future rehabilitation. The purpose of this study is to apply the known prosthodontic maxillectomy classification systems and propose a universal classification system based on a 46 year experience in a single institution.

Materials/Methods: Records from 1963 to April 2009 were reviewed for patients who underwent a maxillectomy, craniofacial resection, soft palate resection, or delivery of a surgical obturator at Memorial Sloan-Kettering Cancer Center.

Patients were excluded if there was no oroantral communication with the need for an obturator. Following approval by the Institutional Review Board, the following data were collected: hospital medical record number, gender, operating surgeon, operating dental surgeon, date of procedure, histological diagnosis, anatomical site, size of lesion as described by final pathology report, and extent of maxillectomy. A schematic diagram of the oral cavity was obtained and the defect was drawn for each patient. Using established prosthodontic oriented classifications, the patients were grouped for analysis.

Results: The database query resulted in a total of 1310 patients and the charts were made available for data collection. A total of 436 patients met the criteria and had complete records for data collection. Using the established prosthodontic classifications an overwhelming majority were Aramany Class II and Okay Class 1b. The second majority was Aramany Class I corresponding with Okay Class II. Finally, this was followed by Aramany Class III and Okay Class 1a.

Conclusions: The well-known prosthodontic classification systems developed by Aramany and Okay are based on the clinical experience of 123 patients in 6 years and 47 patients in two years, respectively. Using retrospective data from our 436 patients and applying the previously developed classification systems, a proposed classification system was developed. This new system utilizes three defined parameters (D- defect size, L- defect location, T- number of teeth remaining) describing the complexity of rehabilitation, while promoting standardization of communication among colleagues, patients, and third party carriers.

Learning Objectives:

1. Recall previously developed maxillectomy classification systems from both head and neck and plastic surgeons as well as maxillofacial prosthodontists.
2. Understand the rationale for the development of a universally accepted maxillectomy classification system.
3. Classify different hard palatal defects using the DLT classification system.

12:00 **David J. Reisberg, DDS**

Diplomate of American Board of Prosthodontics
The Craniofacial Center at the University of Illinois
Medical Center in Chicago
Chicago, IL USA

Surgical Guide for Craniofacial Implants: Better Than Throwing Darts In Your Local Pub

Proper implant position is critical for the success of a prosthesis. The importance of a surgical guide is well understood from extensive experience in the oral cavity. While the number of craniofacial implants placed does not come close to approaching the number placed in the oral cavity, nonetheless proper implant position is a key for a successful, auricular, nasal, or orbital prosthesis. This presentation will discuss the history and development of the surgical guide and describe several reliable techniques for fabrication and use.

Learning Objectives

1. Appreciate the importance of using a surgical guide for craniofacial implant placement
2. Understand the history and development of the craniofacial surgical guide
3. Understand the techniques used to fabricate the guides

Reserve Speaker:

Harry Reintsema , DDS, PhD
University Medical Center Groningen
University of Groningen, Department of Oral Maxillofacial Surgery and Maxillofacial Prosthetics, Groningen, The Netherlands

Rehabilitation Management in Head and Neck Oncology Patients

Surgical treatment of tumours in the head and neck area and/or more often applied subsequent (chemo) radiation therapy in general result in anatomical and physiological conditions unfavourable for prosthodontic rehabilitation. Interdisciplinary planning of oncological treatment and rehabilitation helps to diminish the unfavourable outcomes and to regain quality of life. The maxillofacial prosthodontist plays an important role in that process.

The use of implants to retain prostheses in these compromised patients has improved the possibilities to obtain rehabilitation and as such to improve patients' quality of life.

The outcomes of implant treatment in head and neck oncology patients have been reported sparsely, especially because the groups of patients to report on are small and diverse. As well the tools to determine quality of life related to oral rehabilitation and to obtain objective measures of oral functioning still seem not well developed. Treatment strategies are more often based on expert opinions and local arrangements.
In the UMC Groningen in a prospective study regarding implant treatment in the edentulous mandible during ablative surgery for malignancies in the oral and oropharyngeal area the effects on treatment outcomes (condition of peri-implant tissues, implant survival, oral functioning and quality of life) of prosthodontic rehabilitation with implant-retained lower dentures was obtained over a five year period of follow up. As well as the outcomes regarding the effect of implant treatment after previously applied radiotherapy, in which the use of hyperbaric oxygen treatment for preventive reasons was taken into account also. Also the use of implants to retain facial

prostheses has been taken in account.

The general outcomes available and multi-disciplinary procedures will be discussed.

12:45 ***Session Adjourns***

14:00-17:00 **Workshop 3-**
Sponsored by Cochlear Americas
Osseointegrated Implants and Facial Prosthetic

Sunday, October 30th

Johan Wolfaardt, BDS, MDent, PhD
Professor and Director
Institute for Reconstructive Sciences in Medicine
Division of Otolaryngology-Head and Neck Surgery,
Department of Surgery, Faculty of Medicine and
Dentistry, University of Alberta/Covenant
Health/Alberta Health Services
Edmonton, Alberta

Dr Wolfaardt is Director of Clinics and International Relations, the Institute for Reconstructive Sciences in Medicine (iRSM) and a Full Professor, Division of Otolaryngology-Head and Neck Surgery, Department of Surgery, Faculty of Medicine and Dentistry, University of Alberta, Canada. His clinical and research interests are in the area of maxillofacial prosthetics with particular emphasis in the area of head and neck reconstruction, osseointegration and treatment outcomes. Dr Wolfaardt has led the development of the research program at iRSM. His research interests involve treatment outcomes, digital technologies in head and neck reconstruction and biomechanics of osseointegrated implants. Dr Wolfaardt has a special interest in quality management and he led the quality initiative that enabled iRSM to register an ISO9000 quality system for the clinical and research aspects of osseointegration care. Dr Wolfaardt has published over 90 papers in refereed journals and contributed to a variety of texts. He has lectured both nationally and internationally on maxillofacial prosthetics,osseointegration in head and neck reconstruction, challenges of introduction of advanced digital technology, knowledge work, team work and quality management. Dr Wolfaardt has served on Boards of the American Academy of Maxillofacial Prosthetics, the International Society for Maxillofacial Rehabilitation, Advanced Digital Technology(on Head and Neck Reconstruction) Foundation (ADT Foundation) and the International College of Prosthodontists.

Rhonda F. Jacob, DDS, MS
Professor and Maxillofacial Prosthodontist in the
Department of Head and Neck Surgery
University of Texas M.D. Anderson Cancer Center
Houston, TX USA

Rhonda F. Jacob received her DDS and MS in prosthodontics from the University of Iowa. She completed training in maxillofacial prosthodontics and dental oncology at the University of Texas M.D. Anderson Cancer Center, where she is Professor and maxillofacial prosthodontist in the Department of Head and Neck Surgery. Dr. Jacob is a Diplomate and Examiner of the American Board of Prosthodontics and Fellow of the American College of Prosthodontists, and Past President of the American Academy of Maxillofacial Prosthetics and Academy of Prosthodontics. She is the current secretary of the ICP. Her clinical and academic interests relate to the orofacial endosteal implant rehabilitation of the head and neck cancer patient.

Roman Skoracki, MD
Associate Professor of Plastic Surgery
University of Texas M.D. Anderson Cancer Center
Houston, TX USA

Roman Skoracki is an Associate Professor of Plastic Surgery at the University of Texas MD Anderson Cancer Center. He is Associate Director of the Microvascular Fellowship Training Program. He holds an appointment as clinical assistant professor, Department of Surgery at Baylor College of Medicine. He trained in Canada at the University of Calgary and University of Manitoba and is a

Fellow of the Royal College of Physician and Surgeons. He also completed a fellowship in microvascular reconstructive surgery at the University of Texas, MD Anderson Cancer Center.

Dr. Skoracki has lectured nationally and internationally on a broad range of topics related to reconstructive surgery and has authored numerous peer reviewed articles and book chapters.

Edmond Bedrossian, DDS
Diplomate of the American Board of Oral & Maxillofacial Surgeons
San Francisco, CA USA

Dr Bedrossian received his dental degree from the University of the Pacific. He completed his Oral & Maxillofacial surgery training at Alameda Medical Center and is a Diplomate of the American Board of Oral & Maxillofacial Surgeons.

In addition to maintaining a private practice in San Francisco, California; He is the Director of Implant Surgical training at UOP's Oral & Maxillofacial Surgery Residency Training Program as well as the Director of Prosthetic Implant training for the AEGD Residency program.

Dr Bedrossian has lectured and authored numerous articles and text book chapters with Professor Branemark on the topics of bone grafting techniques, immediate load protocols, the management of the Zygomatic implants as well as indications for maxillofacial implants. He is the author of "Implant treatment Planning For the Edentulous Patient; A Graftless Approach to Immediate Loading".

Dr Bedrossian is a member of the Board of directors for the Branemark institute and the current President of the PI Brånemark Foundation, North America

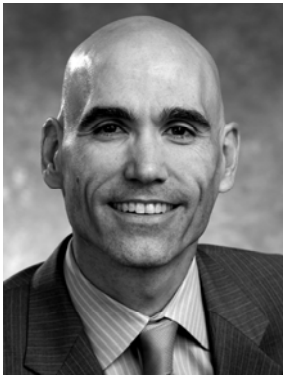
Arun B. Sharma, BDS, MSc.
Diplomate of the American Board of Prosthodontics
Clinical Professor – UCSF
San Francisco, CA USA

Dr. Sharma is a Clinical Professor in the Division of Prosthodontics at the University of California, San Francisco School of Dentistry. Since 1990 he has been the director of the maxillofacial prosthetic clinic and the prosthodontist for the Craniofacial Anomalies Center at UCSF. Dr. Sharma is a diplomate of the American Board of Prosthodontics. He maintains a private practice, and is actively involved with the graduate program in prosthodontics serving as the Associate Director. Dr. Sharma received his dental degree from the University of Bombay in 1983 and a Masters in Prosthetic Dentistry from the University of London. He then completed a prosthodontic residency from UCSF and a maxillofacial prosthetic residency from UCLA. Dr. Sharma is a fellow of the American College of Prosthodontists and the American Academy of Maxillofacial Prosthetics. He is a member of the International College of Prosthodontists, the International Society for Maxillofacial Rehabilitation, American Prosthodontic Society, The Academy of Prosthodontics and the Pacific Coast Society for Prosthodontics. Currently he is the Vice Chair of the Editorial Council of the Journal of Prosthetic Dentistry. Dr. Sharma has contributed to textbooks, authored many articles and has served as the Assistant Editor of the Journal of Prosthetic Dentistry and as President of the Pacific Coast Society for Prosthodontics.

Monday, October 31st

Sreenivas Koka, DDS, MS, PhD
Professor of Dentistry and Chair of the Department of Dental Specialties at the Mayo Clinic
Rochester, MN USA

Sreenivas Koka was raised in the UK before emigrating to the USA in 1985. Holding DDS and MS degrees from the University of Michigan and a PhD degree from the University of Nebraska, he is currently Professor of Dentistry and Chair of the Department of Dental Specialties at the Mayo Clinic. He is actively engaged in patient care as well as teaching of post-graduate students and pursuing his research interests in oral-systemic links with an emphasis on osteoporosis effects on the oral cavity as well as the relationship of clinical decision making in prosthodontics and patient outcomes. Dr. Koka is a member of the Editorial Advisory Board of the International Journal of Prosthodontics, a Diplomate of the American Board of Prosthodontics and a member of the Executive Council of the Academy of Prosthodontics.



Brian L. Schmidt, DDS, MD, PhD
Professor, Departments of Oral & Maxillofacial Surgery and Physiology and Neuroscience Director, Bluestone Center for Clinical Research
New York, NY USA

Brian Schmidt is a clinician scientist whose clinical practice and laboratory research program are closely integrated. His research is

focused on the identification of diagnostic and predictive cancer biomarkers and symptomatology related to cancer, especially cancer pain. His clinical practice is focused on the comprehensive surgical management of patients with head and neck cancer.

Dr. Schmidt's professional training includes a PhD, a medical degree, a dental degree, as well as surgical oncology training. He completed his advanced degrees at the University of California, San Francisco. Following his training he was appointed to the faculty of the University of California San Francisco. In this position he was the residency program director for oral and maxillofacial surgery. He also started and directed the oral and maxillofacial oncology fellowship. In July, 2010 he became the Director of the Bluestone Center for Clinical Research at New York University. He was appointed as Professor in the Departments of Oral and Maxillofacial Surgery and the Department of Physiology and Neuroscience.

Over the last ten years he has developed an independent laboratory and clinical research program that has been both creative and productive in the area of cancer pain and biomarker discovery. He is co-inventor of a device and assay for the quantification of pain in preclinical models. Dr. Schmidt has published complementary studies utilizing preclinical models of cancer pain and clinical findings in cancer patients. He is the author and/or co-author of more than 80 articles that have been published in peer-reviewed journals. He is the principal investigator of numerous NIH-funded studies.

Joel B. Epstein, DMD, MSD, FRCD(C), FDS RCSE
Adjunct Professor of Oral Medicine
City of Hope, Duarte CA
Cedars-Sinai Health System
Los Angeles, CA USA

Dr. Epstein graduated from Dentistry in 1976 from the University of Saskatchewan in Saskatoon, Saskatchewan, Canada. He received a certificate in Oral Medicine and Masters' of Science Degree in Dentistry from the University of Washington in Seattle, Washington. He is a Fellow of the College of Dental Surgeons of Canada in Oral Medicine/Oral Pathology, a Fellow of the Royal College of Surgeons of Edinburgh and a Diplomat of the American Board of Oral Medicine.

He is currently Adjunct Professor of Oral Medicine, City of Hope, Duarte CA and medical-dental staff at Cedars-Sinai Health System, Los Angeles, CA. He was Professor in the Department of Oral Medicine and Diagnostic Sciences, and Otolaryngology and Head and Neck Surgery and Cancer Center at the University of Illinois. Prior to this, he was on the medical/dental staff of the British Columbia Cancer Agency; and Head of the Department of Dentistry at Vancouver Hospital and Health Sciences Centre, and Clinical Professor in the Faculty of Dentistry at the University of British Columbia.

Dr. Epstein has published in the area of oncology, infectious disease, facial pain and general areas of Oral Medicine, with more than six hundred contributions to the literature.

Clark M. Stanford, DDS, PhD
Associate Dean for Research and
Centennial Fund Professor for Clinical Research
Iowa City, Iowa USA

Dr. Clark Stanford is the Associate Dean for Research and Centennial Fund Professor for Clinical Research, Dows Institute for Dental Research and Department of Prosthodontics, College of Dentistry, University of Iowa. He holds secondary appointments in the Department of Orthopaedic Surgery and the Department of Biomedical Engineering. Dr. Stanford received his BS (1984), DDS (1987), Certificate in Prosthodontics and Ph.D. (Cell Biology; 1992) from the University of Iowa. He has been on the faculty since 1992. His research areas deal with osteoblastic gene expression and signally pathways. He runs the Office for Clinical Research and is a Key Function Director for the Nanoscience section of the NIH Institute for Clincal and Translational Sciences (ICTS) at University of Iowa Hospitals and Clinics. In this role he helps to organize and perform basic, translational and clinical research studies. He is the author 6 book chapters, 94 published papers and more than 140 published research abstracts. He receives research funding from NIH, Foundations and from industry. He currently serves on multiple national and international committees. He is the recipient of 15 academic awards including the 2007 State of Iowa Regents Award for Faculty Excellence and the IADR Distinguished Scientist Award (2007).

John L. Ricci, Ph.D
Associate Professor
Department of Biomaterials and Biomimetics
New York University College of Dentistry
New York, NY USA

John L. Ricci, PhD holds a Bachelor of Science degree from Muhlenberg College and a PhD from the University of Medicine and Dentistry of New Jersey (Department of Anatomy) where he graduated in 1984. He is an Associate Professor in the Department of Biomaterials and Biomimetics at New York University College of Dentistry, where he directs the Masters Program in Biomaterials Science. Dr. Ricci is an active member of the Society for Biomaterials, the American Association of Dental Research/International Association of Dental Research, and the Academy of Osseointegration, and is on the editorial boards of the Journal of Biomedical Materials Research (Applied Biomaterials) and Implant Dentistry. His active areas of research involve cell and tissue response to permanent and resorbable biomaterials, and development of implants, bone graft substitutes, and tissue engineered devices.

James Kelly, DDS
Director of Maxillofacial Prosthetics
University of California, Los Angeles (UCLA)
Los Angeles, CA USA

James Kelly is the current director of Maxillofacial Prosthetics at the University of California, Los Angeles (UCLA). He graduated from Creighton University's School of Dentistry and obtained his

Advanced Prosthodontics Certificate and M.S. in Oral Biology from UCLA in 2007. After studying at UCLA, James did his fellowship in Maxillofacial Prosthetics at the University of Texas, M.D. Anderson Cancer Center. After teaching and practicing MFP at Creighton University, James joined UCLA's Weintraub Center for Reconstructive Biotechnology as Assistant Professor.

Tuesday, November 1st

Gerald T. Grant, DMD, MS, CAPT. USN
Director of Craniofacial Imaging Research at the Naval Postgraduate Dental School (NPDS)
Service Chief of the 3D Medical Applications Center, Department of Radiology, Walter Reed National Military Medical Center
Bethesda, MD USA

Captain Grant received his D.M.D. degree from University of Louisville, School of Dentistry in 1985. He received a certificate in Prosthodontics from the Naval Postgraduate Dental School, Bethesda, MD. In 1995 and a certificate in Maxillofacial Prosthetics from Naval Postgraduate Dental School in 1999. He is a Diplomate and of the American Board of Prosthodontics, Fellow of the ACP, AAMP and previous Specialty Leader to the Surgeon General for Maxillofacial Prosthetics and Implant Dentistry. Captain Grant served as Chairman and Program Director for the Maxillofacial Fellowship Officer program, Naval Postgraduate Dental School from 2004 – 2008, professor at the Naval Post-graduate and the Washington VA's Prosthodontics Residency Program, and currently is the Director of Craniofacial Imaging Research at the Naval Postgraduate Dental School (NPDS) and Service Chief of the 3D Medical Applications Center, Department of Radiology, Walter Reed National Military Medical Center, Bethesda, MD.

Daniel D. Dunham, DDS, LTC, DC, USN
U.S. Army Dental Corps
Diplomate of the American Board of Prosthodontics
Fellow in the American College of Prosthodontists
Bethesda, MD USA

Lieutenant Colonel Dunham is a prosthodontist serving in the U.S. Army Dental Corps. He is a graduate of the University Of Michigan School Of Dentistry and completed his specialty training at the U.S. Army Prosthodontic Residency Program at Ft. Gordon, GA. He is a Diplomate of the American Board of Prosthodontics and a Fellow in the American College of Prosthodontists. LTC Dunham recently completed a one-year fellowship in Maxillofacial Prosthetics at the National Naval Medical Center in Bethesda, MD.

William Wilson, Jr., D.D.S., M.S.
Naval Postgraduate Dental School
Bethesda, MD USA

Dr. Wilson is a Lieutenant Commander in the United States Navy Dental Corps and is currently serving as the Department Chairman and Program Director for the Maxillofacial Prosthetics Fellowship at the Naval Postgraduate Dental School in Bethesda, MD. He is also serving as a consultant to the Navy Surgeon General as the Navy Specialty Leader for Maxillofacial Prosthetics and Dental Implants.

He received his D.D.S. degree from the West Virginia University School of Dentistry in Morgantown, WV. He received his M.S. in oral biology from The George Washington University, Washington, D.C. and completed his prosthodontic residency training as well as a fellowship in maxillofacial prosthetics at the Naval Postgraduate Dental School.

Dr. Wilson is a Diplomate of the American Board of Prosthodontics, and a fellow in both the American College of Prosthodontics and the American Academy of Maxillofacial Prosthetics.

Alan Sutton, Col, USAF, DC
59th Dental Training Squadron/SGDTP
Lackland AFB, TX USA

Col (Dr.) Alan Sutton completed his Prosthodontics Specialty Training at Wilford Hall Medical Center in 1997. He then accomplished his Fellowship in Maxillofacial Prosthetics at WHMC. In 1998, he became a member of the teaching staff as the Director of 1st-Year Resident Education. In June 1998, he received his Prosthodontics Board Certification. In 2000, he became the Director of Fixed Prosthodontics and then Prosthodontics Program Director. June 2002, he deployed in support of OEF. In September 2002, he was the Dental Laboratory Commander at Lackland AFB. In March 2003, he again deployed in support of OEF/OIF. Following this, he was the Chief, Department of Prosthodontics and Dental Laboratory Commander at Ramstein, Germany. From 2006 to 2010, he was the Military Consultant to the Surgeon General for Dental Laboratories and the Director, of the Peterson Area Dental Laboratory. Col Sutton is currently the Director, Maxillofacial Prosthetics at Wilford Hall Medical Center.

Todd Kubon, BA, MAMS, CCA
Sunnybrook Odelte Cancer Center
Toronto, Ontario, Canada

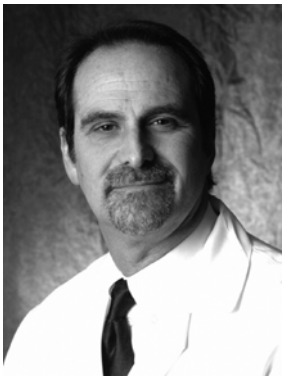
Todd Kubon is an Anaplastologist in the Craniofacial Prosthetic Unit (CPU) at the Sunnybrook Odette Cancer Centre and Research Fellow at the Hospital for Sick Children, Toronto, Ontario, Canada. Todd received his Bachelor of Arts Degree in Art and Biology from Tulane University in New Orleans, LA and a Masters Degree in Biomedical Visualization from the University of Illinois at Chicago in 1997. Todd's research interests address psychosocial outcomes in prosthetic rehabilitation. Todd has published and lectured internationally on the discipline of Anaplastology and twice has won the Judson C. Hickey Scientific Writing Competition sponsored by the Journal of Prosthetic Dentistry. Todd serves on the Health Care Advisory Board & Publications Committee for AboutFace International and was named the recipient of the 2004 Professional Community Service Award. Todd is the Chair of the Assistive Devices Program Standing Committee for the Ministry of Health Canada and was recently elected to serve as President on the Board for Certification in Clinical Anaplastology.

Michael W. Klotz, D.M.D., M.Dent.Sc., F.A.C.P.

Diplomate of the American Board of Prosthodontics
Fellow of the American College of Prosthodontists
New York, NY USA

Dr. Michael W. Klotz is a 2006 graduate of the University of Medicine and Dentistry of New Jersey. He completed the Prosthodontic residency program at the University of Connecticut Health Center in 2009. During his post graduate training, he obtained a Master's degree in Dental Science and completed novel research pertaining to the biomechanics of dental implants. Dr. Klotz completed a fellowship in Maxillofacial Prosthetics at Memorial Sloan-Kettering Cancer Center in 2010.

He is a Diplomate of the American Board of Prosthodontics and Fellow of the American College of Prosthodontists. He is a member of the American Dental Association, the New Jersey Dental Association, and the International Team for Implantology. He has won numerous awards in Prosthodontics and has lectured extensively on various topics including the surgical placement of dental implants, maxillofacial prosthetics, and successfully challenging the American Board of Prosthodontics.



David J. Reisberg, DDS
Director, The Craniofacial Center at The University of Illinois Medical Center
Chicago, IL USA

Dr. David J. Reisberg is a member of a team of medical and dental specialists and allied health professionals who provide comprehensive care for children and adults with congenital or acquired craniofacial conditions in The Craniofacial Center at the University of Illinois Medical Center in Chicago. He has been actively involved in the application of craniofacial implants to retain facial prostheses since 1990. Dr. Reisberg has written and lectured extensively on this topic. He is Director Emeritus of The UIC Craniofacial Center as well as a past board member of AAMP, past president of the International Society for Maxillofacial Rehabilitation, and current president of Ameriface, a national organization supporting people with facial differences. Dr. Reisberg is a diplomate of American Board of Prosthodontics.

Harry Reintsema , DDS, PhD
University Medical Center Groningen
University of Groningen, Department of Oral Maxillofacial Surgery and Maxillofacial Prosthetics, Groningen, The Netherlands

Harry Reintsema (DDS, PhD) graduated from Dental School in Groningen, The Netherlands in 1982 and defended his PhD-thesis at that University in 1988. He works as a dentist/maxillofacial prosthodontist since 1984, and is head of the UMCG Center for Special Dental Care and Maxillofacial Prosthetics in the UMC Groningen since 2003. His fields of interest concern e.g. dental treatment and rehabilitation of Head-and-Neck Oncology patients and patients with congenital or acquired orofacial defects. He is (co-)author of several articles and books on implant dentistry and maxillofacial prosthetics, and has participated in the organization of several conferences and workshops on maxillofacial rehabilitation subjects.
He has served on the board of the Dutch Society for Gnathology and Prosthetic Dentistry (NVGPT) from 1992- 2002 and is member of the ISMR executive council since 2007, serving as vice-president since 2010.

notes

divider
(front)

divider
(back)

AAMP WORKSHOP COURSE #1:
Treatment Planning the Edentulous Patient;
the Immediate Load Concept
Sponsored by Nobel Biocare

Sunday, October 30, 2011 14:30-16:45

The increased acceptance and understanding of the benefits of dental implants used in the "Graftless-Immediate load Concept", demands consideration in developing guidelines for the treatment planning this group of patients for a fixed, implant supported prosthesis. The establishments of large centers offering this treatment modality further highlights the need for the contemporary oral & maxillofacial surgeons and prosthodontists to familiarize and incorporate this treatment concept in their practice. This presentation will discuss the treatment planning protocols, both surgical and prosthetic, the scientific literature as well as the management of complications when considering the Graftless-Immediate load Concept.

Instructor Biography

Edmond Bedrossian, DDS
Diplomate of the American Board of Oral & Maxillofacial Surgeons
San Francisco, CA USA

Dr. Edmond Bedrossian is a Diplomate, American Board of Oral and Maxillofacial Surgery. He is Professor of Oral & Maxillofacial Surgery and Director of Implant Surgical training at Highland Hospital Oral and Maxillofacial Residency Training Program, as well as the Director of Prosthetic Implant training at the University of the Pacific's AEGD Residency Program. He has authored numerous articles and text book chapters on the management of the Zygomatic implant. He is also the author of the book "Implant treatment planning for the edentulous patient", Foreword by P-I Brånemark. He has lectured internationally with Professor Brånemark on various topics specially the rehabilitation of patients with maxillofacial defects. He is a member of the Board of Directors for the Brånemark Institute and the current President of the Brånemark Foundation North America.

AAMP WORKSHOP COURSE #2:
3D Surface Imaging in Maxillofacial Prosthetics
Sponsored by 3dMD

Monday, October 31, 2011 14:00-17:00

3dMD will present a basic and advanced track program allowing all attendees the opportunity to gain hands-on experience using a 3D Surface Imaging system.

The session will provide a basic background in system operation and allow attendees to move at their own pace operating the software. The advanced track program will allow attendees to build on the experience from last year or further develop the skills of current users.

Instructor Biography

Mr. Chuck Heaston
Vice President, Operations & Customer Service
Atlanta, GA USA

Heaston has 25-plus years of experience in computer technology and quality systems engineering. After serving as a Communications Electronics officer in the U.S. Army, Heaston transitioned to the private sector in the field of technology, where he has held management positions in Development, Quality Engineering, Professional Services, and Product Management.

During his 9 year tenure at 3dMD, Heaston has served as the vice president of operations and customer service. Heaston holds a Bachelors Degree in Business and Accounting from Augusta State University and an MBA from New Mexico State University.

AAMP WORKSHOP COURSE #3:

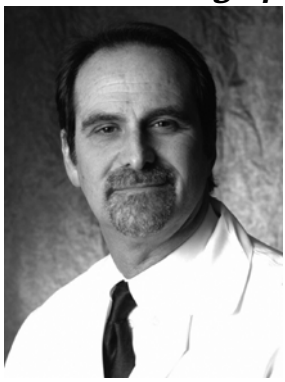
Osseointegrated Implants & Facial Prosthetics

Sponsored by Cochlear Americas

Tuesday, November 1, 2011 14:00-17:00

Dr. David Reisberg and Susan Habakuk, M.Ed, will lead a hands-on training course focusing on both surgical and prosthetic aspects of craniofacial rehabilitation utilizing osseointegrated implants. Course participants will have the opportunity to interact with a patient who is an implant recipient and prosthetic user. Topics include implant placement and facial restoration through prosthetic design will be covered in this unique in-depth workshop.

Instructors Biographies



David J. Reisberg, DDS

Director, The Craniofacial Center at The University of Illinois Medical Center
Chicago, IL USA

Dr. David Reisberg received his dental degree from Case Western Reserve University in 1977. He received a specialty certificate in Prosthodontics from Tufts University in Boston and one in Maxillofacial Prosthetics from The University of Chicago. He has been Director of the Maxillofacial Prosthetics Clinic at The University of Illinois Medical Center in Chicago since 1981. From 1998 to 2010 he served as Medical Director of The Craniofacial Center there. Dr Reisberg is part of an interdisciplinary team of medical and dental specialists and allied health professionals providing care for children and adults with congenital or acquired craniofacial conditions.

He has served on the Board of Directors of the American Academy of Maxillofacial Prosthetics and is past president of the International Society for Maxillofacial Rehabilitation. He currently serves as president of Ameriface, a national organization that supports people with facial differences. Dr. Reisberg has contributed many scientific articles and textbook chapters on the use of osseointegrated implants for craniofacial rehabilitation. He has also lectured extensively both in the United States and abroad on this topic. Dr. Reisberg is certified by the American Board of Prosthodontics.

Susan Habakuk, M.Ed
University of New Mexico
Department of Surgery
Santa Fe, NM USA

Susan Habakuk, M.Ed, is a certified clinical anaplastologist who has been practicing clinically at the University of Illinois Craniofacial Center in Chicago as a member of the maxillofacial rehabilitation team for over thirty years and more recently at the University of New Mexico in the Department of Surgery in Albuquerque. Her teaching, research and clinical interests focus on the use of osseointegrated implants for facial restoration and rehabilitation. The graduate program in clinical anaplastology/medical art she directed at the University of Illinois has gained international recognition for setting the standards in the field of anaplastology.

Professor Habakuk received her Bachelor of Science degree in Medical Art and Masters Degree in Medical Education from the University of Illinois at Chicago. She is an active member in her professional and peer associations which include the International Anaplastology Association, the American Academy of Maxillofacial Prosthetics, the International Society of Maxillofacial Rehabilitation and the Academy of Osseointegration. She has presented lectures and workshops nationally and internationally, served as a consultant and authored articles and book chapters on her research interests and clinical experience. Throughout her professional career, she has received honors and awards for her academic and clinical achievements.

Table 1

Fabrication of a Custom SCUBA Mouthpiece

Abdolazadeh, L.*, Bell, D., LCDR, Wilson, W., LCDR
Naval Postgraduate Dental School
Maxillofacial Prosthetics
Bethesda, MD USA

Purpose: SCUBA-diving mouthpieces of diverse designs have been used for years. The majority of these mouthpieces are not customized for individual users. SCUBA mouthpieces are typically held in place by means of the diver's bite on retaining platforms which project inwardly from a lip-engaging portion to position between the upper and lower teeth. The mouthpiece needs to be secured in such a way that unwanted pressures coming from water currents or the diving apparatus are counteracted. This introduces a challenge for a diver that may present with missing teeth, partially missing maxilla or mandible.

Methods & Materials: A stock mouthpiece was utilized and functionally customized with the use of resilient denture liner. It was then invested in type three stone and processed in silicone.

Results: The customized SCUBA mouthpiece was successfully deflasked, recovered and polished for use.

Conclusion: This table clinic depicts a technique to fabricate a custom SCUBA mouthpiece for an individual presenting with an edentulous mandible and a history of an unrestored hemi-mandibulectomy.

Table 2

Use of Indexes to Control Final Outcome of Metal Ceramic Restorations

Bak, S.Y.
Michael E. DeBakey VA Medical Center
Prosthodontics
Houston, TX USA

Purpose: To use an effective method of determining proper full contour wax-up and cutback for fabrication of metal ceramic restoration using indexes.

Methods & Materials: Various indexes were used to control the final outcome of a metal ceramic restoration
1. Putty index for provisional and for porcelain application 2. Cellulose acetate template as a preparation guide 3. Custom incisal guide table for forming lingual contours of the restoration 4. Drill guide for correction of preparation.

Conclusion: For proper contouring of ceramics on metal copings, there has to be adequate reduction for both the metal and ceramics for esthetics and functionality. The final outcome of metal ceramic restorations can be controlled through the use of various indexes.

Table 3

CAMBRA and its Effect on Surface Roughness of Various Restorative Materials

Bolding, L.
University of Maryland, Baltimore
Department of Endodontics, Prosthodontics and Operative Dentistry
Baltimore, MD USA

Purpose: The purpose of this study was to investigate the effect of various anti-caries agents on the surface roughness of three different restorative materials. The anti-caries agents tested were prescription strength fluoride mouthwash, over the counter strength fluoride mouthwash, chlorhexidine gluconate rinse, and distilled water. The restorative materials tested were porcelain, titanium, and base metal alloy.

Methods & Materials: Three different anti-caries agents recommended in the CAMBRA guidelines were used in this study. Prevident Dental Rinse was used as the prescription strength fluoride mouthwash. ACT mouthwash was used as the over the counter fluoride mouthwash. A solution of 0.12% chlorhexidine gluconate was also used. Distilled water served as the control for this study. Three different materials were used for fabrication of testing discs. Sixty-four specimens of each different material were made. The porcelain powder was mixed with modeling liquid and stacked onto a glass slab. A copper band was then used to cut a disc of about 15 mm diameter and about 3 mm in thickness. Excess moisture was absorbed with tissue. The porcelain discs were then dried, removed from the glass slab, and transferred to the porcelain oven. The discs were then fired according to the manufacturers' recommendations in a porcelain oven and self-glazed. A putty mold of about 10mm in diameter and 2mm in thickness was used to standardize the fabrication of the base metal discs. Casting wax was melted into the mold. Once the wax hardened, it was removed from the

mold, sprued at a 45° angle from the edge of the disc, and was then positioned in a casting ring. Phosphate-bonded investment was mixed according to manufacturer's instructions and used to invest the wax discs. The investment was allowed to bench set for 90 minutes, and then placed in a burnout oven at the manufacturer's recommended time and temperature. Once burnout was complete, the discs were casted using a base metal alloy. Once cooled, the investment was broken away from the metal discs and the remaining investment was air-particle abraded until the discs were free of investment. The discs were separated from the sprue using a carborundum disc at 40 rpm. The area of the sprue was contoured with a heatless stone to match the contour of the disc. The discs were then polished using polishing stones and discs in a handpiece. Pre-fabricated titanium bars were obtained from the manufacturer and used as is. The initial surface roughness (Ra) was measured for each disc using a profilometer located at the University of Maryland, Baltimore County campus. Each disc was analyzed by two passes of the profilometer which were performed at right angles to each other. Each reading was analyzed independently. One of each restorative material disk was placed in each of the testing solutions in a plastic container and allowed to soak for varying times according to manufacturer's instructions equaling two years of simulated use. After each disk had been immersed in its solution for the designated amount of time, it was rinsed with distilled water and air-dried. The discs were placed into individual containers marked to identify the solution in which it was immersed and its initial Ra value. The Ra values for surface roughness of each material were again measured with a profilometer and recorded. A power analysis was completed to determine sample size. The most important hypothesis is that regarding the effect on surface roughness of the anti-caries agents. With N=14, a p level of 0.05, an effect size of 0.25, and three different anti-caries agents plus water as a control, Power = 0.81. For comparison of surface roughness of the three restorative materials, with N=14, a p level of 0.05, and an effect size of 0.25, Power = 0.89. A sample size of N=16 was chosen.

The difference between the initial and final values of surface

roughness, or change in surface roughness, was analyzed using factorial ANOVA. Significant differences for the anti-caries agents and the restorative materials were analyzed by Tukey's Honestly Significant Difference (HSD) test. A p value of 0.05 was considered significant.

Results: In this study, the effect of different mouthwashes on the surface roughness of porcelain, titanium, and base metal was examined. In the experimental group, soaking of the various materials in each solution was carried out to simulate two years of usage. The difference in surface roughness before and after soaking was measured in two different directions for each sample and both values were included in the statistical analysis. Statistical analysis using ANOVA revealed that there were no significant differences in change of surface roughness between the materials. There were statistically significant differences within the anticaries agents group and also in the interaction between the materials and anticaries agents. Post hoc analysis revealed that the significant difference in mean change in surface roughness was between Prevident Dental Rinse and chlorhexidine gluconate (0.1656; p=0.011). Prevident Dental Rinse produced a negative change in surface roughness, or a smoother surface, compared to chlorhexidine gluconate which produced a positive change in surface roughness, or a rougher surface. The greatest effect of these two mouthwashes was found within the porcelain samples.

Conclusion: In this study, soaking of restorative materials in different mouthwashes produced statistically significant changes in surface roughness in porcelain specimens only. This change resulted in a smoother surface after soaking in Prevident Dental Rinse and a rougher surface after soaking in chlorhexidine gluconate. These findings suggest that some surface roughness change in porcelain may occur with continued use of anticaries agents.

Table 4

Lead Foil Technique for Partially Edentulous Radiographic Guide

Chong, J.*, Delima, L., Keyes, R., Dryer, R., Jeong, S.C., James, K., Kiangsoontra, L.
University of Minnesota School of Dentistry
Graduate Prosthodontics
Minneapolis, MN USA

Purpose: Radiographic and surgical guides are often used by specialists in successful dental implant therapy, particularly in complex cases. This article presents a technique in fabrication of a guide that can be used both as a radiographic and surgical guide using low-cost materials readily available in many dental clinics.

Methods & Materials:

1. Arrange denture teeth (Portrait IPN; Dentsply Intl, York, Pa on a diagnostic cast and contour wax (Baseplate Wax; Henry Schein, Melville, NY) to the edentulous site. Impress tooth arrangement on diagnostic cast with vinyl polysiloxane putty (Express; 3M ESPE, St. Paul, Minn) and pour with Type III dental stone to fabricate a duplicate cast.

2. Fabricate a vacuum-formed matrix over the duplicate cast using 0.020 inch temporary splint material (Buffalo Dental Manufacturing Co. Inc., Syosset, NY) and a vacuum forming machine (Tray-Vac; Buffalo Dental Manufacturing Co. Inc.). Without removing the vacuum-formed matrix from the duplicate cast, trim the excess material beyond the depth of the vestibule and lingual sulcus with an electric knife (Buffalo Dental Manufacturing Co. Inc.) With a #8 round bur (Brasseler USA, Savannah, GA), prepare holes through the matrix where implant placement is desired.

3. Apply irreversible hydrocolloid impression tray adhesive (Hold; Waterpik Inc. Fort Collins, CO) over the entire surface of the vacuum-formed matrix and allow to dry for 10 minutes.

4. Using periapical size 2 lead foil backing recovered from used dental radiographic film, (Ultra-speed Dental Film; Kodak Dental Systems, Rochester, NY) burnish one thickness over the edentulous area. Trim lead foil to extend 2 mm apical to the free gingival margin of the denture tooth arrangement. Additionally, trim lead foil away from the margins of the prepared holes by approximately 2 mm to allow for future sealing of the lead within the radiographic guide.

5. To ensure adhesion of the lead foil within the radiographic guide, paint another layer of tray adhesive over the burnished foil and the exposed vacuum-formed matrix and allow to dry for 10 minutes.

6. Create a second vacuum-formed matrix over the burnished foil and first vacuum-formed matrix that remains on the duplicate cast. This results in a "sandwich" effect of the lead foil in between the 2 layers of temporary splint material.

7. Trim the temporary splint material 2 mm beyond the lead foil sandwiched in between the 2 layers using the electric knife.

8. Remove the trimmed radiographic guide from the duplicate cast and smooth the edges with wet/dry sandpaper.

9. Position the radiographic guide in the patient's mouth while the CBCT is taken.

Results: This technique results in the fabrication of a radiographic and surgical guide that is made from readily available materials in the average dental clinic.

Conclusion: This technique provides a way to easily create an inexpensive and highly functional guide that can aid in both treatment planning and implant surgery for partially edentulous patients. The guide allows for imaging the planned restoration including the extensions and contours, and also can provide the desired location for implant placement. With the double vacuum-formed matrix technique, lead foil can be effectively sealed within the matrix and be safely used to provide imaging of the planned prosthesis position and guide surgical implant placement.

Table 5

Immediate Implant Placement and Immediate Loading in Ectodermal Dysplasia and Cleft Palate after Maxillary Distraction Osteogenesis: A Clinical Case

Dhima, M.*, Rieck, K.L., Salinas, T.J.
Mayo Clinic
Division of Prosthetic and Esthetic Dentistry
Rochester, MN USA

Purpose: To describe a case of ectodermal dysplasia and cleft palate rehabilitated with maxillary distraction, implant placement and immediate loading.

Background: The use of endosseous implant supported restorations with immediate load protocols for fixed restorations has been shown to provide predictable and successful long term outcomes.1 The literature is scarce on the application of these protocols in patients afflicted with ectodermal dysplasia where hypodontia or anodontia compromises bone development further affecting the process of osseointegration.

Methods & Materials: A 17 year old male with anhidrotic ectodermal dysplasia, cleft palate, velopharyngeal insufficiency, maxillary hypoplasia and hypodontia presented for treatment. After diagnosis and treatment planning, he underwent maxillary external distraction osteogenesis in the anteroposterior and vertical dimensions. Velopharyngeal insufficiency and hypernasality already present prior to distraction osteogenesis were addressed with injection augmentation of the soft palate and nasopharynx. Prosthetic rehabilitation to improve function and esthetics followed. To remove carious and periodontally diseased teeth, the patient underwent complete edentulation, alveoloplasty, immediate placement of eight endosseous implants in the maxilla and six endosseous implants in the mandible. Due to compromised

implant stability in the maxilla and lack of scientific documentation, a two stage approach was employed. The mandibular implants were immediately loaded after conversion of a conventional mandibular complete denture to a fixed implant supported provisional prosthesis. Patient was seen 90 days post placement for uncovering of the maxillary implants and rehabilitation with a definitive prosthesis.

Results: Functional and esthetic needs of a patient with ectodermal dysplasia, cleft palate, velopharyngeal insufficiency, hypernasality, maxillary hypoplasia, and hypodontia were met with a multidisciplinary team approach. Following external distraction osteogenesis, immediate implant placement and immediate load protocols 1 2 were applied.

Conclusion: A multidisciplinary approach to restoration of function and esthetics in patients with ectodermal dysplasia and its associated clinical manifestations with a combination of distraction osteogenesis, ground substance augmentation injections and immediate load implant placement protocols may assist accomplishing treatment goals for these patients.

Table 6

The Use of Laser Doppler Flowmetry and IMRT Cumulative Dose-Volume Histograms to Evaluate the Nature of the Radiation Induced Ischemic Process

Hanna, C.
New York University
Posthodontics
New York, NY USA

Intensity-modulated radiation therapy (IMRT) is an effective modality in the treatment of head and neck cancer. Through the generation of dose distributions, IMRT minimizes the dosage delivered to normal structures while sharply conforming to the tumor target. Despite this complex multi-beam delivery,

osteoradionecrosis (ORN) is still a significant concern when planning for post-radiation dental extractions and implant placement.

In an attempt to better understand the nature of the radiation induced ischemic process, we evaluated IMRT cumulative dose-volume histograms and used a Laser Doppler Flowmetry (LDF) to evaluate the blood flow to the mandible in patients who have had head and neck radiation.

Table 7

The Relationship between Smoking and Quality of Life in Dento-Maxillary Prostheses Wearers

Haraguchi, M.*, Morimata, J., Taniguchi, H.
Tokyo Medical and Dental University, Graduate School
Department of Maxillofacial Prosthetics
Tokyo, Japan

Purpose: Smoking is one of the risk factors in head and neck cancer. But smoking rate in the general Japanese is very high (23.4 % in 2009) in developed countries, especially in male (38.2 %). The purpose of this study was to investigate the smoking rates in dento-maxillary prostheses wearers at pre- and post-surgical operation caused by tumors. The relationships between smoking and non-smoking patients were also evaluated by the chewing function and quality of life (QOL).

Method: Fifty-five dento-maxillary prostheses wearers (36 males and 19 females, mean age 70.2 years) participated as the subjects in this study. Smoking rate, satisfied level for dento-maxillary prostheses and QOL were investigated by a questionnaire. Data on masticatory performance were measured by a sieve method using hydrocolloid material and a food intake questionnaire with 35 foods listings. The relationships between ever or current smokers and non-

smokers were analyzed for masticatory performances (1.40- and 1.18-mm mesh sieves), masticatory score by food intake questionnaire, satisfied level for dento-maxillary prostheses and QOL at until and over 5 years after surgical operation by unpaired t-test. The level of significance was $P < 0.05$.

Results: Smoking rates of pre- and post-surgical operation decreased from 27.3 to 9.1 % at until 5 years after operation, from 54.5 to 30.3 % at over 5 years, and from 43.6 to 21.8 % in all. These results were greatly higher than Japanese smoking rate in their 70s. There were no significant differences between ever or current smokers and non-smokers for masticatory performances, masticatory score and satisfied level at until and over 5 years after operation. But there was significant difference between ever or current smokers and non-smokers for QOL at until 5 years after operation ($P < 0.05$).

Conclusion: Recently, the smoking rates in dento-maxillary prostheses wearers tended to decrease as well as that in the general Japanese, but were still higher than that of Japanese through pre- and post-operation. And ever or current smokers wearing dento-maxillary prostheses might need more time than non-smokers for an improvement of QOL.

Table 8

Prosthodontic Consideration in Managing Embryonal Rhabdomyosarcoma Patients

Lin, T.
Memorial Sloan-Kettering Cancer Center
New York, NY USA

Embryonal Rhabdomyosarcoma (ERMS) is the most common subtype of rhabdomyosarcoma which affects infants and young children. ERMS cancer treatment modalities include radiation therapy, chemotherapy, and surgery. The survival rate of ERMS patients treated in early childhood is between 77%-86%. Due to

the multi-modal cancer treatments, many dentofacial abnormalities arise as a result in ERMS survivors. It includes enamel defects, bony hypoplasia/facial asymmetry, trismus, velopharyngeal incompetency, radiographically underdeveloped mandible, and tooth agenesis. In order to improve psychosocial function and promote health masticatory system, a proper treatment plan must be established and communicated to ERMS survivors and their parents. The aim of this presentation is to help clinicians to better recognize the dentofacial abnormalities and the importance in treatment planning and prosthetic designs for managing ERMS patients.

Table 9

Engineered Injectable Biodegradable Scaffold as a Carrier for PDL (Pdlscs) and Gingival Mesanchymal Stem Cells (Gmscs) for Applications in Maxillofacial Prosthodontics: An In Vitro Study.

Moshaverinia, A.*, Schricker, S.R., Shi, S., Chee, W.W.
Center for Craniofacial and Molecular Biology
Herman Ostrow School of Dentistry
University of Southern California, Los Angeles, CA.
Advanced Prosthodontics and Center for Craniofacial and Molecular Biology
Los Angeles, CA USA

Purpose: To formulate an injectable scaffold based on alginate-nanohydroxypatite (n-HAp) as a carrier for encapsulating PDL (PDLSCs) and gingival mesanchymal stem cells (GMSCs) and to evaluate the amount of periodontal tissues growth (soft and/or hard tissue regeneration) in vitro.

Methods & Materials: The stem cell viability, proliferation and differentiation to adipogenic and osteogenic tissues were studied. Using Oil o Red, Xylenol Orange and alizarin Red staining, respectively to investigate the expression of both adipogenesis and ontogenesis related genes, the RNA was

extracted and RT-PCR was performed. Human bone marrow mesenchymal stem cells (hBMMSC) were used as the positive control and the alginate hydrogel was used as the negative control in this study. The degradation behavior of hydrogel based on oxidized sodium alginate with different degrees of oxidation was studied in phosphate buffer solution at 37oC as a function of time by monitoring the changes in weight loss.

Results: Results showed that not only is alginate a promising candidate as a non-toxic scaffold for GMSCs and PDLSCs, but also it has the ability to direct the differentiation of these stem cells to osteogenic and adipogenic tissues as compared to the control group (hBMMSC) in vitro. The encapsulated cells remained viable and both osteo-differentiated and adipo-differentiated after 4 weeks of culturing in the induction media with higher intensities in comparison to the control group. The density of the differentiated tissue from GMSC and PDLSC was significantly higher than the positive control group ($P<0.05$). Also, it was found that the degradation profile of alginate hydrogel strongly depends on the degree of oxidation showing its tunable chemistry and degradation rate.

Conclusion: This study shows that the proposed stem cell-scaffold system might be a promising approach for treatment of maxillofacial and skeletal defects. The presented technology will enable the clinicians for soft/hard tissue generation and regeneration. Advancing cell and molecular biology is an underlying theme of this study.

Table 10

Quality of Life after Rehabilitation of Edentuious Mandible with Implant Supported Overdentures by OHIP-EDENT

Parkash, H.*, Mehra, P.[1]
Director General, ITS Group of Dental Institutions
[1]Senior Lecturer, ITS-CDSR
Department of Prosthodontics
Ghaziabad, India

Purpose: To evaluate the improvement in Oral Health Impact Profile in the same Edentulous patients following rehabilitation with implant supported mandibular dentures as compared to conventional balanced dentures using OHIP-EDENT.

Methods & Materials: A study was carried out wherein conventional balanced complete dentures were fabricated for 15 edentulous male patients with moderately resorbed ridges. Post 1 month an OHIP-EDENT survey (19 points) was conducted for these patients. CT based planning was done for all these patients. Virtual implant simulation was performed wherein 04 implants were simulated in the interforaminal region in mandible. O4 implants were placed in all the patients in the designated sites. Prosthetic loading was carried out three months post implant placement. The mandibular denture was retained on four Dalla Bona attachments on unsplinted implants. 1 week following prosthetic loading, OHIP-EDENT (19 points) survey was conducted again for these patients.

Results: The results were subjected to paired T Test. $P<0.01$ was considered significant.Highly significant improvement was found in the oral health impact profile after rehabilitation with implant supported mandibular overdentures. An overall 27.91% improvement was observed in OHIP-EDENT scores following rehabilitation with implant supported mandibular overdentures.

Conclusion: There is a significant improvement in Oral Health related quality of life of conventional denture wearers after rehabilitation with implant supported overdentures.

Table 11

The Use of a Laser Level Paralleling Device to Aid in the Fabrication of a Unilateral Auricular Prosthesis

Piper II, J.*, Sutton, A., Hansen, N.
Wilford Hall Medical Center
Maxillofacial Prosthodontics
Lackland, TX USA

Purpose: Determining the orientation of an auricular prosthesis is a demanding task for the maxillofacial prosthetics team. Most classic techniques are subjective in nature and fraught with inaccuracies. The purpose of this technique is to show a method for improving the determination of anatomic features resulting in proper orientation of auricular prostheses.

Methods & Materials: The materials used were 1" square tubing, commercially available from any home improvement store, and 2 Craftsman "Laser Trac TM" Laser Levels. A tripod (Manfrotto 3021BPRO) available from Mackown Dental Clinic was also used. The apparatus was assembled such that the laser levels were connected to the square tubing/frame and positioned bilaterally near the patient's existing ear and contralateral defect. Each laser was activated in the horizontal dimension to mark, using a surgical marker, the superior, middle and inferior anatomic structures of the existing ear on the contralateral side. Then the lasers were switched to the vertical dimension and the long axis of the ear was marked. Following this, impression magnets were placed and a auricular impression was made using PVS and dental stone.

Conclusion: Since natural structures are rarely symmetrical, this procedure will help to remove provider subjectivity when

creating auricular prostheses. This technique is particularly useful for the unilateral auricular patient, however can be used for the bilateral auricular patient. The laser level apparatus will allow for three-dimensional orientation lines to be easily marked while the patient is seated in a corrected head position.

Table 12

Maxillary Reconstruction using a Microvascular Free Fibular Flap and Endosseous Dental Implants; A Case Report

Syros, G.*, Jacob, R.F.
University of Texas MD Anderson Cancer Center
Head & Neck Surgery - Section of Oncologic Dentistry
Houston, TX USA

Purpose: A 45-years-old Caucasian male presented for treatment in the Head and Neck Clinic of MD Anderson Cancer Center in March of 2009. He had a history of chronic ulcerative wound on his maxillary left gingival sulcus since year 2000, for which he had undergone multiple antibiotic treatments without significant improvement. His entire maxillary dentition was extracted in year 2002, but he developed a continuous low grade pain over the following years with subsequent numbness of his left cheek; he was negative for other head and neck symptoms. In terms of medical history, the patient reported Ewing sarcoma of the lumbar spine (L3, L4) in 1991, when he was in active duty on Iraq, for which he underwent surgical resection in Germany followed by chemotherapy and radiation therapy of the whole spine. The histopathologic report that followed the biopsy revealed the presence of epithelioid hemangioendothelioma; this is a vascular neoplasm of borderline malignancy with intermediate properties between hemangioma and angiosarcoma and has rare occurrence in the oral cavity. Diagnostic imaging received in April of 2009 demonstrated a 2.5 cm by 1 cm enhancing mass at the left maxillary alveolar ridge, with destructive characteristics,

extending to the floor of the maxillary left sinus. No perineural invasion or cervical lymphadenopathy was detected. Removal of the tumor would result in oral-nasal communication with possible involvement of the soft palate. Remaining maxilla had inadequate bone volume to receive endosseous dental implants. Obturator prosthesis would have poor retention and support, leading to severely compromised functional and esthetic result. Additionally, there were unspecified fields of prior radiation therapy in the Head & Neck region.

Methods & Materials: Multi-disciplinary treatment included the consultation and subsequent treatment from Head and Neck Surgery, Plastic Surgery, Dental Oncology and Speech Pathology clinicians of the respective institution. It was decided to proceed with immediate right and left maxillectomy and reconstruction with a microvascular osteocutaneous free fibular flap. A 3-dimensional model was used to facilitate the communication with the patient and the other physicians and the fabrication of a surgical template which will guide the surgical reconstruction (4/5 of "O" shape). Left maxillectomy and right partial maxillectomy were followed by reconstruction with an osteocutaneous microvascular fibular free flap in April of 2009. A 3-dimensional stereolithographic model was used for evaluation of available bone and fabrication of a surgical guide for the placement of endosseous dental implants. Seven Astra TechTM 3.5 S x 11mm Osseospeed TX endosseous dental implants were placed in the fibula free flap reconstructed maxilla in August of 2009. A surgical splint after uncovery of the implants and intense oral hygiene were necessary in order to control the soft tissue of the flap under the future prosthesis.

Results: An implant-retained removable prosthesis was delivered. Masticatory performance, deglutition, speech, facial contours and profile were significantly improved, resulting in improved quality of patient's life.

Conclusion: Maxillary reconstruction with a microvascular osteocutaneous free fibular flap and endosseous dental implants supporting a removable prosthesis can be a successful

alternative treatment to maxillectomy followed by an obturator prosthesis, when the clinical outcome of the later is compromised. Delivery of a removable prosthesis enhances the ability of the patient to maintain the underlying tissues healthy and should be considered as a definitive or long-term interim prosthesis.

Table 13

The Effect of Electrical Stimulation on Healing of Bone Grafts: A Pilot Study

Talwar, G.*, Driscoll, C.F., Masri, R.
University of Maryland
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Purpose: Bone grafting is often not predictable and is associated with lower success rate, extended healing times and morbidity. Methods that expedite healing and increase predictability will contribute to the overall success of reconstructive efforts. In this project, the effect of electrical stimulation on bone graft healing in rat calvaria was examined.

Methods & Materials: Fifteen adult male Sprague-Dawley rats were used. A 7 mm diameter bone defect at the midline of the calvarium was grafted using freeze dried mineralized bone. Bipolar platinum stimulating electrodes were overlaid on top of the periosteum on the center of the graft. Animals were divided randomly into two groups. The experimental group (n=8) received electrical stimulation (3 times/day for 10 days) and the control group (n=7) received no stimulation. At 6 weeks, the grafted areas together with the surrounding bone were harvested from the cranium. Tissue sections (5–7 μm) were prepared and stained using hematoxylin and eosin. Mounted slides were analyzed. For each animal, the grafted area was marked and the percent of new bone, remaining graft material and connective tissue was calculated. Data was analyzed using ANOVA followed by Tukey test.

Results: There were statistically significant differences between the experimental and control groups. The electrical stimulation group had more bone (3.81+3.6 %; p=0.03) compared to the control group (0.47+0.52%). The amount of remaining graft material was also significantly higher in the control group (26.11+6.54%; p=0.02) compared to the stimulation group (16.64+5.28%). No significant difference (p=0.15) was found between the 2 groups in the amount of connective tissue (stimulation: 79+5.47%; control: 73.2+6.82%).

Conclusion: In this animal model of bone graft healing, electrical stimulation produced significantly more bone formation and less remaining graft material. These findings suggest that electrical stimulation expedites bone graft healing.

Table 14

Digital Solution of Presurgical Nasoalveolar Molding for Infant Palatal Clefts

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Purpose: The aim of this study was to establish multi-digital approaches using latest three-dimensional scanning, reversed engineering and rapid prototyping techniques for the researches of infant clefts.

Methods & Materials: Infants within 1 week old with clefts were investigated in this study and scanned weekly for their facial digital impressions by a new optical scanner until lip repairs. Meanwhile, plaster models of infants' palate clefts were also prepared for the scanning to fabricate the digital palatal models. All the above original data were carefully compared and documented under a reversed engineering software condition

to observe the laws of development. Three dimensional virtual and rapid prototyping approaches were applied to realize the individual design and rapid auto-manufacture for the appliances of infant's preoperative nasal-alveolar molding. With the new chromatosis technique and special silicone material of Maxillofacial Prosthetics the simulation face of infant lip cleft were fabricated, which was used for the simulation surgery and surgical teaching.

Results: The detailed three-dimensional information of infant nasal-lip and palate clefts from 1 week old to 12 weeks old were firstly successfully acquired. According to each patient's condition, the individual preoperative nasal-alveolar molding program was generated and computer fabricated the series alliances directly. Firstly the simulation facial model of lip cleft was designed and prepared for simulation surgery and teaching.

Conclusion: New advanced techniques of industry showed their great values and will reveal more interests for the clefts researchers.

Table 15

Unilateral Oral Commissure Retractor

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Purpose: Scar contracture resulting from trauma, burns, or surgery can present frustrating esthetic and functional insufficiencies. Fabrication of a unilateral device to treat microstomia following trauma is presented. The maxillary dentition is used as an anchor to allow the retractor to apply a steady force to the commissure. The acrylic commissure retractor is connected to the occlusal anchorage with a .036 stainless steel wire. A helix is placed to allow for flexibility and adjustment. The device is worn as much as possible to provide a constant steady force to the commissure. Success was determined with measurements of maximum opening and patient satisfaction.

Table 16

The Results of Mandibular Reconstruction Assisted by Surgical Guides

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Department of Surgery, Prosthesis and Maxillofacial Traumatology
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Purpose: The present study aimed to compare and evaluate prospectively the patients subjected to mandibular free fibula flap reconstruction when using the guides proposed in this study.

Methods & Materials: It is a retrospective study in patients

with segmentar mandibulectomy and submitted to mandibular reconstruction with fibula free flap between 2006 and 2010. Two groups were formed, Experimental and Control groups. Two surgical guides were made for the experimental group, intra and extra oral, both made of acrylic resin. The intra oral guide was made from the articulated models of the patients and it was supposed to: fix the mandibular segments, preserve the prosthetic rehabilitation space, determine the anterior-posterior limit for the fibula flap positioning and assure the perfect match of the reconstructed mandible with the maxilla. The second was made from a CT and it is supposed to determine the size and angle of the osteotomies. Evaluations took place during the treatment using a questionnaire made for the study and a standard evaluation form of quality of life, Oral Health Impact Profile (OHIP – 14).

Results: Forty patients (average age 43,5 y) formed the sample group. The experimental group was formed by 22 (55,0%) patients. Only two (9,1%) out of 22 patients from the experimental group needed to adjust the free flap in the receptor site ($p<0,001$). The maintenance of the occlusion presurgical was observed in all the patients of the experimental group ($p=0,032$). The occlusal instability did not show any relation with the group studied, but with the condilar involment which was present in 12 (92,3%) out of 13 patients ($p<0,001$). The same was observed in the deviation during opening, which was present in 10 (66,7%) patients ($p=0.017$). When it comes to speech abilities, no statistical difference was observed in the groups ($p=0,065$) however, it was significant when correlated to the diagnosis. The same result was observed in the correlation to the diet ($p=0,049$). Twenty-eight (70,0%) patients of the total sample studied were evaluated as having potential to be rehabilitated, being 19 (67,9%) of the experimental group ($p=0,015$). Eighteen patients (45,0%) were rehabilitated from the total sample, 10 (55,6%) with conventional prosthesis and 8 (44,4%) with implant-supported prosthesis. Eleven (61,1%) rehabilitated patients had non-restriction diets, compared to only 5 (22,7%) of the non-rehabilitated patients ($p<0,001$). The average global value

found in the OHIP–14 form for the experimental group and control group were: 6,15 and 12,13, respectively (p=0,020).

Conclusion: The use of guides improved the quality of the reconstructions and along with the rehabilitation improved the patient's quality of life.

Table 17

Quality of Life after Implant Retained Oral Rehabilitation of Head and Neck Cancer Patients.

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Dental and Prostheticta
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Purpose: The aim of this prospective study was to assess treatment outcome and impact on quality of life (QL) after rehabilitation with implant-retained dental prosthesis (IRDP) in head–neck cancer patients.

Methods & Materials: Twenty seven patients who were diagnosed with tumor of the maxilla & mandible underwent reconstruction and dental rehabilitation with IRDP. After completion of surgical and adjunctive treatment for an amount of time so that the tissues have matured sufficiently to tolerate prosthetic manipulation were selected.
These subjects were assessed clinically and evaluated by standardized questionnaires EORTC QLQ-C30 (version 3). Subjective evaluation by questionnaire consisting of information on evaluation of deglutition, salivation, status of the mandible and teeth in relation to pre-disease level and objective evaluation of speech parameters by Dr. Speech software was done before surgical insertion of the implants and eighteen months after fitting the prosthesis.

Results: Nonparametric Wilcoxon signed rank test was used to

compare QL scores and consequences of radiation preoperatively and 18 months after fitting of the IRDP. Paired t-test was used to compare the speech and swallowing variables for different duration to their pre-operative status. Results will be presented

Conclusion: The function, esthetics, and quality of life in head and neck cancers following resection, reconstruction and rehabilitation is taken care of, though not to predisease level.

Table 18

Auricular Rehabilitation with Brazilian Extraoral Implants: Case Report

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Purpose: The purpose of this case report is to demonstrate the use of Brazilian extraoral implants (Master Extra Porous®, Conexão®, System Prosthesis, São Paulo, Brazil) with immediately anchoring for auricular rehabilitation.

Methods & Materials: After trauma resection of the ear, a 43-years-old Caucasian male was selected by the Department of Head and Neck Surgery of São Paulo Federal University to be rehabilitated. The protocol for this type of rehabilitation is basically composed in one step surgery, two extraoral implants (5 mm) with treated surface, prefabricated bar retention and silicon made prosthesis.

Results: A significantly improvement of esthetics, quality of life and self-esteem could be achieved with one step surgery and rehabilitation.

Conclusion: The literature has shown auricular rehabilitation with extraoral implants is currently the best treatment for

restoring congenital and acquired ear defects because of the low rate of loss and fulfillment of retention, functional performance, biocompatibility and esthetics. Furthermore, the immediately anchoring should be reflected in auricular rehabilitation to increase quality of life.

Table 19

Silicone Conformer for an Acquired Nasopharyngeal Stenosis: A Case Report

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Purpose: The Nasopharyngeal Stenosis is known to be a late complication of tonsillectomy and adenoidectomy largely in cases with suboptimal surgical technique. It results from excess mucosal removal or scarring during surgery or radiotherapy followed by scar contracture and maturation. This acquired complication can cause obstructive sleep apnea syndrome (OSAS).

Methods & Materials: Some of the different treatment modalities used in it's repair are: removal of the scar tissue in combination with dilations, Seton technique, rotational mucosal flaps, transnasal endoscopic repair with power shavers or lasers, split thickness flaps, all of which require numerous and uncomfortable surgical interventions. Other alternatives are the use of chemotherapy agents such as mytomycin, conformers or combination of the therapies.

Results: This case report describes the combination of two treatment modalities. The first is the utilization of a lateral base pharyngeal flap repair, which involved division of the obstruction and resection of the scar tissue and the second is the fabrication and delivery of a series of silicone conformers

with increased diameter to help maintain the opening of the airway in the nasopharynx. The combination of therapies was imperative for the case resolution; the use of a soft silicone conformer was well tolerated since this area is hard to stent for long periods of time due to anatomical location. These conformers were placed for many months until a stable opening was attained.

Table 20

The VKS Attachment System in Facial Prosthetics

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Purpose: The use of the VKS Attachment system offers significant versatility in facial prosthetics when used in conjunction with a connecting bar. Regardless of the position and orientation of the implant fixtures, the attachments can be placed strategically under the prosthesis. Multiple attachments can be used and with a wide latitude for profile in height and two different ball diameters, each with over 6 retention levels. It also allows for an exchangeable titanium stud if the bar is fabricated via titanium CADCAM milling. While parallelism is desirable, the system allows each attachment to have a 15 degree divergence from the path of insertion. This presentation outlines the use of the VKS attachment system in two different clinical situations, a nasal prosthesis and an auricular prosthesis.

Methods & Materials: Clinical Report, Case Presentation #1: This patient is a 68 year old male who was diagnosed with squamous cell carcinoma of the nose and underwent a near total rhinectomy at the Jackson VAMC in December of 2008. Following digital computerized planning with Materialise SurgiCase CMF Software, surgical placement of craniofacial implants was carried out on 8/17/09. Following

osseointegration of the fixtures, they were uncovered on March 11, 2010 with placement of healing abutments. A connecting bar pattern was sculpted in Diralay resin and wax on a master cast and two VKS precision attachments were positioned and incorporated. The bar was cast in type 3 gold alloy. The implant on the left side was oriented somewhat posteriorly and directed toward the nasal septum. Positioning of the attachments resulted in a favorable path relative to placement of the prosthesis biomechanically as well as hygienically. The nasal prosthesis was sculpted in wax and processed in silicone. An acrylic keeper was made incorporating the metal housing and nylon attachment components. Coloration was achieved principally with internal colorization, but some final localized external application as well. The prosthesis was delivered to the patient.

Clinical Report, Case Presentation #2: The patient was a 9 year old girl with a history of right microtia and conductive hearing loss. She was missing the right ear with an anterior remnant remaining. On review of treatment options, the patient's family elected to have a BAHA (bone anchored hearing aid) to address hearing loss as well as an implant supported prosthetic ear. For digital planning, the patient had a conebeam CT scan with the images obtained as DICOM files. Using Materialise Surgicase software, a mirrored ear was positioned on the right side and locations for placing implants were selected. A CADCAM manufactured resin prototype model of the absent ear was made, duplicated in laboratory silicone and a wax pattern was evaluated on the patient. After final modifications, the wax pattern was processed into acrylic resin for a surgical guide. Fabrication of the connecting bar and prosthesis was begun 4 months after surgical placement of the implants. A connecting bar pattern was made on a master cast and three VKS attachment patterns were positioned and aligned. The bar and attachments were cast in gold alloy. An acrylic keeper was fabricated with Eclipse resin incorporating the metal housings and nylon attachment components. The 3-D CAD/CAM epoxy model also serves as a guide in the sculpting on the ear prosthesis, Intrinsic colorants were added to the silicone to

establish a variety of intrinsic shades along with the base shade. Upon polymerization, it was removed, trimmed and readied for extrinsic colorization and insertion and delivered to patient with instructions for use and care.

Conclusion: The VKS attachment system is versatile, hygienic, offers a wide spectrum of retentive options and with a connecting bar is adaptable to the location and path of insertion of the prosthesis.

Table 21

Morphological Design for Enhancing Dental Implant Osseointegration

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Purpose: As a new surface treatment technology, porous-coating has shown considerable promise in improving osseointegration of dental implant. However, it is essential to establish the relationship between the coating parameters and osseointegration outcomes. From biomechanics of the Fully Porous-Coated (FPC) implant, this paper optimizes the surface morphology for enhancing osseointegration, thereby accelerating the healing process.

Methods & Materials: In order to capture the morphological details on the implant surface, multiscale modeling and remodeling techniques are developed in this study. The multiscale model consists of two distinct length scales in macro level of bone-implant-crown and micro level of particles-pores-blood clot layer in the coated implant. The remodeling relates the apparent densities to strain energy density for predicting

resorption, equilibrium and apposition [1].
The macro model comprises dental implant fixture, implant abutment, ceramic crown and a section of bone, in which dental CT scanner was used to capture bone and adjacent tooth anatomies prior to implantation. The CT images were used to construct a baseline 3D solid model in Rhinoceros, which was sectioned in the bucco-lingual direction to create a 2D finite element (FE) model in commercial package Abaqus. Each bony element allows assigning different properties for bone remodeling calculation over the 48 month healing.

The 2D micro model has 1mmx1mm size in the interface of porous implant and cancellous tissues in a representative location, which comprises spherical particles of Ti6A14V alloy(diameter 30, 50 and 70um) and 30% porosity in blood layer. For the three different particle sizes, 27 micro models were created. The displacement fields in the macro model were mapped to the micro model for microscopic remodeling in the corresponding 48 month time-steps [2].

Results: The bone-implant-contact (BIC) ratio and Tresca stress are used to assess osseointegration outcomes from the biomechanics analysis. Based upon the sample points, the response surface models are established for these quantities. The remodeling results revealed that BIC varies from 56% to 76%, while the Tresca stress varies from 350kPa to 500kPa over 48 month healing. Following the models, the multiobjective optimization maximized the BIC while minimized the Tresca though plotted Pareto optimum with respect to the particle size distribution.

Conclusion: The particle size close to implant core had more significant effect on osseointegration than the outer layer in short-term. Increasing the particle size from 30 to 50 μm generally improved the BIC ratio but introduced more severe stress concentration.

Table 22

Finite Element Analysis of Bone Stress in Aramany Class IV Prosthesis

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Purpose: Retention of Aramany Class IV removable partial denture prosthesis is compromised by the lack of support. The biomechanics of Aramany Class IV removable partial obturator prosthesis is compromised by the lack of support, resulting in unusual stress distribution on the residual maxillary bone. This study used finite elements analysis to evaluate the biomechanics of the Aramany Class IV prosthesis.

Methods & Materials: A digital 3-dimensional (3-D) model developed from a computed tomography scan was used to evaluate bone stress according to the load placed on the prosthesis. A 3-D model of Aramany Class IV maxillary resection and prosthesis was constructed. This model was used to develop the finite element mesh. A 120 N load was applied to the occlusal and incisal platforms corresponding to the prosthetic teeth. Qualitative analysis was based on the scale of maximum principal stress; quantitative analysis was expressed in MPa values.

Results: Under posterior load, tensile and compression stress was observed; tensile stress was greater than compressive stress, regardless of the bone region; greater compression stress was observed on the anterior palate, near the midline. Under anterior load, tensile stress was observed in all bone regions evaluated; tensile stress was greater than compression stress, regardless of the bone region.

Conclusion: The Aramany Class IV obturator prosthesis tends

to rotate toward the surgical resection when submitted to posterior and anterior loads. The understanding of the biomechanics of this removable partial denture prosthesis is central to the prosthetic planning of this obturator prosthesis to rehabilitate the patient and preserve the residual anatomical structures.

Table 23

Reconstruction of a Maxillectomy Patient with an Osteocutaneous Flap and Implant Retained Fixed Dental Prosthesis

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Purpose: Recent surveys show that most oral and maxillofacial surgeons prefer to treat oral cancer patients with maxillary resections rather than with radiation and chemotherapy, which can result in multiple challenges in the rehabilitation of the maxillectomy patient, The use of free tissue transfer and endosseous implants to reconstruct composite defects of the mandible have been studied in the literature but reports of their combined use for maxillary reconstruction in oral cancer patient remains limited.The purpose of this paper is to describe the comprehensive reconstructive and prosthodontic approach in the reconstruction of a right/left infrastructure maxillectomy defect in a 53-year-old white male diagnosed with chondrosarcoma.

Methods & Materials: A 53-year-old white male with a history of hepatitis C and recurrent sinus infections presented for treatment. He was diagnosed with a chondrosarcoma in May 2007 and underwent a right/left infrastructure maxillectomy and was initially provided with a surgical obturator, but the patient stated that he never adapted to the

removable prosthesis. A microvascular reconstruction of the maxilla followed with implant fixed dental prosthesis rehabilitation was offered to the patient.

Results: An obturator prothesis is the most frequent treatment option in the rehabilitation of patients undergoing maxillectomy involving the oral cavity. However, oral access for hygiene procedures, support and retention can become problematic, especially in the presence of large maxillary defects. Recent advances in microvascular surgery with free tissue transfer in conjunction with dental implants allow consideration of various approaches in the treatment of oral cancer patients.

Conclusion: Although the use of implants for maxillary reconstructions is still controversial due to multiple reasons, this presentation shows that the use of an osteocutaneous free fibula flap and implants can successfully provide retention, support and stability for a maxillofacial prosthesis, and considerably increase the patient's quality of life.

Table 24

Sculpture Orbital Prosthesis: Development and Evaluation of Digital Technology

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Department of Surgery, Prosthesis and Maxillofacial Traumatology
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Purpose: New digital technique of making sculpture from around the eyes, and eyelids separately and later inserted symmetrically in the rest of the orbital sculpture.

Methods & Materials: For this study, 12 were obtained facial plaster models and made them wear simulating an orbital

defect. In each model were made two sculptures - Group 1 free sculpture and Group 2 sculpture guided by the proposed technique through photographs of the face and model positioned in a device calibrated with millimeter scale and setting of head and face model. Were established 10 facial anthropometric measurements. For measuring and obtaining measurements of the face and the sculpture was used for the digital photometry and Corel Draw. The data were analyzed by t-test ($p < 0.05$).

Results: In group 1, measures 1 and 2 in the region of the palpebral fissure (width and height) and measures 5 and 6, distances along the edges of eyelids facial axis showed significant differences, while in Group 2 there was no statistically significant difference.

Conclusion: The results can be explained because of the facial model is obtained with closed eyes and difficulty in obtaining a perfect centering of the eyes in relation to the unaffected side. The digital technology has removed these restrictions and allowed the making of the sculpture of the eye area without the physical presence of the patient, reproducing faithfully the anatomical details and further centralize the rest of the sculpture with precision in the symmetry

Table 25

Antibacterial Properties of Soft-Liner Materials Incorporated with Quaternary-Ammonium Polyethylenimine Nanoparticles

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Purpose: Colonization of obturator soft lining materials by various oral microorganisms can result in surgery site

infection.Thus, soft lining materials encompassing antibacterial properties are favorable. The aim of the present study was to evaluate the antibacterial activity of crosslinked quaternary ammonium polyethylenimine (PEI) nanoparticles incorporated at 1-2% w/w in soft liner materials (linning obturators) compared to the non-modified soft liners.

Methods & Materials: The antibacterial activity was tested against: Enterococcus faecalis, Streptococcus mutans, Candida albicans, Staphylococcus aureus, Pseudomonas aeruginos and Staphylococcus epidermidis using: (i) the agar diffusion test (ADT); (ii) the direct contact test (DCT); (iii) and bacterial growth in the materials' elute was also tested. Additionally, flexural modulus and flexural strength of the soft liner materials were also tested using a loading machine.

Results: DCT results showed antibacterial activity in all three types of soft liner materials incorporating PEI nanoparticles. The effect lasted for at least 1 month. ADT showed no inhibition halo in all tested bacteria, indicating the antibacterial nanoparticles are not diffusing into the agar. Bacterial growth curves for the 1-2%w/w added nanoparticles in the elution test were similar to the appropriate control. Flexural modulus and the flexural strength were not affected at 1%w/w when compared to controls.

Conclusion: Quaternary ammonium PEI nanoparticles incorporated in soft liner materials (linning obturator), have a strong antibacterial activity without leaching-out and without compromising mechanical properties.

Table 26

Higashi Syndrome

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Purpose: Chediak-Higashi syndrome is a rare autosomal recessive disorder which involves mutation of the lysosomal trafficking regulator gene resulting in abnormalities of neutrophil chemotaxis, degranulation, and bactericidal activity. Clinical manifestations include neutropenia with recurrent pyogenic infections, coagulopathies, and progressively debilitating neurologic symptoms. Development of lymphoma-like progression in late childhood is often fatal.

Methods & Materials: Two siblings with Chediak-Higashi syndrome, a brother and sister, are reported. Both presented with severe juvenile periodontal disease in infancy and early adulthood leading to loss of the permanent dentition. Both also demonstrated severely under-developed maxilla in all dimensions. Functionally and mentally unsatisfied with wearing complete dentures, they sought a "fixed type" denture prosthesis to improve their quality of life and self-esteem. Treatment of the maxilla included two zygoma implants and two "speedy groovy" implants (Nobel Biocare). Two straight and two angled "speedy groovy" implants were placed in mandibular arch with placement of immediately loaded complete dentures. A second set of horse-shoe type complete dentures with metal bases, attached to the maxillary milled bar and mandibular Hader bar were fabricated one year later. Despite adequate oral hygiene and regular clinical prophylaxes during two year follow up gingival inflammation and hyperplasia persisted. Gingivectomy combined with peri-implant placement of Arestin microspheres (minocycline hydrochloride) was tried to resolve the chronic periodontal inflammation. The implants are currently stable 2 years following placement. Long term

antibiotic administration and vigorous local therapy are indicated for continued management. This is the first report of dental implants placed in siblings with this difficult immune deficiency disorder.

Table 27

Implant Supported Prosthetic Rehabilitation of a Patient with Bilateral Microtia

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Purpose: Restoration of missing facial tissues is very important for the quality of life. The success of the preoperative planning, surgical and prosthetic procedures are very important for the success of the rehabilitation and the comfort of the patient. In this case, a modified application procedure of Cosmesil, a silicone material used frequently in the fabrication of missing facial tissues, will be described.

The purpose of this report is to show that Cosmesil colouring agents may be used in connection with Biodent resin material for a better color synchronisation in the fabrication of auricular prosthesis. It is also to show that when the patient participates in the size and shape selection decision, a better patient acceptance of the prosthesis may be achieved.

Methods & Materials: Straumann extra oral implants are bilaterally positioned in left and right mastoid bones of the patient. After an osseointegration period of six months, healing abutments are positioned. Coltene Whaledent is used as the impression material of choice. In laboratory, original Straumann bars are soldered to the abutments. The clips are

seated on the bar in a well distanced and balanced position. They are connected to each other with a Biodent resin, colored with Cosmesil colouring agents. The auricular wax patterns are prepared according to the patient selection, tried, flasked and processed. After retry and correction of the final shape external colouring is applied with Cosmesil pigments.

Results: The perfect osseointegration of extraoral implants and modification of some of the laboratory steps resulted in esthetically and retentionally successful auricular prosthesis.

Conclusion: A very good osseointegration quality and retention for the auricular prosthesis is reached with Straumann implants. Cosmesil color pigments proved very useful in the colour synchronisation of the supporting interclip connection fabricated in Biodent. In unilateral microtia cases, three dimensional modelling with contralateral ear through computer software is possible. But in bilateral microtia cases, selection of human models among patient's relatives or the subjects that the patient approves as in this case, seem to be among the best solutions.

Table 28

Alternative Technics to Improve the Retention and Esthetic Properties of Orofacial Prosthesis

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Use of endosseous implants for the rehabilitation of patients with maxillofacial defects may not always be possible due to oncologic therapy, advanced age, low bone density or cost of the treatment. As a second solution alternative options increasing the retention of the prosthesis and decreasing the weight of the appliance should be sought.

Purpose: Retention and stability are two very serious problems in patients with complex maxillofacial tissue losses. The purpose here is to describe two different solutions minimizing the burden of these complications and facilitating the use of complex appliances.

Methods & Materials: To reduce the weight of the facial prosthesis a hollow Biodent frame is prepared as a mask and it is coloured with cosmesil coloring agents. Then the facial prosthesis is prepared on the cast using Cosmesil as the silicone facial material. Chemical bonding is performed between the Biodent mask and the silicone prosthesis. Magnets are used on the obturator and the facial prosthesis to increase retention. In addition eye glases are used as a third measure to increase the retention of the facial prosthesis. A bar clip sistem is the connection bridge between the facial prosthesis and the eyeglasses.

Results: The patient, his relatives and our prosthetic team were satisfied with the retention, stability and cosmetic results of this complex appliance.

Conclusion: The use of weight reduction procedure, auxilliary retention technics and coloring modifications augmented the retention, stability and esthetic quality of this complex oro-facial restoration.

Table 29

Use of a Functional Impression Material in Fabrication of Definitive Maxillary Obturator

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Purpose: This presentation will review the use of a functional impression material to develop the bulb of the obturator.

Methods & Materials: Following fabrication of the prosthesis in a conventional manner, Hydrocast functional impression material is mixed and placed to trace the defect. First, it acts as an indicator of overextension, and then it acts to trace the defect according to normal functional movements. Following modification, the patient goes home with this,, and returns after at least 24 hours. The tracing is modified further, then a light coat of microseal is placed. This is then converted in the laboratory using autopolymerizing resin.

Conclusion: This poster will review the technique and caveats to avoid potential problems.

notes

divider
(front)

divider
(back)

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