Our Mission

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.

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AMERICAN ACADEMY OF MAXILLOFACIAL PROSTHETICS

2010 CONFERENCE PROGRAM

2010 CONFERENCE PROGRAM

58th Meeting of the

AMERICAN ACADEMY OF MAXILLOFACIAL PROSTHETICS

October 30 - November 2, 2010

Hyatt Regency Grand Cypress
Orlando, Florida USA

Endless Possibilities, through Science, Innovation and Collaboration




Welcome Colleagues
to the 58th meeting of the

American Academy of Maxillofacial Prosthetics

Conference Dates: October 30-November 2, 2010
Hyatt Regency Grand Cypress
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STEVEN ECKERT, D.D.S., M.S.

Biography

Dr. Eckert is a graduate of the Ohio State University College of Dentistry. Following dental school he completed a General Practice Residency at Mount Sinai Medical Center of Chicago. He was certified in Prosthodontics and completed his Master of Science degree at the Mayo Graduate School of Medicine. Dr. Eckert is a Diplomat of the American Board of Prosthodontics. He is a Fellow in the American College of Prosthodontists, Academy of Prosthodontics, Academy of Osseointegration, American Academy of Maxillofacial Prosthetics and the International Team for Implantology.

He is Professor Emeritus at the Mayo Clinic College of Medicine. He serves as President of the American Academy of Maxillofacial Prosthetics, previous President of the Academy of Osseointegration and President elect of the Academy of Prosthodontics. He also serves as Secretary of the American College of Prosthodontists and is a member of the Board of Directors for the International College of Prosthodontics. He is a director and examiner for the American Board of Prosthodontics.

He has served in editorial capacities for a variety of prosthodontic journals and is now Editor in Chief of the International Journal of Oral and Maxillofacial Implants. He has published extensively in the scientific literature and presents at numerous scientific meetings. His research interests are in the fields of osseointegration and maxillofacial prosthetics.

Welcome Message

It's hard to believe it but this year is passing by more quickly than any others in my memory. Soon we will meet again at the AAMP meeting in Orlando. Although not in Disney World itself, we are certain to have a Disneyesque experience as Dr. Steve Haug has assembled an incredible program that will show us where we are in maxillofacial prosthetics and where we can expect to be going in the near future.

Although the program is always great I think that you'll agree that the fellowship we share at the meeting is at least as important as the scientific content. Where else can you share experiences with friends and colleagues who truly understand what it means to be a maxillofacial prosthodontist? I'm sure that you are looking forward to this gathering as much as I am.

We are all aware that the times are changing in our specialty. Our unique ability to adapt to change continues to be our greatest asset. As the AAMP enters the second decade of the 21st century we continue to recognize the need to gather forces to seek solutions. Let's take this time to do just that as we meet in Orlando.

Steven Eckert, D.D.S., M.S.
AAMP President

For the second time at an annual session, we are going to designate 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.

Purple Lanyards
Past Presidents

Red Lanyards
AAMP Full Fellows and Life Fellows

Royal Blue Lanyards
AAMP Members
Associates and Affiliates

Yellow Lanyards
Student Members

Green Lanyards
ACP Members, Technicians/Allied Professionals,
Exhibitors and Guests

IN-MEMORIUM
CARL J. ANDRES
Oct. 16, 1942-June 16, 2010

By Tom Vergo & Craig Van Dongen

The American Academy of Maxillofacial Prosthetics Fellow and past Executive Secretary/Treasurer (1991-1993), Past-President (1997) and Ackerman Award recipient (2003), Carl J. Andres, D.D.S., M.S.D., died on June 16, 2010. He is survived by his wife, Ida; children, David Andres of Ft. Worth, Texas, Duane Andres and his wife, Kiran, of Schaumburg, Ill., Dawn Hostetler and her husband, Joe, of Brownsburg, and Daniel Andres and his wife, Melissa, of Carmel; 12 grandchildren; brothers, Joe and Marlin Andres and his wife, Vicki; and sisters, Janet Regan and her husband, Dan, Virginia Balmer, Joyce Young and her husband, John, Jackie Colin and her husband, Mike, Judy Sullivan, Gina Cox and her husband, Mike, Connie Missi and her husband, Tim, and Shelly Cox and her husband, Tim.

Carl "Jerry" Andres was born Oct. 16, 1942, in Starlight, IN to Marcella and Carl Andres. He married Ida Kerstiens on Aug. 31, 1963 and went on to graduate from the Indiana School of Dentistry in 1966. Dr. Andres then signed up for a tour of duty in the U.S. Air Force which ended 20 years later as a retired Colonel. While in the Air Force, Jerry completed his M.S.D. in Dentistry at Indiana University in Indianapolis and a Maxillofacial Prosthetics Fellowship at the MD Anderson Medical Center. He then enjoyed a second career as a tenured professor at Indiana University School of Dentistry, where he served as the Director of Graduate Prosthodontics for more than 20 years as well as Director of the Maxillofacial Prosthetics program. Jerry retired from Indiana University School of Dentistry as a Professor Emeritus in 2008.

Jerry was actively involved with several professional organizations, including the American Board of Prosthodontics, American Dental Association, American College of Prosthodontists (Charter Member), American Academy of Fixed Prosthodontics, Academy of Prosthodontics, Indianapolis District Dental Society and John F. Johnston Society. Dr. Andres also served on several editorial review boards, including the *International Journal of Prosthodontics*, *Journal of Prosthetic Dentistry*, *Journal of Dental Materials and Journal of Prosthodontics*.

Jerry had many hobbies. A farmer at heart, he loved gardening. He was an avid woodworker applying his dental skills to wildlife carvings. He enjoyed fishing and boating. Dr. Andres also spent a great deal of his life serving others. He completed six trips to perform dental services on Native American reservations and volunteered at the Gennesaret Free Dental Clinic. He served as a Cub Master, Scout Master, District Commissioner, and District Vice-Commissioner in the Boy Scouts of America, and he was a member of the Knights of Columbus.

It is with sadness and a true sense of loss that we say "goodbye" to Jerry Andres today, and by dedicating this meeting to him we recognize and honor his many years of service to the AAMP.

60th Meeting of the
American Academy of Maxillofacial Prosthetics

Joint meeting with the
International Congress on Maxillofacial Rehabilitation

SAVE THE DATE

Conference site
Hyatt Regency Baltimore
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Dates
Saturday, October 27, 2012-
Tuesday, October 30, 2012

Conference websites
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Make plans to join us!

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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

Individuals eligible for membership in the AAMP include:

• 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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Thomas R. Cowper, D.D.S.	2008
Jonathan P. Wiens, D.D.S.	2009

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*Arthur H. Bulbulian, D.D.S.....	1957 Chicago, IL
*Mervin C. Cleaver, D.D.S.....	1958 Dallas, TX
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*Victor J. Niiranen, D.D.S.....	1967 Washington, DC
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*Thomas A. Curtis, D.D.S.....	1972 Las Vegas, NV
Sebastian A. Bruno, D.D.S.....	1973 San Antonio, TX
Varoujan A. Chalian, D.D.S.....	1974 Williamsburg, VA
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Donald L. Mitchell, D.D.S.....	1992 Tampa, FL
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Glenn E. Turner, D.M.D., M.S.D....	2009 San Diego, CA

**Denotes Deceased*

We thank all past AAMP Presidents for their dedication and service.

Social Events

Saturday, October 30th

08:00 - 16:00	AAMP Board of Directors Meeting
15:00 - 18:00	Conference Registration
16:30 - 18:00	Poster Session & Exhibit Reception *Sponsored by* **Audi**

Sunday, October 31st

06:45-07:45	Continental Breakfast and Exhibit Networking *Located in the Regency Ballroom*
07:45-12:15	General Session *Located in the Grand Cypress Ballroom*
08:00-10:00	Hospitality Continental Breakfast *Located in Atrium 1460*
12:15	Conference Lunch & AAMP Business Meeting *Located in Palm Ballroom*
12:30-15:00	Guest Tour: World Famous Morse Museum of American Art *Meet at Conference Registration Desk*
16:30	**AAMP Social Outing** Dinner at Emerils and the Blue Man Group Show *(elective)* *Meet at Conference Registration Desk*

Monday, November 1st

07:00-08:00	Continental Breakfast and Exhibit Networking *Located in the Regency Ballroom*
08:00-12:00	General Session *Located in the Grand Cypress Ballroom*
08:00-10:00	Hospitality Continental Breakfast *Located in Atrium 1460*

10:00	Guest Tour: Shuttle to Major Theme Parks *Reservations Required*
14:00-16:00	Insurance Workshop *Located in Atrium 1436*
14:00-16:00	AAMP Workshop 1 *Located in the Grand Cypress Ballroom*
19:00-22:00	**AAMP President's Reception & Banquet** *(elective)* *Located in the Grand Cypress D Ballroom*

Tuesday, November 2nd

07:00-08:00	New Members Breakfast *Located in Magnolia AB*
07:00-08:00	Continental Breakfast and Exhibit Networking *Located in the Regency Ballroom*
08:00-12:00	General Session *Located in the Grand Cypress Ballroom*
08:00-10:00	Hospitality Continental Breakfast *Located in Atrium 1460*
14:00-16:00	AAMP Workshop 2 *Located in the Grand Cypress Ballroom*

SCIENTIFIC PROGRAM OVERVIEW

Saturday, October 30th

08:00 - 16:00	AAMP Board of Directors Meeting
15:00 - 18:00	Conference Registration
16:30 - 18:00	Poster Session & Exhibit Reception *Sponsored by* **Audi**

Sunday, October 31st

06:45-07:45	Continental Breakfast and Exhibit Networking

AAMP 2010 Conference Title:

Endless Possibilities, Through Science, Innovation and Collaboration

07:45-12:15 General Session

Session Title: *Multidisciplinary Patient Care*

07:45	Dr. Steven Eckert *President's Address*
07:50	Dr. Thomas Vergo *In Memorium*
07:55	Dr. Steven P. Haug *2010 Program Chair Welcome*
Moderator:	**Dr. Lawrence Brecht**
08:00	Dr. Don-Jon Summerlin *HPV and Oral Cancer; Fact or Fiction*
08:45	Dr. Eric Blom *The Evolution of the Voice Prosthesis*
09:30	Dr. Tod Huntley *The Microvascular Free Flap Foundation for Prosthetic Rehabilitation*
10:15	Coffee Break and Exhibit Networking

10:45	Dr. Trevor Treasure *Current Management of Bis-Phosphonate Induced Osteonecrosis*
11:30	Dr. Robert G. Hale *Regenerative Medicine to Address Conventional Treatment Limitations of Cranio-Maxillofacial Battle Injuries*
12:15	Session Adjourns
12:15	**Conference Lunch & AAMP Business Meeting** *Located in Palm Ballroom*
16:30	**AAMP Social Outing** Dinner at Emerils and the Blue Man Group Show *(elective)* *Meet in Hotel Lobby*

Monday, November 1st

07:00-08:00	Continental Breakfast and Exhibit Networking *Located in the Regency Ballroom*

08:00-12:00 General Session

08:00-10:15 Session Title:

Implants in Head and Neck Rehabilitation

Moderator:	**Dr. Robert M. Taft**
08:00	Dr Eleni D. Roumanas *Prosthetic Rehabilitation of Maxillectomy Defects-Clinical Outcomes*
08:45	Dr. Lawrence E. Brecht and Dr. David L. Hirsch *Mandibular Reconstruction 101: Use of Computer Aided Technology to Produce the Ideal Mandibular Reconstruction with Dental Implants*

09:30	Dr. George Bohle *Use of Mini Dental Implants in Maxillofacial Prosthetics*
10:15	Coffee Break and Exhibit Networking

10:45-12:00 Session Title: *Sleep Medicine*

10:45	Dr. Sabin Bista *Obstructive Sleep Apnea: Current Concepts and Management*
11:30	Dr. Alvin G. Wee *Dental Management of Obstructive Sleep Apnea in a Maxillofacial Prosthodontic Practice*
12:00	Session Adjourns
14:00-16:00	**Concurrent Workshops**
14:00-16:00	**Insurance Workshop** *Located in Atrium 1436*
14:00-16:00	**AAMP Workshop 1** *Advances in the Use of Magnetic Retention for Maxillofacial Prostheses and Dentures* *Located in the Grand Cypress Ballroom*
19:00-22:00	**AAMP President's Reception & Banquet** *(elective)* *Located in the Grand Cypress D Ballroom*

Tuesday, November 2nd

07:00-08:00	Continental Breakfast and Exhibit Networking *Located in the Regency Ballroom*
07:00-08:00	New Members Breakfast *Located in Magnolia AB*

08:00-12:00 General Session
Session Title: *The Practice of Maxillofacial Prosthodontics*

Moderator:	**Dr. Alvin G. Wee**
08:00	Jeffery Markt, D.D.S. Dr. Samuel R. Zwetchkenbaum *Wikipedia: How to Contribute and Edit Information on Maxillofacial Prosthodontics*
08:30	Dr. Craig A. Van Dongen *Reimbursement in Private Practice*
09:00	Dr. Betsy K. Davis *Institutional Reimbursement*
09:30	Dr. Candice Zemnick *The Adjustable Palatal Lift Prosthesis*
10:00	Coffee Break and Exhibit Networking
10:30	Pattii Montgomery *Trauma, Disfigurement, Fame and Facial Prosthetics*
11:00	Dr. Sudarat Kiat-amnuay *Ten Year Results of Color Stability of Silicones*
11:30	Dr. Theresa Hofstede *Radiation-Induced Salivary Gland Dysfunction: Burden, Biomarkers, and Alternative Therapies*
12:00	Session Adjourns
13:30 - 16:30	**AAMP Workshop 2:** *3D Surface Imaging in Maxillofacial Prosthetics* *Located in the Grand Cypress Ballroom*

WELCOME FROM AAMP 2010 CONFERENCE PROGRAM CHAIR

Endless Possibilities, through Science, Innovation and Collaboration

Maxillofacial Prosthetics cannot be constrained by its mere physical definition. The art of the hand improves daily thanks to new technologies having a direct impact at each level of treatment (surgical or restorative), each being less invasive, and making the unpredictable more predictable with increased precision.

Never has there been a time where education, research and the expansion of the treatment team been so pivotal in the advancement of health care. We need to embrace these concepts and actively participate in support of the patients entrusted to our care.

This year's program will build on the concept of Maxillofacial Prosthetics at the crossroads and focus on four areas of interest: Multidisciplinary Patient Care, Implants in Head and Neck Rehabilitation, Sleep Medicine, and The Practice of Maxillofacial Prosthodontics. Our goal is to emphasize how diverse and invaluable the multidisciplinary treatment team is today in maxillofacial rehabilitation and its direct impact on the outcome of our care.

Thank you for joining us at the AAMP meeting in Orlando and be a part of this exciting program.

Steven P. Haug, D.D.S., M.S.D.
AAMP 2010 Program Chair

AAMP 2010 Scientific Program

Saturday, October 30th

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Sunday, October 31st

AAMP 2010 Conference Title:
Endless Possibilities, Through Science, Innovation and Collaboration

07:45-12:15 General Session
Session Title: ***Multidisciplinary Patient Care***

7:45	**Dr. Steven Eckert** *President's Address*
7:50	**Dr. Thomas Vergo** *In Memorium*
7:55	**Dr. Steven P. Haug** *2010 Program Chair Welcome*

Moderator:

Lawrence Brecht, D.D.S.
New York University
Langone Medical Center
Institute of Reconstructive Plastic Surgery
Director of Craniofacial Prosthetics
New York, New York USA

08:00 **Don-Jon Summerlin, D.M.D., M.S.**
Indiana University
School of Medicine
Indianapolis, Indiana USA

HPV and Oral Cancer; Fact or Fiction?

Head and neck cancer represents one of the few common malignancies that has not demonstrated a significant improvement in survival with the advent of new therapeutic modalities. Because of this, renewed efforts have been waged to further define the etiologic factors that influence head and neck cancer development. In the last decade, considerable research has been undertaken to elucidate the role that Human Papillomavirus plays in the pathogenesis of this deadly disease. The intent of this presentation is to illuminate the role of this virus in cancer of the head and neck and to make some sense of the hyperbole enveloping this avenue of carcinogenesis.

08:45 **Eric Blom, Ph.D.**
The Center for Ear, Nose, Throat and Allergy
Carmel, Indiana USA

The Evolution of the Voice Prosthesis

Total laryngectomy is a functionally destructive procedure with substantial consequences that even the most experienced clinician cannot fully appreciate.

Altered respiration, voice, and swallowing, coupled with disfigurement and uncertainty about the future, profoundly affect the recently laryngectomized person and his or her family. Rapid reestablishment of an acceptable voice and fluent, intelligible speech is critical to successful psychosocial adjustment.

This presentation describes the author's co-development, with Mark I. Singer, M.D., of a simple surgical technique and prosthetic valves that have evolved over the past 30 years into the gold standard for post-laryngectomy speech restoration.

09:30 **Tod Huntley, D.M.D., M.S.**
Otolaryngologist
The Center for Ear, Nose, Throat and Allergy
Carmel, Indiana USA

The Microvascular Free Flap Foundation for Prosthetic Rehabilitation

Cancer of the oral cavity, oropharynx, and maxillofacial skeleton is among the most difficult set of cancers to treat for a variety of reasons. Chief among them is the fact that these tumors affect structures with vital importance to the patient's daily quality of life. Swallowing, speech articulation, and appearance all can be significantly impacted by the cancer, as well as its treatment. Such treatment should optimally be delivered in the multidisciplinary setting, or at least in a setting that allows for a close working relationship between the ablative surgeon, reconstructive surgeon, and the maxillofacial prosthodontist.

Dr. Tod Huntley and his partners work in a weekly multidisciplinary head and neck tumor clinic in Indianapolis with a maxillofacial prosthodontist. They examine all preoperative patients together and discuss the ablative surgery, reconstructive options, and prosthodontic implications of the treatment in a conference setting. This relationship and communication between surgeon and prosthodontist has proven highly beneficial, by improving patient education and outcomes. In addition, the surgeons have learned greatly from the experience, and are cognizant of techniques at their disposal which can make the prosthodontist's work easier and the patient's dental rehabilitation better.
Nobody can dispute the tremendous benefits that can be offered by the appropriate use of dental implants for head and neck rehabilitation, and this subject will be discussed later by others. And though Dr. Huntley's group is not opposed to implant use, financial concerns frequently preclude implant usage in this population. Yet there are a number of things that the surgeon can do to allow for effective and safe rehabilitation of a majority of free flap patients without the use of implants,

and this lecture will discuss them in detail.
This presentation will discuss a variety of surgical nuances, including the appropriate flap selection and insetting, the use of soft tissue flap revisions when necessary, vestibuloplasties, proper surgical treatment of surrounding structures, and other topics which can allow the surgeon to help the prosthodontist optimize his or her outcomes in the rehabilitation of this challenging patient population.

10:15 Coffee Break and Exhibit Networking

10:45 **Trevor Treasure, D.D.S., M.D., M.B.A., F.R.C.D. (C).**
Indiana University
School of Dentistry
Indianapolis, Indiana USA

Current Management of Bis-Phosphonate Induced Osteonecrosis

Bisphosphonate related osteonecrosis of the jaws (BRONJ) is a morbid condition. It is presumed, although not proven, to occur as a side-effect from high dose, potent Bisphosphonate therapy. This association was first noted in the dental literature in 2003. Bisphosphonates (BP's) are used widely in Medicine to treat osteoporosis, metastatic bone disease/hypercalcemia, Osteogenesis Imperfecta, Paget's disease of bone and most recently Fibrous Dysplasia.

The diagnosis of BRONJ is a clinical diagnosis of exclusion. It appears at this time that the incidence of BRONJ is between 1-12% for IV amino BP's at 36 months of exposure. Two-thirds of the cases appear in the mandible. Pamidronate and Zoledronate are IV forms of BP's with an amino group at the R2 side chain and are most often associated with BRONJ development. However, a small percentage of person's taking oral BP's will develop BRONJ. Typically, these patients have a milder clinical presentation. Depending upon the stage of disease, treatment may vary from simple oral rinses, antibiotics and observation to jaw resection with or without muscle flaps.

The dilemma for the treating dentist is how to prevent BRONJ from occurring in the first place. Most patients with severe osteoporosis or hypercalcemia from metastatic bone involvement cannot be withdrawn from these medications. They are essential for a reasonable quality of life.
Therefore, it is recommended that all invasive dental treatment be performed 21 days before these BP medications are started. Emergent dental care is a potential problem in that oral wounding is associated with the development of BRONJ. It is unclear at this time if a 3 month drug holiday prior to dental treatment can lessen the incidence of BRONJ. A drug holiday can only be undertaken *if systemic conditions permit*. A close interaction with the treating physician is essential in the team management of these patients.

11:30 **Robert G. Hale , D.D.S.**
Commander of the US Army Dental and Trauma ,Research Detachment
San Antonio, Texas USA

Regenerative Medicine to Address Conventional Treatment Limitations of Cranio-Maxillofacial Battle Injuries

This presentation will focus on currently uncorrectable craniomaxillofacial (CMF) battle injuries (BI) seen in Iraq and Afghanistan. Open wounds and facial fractures predominate, which are often further complicated by avulsions and burns: A study analyzed Joint Theatre Trauma Registry database for maxillofacial battle-injuries experienced by U.S. Soldiers in Iraq/Afghanistan conflict to describe type, distribution and mechanism of injury. Methods and Materials: JTTR was queried from October 19, 2001 to December 12, 2007 for maxillofacial BI entered in the database using ICD-9 codes; the data was compiled for BI Soldiers. Results: 7,770 BI were identified. Approximately 26% had maxillofacial BI. There were 4,783 maxillofacial BI among the 2,014 BI (2.4 injuries per Soldier). Majority of maxillofacial BI were male (98%). Average age was 26 years old. Penetrating soft tissue injuries and

fractures were 58% and 27%, respectively. 76% of fractures were open. Frequency of facial fractures was mandible 36%, maxilla/zygoma 19%, nasal 14%, and orbit 11%. Remaining 20% not otherwise specified. Primary mechanism of injury was explosive devices (84%).

Another study of 142 combat injured burn casualties demonstrated that 77% had face burns. The outcomes of four severely injured service members were also studied: despite multiple, extensive surgical reconstructions these service members, representative of approximately 10% of all CMF battle injured service members, end up with poor facial form and function.

Regenerative medicine and tissue engineering offers promise to the severely wounded service member by leveraging the latest advances in stem cell biology with bioengineering and surgery to reconstruct currently uncorrectable deformities with fewer surgeries, less invasive surgeries and with better results. The aim of the Dental and Trauma Research Detachment is to develop solutions by collaborating with scientists and clinicians of civilian research institutions to return wounded service members back to function as soon as possible. Examples of current research initiatives will be presented: regenerative medicine bone putty to potentially give us a biomaterial to regenerate CMF bone reliably and with better control than even autologous sources and a "Biomask" to serve as an in situ bioreactor to regenerate facial skin on burn casualties.

12:15 Session Adjourns

12:15 **Conference Lunch &**
AAMP Business Meeting
Located in Palm Ballroom

16:30 **AAMP Social Outing**
Dinner at Emerils and the
Blue Man Group Show *(elective)*
Meet at Conference Registration Desk

Monday, November 1st

07:00-08:00 Continental Breakfast and Exhibit Networking
Located in the Regency Ballroom

08:00-12:00 General Session
08:00-10:15 Session Title:
Implants in Head and Neck Rehabilitation

Moderator: **Robert M. Taft, D.D.S.**
Naval Postgraduate
Dental School
Bethesda, Maryland USA

08:00 **Eleni D. Roumanas, D.D.S**.
University of California Los Angeles
School of Dentistry
Los Angeles, California USA

Prosthetic Rehabilitation of Maxillectomy Defects-Clinical Outcomes

Traditional methods of functional and esthetic rehabilitation of post-maxillectomy defects include the use of obturator prostheses, local and regional flaps, vascularized free tissue transfer, or a combination of these modalities. Among these options, obturator prostheses have been one of the most widely used and the evidence demonstrates significant improvements in speech, mastication, swallowing, and esthetics. However, obturator prostheses are not without limitations. Problems such as compromised retention and stability in extensive defects results in leakage of fluids into the maxillary sinus or nasal cavity, and hypernasal speech. Osseointegrated implants facilitate obturator retention and may overcome some of these shortcomings. Although promising, the benefits of implant-retained obturators have yet to be clearly established due to conflicting methodology and the small number of cases studied.

The purpose of this presentation is to review the current evidence and our prospective study designed to evaluate post

surgical loss of function and restoration with conventional versus implant retained obturator prostheses.

08:45

Lawrence Brecht, D.D.S.
New York University
Langone Medical Center
Institute of Reconstructive
Plastic Surgery
Director of Craniofacial Prosthetics
New York, New York USA

David L. Hirsch, D.D.S., M.D., F.A.C.S.
The Institute of Reconstructive
Plastic Surgery
New York University-Langone Medical Center
New York University College of Dentistry
New York, New York USA

Mandibular Reconstruction 101:
Use of Computer Aided Technology to Produce the Ideal Mandibular Reconstruction with Dental Implants

The transfer of the micro-vascular fibular free flap has become a common procedure in the reconstruction of comprehensive orofacial defects. Besides its length, major advantages of the fibula-free flap include the trigonal diameter of the fibula that allows placement of dental implants. There has been controversy as to whether the fibular construct is an acceptable mandibular reconstruction suitable for implantation. In addition there have been very poor rates of implant reconstruction reported in the literature. This rate has been reported as low as 10-15% in patients with malignant disease.

The fibula osteocutaneous free flap provides the ideal vascularized tissue for reconstruction of segmental mandibular defects. Over the past decade our approach to these cases has evolved to provide our patients single stage reconstructions with satisfactory orthognathic and aesthetic outcomes. The modalities we have employed for surgical planning progressed

from gross intraoperative measurements, to preoperative planning based on stereolithographic models and now computer-aided three dimensional planning with prefabricated splints and jigs to allow precise double-barrel restoration of the mandibular archform, contour and implant position.

09:30 **George Bohle, B.A., D.D.S.**
Memorial Sloan-Kettering
Cancer Center
New York, New York USA

Use of Mini Dental Implants in Maxillofacial Prosthetics

Mini dental implants have been gaining notoriety over the past several years. Increasing evidence in the literature is beginning to compel practitioners from general practice through several specialties to treatment plan these implants without reservation. Once viewed as a "temporary" implant meant to stabilize a provisional while conventional implants were healing are now being treatment planned with sound success rates as definitive treatment. New surface designs, implant geometry, and a choice in retentive elements or four wall abutment designs are providing new options to existing treatment dilemmas. The narrow diameter, less invasive surgical placement, and reduced financial burden is allowing more patients to be candidates and to choose implant therapy as part of their treatment.
This lecture will present information from the inception of several manufacturers of mini implants through treatment planning, surgical placement, and will attempt to answer with the aid of current literature several highly debated questions. Prospective patient data describing the success rates of mini implants and laser Doppler blood flow data of patients undergoing radiation therapy for Head and Neck cancer will be discussed in treatment planning for the oncology patient population. At the conclusion practitioners should feel confident in planning and placing mini dental implants for patients undergoing or who have completed Head and Neck cancer treatment.

10:15 Coffee Break and Exhibit Networking

10:45-12:00 Session Title: *Sleep Medicine*

10:45 **Sabin Bista, M.D.**
University of Nebraska
Medical Center
Omaha, Nebraska USA

Obstructive Sleep Apnea: Current Concepts and Management

Purpose: The purpose of this presentation is to give a general outline on the current understanding in the occurrence and management of Obstructive sleep apnea (OSA). This presentation will emphasize the need for actively screening for OSA, and will explore the treatment options as well.

Materials and Methods: OSA is a growing health problem. It is characterized by recurrent complete or partial narrowing of the upper airway passage that can result in arousals and hypoxemia. This will lead to a compromise in nighttime sleep quality and quantity, and impaired daytime functioning commonly manifested as fatigue, excessive sleepiness and problem with concentration. On the long run, it can increase the risk of hypertension, cardiovascular disease, and stroke. There is also increased risk for traffic and occupational accidents. There are factors inherent in and around the upper airway tissues that increase pharyngeal collapsibility. However, active neuromuscular control of the upper airway muscles helps stabilize patency, and therefore prevents collapse during both wakefulness and sleep. Sleep apnea patients have either increased collapsibility or impaired response to such collapsibility, or a combination of both. The most common site of collapse is the retro palatal and oropharyngeal regions. The collapse can extend down to the base of tongue and in some, to the hypo pharyngeal region.

The prevalence of OSA in a middle-aged population is 24% in men and 9% in women. This is when OSA is defined by 5 or more apneas and/or hypopneas per hour. Respiratory effort related arousals, RERAs, are also increasingly included in the overall evaluation as they are manifestations of partial upper airway

obstruction as well. Polysomnography (PSG) is the gold standard for diagnosis. ICSD-2 clearly outlines the diagnostic criteria for diagnosing OSA. Age, male sex, and obesity are important risk factors. Any factor that can reduce the upper airway anatomy can predispose to occurrence of OSA.

CPAP, oral appliances and upper airway surgery all increase upper airway aperture. CPAP is indeed the treatment of choice, treating both OSA and the consequences thereof. No medications or devices are currently available to improve the neuromuscular response to collapsibility.

Conclusion: Identifying patients with OSA and properly treating them may not only improve the quality of life, but also may modify future cardiovascular risks involved. Because many medical specialties could be involved, an interdisciplinary approach would be the best way to properly manage OSA patients.

11:30

Alvin G. Wee, B.D.S., M.S., M.P.H.
University of Nebraska
Medical Center
Department of Otolaryngology
Omaha, Nebraska USA

Dental Management of Obstructive Sleep Apnea in a Maxillofacial Prosthodontic Practice

This presentation will provide an overview of how the maxillofacial prosthodontist can participate in providing treatment for patients who have been diagnosed with either snoring or obstructive sleep apnea by using oral appliance therapy. This will be a review for clinicians who are already providing this service and will also serve as a comprehensive overview on how to initiate this service.

For the maxillofacial prosthodontist who is already familiar with the oral pharyngeal region, this initiation of service is easily carried out with the fabrication of the appliance. It is necessary to learn the new terminology, how to interact with the sleep

physician, how to interpret the diagnoses and how to follow the proposed protocol.

Participating in this new area includes the following: (1) providing screening for head and neck cancer patients who have a high probability of obstructive sleep apnea after cancer treatment and (2) fabricating an oral appliance for patients referred by the physician. Information on how to act in these two capacities will be provided in this presentation.

Most of the information collection, screening and clinical procedures can be done by auxiliary staff who have been trained. Advantages of providing this service include increasing the quality of life of patients and/or their bed partners and generating income that is usually paid by medical insurance if patients are diagnosed with obstructive sleep apnea, so as to balance the cost of providing care for head and neck cancer patients.

12:00	Session Adjourns
14:00-16:00	**Concurrent Workshops**
14:00-16:00	**Insurance Workshop** *Located in Atrium 1436*
14:00-16:00	**AAMP Workshop 1** *Advances in the Use of Magnetic Retention for Maxillofacial Prostheses and Dentures Located in the Grand Cypress Ballroom*
19:00-22:00	**AAMP President's Reception & Banquet** *(elective) Located in the Grand Cypress D Ballroom*

Tuesday, November 2nd

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Located in the Regency Ballroom

07:00-08:00 New Members Breakfast
Located in Magnolia AB

08:00-12:00 General Session
Session Title: *The Practice of Maxillofacial Prosthodontics*

Moderator: **Alvin G. Wee, B.D.S., M.S., M.P.H.**
University of Nebraska
Medical Center
Department of Otolaryngology
Omaha, Nebraska USA

08:00 **Jeffery Markt, D.D.S.**
University of Nebraska
Medical Center
Department of Otolaryngology
Omaha, Nebraska USA

Samuel R. Zwetchkenbaum, D.D.S.
University of Michigan
Department of Oral and Maxillofacial Surgery/Hospital Dentistry
Ann Arbor, Michigan USA

Wikipedia: How to Contribute and Edit Information on Maxillofacial Prosthodontics

Wikipedia.org is in the top 5 of websites in hits in America (and perhaps the world)? Patients use it as a resource to find information regarding health care, yet entries related to topics in maxillofacial prosthetics are sorely lacking. This presentation will review what is Wikipedia, what information is currently available, and how the information is entered and evaluated. A case example will be presented, including the use of the "sandbox" to help novices become comfortable with this new media.

This presentation will serve as a call for the AAMP to take the lead and populate Wikipedia with informative and beneficial information about maxillofacial prosthodontics for patients and the public at large.

08:30 **Craig A. Van Dongen, D.D.S.**
Private Practice
Providence, Rhode Island USA

Reimbursement in Private Practice

It is important that we Maxillofacial Prosthodontists in private practice be reimbursed adequately for our services. This, unfortunately, can often be more difficult and time-consuming than the actual services we provide.

This presentation will provide guidelines and recommendations for obtaining reimbursement from both medical and dental benefit plans.

09:00 **Betsy K. Davis, D.M.D., M.S.**
Medical University of
South Carolina
Maxillofacial Prosthodontic Clinic
Charleston, South Carolina USA

Institutional Reimbursement

In today's economic environment, proper reimbursement is critical to the success of the maxillofacial prosthodontic clinic in an institution. The focus of this presentation will be to outline the differences in a provider based and doctor's office within an institution and the role of managed care, financial counseling, and compliance.
The role of managed care in the negotiation process so clinicians are paid fairly for the value of their prostheses and the use of financial counseling will be emphasized. A review of E/M and CPT codes, DME codes for sleep apnea and facial prostheses, and Medicare's professional reimbursement methodology will be given. Finally, a short review of the use of facility/supply charges will be included.

09:30 **Candice Zemnick, D.M.D., M.P.H., M.S.**
Columbia University &
Bronx VA Medical Center
Division of Prosthodontics &
Maxillofacial Prosthetics
New York, New York USA

The Adjustable Palatal Lift Prosthesis

Management of the amyotrophic lateral sclerosis patient is often challenging due to the progressive deteriorating neurological status and the spectrum of motor dysfunction affecting the tongue, soft palate, pharynx and associated oral structures.

Cerebral arteritis, stenosis, and infarcts can cause similar results with dysarthria, dysphonia, and dysphagia often collectively present. Palatal lift and augmentation prostheses have been prescribed to treat palatopharyngeal and palatolingual incompetency and will be reviewed. The goal of this presentation is to describe the use of a palatal lift with an adjustable extension to address the challenging sequelae of neuromyogenic disorders. Prosthetic construction variations will be discussed as well as how this treatment approach can enhance diagnostic and therapeutic procedures that accommodate neuromuscular changes. The importance of collaborative efforts with speech pathologists will be stressed as essential to maximizing the outcome of prosthetic intervention.

10:00 Coffee Break and Exhibit Networking

10:30 **Pattii Montgomery, Anaplastologist**
M.D. Anderson Cancer Center
Department of Head & Neck Surgery,
Oncologic Dentistry
and Prosthodontics
Houston, Texas USA

Trauma, Disfigurement, Fame and Facial Prosthetics

Purpose: The life-threatening effects of domestic violence resulted in a woman's desperate need for facial reconstruction. She became known as "the woman without a face" until a year later when a group of facial plastic surgeons, a maxillofacial surgeon and an oculoplastic surgeon donated their expertise to a series of seven reconstructive surgeries. Her story made her the face of domestic violence and she was featured in multiple magazines including People, SELF and Texas Monthly. Her struggles made such an impact that the Discovery Health channel and the Oprah show followed her story. Her fame grew throughout the progress of her surgeries culminating in the making of her prosthetic nose.

Methods & Materials: A prosthetic rehabilitation consultation with the woman was conducted to determine her expectations and limitations due to her reconstructive surgeries. A timeline for the completed prosthetic was accelerated due to media coverage and media deadlines for her story. Numerous photographs were taken to be used as a digital reference in the design of her nasal prosthesis. The design and fabrication of her new nose involved the sculpting of several wax noses in different sizes and shapes to determine the most natural profile to her asymmetrical face.

Results: The woman's first silicone nasal prosthesis was delivered two and a half years after her reconstructive surgeries. Her physical transformation was complete but her emotional journey continues. Throughout her ordeal, the woman began building a national reputation as a woman who not only survived a horrific attack from an abusive boyfriend but found the courage to speak out against domestic violence.

Conclusion: The 15 minutes of fame clock begins whenever an individual receives his or her first mainstream media exposure. The individual can become enthralled with the media attention. In most cases, this fame is over shortly after it began. Instant celebrity status and abrupt return to reality can be disruptive and disorienting to the individual.

11:00 **Sudarat Kiat-amnuay, D.D.S., M.S.**
University of Texas
Dental Branch at Houston
Restorative Dentistry
and Biomaterials
Houston, Texas USA

Ten Year Results of Color Stability of Silicones

Although the silicone elastomers have been used in the maxillofacial prosthetics field for over 50 years, there are still numerous reports of dissatisfaction with color stability and longevity. The final esthetic result and color stability are the most important factors affecting clinical success or failure of maxillofacial prostheses. Color changes have directed most investigations on the color stability of elastomers and colorants.

It is the aim of this presentation to summarize the past 10 years of results of color stability studies of silicone elastomers, and the translation of the results to the clinical setting. The presentation will cover a review of most common types of opacifiers, pigments, and silicone elastomers used to fabricate maxillofacial prostheses according to the current survey, and a review of their color stability research in related studies. This presentation will also cover the color difference thresholds of maxillofacial skin replications. Based on the 10-year results of the presenter and her collaborator's laboratory studies, recommendations will be made to help clinicians decide which types of opacifier, pigment, and silicone elastomer combinations create the most color stable prostheses.

The subsequent review will help clinicians fabricate better and

more predictable color-stable prostheses, enhancing the quality of life for maxillofacial prosthetic patients.

11:30 **Theresa M. Hofstede D.D.S.**

David I. Rosenthal, M.D.
M. Kay Garcia, Ph.D.
Lorenzo Cohen, Ph.D.
Adel K. El-Naggar, M.D.
Mark S. Chambers, D.M.D., M.S.
University of Texas
MD Anderson Cancer Center
Oncologic Dentistry and Prosthodontics
Department of Head and Neck Surgery
Houston, Texas USA

Radiation-Induced Salivary Gland Dysfunction: Burden, Biomarkers, and Alternative Therapies

Standard radiation treatment for most advanced head and neck tumors typically involves a high radiation dose to one or more major salivary glands, often leading to markedly reduced salivary output resulting in xerostomia. We address the oral symptom burden, biomarkers, and alternative therapies for radiation-induced xerostomia. Xerostomia is associated with qualitative and quantitative changes in saliva that cause severe symptoms and reduce function and quality of life. These effects were demonstrated with use of the MD Anderson Symptom Inventory—Head and Neck (MDASI-HN) in a recent phase III trial. Biomarkers to predict susceptibility to xerostomia would help tailor the management of patients with head and neck cancer to minimize the effects of this morbidity. Proteomics and other molecular analyses have advanced the search for biomarkers predictive of post-treatment oral morbidity and signal the development of new clinical interventions for these patients. In parallel, an alternative, integrative intervention that has shown great promise is acupuncture. A recent pilot study determined that acupuncture was effective in alleviating radiation-induced xerostomia in select patients with head and neck cancer. Nineteen patients received acupuncture twice a week for 4 weeks and completed a xerostomia inventory (XI) and

patient benefit questionnaire (PBQ). XI and PBQ scores obtained at weeks 4 and 8 were significantly higher than those at baseline (XI: p = .0004 and .0001; PBQ: p = .0004 and .0011, respectively). For QOL at weeks 4 and 8, there was a significant difference for questions related to head/neck cancer (p = .04 and .006, respectively). At week 8, there was a significant difference in physical well-being (p = .04). At weeks 5 and 8, there were significant differences in the total score (p = .04 and .03, respectively). Thus, recent insights into the post-treatment oral symptom burden and predictive salivary biomarkers show significant promise in advancing the development of more effective clinical and alternative therapies for patients with xerostomia.

12:00 Session Adjourns

13:30 - 16:30 **AAMP Workshop 2:**
3D Surface Imaging in Maxillofacial Prosthetics
Located in the Grand Cypress Ballroom

Reserve Papers

Thomas Salinas, D.D.S.
Mayo Clinic
Department of Dental Specialties
Rochester, MN USA

Endosseous Implant Survival in Radiated Tissues-Can We Expect Better Outcomes?

Patients treated for malignancies of the head and neck may benefit from the use of endosseous implants. Occasionally, this necessitates placement of implants in radiated bone, questioning the long term survival. Two populations of patients treated for head and neck malignancies and later treated with endosseous implants will be compared.

John Wolfaardt, B.D.S., MDent, Ph.D
Institute for Reconstructive
Sciences in Medicine
Division of Otolaryngology
Head and Neck Surgery
Department of Surgery
Faculty of Medicine and Dentistry
University of Alberta,
Edmonton, AB CA

Dysphagia: A Maxillofacial Prosthetic Perspective

Dysphagia is a far more common condition than is routinely understood. It may present from childhood to old age and on occasion can be life threatening. Dental practices are environments that may encounter patients with dysphagia and yet this appears to seldom be considered in dental treatment. By distinction, dysphagia is a common presentation in maxillofacial prosthetic practices.

The presentation will consider the prevalence of dysphagia, provide a review of the swallowing process, describe how dysphagia is assessed, discuss how a the maxillofacial prosthetic service should connect with a dysphagia team and describe an ethical challenge that may present to the prosthodontists providing care to head and neck reconstruction patients with dysphagia.

SPEAKER BIOGRAPHIES

IN ORDER OF APPEARANCE ON THE PROGRAM

Sunday, October 31st

Session Title: *Multidisciplinary Patient Care*

Don-Jon Summerlin, D.M.D., M.S.
Indiana University
School of Medicine
Indianapolis, Indiana USA

Dr. Summerlin, currently an Adjunct Professor at Indiana University School of Medicine, received his dental training at the University of Alabama School of Dentistry. From there, he completed a residency in Oral Pathology at Indiana University School of Dentistry, culminating in a Masters Degree in 1989.

He gained Diplomate status bestowed by the American Board of Oral & Maxillofacial Pathology in 1990. Dr. Summerlin has served as an Oral & Maxillofacial Pathology consultant to the Commission on Dental Accreditation as well as the Pathology representative to their Appeal Board. Additionally, he has served on the Nomination, Parameters of Care and Fellowship committees of the American Academy of Oral & Maxillofacial Pathology and as a peer review consultant for the National Institutes of Health. Dr. Summerlin is actively involved in diagnostic oral & maxillofacial pathology endeavors, both as a private practitioner in association with the Dermatopathology Laboratory, as director for Head and Neck Pathology for Clarian Pathology Laboratory and as a consultant to the Center for Ear, Nose, Throat and Allergy.

Eric Blom, Ph.D.
The Center for Ear, Nose, Throat and Allergy
Carmel, Indiana USA

Eric D. Blom, Ph.D, is an internationally recognized speech pathologist and medical device inventor who is in private practice with The Center for Ear, Nose, Throat and Allergy in Carmel, Indiana. He is most noted as the co-developer of the tracheoesophageal voice restoration technique and numerous Blom-Singer® voice prostheses and valves, utilized around the world following total laryngectomy.

Dr. Blom earned his Ph.D from the University of Maryland in 1972. Recognition of his achievements by his colleagues during his 35 year career includes Outstanding Clinical Achievement Award (1984), Fellow of the Association (1989), and Honors of the Association (1998) - all bestowed by the American Speech-Language-Hearing Association. Dr. Blom has authored or co-authored 60 scientific publications and has been an invited guest lecturer at conferences throughout the United States and 24 foreign countries. His efforts as an inventor have earned 29 United States and foreign patents.

Tod Huntley, D.M.D., M.S.
Otolaryngologist
The Center for Ear, Nose, Throat and Allergy
Carmel, Indiana USA

Tod Huntley is an otolaryngologist in Indianapolis, Indiana. He joined a private practice tertiary referral ENT group after completing a fellowship in head and neck reconstructive and microvascular surgery in 1991. His practice involves head and neck cancer ablative and microvascular reconstructive surgery, as well as the treatment of obstructive sleep apnea. Dr. Huntley realizes the importance of maintaining a close working relationship with his maxillofacial prosthodontic colleagues, and he works with Dr. Steve Haug of our academy in a weekly multidisciplinary head and neck cancer clinic. They evaluate all new patients together and strive for the best possible oncologic, functional, and cosmetic outcomes.

Dr. Huntley has published and lectured extensively and various head and neck surgical topics and is honored to have been asked to participate in this year's AAMP conference.

Trevor Treasure, D.D.S., M.D., M.B.A., F.R.C.D. (C).
Indiana University
School of Dentistry
Indianapolis, Indiana USA

Board Certification:
American Board of Oral and Maxillofacial Surgery
Fellowship Certification: Royal College of Dentists of Canada
Education:

- MBA – Masters of Business Administration, Texas Tech University 8/9/2003
- MD – Medical Doctor, University of Texas-Southwestern Medical School, 6/5/1993
- DDS – Doctor of Dental Surgery, University of Toronto, 5/29/1986

Academic Appointments:

- Assistant Professor - Indiana University School of Dentistry, 3/2005-present
- Assistant Professor- Department of Surgery, Texas Tech University Health Sciences Center, 1999-2002
- Assistant Professor – Department of Oral and Maxillofacial Surgery, UCSF, 1996-1997

Residency Training:

- 1990-1996 Oral and Maxillofacial Surgery, University of Texas Southwestern Medical Center at Dallas, TX
- 1993-1994 General Surgery Internship, Parkland Memorial Hospital, Dallas, TX

Undergraduate Education: 1979-1981, University of Toronto, Faculty of Arts and Sciences
Editorial Peer review: American Cleft Palate Craniofacial Journal, Journal of Oral and Maxillofacial Surgery
Professional Service:
AO ASIF Craniomaxillofacial Faculty, 8/2005-present

OMSAAT Item Writer, Anesthesia Section, 2005-present
AAOMS Meeting Moderator Oral Abstracts,
Orthognathic Surgery
AO Visiting Professor Allegheny Hospital,
Pittsburgh, PA, 6/2006

Robert G. Hale, D.D.S.
Commander of the US Army Dental and Trauma, Research Detachment
San Antonio, Texas USA

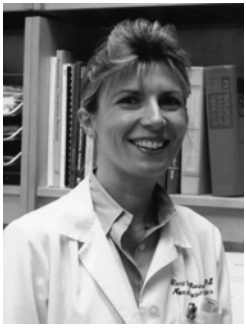
COL Hale completed undergraduate studies at UCLA and earned his Doctoral and Postdoctoral Certificate in Dentistry and Oral and Maxillofacial Surgery at Emory University. He is Diplomate of the American Board of Oral and Maxillofacial Surgeons and Fellow, American Association of Oral and Maxillofacial Surgeons and American College of Oral and Maxillofacial Surgeons.

COL Hale is Commander of the US Army Dental and Trauma Research Detachment in San Antonio, Texas, and representative to the Armed Forces Institute of Regenerative Medicine. COL Hale is published in numerous professional journals, and has lectured extensively on craniomaxillofacial battle-injuries. COL Hale was awarded the "A" Proficiency Designator from the US Army Surgeon General to recognize professional expertise, leadership, and academic achievements.

COL Hale received the American Association of Oral and Maxillofacial Surgeons' Humanitarian Award for 2009.

Monday, November 1st

Session Title: ***Implants in Head and Neck Rehabilitation***



Eleni D. Roumanas, D.D.S.
University of California Los Angeles
School of Dentistry
Los Angeles, California USA

Dr. Eleni Roumanas completed her BS degree at UCLA (1983) and received her D.D.S. degree from Northwestern University, Chicago (1988). Postgraduate training included General Practice Residency (UCLA 1989), Advanced Prosthodontics Residency (UCLA/VAMC 1991), Maxillofacial Prosthetics Residency (UCLA 1992) and Mid-Career/Geriatric Fellowship (UCLA-Multicampus Program 1996).

Dr. Roumanas joined the faculty at the UCLA School of Dentistry in 1992 as Adjunct Assistant Professor and Director of Maxillofacial Prosthetics at the City of Hope National Medical Center. She is presently Professor in the Division of Advanced Prosthodontics, Biomaterials and Hospital Dentistry, Director of the Advanced Prosthodontics Residency Program and Co-Director of the Maxillofacial Prosthetics Residency Program.

Dr. Roumanas' research focuses primarily on clinical outcomes, determining the efficacy of implant prosthodontics and maxillofacial prosthetics.

Lawrence Brecht, D.D.S.
New York University
Langone Medical Center
Institute of Reconstructive
Plastic Surgery
Director of Craniofacial Prosthetics
New York, New York USA

Lawrence E. Brecht, DDS, is Clinical Associate Professor of Prosthodontics and Occlusion in the Division of Prosthodontics and Restorative Dentistry at New York University College of Dentistry. He also serves as the Director of Maxillofacial Prosthetics in the Advanced Education Program in Prosthodontics at NYU. He has a joint appointment at the Institute of Reconstructive Plastic Surgery of New York University School of Medicine where he is Director of the Center for Craniofacial Prosthetics and serves on the Institute's Cleft Palate, Craniofacial and Ear Anomalies teams.

He received his DDS from New York University and his Certificates in both Prosthodontics, as well as Maxillofacial Prosthetics from the New York Veterans Administration Hospital. He is a Fellow of The Greater New York Academy of Prosthodontics, American Academy of Maxillofacial Prosthetics, The Academy of Prosthodontics, and a member of the American College of Prosthodontists and the American Cleft Palate/Craniofacial Association. He serves on the Board of Directors of the ACP as well. His clinical research interests include nasoalveolar molding and the extraoral application of osseointegration in both pediatric and adult patients.

Dr. Brecht has made numerous contributions to the cleft palate and maxillofacial prosthetics literature. He maintains a practice limited to prosthodontics and maxillofacial prosthetics in New York City.

David L. Hirsch, D.D.S., M.D., F.A.C.S.
The Institute of Reconstructive Plastic Surgery
New York University-Langone Medical Center
New York University College of Dentistry
New York, New York USA

David L. Hirsch, DDS, MD, FACS is a graduate of Cornell University and received his DDS from NYU College of Dentistry and MD degree from NYU School of Medicine. He is a Clinical Associate Professor of Surgery at NYU Langone Medical Center and the Director of the the Oral and Maxillofacial Surgery Service at Bellevue Hospital Center He is a frequent contributor to the OMFS literature and the Co-Director of the Center for Head, Neck and Face Reconstruction at the Institute of Reconstructive Plastic Surgery at NYU.

George Bohle, B.A., D.D.S.
Memorial Sloan-Kettering
Cancer Center
New York, New York USA

Dr. Bohle graduated from the University of Missouri-Kansas City 6-year combined B.A./D.D.S. program in 1997. He then completed his prosthodontic residency at U.M.K.C. followed by a Maxillofacial Prosthetics Fellowship at the Memorial Sloan-Kettering Cancer Center in 2001.

After completing this training, he started a private practice in Baltimore, Maryland, while on staff at the Johns Hopkins Medical Institute. In 2005, he returned to the Memorial Sloan-Kettering Cancer Center and was named Director of the Maxillofacial Prosthetics training program in 2006.

Dr. Bohle practices full time at the hospital and his research interests include: the technological advancement of ocular prosthetics, CAD/CAM assisted medicine, the study and prevention of osteoradionecrosis, and implant rehabilitation in irradiated bone.

10:45-12:00 Session Title: *Sleep Medicine*

Sabin Bista, M.D.
University of Nebraska
Medical Center
Omaha, Nebraska USA

Education:

2006-2007	Fellow, Sleep Medicine University of Nebraska Medical Center, Omaha
2003-2006	Resident, Internal Medicine Albert Einstein College of Medicine (AECOM) Jacobi Medical Center, Bronx, NY.

Committee Assignments:
Member, Standards of Practice Committee, American Academy of Sleep Medicine

Bibliography:
Articles published

1. Efficacy and cost comparisons of bronchodilator administration between metered dose Inhalers with disposable spacers and nebulizers for acute asthma in an inner-city adult population. Journal of Emergency Medicine.

2. Best Practice Guide for the Treatment of Nightmare disorder in adults. Journal of Clinical Sleep Medicine.

3. Practice Parameters for the Surgical Modifications of the Upper Airway for Obstructive Sleep Apnea in Adults. Sleep: Accepted 5/29/2010.

4. A college student with excessive sleepiness. What's keeping this coed from sleeping at night? What can be done to help her stay awake during the day? *A CME accredited Medscape article*.

5. Central sleep apnea in a patient presenting with daytime fatigue and sleepiness. *A CME accredited Medscape article*.

Chapters in books

1. Chapter 12: Behavioral and Medical Interventions in Sleep Breathing Disorders. Therapy in Sleep Medicine. First author; *submitted to the Editor Aug 2010*.

2. Chapter 41: Knowing Practice Parameters. Review of Sleep Medicine. Sole author; in progress, due by Sept 10, 2010.

Presentations:

1. "Obstructive sleep apnea, diabetes, hypertension and obesity: interrelated cardiovascular risk factors" at Metrohealth Medical Center of Case Western Reserve University at Cleveland on December 18, 2006.

2. "Sleep disorders and management: an overview" at Georgetown Club, Omaha on April 25, 2007.

Alvin G. Wee, B.D.S., M.S., M.P.H.
University of Nebraska
Medical Center
Department of Otolaryngology
Omaha, Nebraska USA

Dr. Wee obtained his dental degree in 1992 from the National University of Singapore. He then continued his studies at the University of Iowa with a Rotary International Foundation Scholarship. In 1997, he graduated with a Certificate and MS degree in the specialty of Prosthodontics. An additional year was spent at the University of Pittsburgh Medical Center as a Clinical Fellow in Maxillofacial Prosthetics. He joined the faculty at The Ohio State University and was promotion to Associate Professor with tenure in 2004. In June of 2007, he joined the faculty at the University of Nebraska Medical Center's Department of Otolaryngology and obtained membership with the Eppley Cancer Center (Cancer Prevention and Control Program).

He has authored more then 56 peer-reviewed publications, 41 peer-reviewed abstracts, and three chapters in textbooks. He has also received funding as principal investigator from several sources, including two grants from the National Institutes of Health.

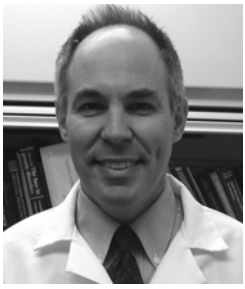
Tuesday, November 2nd

Session Title: *The Practice of Maxillofacial Prosthodontics*

Jeffery Markt, D.D.S.
University of Nebraska
Medical Center
Department of Otolaryngology
Omaha, Nebraska USA

Dr. Jeffery Markt was raised in Kansas City, Missouri and received D.D.S. degree from the University of Missouri at Kansas City (UMKC) College of Dentistry in 1986. He completed a prosthodontic residency at UMKC in 1994 and his maxillofacial prosthetic fellowship at the University of Texas M.D. Anderson Cancer Center in 1995.

He is now associate professor and director of the maxillofacial prosthetic clinic in the Department of Otolaryngology – Head and Neck Surgery at the University of Nebraska Medical Center since 2008.



Samuel R. Zwetchkenbaum, D.D.S.
University of Michigan
Department of Oral and
Maxillofacial Surgery/Hospital Dentistry
Ann Arbor, Michigan USA

Dr. Samuel Zwetchkenbaum was raised in Providence, Rhode Island and received his D.D.S. from the University of North Carolina in 1987. He completed prosthodontic training at the University of Medicine and Dentistry of New Jersey in 1992 and his maxillofacial prosthetic fellowship at M.D. Anderson Cancer Center in 1995.

He is now clinical associate professor in the Department of Oral and Maxillofacial Surgery/Hospital Dentistry at University of Michigan.

Craig A. Van Dongen, D.D.S.
Private Practice
Providence, Rhode Island USA

Dr. Craig Van Dongen has been in full time private practice in Providence, Rhode Island, from 1990 to the present time. He is a Fellow in the Academy, and served as Chairman of the Insurance and Oral Health Committee from 2005-2009.

He is currently on the Board of Directors for the AAMP.

Betsy K. Davis, D.M.D., M.S.
Medical University of South Carolina
Maxillofacial Prosthodontic Clinic
Charleston, South Carolina USA

Dr. Betsy Davis is an Associate Professor of Otolaryngology - Head and Neck Surgery, College of Medicine, Associate Professor of Oral & Maxillofacial Surgery, College of Dental Medicine, and Associate Professor of the College of Graduate Studies at the Medical University of South Carolina.

Dr. Davis is a cum laude graduate of Wofford College and received her D.M.D. degree from the Medical University of South Carolina. Dr. Davis received her Certification and Master's degree in Prosthodontics at the University of Iowa. She joined the faculty at Ohio State University where she taught and practiced from 1989-1992. Davis completed her fellowship training in Maxillofacial Prosthodontics at M.D. Anderson Cancer Center in Houston, Texas, followed by a Maxillofacial Prosthetic/Implant Residency at UCLA Maxillofacial Prosthetic Clinic.

Dr. Davis is an adjunct faculty member in the Department of Bioengineering at Clemson University. Dr. Davis' research focuses on rehabilitation of the maxillofacial patient.

Candice Zemnick, D.M.D., M.P.H., M.S.
Columbia University &
Bronx VA Medical Center
Division of Prosthodontics &
Maxillofacial Prosthetics
New York, New York USA

Received her MPH from New York Medical in Emergency Medicine. Worked as Administrative and Research Coordinator of Emergency Departments in NYC prior to attending Tufts University Dental School of Dental Medicine. She received her Prosthodontics training at Columbia University, and then went on to complete the Maxillofacial Prosthetics Program at Columbia and the James J. Peters VA Medical Center.

Currently she is Director of Predoctoral Prosthodontics and is Associate Director of Maxillofacial Prosthetics at Columbia University, NY Presbyterian Hospital and after receiving several teaching awards has been inducted into the Glenda Garvey Teaching Academy. She continues to work at the VA Medical Center as well as Faculty Practice and Private Practice.

Pattii Montgomery, Anaplastologist
M.D. Anderson Cancer Center
Department of Head & Neck Surgery
Oncologic Dentistry and Prosthodontics
Houston, Texas USA

Pattii Montgomery utilizes her extensive experience in concept development, graphic design, graphics software and digital imaging in the field of anaplastology. In 2003, Pattii joined the Dental Oncology and Maxillofacial Prosthetics Clinic at M.D. Anderson (MDACC) as an anaplastologist. Through her training at MDACC she has developed a process of digital imaging for

fabrication of ocular prosthetics and an innovative custom contour peristomal device for deep or irregular shaped stomas after a total laryngectomy. She brings creative thinking to the design and fabrication of facial prosthetics.

Before starting her career at (MDACC) Ms. Montgomery was Vice President/Creative Director of Marion, Montgomery, Incorporated (MMI), a full service marketing and advertising firm that she co-founded in 1985 with a specialty in healthcare marketing.

Sudarat Kiat-amnuay, D.D.S., M.S.
University of Texas
Dental Branch at Houston
Restorative Dentistry and Biomaterials
Houston, Texas USA

Dr. Kiat-amnuay received her D.D.S. from Khon Kaen University, Thailand. She earned her prosthodontic certificate and master of science degree in oral biology from the University of Louisville, Kentucky, and her maxillofacial prosthetics and dental oncology certificate from the University of Texas M.D. Anderson Cancer Center in Houston.

Dr. Kiat-amnuay holds academic appointments as an Associate Professor and Director of Postgraduate General Dentistry Clinics, Department of Restorative Dentistry and Biomaterials, University of Texas Dental Branch at Houston. She is a diplomate of the American Board of Prosthodontists and is a board certified in Clinical Anaplastology. She is a fellow of the American College of Prosthodontists, the American Academy of Maxillofacial Prosthetics, the International Congress of Oral Implantologists, and the International Academy of Oral Oncology.

She is a member of numerous dental and medical organizations and has served as a member of AAMP materials and devices, and research committees.

Theresa M. Hofstede D.D.S.
University of Texas
MD Anderson Cancer Center
Oncologic Dentistry and Prosthodontics
Department of Head and Neck Surgery
Houston, Texas USA

Dr. Hofstede is an Assistant Professor in the Section of Oncologic Dentistry and Prosthodontics, Department of Head and Neck Surgery, at The University of Texas MD Anderson Cancer Center (MDACC). She completed her Doctorate of Dental Surgery and a General Practice Residency at the University of Western Ontario in London, Canada. She received her Certificate in Prosthodontics from the University of Rochester Eastman Dental Center. After several years of private practice in Rochester NY, Dr. Hofstede completed a Fellowship in Maxillofacial Prosthodontics and Oncologic Dentistry at MDACC.

Dr. Hofstede is a Diplomate of the American Board of Prosthodontics, Fellow in the American College of Prosthodontics, and an Associate Fellow in the American Academy of Maxillofacial Prosthetics (AAMP). Her clinical practice is focused on advanced maxillofacial prosthetic rehabilitation, implant restoration, radiation prosthetics, and pre- and post-cancer treatment oral management. Dr. Hofstede's clinical research activities include outcomes research in prevalence and management of the oral sequelae of chemo-radiation therapy of head and neck cancer patients, maxillofacial biomaterials, and pathophysiology of treatment-induced salivary dysfunction.

Thomas Salinas, D.D.S.
Mayo Clinic
Department of Dental Specialties
Rochester, MN USA

Dr. Salinas is Associate Professor of Dentistry at the Mayo Clinic College of Medicine. He has appointment as a consultant in the Department of Dental Specialties devoting his practice to rehabilitation of patients requiring prosthodontic care. His research interests include biomechanical aspects of dental materials, implant prosthodontics, and clinical outcome studies.

John Wolfaardt, B.D.S., MDent, Ph.D
Institute for Reconstructive
Sciences in Medicine
Division of Otolaryngology
Head and Neck Surgery
Department of Surgery
Faculty of Medicine and Dentistry
University of Alberta,
Edmonton, AB CA

Dr Wolfaardt is a Director of Clinics and International Relations of the Institute for Reconstructive Sciences in Medicine (iRSM) and is appointed as a Full Professor in the 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 80 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, teamwork and quality management. Dr Wolfaardt is elected to the Boards of the International Society of Maxillofacial Rehabilitation, ADT Foundation and the International College of Prosthodontists.

Monday, November 1, 2010
14:00-17:00

I. 14:00-14:15 Welcome & Update on Medicare	**Dr. Craig van Dongen** **Dr. Betsy Davis**
II. 14:15-15:00 The ABC's of Professional Billing Including: * Review of bill forms, charge tickets * Place of service designation & reimbursement- Drs. office vs. Outpatient hospital * Overview of Medicare payment/RVU methodology * Role of Financial Counseling & Pre-Certification * Summary of a University experience billing & collecting for Maxillofacial Prosthodontics	**Patricia C. Mahoney** Director of Operations UMA Patient Accounting Medical University of South Carolina Charleston, SC USA
III. 15:00-15:30 Coding Review and Challenges: ICD codes & CPT Codes 21076-21089 and E/M Codes Billing	**Dr. Betsy Davis** **Dr. Craig van Dongen**
IV. 15:30-16:00 Auditing for Compliance	**Julie Daube, BS, RHIT, CCS, CCS-P** Manager of Coding Quality ReviewAnd Education Care Communications, LLC Chicago, IL USA

V. 16:00-16:30 **Dr. Betsy Davis**
Compliance Approved
Dictation Templates

VI. 16:30-17:00 **All Instructors**
Individual Consultation /
Questions

Instructors Biographies in Order of Appearance

Craig A. Van Dongen, D.D.S.
Private Practice
Providence, Rhode Island USA

Dr. Craig Van Dongen has been in full time private practice in Providence, Rhode Island, from 1990 to the present time. He is a Fellow in the Academy, and served as Chairman of the Insurance and Oral Health Committee from 2005-2009.

He is currently on the Board of Directors for the AAMP.

Betsy K. Davis, D.M.D., M.S.
Medical University of South Carolina
Maxillofacial Prosthodontic Clinic
Charleston, South Carolina USA

Dr. Betsy Davis is an Associate Professor of Otolaryngology - Head and Neck Surgery, College of Medicine, Associate Professor of Oral & Maxillofacial Surgery, College of Dental Medicine, and Associate Professor of the College of Graduate Studies at the Medical University of South Carolina.

Dr. Davis is a cum laude graduate of Wofford College and received her D.M.D. degree from the Medical University of South Carolina. Dr. Davis received her Certification and Master's degree in Prosthodontics at the University of Iowa. She joined the faculty at Ohio State University where she taught and practiced from 1989-1992. Davis completed her fellowship training in Maxillofacial Prosthodontics at M.D. Anderson Cancer Center in Houston, Texas, followed by a Maxillofacial Prosthetic/Implant Residency at UCLA Maxillofacial Prosthetic Clinic.

Dr. Davis is an adjunct faculty member in the Department of Bioengineering at Clemson University. Dr. Davis' research focuses on rehabilitation of the maxillofacial patient.

Patricia C. Mahoney
Director of Operations
UMA Patient Accounting
Medical University of South Carolina,
Charleston, South Carolina USA

Ms. Mahoney is the Director of Patient Accounting Operations for University Medical Associates of the Medical University of SC.

She has 15+ years leadership experience in central business office operations for this multi-specialty academic medicine faculty practice plan. In her role she is responsible for functional areas of insurance claims processing; insurance collections and denial management; payment posting and refund processing; customer service and statement production.

Ms. Mahoney's background also includes clinical practice management in Aesthesia and Family Medicine specialties, including managing primary care private practice offices. She holds a BS degree in Health Planning & Administration from Penn State University and is a long standing member of the Medical Group Management and SC Medical Managers associations.

Julie Daube, BS, RHIT, CCS, CCS-P
Manager of Coding Quality Review
And Education
Care Communications, LLC
Chicago, Illinois USA

Since joining Care Communications in 2005, Julie has collaborated with many of Care Communications' 300+ hospital and health system clients nationally to address their consulting and education needs and designed a customized review to best fit each organization's unique needs. Many of these projects included working with physician groups to audit and educate them on E/M coding and documentation.

Prior to joining Care Communications, Julie served as the HIM department manager at a Chicago area hospital. She also taught Medical Terminology and ICD-9-CM coding as an adjunct faculty member at a Chicago area college.

Julie graduated from National Louis University with a bachelor's degree in Healthcare Leadership. She also holds a degree in Health Information Management with the Registered Health Information Technician (RHIT) credential. She also earned her Certified Coding Specialist (CCS) and Certified Coding Specialist Physician (CCS-P) credentials from the American Health Information Management Association

AAMP WORKSHOP COURSE #1:
Advances in the Use of Magnetic Retention for Maxillofacial Prostheses and Dentures

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Monday, November 1, 2010
14:00-17:00

This workshop is designed so each participant will gain a complete understanding of the advantages of using magnetic attachment over other attachment systems.

Presentation will include an overview of the technique of producing a magnetically retained prosthesis, from choosing the correct attachments, impression techniques, and construction of a magnetically retained silicone prosthesis.

Additional Topics Covered:

- The proper use of acrylic resins in the construction of a magnetically retained prosthesis
- The use of magnets in dentures and obturators, including time devoted to understanding the principals and techniques on bonding magnetic attachments into a silicone appliance
- The new improved Technovent magnetic system

Instructors Biographies

Alan Bocca MSc FIMPT
Consultant in Maxillofacial Prosthetics
Maxillofacial and Cleft Units
ABM University Health Board
Morriston Hospital and
Swansea University
Swansea, Wales, UK

Alan is one of the UK's leading Maxillofacial Prosthetists, having practised for over 30 years in the field of facial and body prosthetic rehabilitation. His career began at Kings College Hospital, London moving to Wales in 1990 to lead the Prosthetic team at the Welsh Burns, Plastics and Maxillofacial Unit in Chepstow. Presently Head of the Maxillofacial Laboratory Services at Morriston Hospital,

Alan lectures extensively in the UK and worldwide. His specialist areas of interest include Craniofacial Implantology, Silicone Technology and 3D Imaging. Professionally, Alan is a Fellow of the Institute of Maxillofacial Prosthetists and Technologists.

Peter Evans
Consultant in Maxillofacial Prosthetics
Maxillofacial and Cleft Units
ABM University Health Board
Morriston Hospital and
Swansea University
Swansea, Wales, UK

Peter is world-renowned in the field of Maxillofacial Prosthetics, being part of the team that pioneered the use of Craniofacial Implants for the retention of Maxillofacial Prosthetics. Studying Maxillofacial Prosthetics in London in

1987 he moved to Wales in 1989 to join the South Wales Craniofacial Implant Team. He is presently Head of Prosthetic Maxillofacial Rehabilitation at Morriston Hospital, Swansea.

His main areas of interest include facial prosthetics for children, craniofacial implantology and 3D modelling and imaging. Professionally, Peter is a member of the Institute of Maxillofacial Prosthetics and Technology and Executive Director of the International Association of Anaplastologists.

Mr. John McFall
Executive Director of Factor II, Inc
Lakeside, Arizona USA

John McFall is the Executive Director of Factor II, Inc. John trained at the University of Texas, M.D. Anderson Hospital in Maxillofacial prosthetics in 1976.

John majored in Pre- Dental at Northern Arizona University before joining the US Navy Dental Corp as a Dental Laboratory Technician, Honorable Discharge as a DT2 in 1975, Opened commercial dental laboratory in Albuquerque New Mexico 1978 and established Factor II Inc as a comprehensive Maxillofacial Supply in 1980 Where it continues to serve the industry and other medical markets in silicone technology.

Professor Mark Waters, BSc(Hons), PhD,Director
MBI (WALES) Ltd / Technovent Ltd
Principality House
Newport, UK

Professor Waters has been involved in his field of research for nearly 20 years and has had led many industrial/academic collaborations. He has worked in the School of Dentistry in Cardiff University for nearly 20 years and was awarded a Chair in Biomaterials in 2004. His research has included work on the development of new denture soft lining materials, improved maxillofacial prosthetic materials and strategies to overcome bacteria/fungal accumulation on denture/maxillofacial appliances.

He has lectured internationally, published numerous papers in national and international journals and has been the recipient of funding from commercial and public body sources. He currently holds a Chair in Biomaterials at Cardiff University in addition to being a Director of Technovent.

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

Tuesday, November 2, 2010
13:30-16:30

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.

Table 1

Radiographic Analysis Of The Bisphosphonate Related Osteo Necrosis Of The Jaw (BRONJ) In Cancer Patients: A Retrospective Memorial Sloan-Kettering Cancer Center Review

Ahmad, O.K, Bohle , G.C., Huryn, J.M
Memorial Sloan-Kettering Cancer Center
Dental Service, Maxillofacial Prosthetics,
New York, NY USA

Purpose: Bisphosphonate related Osteonecrosis of the jaw (BRONJ) is a well described clinical condition which presents with specific clinical and radiographic features. A retrospective evaluation of the radiographic features of bisphosphonate related osteonecrosis of the jaw (BRONJ) in cancer patients and to correlate these findings with clinically known BRONJ.

Methods & Materials: A total of 40 patients (21 females – 19 males) were randomly selected from 136 patients in the BRONJ data group seen at the Dental Service of the Memorial Sloan-Kettering Cancer Center. The mean age group was 64.1 years (42-85 years). All the cancer patients (15 Breast cancer, 12 Prostate cancer, 8 Multiple myeloma, 3 Lung cancer, 1 Renal cancer, 1 Gastrointestinal Stroma Cancer) had panoramic and periapical radiographs, which were evaluated by an Oral Maxillofacial Radiologist/Prosthodontist; later the clinical records were reviewed and then all of the radiographs were revisited, data was compiled for analysis. All the patients except one patient received intervenous bisphosphonate during the course of their cancer treatment.

Results: The radiographic features varied in appearance from small lytic radiolucent areas to gross necrosis of bone with

sequestrum formation, thickening of lamina dura, widening of periodontal ligament space. The majority of the patient developed BRONJ spontaneously, 9 out of forty patients developed necrosis after extractions. One ended up with pathological fracture. Periosteal bone reaction was noted in 4 patients. The lesions were found to be more pronounced in the mandible as compared to the maxilla.

Out of the total 40 patients, twenty seven received intervenous Zoledronic acid, two received Pamidronate, ten received both Zoledronic acid and Pamidronate. One patient received only Alendronate**.**

Conclusion: Within the limitations of this review it was concluded that; a majority of BRONJ appeared spontaneously; Extraction was one of the predisposing factors; Osteolytic features were noted in most of the lesions; Reactive periosteal bone formation was observed especially in patient with multiple myeloma and lung cancer patient.

Table 2

Inhibitory Effect On Candida Albicans Of Thai-Herbal-Extracts Supplemented With Tissue-Conditioner, In Vitro

Amornvit, P., Choonharuangdej, S. , Srithavaj, T. ,
Thaweboon, S. , Thaweeboon, B.
Mahidol University
Maxillofacial Prosthesis Clinic
Department Of Prosthodontics
Bangkok, Thailand

Purpose: This study aims to evaluate the inhibitory effect of tissue conditioner with Thai herb extract on Candida albicans, in vitro. The newly delevoped herbal conditioner is supposed to improve the quality of life of cancer patients undergone treatment and suffered from oral candidiasis with /without mucositis.

Methods & Materials: Three Thai herbal extracts (Clinacanthus nutans, Caesalpinia sappan Linn. Cymbopogon citratus) were dissolved and diluted with propylene glycol, then determined for their antifungal activity against Candida albicans ATCC 10831 by microdilution method (planktonic condition). Minimum Inhibitory Concentrations (MICs) were evaluated after 48 h incubation. MIC corresponds to the lowest herbal concentration that showed the optically clear in microdilution plates, and determined Minimum Cidal Concentrations (MCCs) from the growth of the yeast in clear well on agar.

The MCC and higher concentrations of each herbal extracts were mixed in tissue conditioner. According to the manufacturer's recommendation, 6 g of tissue conditioner powder is mixed with 4.5 ml liquid. To conduct antifungal activity testing, 0.5 ml of herbal extract was primarily added to 4.5 ml of liquid prior to being mixed with powder. The mixture was then spread into a 6-well plate. The surface was covered with 4 ml of Sabouraud agar and allowed to set before inoculated with microbial suspension and incubated at 37°C for 48 hr. Absence of any colonies indicated the inhibitory effectiveness of each herb supplemented tissue conditioner.

Results: Clinacanthus nutans, Caesalpinia sappan Linn. and Cymbopogon citratus presented inhibitory effect on C. albicans. Cymbopogon citratus illustrated the greatest inhibitory effect on such microorganism (MIC and MCC value of 0.0625 and 0.125 µl/ml) whereas Clinacanthus nutans contained the least antifungal activity (MIC and MCC value of 12.5 and 12.5 mg/ml). Caesalpinia sappan Linn. showed moderate antifungal efficacy (MIC and MCC value of 3.125 and 6.25 mg/ml). As with the result in planktonic condition, Cymbopogon citratus supplemented tissue conditioner expressed the potent inhibitory effect on C. albicans in vitro.

Conclusion: Thai herbs, especially Cymbopogon citratus, supplemented tissue conditioner seems to be an alternative mean to treat and prevent candidiasis normally developed in radiated patients with head and neck cancer.

Table 3

A Systematic Review Of Variables Reported In Facial Prosthetics Outcomes Literature

Calhoun, M., Seelaus, R., Reisberg D.J., Dieter, M., Stevenson, G.
University Of Illinois At Chicago
Craniofacial Center, Department Of Surgery
Chicago, IL USA

Purpose: The use of facial prostheses can be traced back to ancient history. Metal and paper mache prostheses retained by leather harnesses have been replaced by modern medical-grade silicone elastomers and osseointegrated retention systems. Throughout this evolution, however, relatively few scientific studies have been published regarding the clinical outcomes of this treatment. Varied study designs and methodologies often preclude data pooling and comparison among these studies, preventing the field from achieving high standards of evidence-based practice (EBP). The goal of the present study is to identify a body of literature that reports outcomes of facial prosthetic treatment and to extract and rank a list of all variables reported. This study is a first step toward achieving an appropriate methodology for data collection that will yield relevant outcomes reporting for the implementation of EBP in facial prosthetics.

Methods & Materials: A systematic review was performed to answer the question: What variables are reported in published studies that report treatment outcomes for patients who have undergone facial prosthetic rehabilitation? Database searches were performed in Medline, Google Scholar, and Science Direct, and forward and backward citation searches were performed on all full-text studies identified. Data extracted included title, authors and institutions, year of publication, study design, methods, each variable reported, and the number of times each variable was mentioned. A weighted mean was calculated to rank

the most common variables.

Results: Sixty studies reporting facial prosthetic outcomes were identified and 256 variables were extracted. Quality assessment revealed that 91% of the studies fell into the bottom tier of hierarchy of evidence. Statistical analysis revealed 38 variables that were reported most commonly, 14 were patient demographic variables, 12 osseointegration variables, 6 prosthetic variables, 2 quality-of-life variables, and 4 were date or time-related variables.

Conclusion: A majority of the facial prosthetic outcomes literature falls within the lowest tier of evidence, and prosthetic and quality-of-life variables are underrepresented within this body of literature; these issues should be addressed through the implementation of EBP in facial prosthetics. The hierarchy established among the variables identified in this review should be considered in the development of methods or instruments for data collection in facial prosthetics, leading to improved standardization of best practices and the best possible care for our patients.

Table 4

Serial CT Analysis Of Bone Resorption In Fibula Free Flap Reconstruction Of The Mandible

Cashman, P.M., Hanasono, M, Skoracki, R, Jacob, R.F.
The University Of Texas M.D. Anderson Cancer Center
The Eastman Dental Institute, University College London
Dept Of Head And Neck Surgery, Section Of Oncologic Dentistry And Prosthodontics
North Liberty, IA USA

Purpose: The osteocutaneous fibula free flap (FFF) is commonly employed to restore mandibular form and function in reconstruction of mandibular cancer or osteoradionecrosis

(ORN). While there is a reported success rate of >95%, loss of bone volume during remodeling may limit future function e.g. placement of endosseous dental implants. Previous studies evaluating boney remodeling over time, measured bone height using 2-dimensional (2D) Dental Panoramic Tomographs (DPT). This study chose to examine the advantages of cancer surveillance serial CT and 3D reformation software to evaluate remodeling using measurements of anterior/lateral heights and anterior/lateral cross-sectional areas.

Methods & Materials: Of 91 sequential patients that underwent mandibular reconstruction with osteocutaneous fibula free flaps between July 1st 2007 and July 1st 2009, 39 were eligible for inclusion. CT images were rendered 3 dimensional and superimposed on the baseline post-operative scans. This allowed sequential measurements of bone height and cross sectional area at a controlled location. Bone height measurements were also made using DPT's rendered from the same CT data-set in order to reflect the methodology of previous literature.

Summary statistics were calculated to evaluate the effect of time and clinical characteristics on bone resorption. Comparisons were made between the DPT and CT using the paired t-test or the nonparametric Wilcoxon rank sum test as appropriate. P-values less than 0.05 were considered statistically significant

Results: There were statistically significant differences between the 2D panoramic view and cross sectional measurements of height in the body of the mandible ($P < 0.001$), and ramus ($P = 0.02$). Differences in cross-sectional serial imaging was limited to anteriorly-located osteotomy bone height from 6 months to 36 months ($P = .04$).

No significant differences in laterally- located osteotomy bone height or anterior/lateral cross-sectional bone area were noted.

Conclusion: While there is overall conservation of bone volume, the 3D renderings demonstrated variability related to bony

remodelling, with isolated potentially catastrophic resorption. Further investigation is required to determine clinical characteristics that predispose to increased bone loss in order to predict and prevent complications from arising over time.

Table 5

The Use Of Photogrammetric Imaging For Tracking And Recording Progress In Nasoalveolar Molding Patients

Duncan, J.M., Gamer, S.
University Of Southern California
Herman Ostrow School Of Dentistry Los Angeles, CA
Advanced Prosthodontics
Huntington Beach, CA USA

Purpose: The purpose of this study is to describe a reliable method of tracking progress of movements during nasoalveolar molding and columella elongation using 3DMD photogrammetric imaging.

Methods & Materials: This case series follows the initial progress of movements in both unilateral and bilateral cleft lip and palate patients using the traditional nasoalveolar molding appliance. The traditional appliance is a plate held in with outriggers that are held in place with steritape and ¼" orthodontic elastics. This appliance prevents the cleft-widening effect of the tongue, helps with tongue tip placement, and utilizes the functional movements of the facial musculature to guide and relocate the major segment medially to its normal position. Nasal molding is undertaken after most of the lateromedial correction of the alveolar position has been achieved.

Results: To date one unilateral and one bilateral cleft lip and palate patient have been followed from initial examination through to post surgical follow-up. The results show that there are no statistically significant differences between

photogrammetric and clinical measurements.

Conclusion: The presented technique, that measures the facial changes of nasoalveolar molding with the use of photogrammetry, helps to improve the monitoring of the progress of this procedure. Some of the advantages of the digital 3DMD imaging methods are: 1) increased speed of data collection, 2) less invasive (especially not threatening the baby's airway), and 3) the ability to obtain a 3D archive of the changes in the subject's facial morphology both before and after surgical intervention. The reliability of several photogrammetric systems along with ease of cataloging this data will allow for future study and the traditional facial moulage impression that was made prior to and after nasoalveoar molding will be eliminated.

Table 6

Dynamic Oral Expansion Using A Custom Fabricated Horizontal Lip-Stretching Device: A Clinical Case Report

Dunham, D. Wilson, W.O. Belle, D.L.
Naval Postgraduate Dental School
National Naval Medical Center
Maxillofacial Prosthetics
Bethesda, MD USA

Purpose: A common sequela to lip reconstruction employing transposition/advancement flap procedures is a narrowing or tightening of the oral aperture with resulting microstomia during healing. The microstomia can be partially attributed to scar contraction, but may be more related to the nature of the procedure and the flap design itself. A patient may increasingly experience difficulty inserting a sandwich or otherwise normal size portion of food with a spoon within several weeks of surgery, if not immediately after the surgery. The purpose of this clinical case report is to present a novel technique used to expand the oral stoma following reconstructive lip surgery that resulted in a limiting microstomia.

Methods & Materials: A 33 year old male soldier sustained severe trauma to the face, neck, right upper and left lower extremities from an improvised explosive device (IED) blast in Iraq on 20 November 2007. Oral and maxillofacial injuries included a right mandibular discontinuity defect with significant avulsion of the perioral soft tissue. A mandibular reconstruction bar along with a microvascular radial forearm free flap to reconstruct the lower lip were placed within 10 weeks of the trauma. This was followed by a posterior iliac crest autogenous bone graft procedure to accommodate future dental implants and tooth replacement. Continued concerns regarding lip incompetency and drooling prompted an additional surgery to reconstruct the central and lateral lower lip deficiencies using bilateral Karapandzic flap procedures. The resulting microstomia was immediately apparent and very uncomfortable for the patient. Surgical correction of the microstomia was subsequently performed using bilateral commissuroplasties. The patient was allowed to heal for approximately 3 weeks before further therapy was initiated. A customized lip- stretching device was fabricated utilizing orthodontic cervical-pull head gear (Spring-Gear, RMO, Inc.) The goal of this prosthesis design was to place continuous even tension at the commissural areas in an effort to expand, or at least maintain, the patient's intercommissural distance during the healing phase.

Results: An improvement in oral aperature dimension and access has been noted and has allowed for continuation of the restorative phase.

Conclusion: A dynamic oral expansion device has been presented which may be useful in the treatment of post-surgical microstomia. Further research is necessary to determine the effectiveness of this treatment modality.

Table 7

Color Stability Of Pigmented Maxillofacial Silicone Mdx4-4210/ Type A Subjected To Ten Years Of Dark Storage And Artificial Aging

[1]Han, Ying D.D.S, M.S. [2]Powers, John M. Ph.D [2]Kiat-Amnuay, Sudarat D.D.S., M.S.
[1]School Of Stomatology, Fourth Military Medical University, Xi'An, China [2]Uthealth Dental Branch, Houston, Texas, USA
[1]Department Of Prosthodontics, [2]Department Of Restorative Dentistry And Biomaterials
Houston, TX USA

Purpose: This investigation focused on observing the color changes of oil-pigmented maxillofacial elastomer with different opacifiers subjected to 10 years of dark storage and artificial aging.

Methods & Materials: Five widely used opacifiers were evaluated: Georgia kaolin powder neutral (Georgia), Kaolin powder calcined (Calcined), Artskin white (Artskin), Dry pigment titanium white (Ti Dry), and Titanium white artists' oil color (Ti Oil) at 5%, 10%, 15% concentrations. Five pigment conditions were chosen: no pigment, cadmium-barium red deep, yellow ochre, burnt sienna, and a mixture of the 3 pigments. Pigments were mixed with MDX4-4210/type A silicone maxillofacial elastomer. Five specimens were fabricated for each of the 75 experimental groups with a total of 375 specimens. The CIE L*a*b* values of all specimens were measured by a spectrophotometer before and after artificial aging (Delta E*1999AA) at 450kJ/m2 exposure in 1999. Then, all specimens were settled in the dark storage (DS) for 10 years and CIE L*a*b* values were measured in 2009 (Delta E*1999-2009DS). The specimens were then placed once again in an artificial aging chamber for another 450kJ/m2 exposure and CIE L*a*b* values

were measured (Delta E*2009AA). The data from baseline reading in 1999 were also compared with the final reading after AA in 2009 as an overall color changes (Delta E*1999-2009). Color differences were subjected to three-way analysis of variance. Means were compared by Fisher's PLSD intervals at the 0.05 level of significance.

Results: For mixed group, Delta E*1999-2009DS, Ti Oil with 3 concentrations had the highest color changes (Delta E*=22.0-28.8), followed by Georgia, Calcined, Ti Dry, and Artskin with the least (Delta E*=1.1-2.3). The five opacifers were significantly different from each other ($P<0.0001$). For Delta E*2009AA, Artskin had the greatest color change (Delta E*=0.6-8.5), followed by Ti Oil, Ti Dry, Calcined and Georgia with the least (Delta E*=0.7-1.8). For Delta E*1999-2009, Ti oil had the greatest color changes (Delta E*=22.3-28.5), followed by Artskin, Calcined, Georgia and Ti dry with the least (Delta E*=2.0-3.8) ($P<0.0001$).

Conclusion: Overall, after 10 years dark storage and 900 kJ/m2 artificial aging, Dry titanium white opacifier protected oil-pigmented MDX4-4210/typeA silicone elastomer the most from color degradation over time, followed by Calcined kaolin=Georgia kaolin ($P>0.05$), Artskin, and Titanium white oil pigment ($P<0.0001$).

Table 8

Antimicrobial Activity Of Thai Herbs Against Cariogenic Agents In Vitro

Jangrod, N., Choonharuangdej, S. , Srithavaj, T. ,
Thaweboon, S. , Thaweeboon, B.
Mahidol University
Maxillofacial Prosthesis Clinic
Department Of Prosthodontics
Bangkok, Thailand

Purpose: This study was conducted to investigate the antimicrobial effect of Thai herbs including Caesalpinia sappan (Fang), Cymbopogon citratus (Lemongrass), Clinacanthus nutans (Payayor) and Houttuynia cordata (Plukow) against planktonic Streptococcus mutans and lactobacilli as well as to test antiplaque effects against S. mutans biofilm.

Methods & Materials: These four herbal extracts were dissolved and screened for their antimicrobial activity against those two cariogenic agents using agar disk diffusion method. The Minimum Inhibitory Concentration (MIC) and Minimum Bactericidal Concentration (MBC) were determined by a broth micro-dilution method. Antimicrobial exhibiting extracts were further tested for their antiplaque effects. The biofilm-mass was quantitated by crystal violet staining method. Results: The extracts of Fang and Lemongrass exhibited potent antimicrobial activity against the tested microorganisms.

Results: The MICs and MBCs of Fang against S. mutans and lactobaccilli were 0.39 and 1.562 mg/ml, respectively. The MICs of Lemongrass were 1.562 and 0.781 mg/ml whereas their MBCs were 6.25 and 3.125 mg/ml. Payayor and Plukow extracts did not express such antimicrobial activity. Within 24 hr of exposure to 5% (w/v) of Fang, approximately 12.45% less biofilm was formed. Concomitantly, 31.46% reduction of established biofilm was

observed after treated with the herb for 24 hr. Biofilm dislodgment was in exposure time dependent manner. The reduction ranged from 23.13%, 16.26%, and 14.43% when exposed to the tested agent for 4, 2, and 1 hr, respectively.

Conclusion: Caesalpinia sappan (Fang) and Cymbopogon citratus (lemongrass) exhibited antimicrobial activity against planktonic S. mutans and lactobacilli. However, only Fang expressed antiplque effects on S. mutans biofilm.

Table 9

A Novel Bioactive Collagen Membrane Carrying Pdgf For Tissue Engineering

Lin, T., Dai, J., Fabella, K. And Yamano, S.
New York University College Of Dentistry
Advanced Education In Prosthodontics Program
New York, NY USA

Purpose: Tissue regeneration has always been an ultimate goal in rehabilitating maxillofacial prosthetic patients. Many clinicians have used resorbable collagen products in combination with growth factors to repair maxillofacial defect. However, there is a very little understanding on the exact molecular mechanism of such delivery method with respect to its release pattern and target specificity. One commonly used growth factor is Platelet-derived growth factor (PDGF). It plays an important role in tissue regeneration and wound repair. We formulated a novel way to retain PDGF on collagen membrane and hypothesized that controlled release of PDGF may optimize bone regeneration. The objective of this study was to evaluate the ability of collagen membrane to successfully deliver PDGF and to observe the subsequent effects of the growth factor on the expression levels of differentiation marker genes in preosteoblasts in vitro.

Methods & Materials: MC3T3-E1 mouse preosteoblasts were

cultured with a commercially available collagen membrane Osseoguard (OG, Biomet 3i, noncross-linked bovine type I collagen) contained with/without PDGF. After a two-day cell culture, the expression of runt-related transcription factor 2 (RUNX2), osteopontin (OPN), collagen type I a1 (COL1A1), osteocalcin (OCN), Osterix (OST), Bone Sialoproteins (BSP) and Bone Morphogenic Protein (BMP-2) were measured by quantitative real-time PCR (QRT-PCR).

Results: Based on QRT-PCR results, RUNX2, OPN, OCN and BSP show significantly increased gene expression in OG with PDGF in MC3T3-E1 cells compared to the cell control ($p < 0.005$).

Conclusion: These results suggest that our novel delivery method using a collagen membrane crosslinking to PDGF can enhance expression levels of osteogenic differentiation marker genes in preosteoblasts and this approach may have therapeutic value for bone regeneration.

Table 10

The Use Of The Laser Doppler Flowmeter To Evaluate The Effect Of Radiation Therapy On Blood Flow To Maxilla And Mandible

Maritim, B.C. Bohle, G.C. Huryn,J.M.
Memorial Sloan-Kettering Cancer Center
Dental Services/Maxillofacial Prosthetics
New York, NY USA

Purpose: Radiation therapy (RT) is often used in the treatment of some head and neck tumors. High dose irradiation is theorized to damage fine vasculature in organs and tissues within the field of radiation. The aim of this study is to use Laser Doppler Flowmeter (LDF) to evaluate dynamic changes in blood flow to the maxilla and mandible for patients undergoing radiation therapy for Head and Neck cancer.

Methods & Materials: Impressions of the maxillary and mandibular arches were made for the fabrication of a stent. Four LDF probes measuring a posterior and anterior tooth (molar and cuspid) were inserted bilaterally and pulpal blood flow measurements were taken for a period of 2 minutes. The values were recorded at three treatment time intervals; pre-radiation, mid-radiation, and post-radiation intervals.

Results: Data was collected from patients who received an average of 6000cGy radiation to the head and neck. The base line data (pre-RT) varies from the mid-RT and post-RT data in the irradiated fields.

Conclusion: Our preliminary data suggests that there are differences in vascularity to irradiated bone when compared to non-irradiated sites. Further evaluation of prospective data is warranted to understand the biologic processes involved and allow for evidence based treatment planning.

Table 11

Effects Of Opacifiers On Mechanical Properties Of Pigmented Maxillofacial Silicone Elastomers Before And After Aging

Nguyen, C.
Chambers, M., Montgomery, Ms., Kiat-Amnuay, S.
The University Of Texas
M.D. Anderson Cancer Center
Head And Neck Surgery
Houston, TX USA

Purpose: There are numerous reports of dissatisfaction with color stability and longevity of extraoral maxillofacial prostheses due to degradation of material over time. Opacifiers and pigments improve color stability of MDX4-4210/ Type A silicone elastomer.

However their affects on mechanical properties are unknown. The purpose of this study was to evaluate the effect of 3 opacifiers combined with pigments on the mechanical properties of MDX4-4210/ Type A silicone elastomer before and after artificial aging. The null hypothesis was that the addition of opacifiers did not affect the mechanical properties of pigmented silicone after aging.

Methods & Materials: Three different types of opacifiers [UV mineral base powder, Titanium white dry pigment (TW) and Silicone Intrinsic white (SW)] were combined at 10% concentration with silicone maxillofacial elastomer (MDX4-4210/type A). Artists' oil pigment was combined to UV and TW, and silicone intrinsic pigments were combined to SW with each of five colors (no pigment=control, red, yellow, blue, or a mixture of the 3 pigments). All specimens (N=5, 320 Total) were aged in an artificial aging chamber at 450 kJ/m2. Specimens were tested for hardness (ASTM D2240), tensile strength (ASTM D412), tear strength (ASTM D624) and percentage elongation in a universal testing machine. For each property, a 3-way ANOVA and Fisher's PLSD test were performed to determine if there were statistically significant differences ($p<0.05$).

Results: After aging, hardness, tear strength, tensile strength, and percent elongation were the lowest with UV, followed by SW and TW ($p<0.0001$). Aging adversely affected the UV group the most of all 3 properties. Silicone became softer after all opacifiers/pigments were added to the control before and after artificial aging ($p<0.0001$). Therefore, the null hypothesis was rejected.

Conclusion: Mechanical properties of pigmented MDX4-4210/ Type A were degraded after being subjected to artificial aging. Specimens using UV had considerable degradation of their mechanical properties and should therefore not be used further with silicone MDX4-4210/type A for fabrication of maxillofacial prostheses. TW preserved the mechanical properties of silicone the best of the opacifiers tested in this study. This study showed that evaluation of physical properties of extraoral maxillofacial

prostheses should be combined with studies on the mechanical properties as these can be considerably damaged following aging.

Table 12

Antimicrobial Effects Of Mangosteen And Grape Seed Extracts Against Peri-Implantitis Microflora Of Craniofacial Implants

Shrestha, B. , Thaweboon, S. ,Choonharuangdej, S. , Srithavaj, T. , Thaweeboon, B.
Mahidol University
Maxillofacial Prosthesis Clinic, Department Of Prosthodontics Bangkok, Bangkok Thailand
Bangkok, Thailand

Purpose: To evaluate the antimicrobial activity of mangosteen and grape seed extracts against peri-implantitis microflora of craniofacial implants.

Methods & Materials: Powdered pericarp extracts of mangosteen (Garcinia mangostana Lynn) and extracts of grape seed (Vitis vinefera) were obtained. Staphylococcus aureus (Coagulase positive), S. aureus (Coagulase negative), Candida albicans and C. parapsilosis isolated from peri-implantitis lesions of the craniofacial implants were used as the test organisms. Inhibition of microbial growth were primarily tested by agar diffusion method. A two-fold dilution method with a millipore membrane technique was then used to determine the minimum inhibition concentration (MIC) and minimum cidal concentration (MCC) of the extracts.

Results: The grape seed was effective against S. aureus (Coagulase positive) and S. aureus (Coagulase negative) with inhibition zones ranging from 14 mm to 9mm and MIC values of 0.625 mg/ml and MCC at 1.25mg/ml. The mangosteen extract was effective against S. aureus (Coagulase positive) and S. aureus (Coagulase negative) with inhibition zones ranging from 11 mm to 9mm and MIC

values of 1.25 mg/ml and 2.5 mg/ml respectively and MCC values of 5mg/ml. However both the extracts failed to inhibit the growth of C. albicans and C. parapsilosis.

Conclusion: The mangosteen and grape seed extracts have antimicrobial effects against peri-implantitits microflora and may be a promising agent for the treatment of skin infections in patients with craniofacial implants.

Table 13

Rehabilitation Of A Repaired Cleft Lip And Palate Adult Patient: A Clinical Case Report

Tonseker, P.T. Difazio, J.D
University Of Medicine And Dentistry At New Jersey
Post Graduate Prosthodontics
Jersey City, NJ USA

Cleft lip and palate is a congenital malformation, the management of which begins at birth and sometimes continues through adulthood. Rehabilitation of adult cleft lip and palate patients can be complex and involves a multidisciplinary team approach. This clinical case report illustrates the comprehensive prosthetic management of a repaired bilateral cleft lip and palate in a 35 year old, partially edentulous adult female patient. Radiographic examination showed that the premaxillary segment lacked bony fusion with the adjacent palatal segments but was stable and immobile. The patient's vertical dimension appeared collapsed forcing her into a pseudo Class III occlusion.

The patient was keen on acquiring a fixed prosthesis but had had traumatic psychological experiences trying to obtain dental treatment in the past. Implants were placed following an all-on 4 concept to avoid additional surgeries in the posterior region. She was thus restored to full form and function with an immediately

loaded implant-supported fixed interim prosthesis on the day of the surgery. Healing was uneventful and the patient was very happy with the result.

Table 14

Implants In The Pterygoid Region: A Systematic Review

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Purpose: To systematically review clinical studies on the short-term and long-term survival of implants placed in the pterygoid region.

Methods & Materials: A literature search was conducted using PubMed, Scopus and Cochrane electronic databases. Specific terms used for search were "pterygoid implants", "pterygomaxillary implants", "tuberosity implants" and "posterior maxillary implants". Relevant studies were selected according to predetermined inclusion and exclusion criteria. Data from the final included studies could only be extracted for calculating interval survival rate (ISR) and cumulative survival rate (CSR) of implants for different time intervals.

Results: The initial database search yielded 693 titles. After subsequent filtering process, 32 abstracts were selected culminating to 17 full text articles. Three additional articles were added through a hand search to obtain a total of 20 articles. Application of exclusion criteria led to elimination of 11 articles. Pooled data from the final 9 articles showed a 1st year ISR of 91.7%. The CSR over a 10 year-period, largely due to data from one study was 90.8%. Majority of implant failures (70/79) were reported to have occurred before they were loaded.

Conclusion: Significant differences exist between tuberosity implants and pterygoid implants; however, many articles in the literature have used these terms interchangeably. Though the 1st year ISR of pterygoid implants seems encouraging, their 1-year survival rate is unknown, as the minimum follow-up period reported for several implants was less than a year. There is insufficient data about failures that occurred beyond the first year interval, making it difficult to draw conclusions about long-term survival of these implants. More studies with longer follow-up periods involving adequate number of pterygoid implants are needed.

Table 15

Prosthodontic Management of Hypernasality: Two Very Different Cases

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This study describes two cases of structurally related hypernasality that were treated with speech bulb appliances. The first case, a young woman with hypernasality of unknown etiology, was treated with a combined palatal lift and speech bulb in order to improve velopharyngeal closure and oral-nasal balance in speech. In order to help her maximize the benefit of the appliance, the patient practiced with online nasalance and pitch biofeedback. However, it was only when she resorted to a vocal play manoeuvre that she was able to consistently improve

her velopharyngeal closure with the speech bulb. The second case had undergone surgery and radiation therapy of the pharynx, which affected the motility of her velum. The patient was first treated with a standard acrylic speech bulb appliance, which lead to only moderate improvement of her speech. An experimental appliance with a flexible silicon end piece was created in order to achieve a greater occlusion of the velopharyngeal opening. The two cases illustrate that speech bulbs are currently not being used to their full potential and that more research is needed to improve both the behavioural interventions and the prosthesis design to achieve consistent success for all patients.

Table 16

Comparison of Dental Economic Outcome Between the Two Arms of a Prospective Phase III Randomized Study Comparing Submandibular Gland Transfer Procedure *vs.* Oral Pilocarpine for Management of Radiation Induced Xerostomia

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Purpose: Xerostomia is a significant morbidity in head and neck cancer patients receiving radiation treatment. The dental economic consequences of xerostomia have not been studied in detail. We studied dental economic impact between the two arms of the prospective trial between patients who receive submanidbular gland transfer versus oral Pilocarpine for management of xerostomia over 11 years.

Methods & Materials: 76 patients, randomly assigned to the two arms of the phase III randomized study comparing oral Pilocarpine vs. submanidbular salivary gland transfer protocol,

were followed for 11 years prospectively. All dental charting and billings were recorded; independent student's t test was used to compare the dental cost in the two study arms. Comparisons were also made by dental procedures (diagnostic, preventative and restorative) and by year of procedure dental costs for both arms of the trial.

Results: No significant difference is detected between the two arms of the trial in terms of diagnostic, preventative or restorative costs incurred by these patients. There is no difference in the dental costs over time on a yearly analysis.

Conclusion: The dental economic comparison between the two arms of the prospective phase III randomized study comparing submandibular gland transfer vs. oral Pilocarpine for management of radiation induced xerostomia showed no statistically significant difference in measured outcomes.

Table 17

Dental Stem Cells

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Purpose: A new adult stem cell modality for the treatment of many chronic illnesses and used for regenerative purposes.

Methods & Materials: First Discovered in bone marrow in the early 60's, Umbilical cord blood in the 70's and In teeth by NIH in 2000. Cells are now removed from teeth, stored in cryo-protected fluid and frozen to 321°f or 193 °c

Used for blood disorders, repair muscle,cardiac tissue after a heart attack, generate bone, cartilage, nerve, brain and fat tissue.

Dental pulp cells provide great support for nerve cells lost in

Parkinson's Disease and other neurodegenerative illnesses.

Affects nerve cells in the brain called basal ganglia, responsible for control of voluntary movement. Injecting tooth cells into specific part of brain will provide support for dying nerve cells and replace dead cells.

Results: Spinal Cord Injuries Treatment with dental pulp stem cells may be the next area of investigation.

FDA APPROVAL AND SANCTION
Needed so that stem cell technology can catch up with tissue engineering possibilities

Latest Studies Show…
Dental pulp cells provide great support for nerve cells lost in Parkinson's Disease and other neurodegenerative illnesses.

Conclusion: Promises formation of dental, oral and craniofacial structures lost to congenital abnormalities, trauma, disease.

Are derivatives of Mesenchymal cells such as, mandibular condyle, calvarial bone, cranial sutures and subcotaneous adipose tissue.

All have been engineered from Mesenchymal stem cells, growth factor and gene therapy approaches

Table 18

Development Of Individual Implants In Pmma And /Or Titanium On Special Molds Obtained By Computer (Fast Prototyping)

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Purpose: Purpose: Aloplastic reconstructions of defects of skull and jaw of traumatic and oncologic etiology were realized respectively, in young patients.

Methods & Materials: Methods & Materials: Due to the particular complexity of the cases, we used a computer technique of reconstruction and the creation of prototype models that involved an image processing 3D.

Results: Results: This allowed the planning and prosthetic reconstruction on a fast prototype, which allowed obtaining an implant (prosthetic) with absolute exactitude.
The interrelation of different technical and medical specialties was essential for the solution of this case, positioning the discipline of the Maxillofacial Prosthesis within the highest integral medicine.

We are presenting the fallow up of the patient before underwent the surgery (laboratory phases), the surgery and a 2 year of clinical controls after the surgery until today.
The patients signed an informed consent and authorized procedures knowing the advantages and disadvantages.
All of them agreed that the most important issues were a

esthetic and function of the prosthetic.

Conclusion: Conclusion: 3D Technology is mandatory to achieve achúrate internal prsthesis. After 2 years evolution stay in place with no trouble or symptoms and this fact allows to think that the technique is valuable.

Table 19

Surgical Obturator With Expander Function

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Purpose: This case is a patient seven years of age who was an accomplished hemimaxilectomía left for submitting a Benigno Aggressive Ossifying fibroma. The purpose of this study is to design a shutter that will operate for a period of 2 years with functional precision and esthetic, to avoid changing it every 8 months and reduce the discomfort and risks of making records.

Methods & Materials: It was designed Prosthesis surgical to function as expander by placing a screw type Hass in the midline at the height of the medial distance of the prosthesis. This screw would be turned on every 30 days to offset the growth in the maxillary and jaw not lose bone harmony or compatibility. Since the remaining hemimaxilar a percentage of atrophy.

Results: Each period of activation is correlated with periods of growth. The functional results were favorable and meet the requirements fon and ideal esthetic.

Conclusion: This design is considered successful for having fulfilled the expectations designed for a period of two years and eight months with minimal adjustments seal. Therefore this project is considered as an alternative to the realization of the

shutters or surgical prosthesis, with all the inconvenience that this implies in patients undergoing a growth. Patient was returned to the emotional stability, which allows social interaction.

Table 20

Ocular-Orbital Prosthesis: Use Of Staged Custom-Conformers For Modeling Of Anophthalmic Socket And Impression-Making

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Purpose: Ocular impression techniques, using a stock ocular tray, custom ocular tray, and stock ocular prosthesis, have been described over the past decades. However, the use of these trays often does not produce the desired contour of anophthalmic socket when surrounding overlying external tissues are scarred from multiple surgeries.

The purpose of this table clinic is to describe the fabrication of an ocular-orbital prosthesis following the exenteration and 28 reconstructive surgeries due to a gunshot. Three modified ocular conformers were constructed to mold the anophthalmic socket to improve and contour the position of eyelids prior to the final impression-making.

The third modified ocular conformer was used to capture the internal tissue and external tissue in function. The definitive ocular prosthesis was completed with the external orbital prosthesis. The advantage of this approach is that the extra-ocular tissue can be conformed to accommodate a final ocular prosthesis that establishes a more acceptable ocular orientation.

Table 21

Development And Evaluation Of Digital Technology In The Sculpture Of Orbital Prosthesis

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Purpose: This paper proposes a new technique using digital overlays from photographic images of the sculpture of the patient's face.

Methods & Materials: For the proposed method to be passible we obtained 12 plaster facial models and asked them to wear simulating an ocular-lid. In each model, there were two sculptures: Group 1 Free sculpture - Group 2 - sculpture guided by the proposed technique. Photograph of the face and the sculptures placed in the device prepared for fixating of head and facial model, and calibrated with millimeter scale. Established anthropometric facial numbered 1-8. Through the program Corel Draw digital images were entered and the records of measurements of the sculpture and face retrieved.

Results: From the results by T-test ($p < 0.05$), only group 1 showed significant differences (measures 1,2 and 4).

Conclusion: Measures 1 and 2 around the region of the palpebral fissure (width and height) and 4 of the upper eyelid, palpebral significant difference was present because the modeling is obtained with closed eyes and that is a barrier to measuring the primary position of gaze in the face. However the proposed technique was proven very effective in allowing during the sculpture process reliable digital measurement in all stages as well as the comparison of anatomical details can be performed without the physical presence of the patient.

Table 22

Clinical Case Report: Obturation Of Maxillofacial Defects

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Purpose: Clinical Case Report of 5 Maxillary obturators of various classifications on the Aramany classification system and with several different materials. Novel approaches to impression making of maxillary surgical sites both pre-operatively, and post operatively. Maxillary obturation using a combinatin of materials to account for severe undercut tissues and lack of bony support, and time constraints.

Methods & Materials: five patients with either planned or present surgical defects of the maxilla were selected for fabrication of interim obturators using Silicone (factor 2), Acrylic (Lucitone 199), and Orthodontic Resin (GC). Alginate, PVS, impression putty, gray stick compound were all used in the impression making stage. The materials were used in combination or independantly depending on the clinical application.

Results: The clear orthodontic resin was useful in a clinical situation where time is the limiting factor. The clear ortho resin also provided a clear evaluation of the underlying soft tissues at time of delivery in the operating room. Alternatively, the traditional method of checking with PIP on the intaglio surface of the Processed acrylic obturator takes more time. Processed acrylic is a more time consuming method of obturator fabrication. Processed acrylic is the most durable obturator material, but when under time restrictions is not best suited for rapid fabrication of surgical obturators. Different impression materials can be used together in combination with the patients

existing prosthesis. Combining existing prosthesis with gain rapid diagnostic casts which can be used to fabricate custom trays and more accurate master impressions.

Conclusion: Clinical situations often dictate the materials that may be used in the construction of surgical obturators. communication with allied healthcare professionals in the treatment of head and neck cancer patients will increase the options for materials based on the time that is required for different materials. Communication with the surgeons also plays a major roll in the success of the prosthesis post surgery. Creativity is a key roll in the daily clinical practice of Maxillofacial Prosthodontics. No two situations are exactly the same. Therefore, keen knowledge of materials available and the creativity to use them in unconventional ways is essential to achieving success in the difficult situations facing the Maxillofacial Prosthodontist.

Table 23

Electrochemical Processes at Interaction of C-B_4C Face Implant Surface with Blood Plasma

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The nanocrystal C-B_4C material obtained under sintering of 15 mass.% B_4C with the crystallite size < 10 nm, uniformly distributed in 85 mass. % carbon with the particle size ~ 10 nm, has an exceptionally high chemical resistance in the human blood plasma. The electrochemical interaction as a resulting of face the prosthesis contact with a possible microadditive, for example iron, on the implant surface is experimentally simulated by the anodic polarization from the external current search, the latter being specially created the extreme corrosion situation.

The kinetic investigation has been carried out at 37 °C using the anodic polarization curves method. For the determination of iron traces in a foam-type film after polarization the emission spectroscopy method is used. It has been established that in the case of microgalvanic elements initiation at the potential of 0.40 V the formation of chemisorped oxygen film is started while at ~ 1.00 V the stable passivation of implant surface takes place as a result of formation an it of low-conductive nanostructured carbon. It has been shown that such film is formed resulting from a discharge an the sample surface of anions of corresponding blood α-aminoacids containing in its structure the heterocycle rings.

Using the sessile drop method the momentary wetting of face prosthesis with blood plasma, the wetting angle being 50°. It also promotes the formation on its surface of the stable protective film.

Keywords: Face implant, C-B_4C composite, blood plasma, interaction mechanism, electrochemical polarization, wetting.

Table 24

The Possibility of Narrow Diameter Implants in the Management of Ectodermal Dysplasia

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Background: Ectodermal Dysplasia (ED) represents a larger heterogeneous group of inherited disease that are characterised by anomalies in the embryonic development of ectoderm derivative (hair, nails, teeth and skin) and of ecto-mesenchymal tissues. Oral manifestations of ED, such as hypodontia with decreased alveolar bone or complete anodontia represent a great challenge to dentists. Patients with the diagnosis of ED require oral rehabilitation at different stages of somatic development and life-long care and maintenance is needed. Implant options have been recognised as an important

alternative for ED patients to support, stabilize and retain prosthesis, especially where early dental loss and alveolar osseous atrophy make conventional removable prosthetic adaptation difficult. However, the placement of endosseous implants for subsequent restoration is complicated, due to the limited bone and reduced growth or absence of alveolar processes, hence may require bone grafting. Narrow diameter transitional implants have been included as apart of possible implant managements of ED patients as an alternative to avoid invasive or demanding grafting until a later age.

Objectives: this article reviews the range of management options available for hypodontia associate with ED with special attention to dental implants through data published between 2000 and 2010 in the English language. A case report of a long term management young adolescent male with ED is included to discuss the use of narrow diameter implants (NDIs)

Selection Strategy: Peer reviewed dental literature through MEDLINE and PUBMED searches and a hand search of relevant textbooks and other published data were undertaken. Primary literature searching shows that most of the available articles are in the format of clinical case reports.

Results/Conclusion: the available literature suggests that clinical data on the use of implants and the management of ED are limited. Similarly, the data available on the clinical success of narrow diameter implants is limited, with short term results only. Following the presented case and reviewed literature there is evidence to support the use of dental implants in the rehabilitation of ED patients to provide excellent support for dental habilitation, both functionally and aesthetically. Furthermore, the use of transitional narrow diameter implants can be considered for patients with atrophied jaws as a long term provisional alternative to more demanding grafting techniques.

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