muskoka-simcoe DENTAL SOCIETY news

Message from the President

Greetings all MSDS members! I sincerely hope everyone is currently coping both mentally and logistically with our "new normal" in both the dental field, and life in general. These are challenging times, to say the least, with the added frustrations of an uncertain professional environment, compounded by the discord between the dental professional college protocols.

In navigating these challenges, I hope everyone remembers to be kind; levels of anxiety in the general populace are high. We do not know exactly what challenges the individual in front of us may be facing.

We have some interesting content from various sources in this edition of the MSDS newsletter; I hope you find the articles thought provoking, professionally helpful, and inspiring.

Please feel free to email me at: drlauriehouston@gmail.com, should you have any suggestions, comments, or wish to participate on the MSDS Executive.

Stay safe Everyone!

Dr. Laurie Houston
MSDS President 2020-2021

Dr. Laurie Houston and patient.

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Prognosis and Confidence in Treatment Planning

One of the hallmarks of prosthetic treatment planning is the decision-making process whereby the clinician and patient must select one treatment option from many alternatives. Sometimes the choice is obvious and the alternatives are truly poor. Other times, the choice is far less obvious and a number of parameters are utilized in making the decision. Among these parameters are things such as cost of treatment, prognosis, invasiveness, and patient preferences. Prognosis is one of the more abstract concepts among those parameters and it can be very difficult to apply because it is, in effect, like attempting to predict the future. Depending on how one defines prognosis, it's use in selecting treatment options can be variable.

According to the Glossary of Prosthodontic Terms: Ninth Edition, prognosis can be defined as "a forecast as to the probable result of a disease or a course of therapy." [1] One is expected to attempt to predict the course of treatment or the course of not treating the patient. How does this prediction come about? For private practicing clinicians, the well of information to draw upon is generally sourced from two reservoirs. The first is their own clinical experience or that of their peers, and the second is published research. There are several issues with both these sources that can lead the clinician to make mistakes when assigning a prognosis. When drawing from clinical experience one has to remember that over time that experience becomes more refined. So someone newly in practice will have very little experience to draw from. Secondarily, clinical experience is highly subject to cognitive biases in particular positive outcome biases whereby we tend to over-represent our positive outcomes in memory over failures. As such, the clinician may have a fairly average success rate for endodontics, for example, but think their success rate is quite high because of this cognitive bias.

The evidence base is another source of prognosis. However, similar issues arise when using this source for developing a prognosis. That is, there are publication biases that lead journals to favorably publish positive outcomes over negative outcomes. [2] The studies tend to compare outcomes of multiple clinicians and as such it is very difficult to compare to results in the average clinical practice.

Once a prognosis is assigned to a clinical procedure or tooth or case, one has to assess how accurate this prognosis is on an ongoing bases. This idea is the confidence in the prognosis. Should a good prognosis be made but the treatment fail, that would be a false positive. The test of a true positive is the sensitivity. On the other hand, if a poor prognosis is assigned and the patient chooses to pursue treatment anyways and the procedure succeeds, this is a false negative. The test for a true negative is the specificity. An assigned prognosis should undergo the same tests of sensitivity and specificity that all of the medical lab tests undergo. The confidence that a clinician expresses in their prognosis should correspond to the sensitivity or specificity but it frequently doesn't and so it would be considered 'overconfidence' in their own treatment. There are problems associated with overconfidence. The main problem is that of inadvertently deceiving a patient into pursuing treatment that may not be his or her best interest. An overconfident clinician is often very convincing because they tend to believe deeply in what they're prescribing, rightly or wrongly. [3]

So how does the average clinician avoid falling into this trap? The simplest method is to create a database and record prognosis at the time it is assigned, and then again when this is upheld or overturned. Overtime a clear picture develops as to the overall prognosis for a given procedure or a particular condition and the confidence in this prognosis will be much higher as it starts to account for true historical data. There will always be outliers, but the goal here is to create a system that allows the clinician to be accountable to their prediction.

Among the many hats that clinicians wear in private practice, one of the least emphasized roles is that of advisor and teacher to the patients. Clinicians are expected to attempt to predict the future every time a patient asks the longevity of the restoration. Many defer to published survival studies and many others defer to their clinical experience. Both of these sources offer a reasonable starting point for assigning a prognosis, but the confidence in these sources should be considered low without truly assessing the specificity and sensitivity. The only way to have a high confidence in the assigned prognosis is by tracking and updating prognoses for specific therapies, complications, and conditions over time. The more often a procedure is performed (success-rate independent), the more likely for a high confidence to be achieved when assigning a prognosis.

1. The Glossary of Prosthodontic Terms: Ninth Edition. ***J Prosthet Dent.*** 2017;117(5S):e1-e105. doi:10.1016/j.prosdent.2016.12.001.
2. Emerson GB, Warme WJ, Wolf FM, Heckman JD, Brand RA, Leopold SS. Testing for the presence of positive-outcome bias in peer review: a randomized controlled trial. ***Arch Intern Med.*** 2010;170(21):1934-1939. doi:10.1001/archinternmed.2010.406.
3. Croskerry P, Norman G. Overconfidence in clinical decision making. ***Am J Med.*** 2008;121(5 Suppl):S24-S29. doi:10.1016/j.amjmed.2008.02.001.

Dr. Mo Taheri, DMD, FRCD(C)
Dip. Prosthodontics.

Dental Mission Trip to Antigua, Guatemala

I had the honor of meeting Dr. Laurie Houston at a meeting in May 2017, just prior to my assuming the role of President of the Ontario Dental Association (ODA). Our discussion quickly moved from one of current issues that the dental profession was facing to one of global access to dental care. I had always been interested in participating in one of these projects, however, carrying out my duties as a Director of the ODA Board, and then as an elected official, left me little time to consider this. That discussion, however, changed my life and over the course of that year and after several discussions with Dr. Houston, I had made the commitment to join her team on one of her mission trips.

On January 29, 2020, I set off to Antigua, Guatemala with a wonderful team, which included two dentists, a registered dental hygienist and myself.

Being an orthodontist and having not practiced general dentistry for 28 years, I was not sure of how I would provide assistance to the team. One of my roles became clear shortly after getting to the hostile, which we would be calling home for the duration of our stay in Guatemala. I did have some rudimentary Spanish language skills, having taken Spanish for two years in university, which came in handy as I quickly became the translator for the group.

In addition to honing my dental assisting and general trouble-shooting skills, put my language skills to use. I used them not only to communicate with the dental clinic staff, but more importantly to communicate with and comfort that patients who came to see us from villages in the area; many of whom had never been to a dentist before and had to have significant dental work done.

I was excited to be a part of this mission and to immerse myself in the Guatemalan culture, but I was not prepared for the effect that this work, these people and this country would have on me! I learned so much from these wonderful people. Many were very apprehensive to be sitting in our chairs, but sat still and quietly through it all, taking the hand that I offered them along with words of encouragement. I felt, at those moments, a bond with each and every one of these people that I will carry with me and cherish; a feeling that I was a part of something much bigger than all of us!

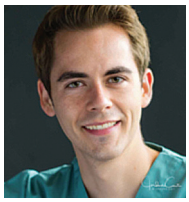
There is a saying; "People do not always remember what you say to them, they do not always remember what you do for them, but they will always remember how you made them feel." Although our verbal communication was limited, I will always remember how these people made me feel through their smiles and hugs expressing their gratitude. This, to me, was truly one of the highlights of my professional career, and one that I would not trade for anything in the world! If you have never gone on one of these trips, I highly recommend that, when we finally put this pandemic behind us and are able to, you take the opportunity to do so. What you get out of it will far exceed what you put into it!

Dr. LouAnn Visconti

Restoring Single-Unit Implant-Supported Restorations

Category 2 - 2 CE Credits

November 12, 2020 - Virtual Event



This program aims to provide the fundamental concepts for restoring single-unit implant-supported restorations. Participants will gain an in-depth understanding of both the clinical and laboratory steps involved in capturing, designing, fabricating and inserting implant restorations. It will focus on the latest technological advancements in implant dentistry including digital impressions, digital designs and manufacturing.

Presenter: Dr. David Powell, DMD, MSc, FRCD(C)

View the speaker biography. | Register Now!

Fun at Dr. Peggy Wong's office

DCR Profile

Dental Community Resource

The Dental Community Resource (DCR) was founded by Drs. Steven Bongard, Manor Haas and John Zarb in March 2019 to provide information regarding clinically relevant topics to dentists and the dental team. It is supported by a faculty of clinical educators, committed to keeping our dental community abreast of emerging information as it relates to the practice of dentistry. We hosted monthly evening Information Nights at our home base, the Allied Centre for Continuing Dental Education in North York, ON until the COVID19 pandemic hit the province of Ontario in March earlier this year.

The onset of the pandemic warranted that we mobilize to interpret the emerging scientific and dental practice guidelines. To this end, we launched a series of weekly webinars entitled “Tuesdays @ 2”. These ran for eleven consecutive weeks and provided the dental community at large with an opportunity to make sense of the rapidly evolving situation at a time of great uncertainty. We also developed a series of Focus Group conversations, meeting in small groups virtually with over eighty dentists scattered all over the province. These conversations provided us with tremendous insight into the concerns Ontario dentists had with dealing with the sudden closure of most of our practices, the safety of our staff and patients, and the viability of our dental practices as we prepared to emerge back into practice.

This week we just launched “DCR Mentorship: Experience at the Back of your Hands”. We plan on meeting virtually on a monthly basis to discuss case presentations provided by general dentists in our DCR community. These will be live interactive sessions with a panel of DCR clinical educators providing guidance regarding diagnosis and treatment planning from a multidisciplinary perspective. Discussions will involve best practices for clinical care in the current COVID19 environment.

The DCR is an inclusive collegial community welcoming all the members of the Muskoka-Simcoe Dental Society and the Ontario Dental Association. Please visit us at dentalcommunity.ca and Dental Community Resource on YouTube.

MSDS Calendar of Upcoming Events:

DATE	EVENT/TOPIC	LOCATION
November 12, 2020, 7:00 pm	**MSDS Evening CE Presentation,** with Dr. David Powell	Zoom
November 18, 2020, 6:30 pm	**MSDS Executive Meeting**	Zoom
November 20, 2020	**ODA General Council Meeting**	Virtual

International experts call for independent probe of Canadian research linking fluoride and lower IQ

This article appeared in the *National Post* on September 22, 2020 – Author Tom Blackwell:

https://nationalpost.com/health/international-experts-call-for-independent-probe-of-canadian-research-linking-fluoride-and-lower-iq

Don't worry. Your dentist probably won't catch COVID-19

This article appeared in *Popular Science* on October 15, 2020 – Author Kat Eschner:

https://www.popsci.com/story/health/dentists-covid-19-risk/?utm_medium=syndication&utm_source=flipboard

AEROSOLS IN DENTISTRY: What is the real story?

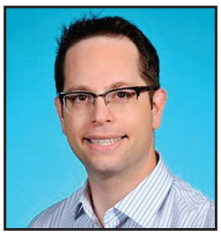
Rella Christensen, PhD, presents valuable information on Dental Treatment Aerosols and Effective Ways to Manage Them.

View the **FREE** video with promo code **CRHGFREE**

https://www.cliniciansreport.org/aerosols-video-hg

Crown lengthening: A new Hope?

View the supporting visual attachments for the article.



Concept of biologic width is important. it is about 2mm (Garguilio 1961; Vacek 1994). However, this does not take into account ferrule required to hold restoration. In total, a minimum 4-5mm of tooth structure coronal to the bone is required for a restoration/crown.

Crown lengthening may be difficult to do as aesthetics and the surrounding structures (teeth, restorations, implants, nerves, sinus) need to be considered when contemplating the final restoration.

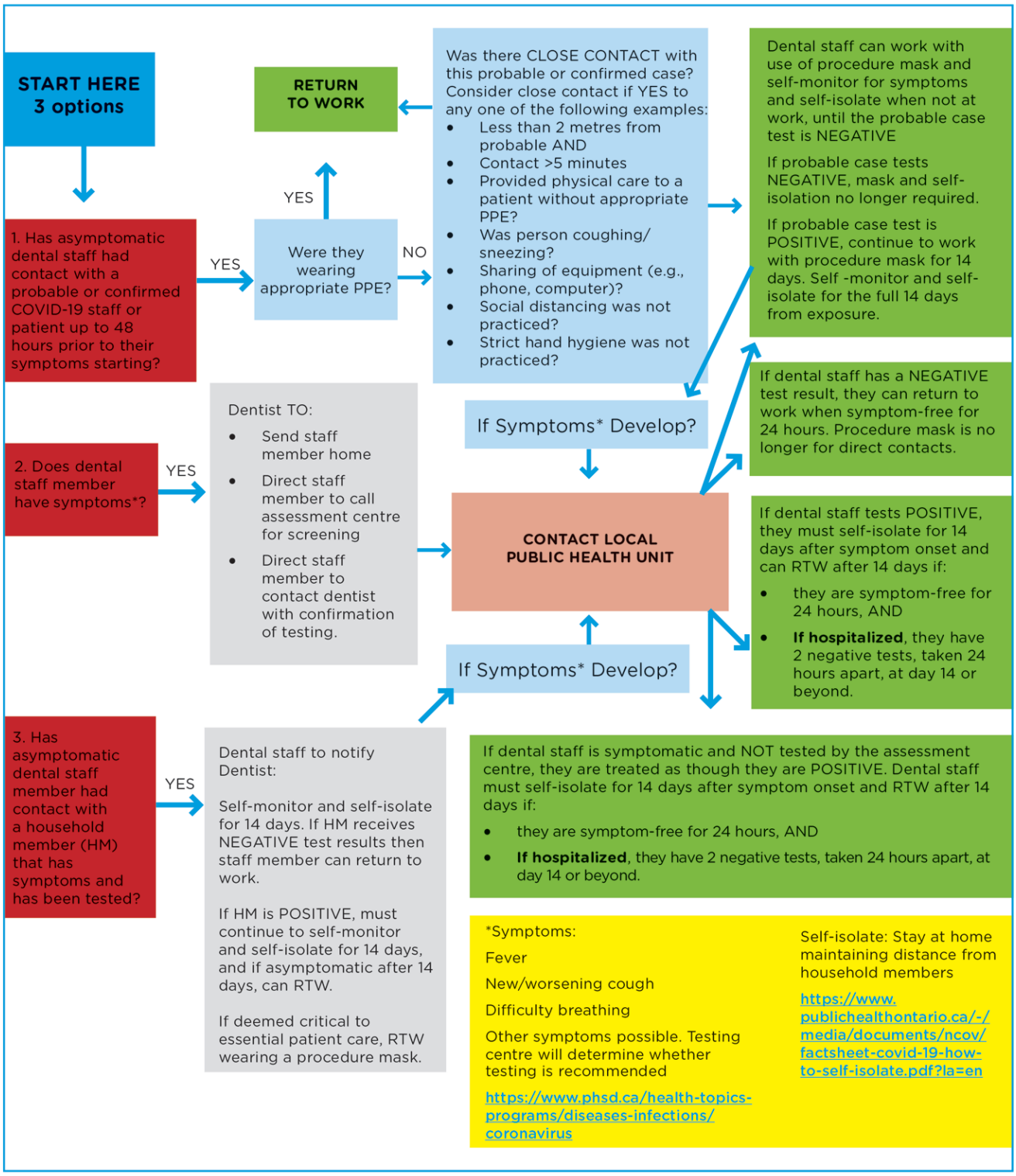
Recession can occur following placement of a restoration margin (composite/amalgam/crown) subgingivally, especially in areas with thin cortical bone.

Implant/restoration survival rate is 97%/96% after 5 years and 95%/89% after 10 years. Survival rate of structurally compromised teeth is 88% after 5 years and 78% after 10 years. But would you rather re-treat a tooth or an implant?

Individuals with a history of periodontal disease have a 38% chance of peri-implantitis, or the odds ratio of peri-implantitis is 5 times greater in an individual with a history of periodontal disease. Would you rather treat a tooth or an implant?

Dr. Daniel Kobric

*Dental Staff Covid-19 Management Algorithm



*Please note, the Dental Staff COVID-19 Management Algorithm is currently being amended to reflect updated information from the Ministry of Health. Look for it in the new ODA Return-to-Practice Toolkit V 6.0

MSDS Evening Meeting

Nov 2019 MSDS evening meeting with a playful shot of our MSDA Executive. Here's hoping we can all safely meet face to face again soon!

MSDS Donation

Dec 2019: MSDS President Dr. Laurie Houston presents $600.00 donation from MSDS to Dr. Bill Kerr, founder of Volunteer Dental Outreach for Haliburton County.