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**Are You
Suffering
From
“Occlusion
Confusion”?**

By Dr. Donald Reid

Are You Suffering From "Occlusion Confusion"?

A Personal Issue:

Occlusion Confusion is the greatest deterrent to presenting comprehensive dentistry. The ensuing lack of confidence to tackle big cases where destructive forces prevail is a major reason for poor case acceptance rates. I understand this well as my personal lack of understanding of my ongoing bite problem prevented me from restoring my own mouth properly for fear of spitting glass all over my bed at night. That same fear fostered a less than comprehensive approach to my treatment planning and subsequently countless opportunities were lost to help patients and to grow my practice. You see, I was the poster child for severe bruxism at Temple Dental Class of 78!

My general unease in knowing the cause for my own and patients' failing dentistry spurred me to study every philosophy of occlusion during the past 28 years. In school, I understood my problem to be stress related. Maybe a tour of duty as an enlisted Marine in Vietnam was the cause I was told. The solution was wearing a guard of some type that I personally detested.

I studied and practiced the teachings of the late Janet Travel, MD from trigger point manual. I learned from the Late Harold Gelb Sr., DDS about applied kinesiology, Gelb splints and Galetti articulators. I studied with Skip Truit, DDS about jaw orthopedics, Bionators, Herbst and Frankel appliances. I practiced their teachings. I practiced neuromuscular dentistry that I learned from the founder of Myotronics, the late Barney Jankleson, DDS.

In the clinical setting, there was never a sense that I could safely predict the outcome of these approaches confidently. Premature failures, dissatisfied patients, frustrated staff and lab technicians were contributing to my personal path of burnout in a profession I deeply loved.

In a crowded classroom in the early nineties, I heard of, and saw with very primitive sketch drawings, a possible solution for which I was

looking. The teacher was a grey haired guy called Peter Dawson, DDS. That weekend vision changed my life and the next day, back at work, confirmed what I thought I envisioned.

Years later, I went back to Dr. Dawson, now even greyer, and told him I wanted to animate what I think I learned from him. As he viewed my primitive animations, he smiled and confirmed that I learned well. I commented, "You taught well."

I've had the distinct honor of spending breakfast, lunch, dinner and sharing a Manhattan at 11pm in a cozy Floridian cocktail lounge with Peter Dawson. His lifelong work has transformed my thinking and benefited countless lives of my patients.

After "seeing" what musculo-stability looked like in the mouth, I had my occlusion balanced and my teeth restored. I've restored many full and partial mouth cases since with extremely predictable successful results. I've had the great pleasure of creating '**Peaceful Musculature**' in over 3,000 patients' lives. I'm a general dentist that enjoys tackling the most serious bite problems possible due to a basic understanding of the science, anatomy and physiology of the human masticatory system.

Subsequently, I, together with Doug Brown of **Dynamic Thought**, developed the software animation company, **BiteFx**. The input received from Dr. Dawson on our release of the latest version has proved invaluable as it's sealed our animation efforts with volumes of knowledge from a century or more of clinical and scientific research.

Our company is dedicated to fostering an understanding of the science behind occlusion to educate dentists, physicians and the general public.

My goals are to practice clinical dentistry until I am no longer able, to teach with a motive of transforming dentists' lives by sharing my knowledge and clinical failures and successes.

My global mission is to motivate dental schools in the USA and abroad to adopt a comprehensive approach to helping all dentists become **physicians of the mouth** so students don't continue to experiment on patients' mouths as I had to.

I believe. ***"We are on the verge of a paradigm shift in which a consuming public will get wind of the multitude of benefits an occlusaly aware dentist can offer."***

This 'Occlusion Edge' is my single most important practice building element.

***I owe special gratitude to Drs. Tanaka, Risbrudt, Spear, Piper and Okeson for their contribution to my clinical successes.**

The Problem

A primary reason for an insufficient general consensus and clinical approach to solving jaw disorders stems from a lack of solid research on occlusion. There are lots of studies that present various pieces and parts of occlusal theories. Without sufficient double-blind studies, we can't fit all the pieces together to say a particular theory is 'right'. An ideal study has to involve human beings and would require allowing pathologic conditions to continue without intervention. That is currently impossible. Until those studies occur, any dentist is entitled to their particular beliefs and no one can state they are either right or wrong.

The Choices

Cafeteria buffets offer a wide variety of delectable choices for the discriminating guest. Similarly, dentists choose from a plateful of philosophies that guide their clinical decisions.

An Occlusion Cafeteria

Bioesthetics
Gnathology
Gelb Splints and applied kinesiology
Trigger point injections
Myotronics Neuromuscular Dentistry
Pankey-Dawson
Joint Based
Conforming Occlusion
Biofeedback
Nutrition and Homeopathy
Cranial Osteopathy

The list will most likely grow in relationship with the ever-increasing knowledge being shared in today's connected world.

How Big is the Problem?

"There are three diseases dentists treat. Tooth disease, gum and bone disease, and occlusion disease. We treat tooth disease too much, gum and bone disease too little and we don't even talk about occlusal disease, yet it is by far the most destructive of all three and is present in the majority of our patients' mouths."

Gorden Christenson DDS

"Occlusal disease is the #1 cause of tooth loss, patient discomfort, patient dissatisfaction, oro-facial pain, missed diagnosis and the # 1 most undiagnosed problem."

Peter Dawson DDS

"The confusion over occlusion abounds but nonetheless, it still remains the single most important element contributing to the long term success of our clinical restorations"

Frank Spear DDS

"There are three reasons implants fail and two of them are related to occlusion"

Glenn Gittleson DDS

Any dentist reader easily recognizes the statements above expound the thoughts and beliefs of the most respected accomplished dentists in the world. Is it conservative to say the problem is **huge**? Just look closely around your patients' mouths for the answer.

The Effects

Confusion

Disagreement

Frustration

Lack of Confidence

Financial loss to dentist and patients

A Solution

Based on everything I've stated thus far, the solution I'll describe can't be based on a single academic clinical study that allows me to say I'm right. However, I can state I've studied intensively the bits and pieces of the masticatory system. In addition, I've employed each and every one of the choices displayed in the occlusion cafeteria above at one time or another since beginning clinical practice in 1978. My 'Ready, Fire, Aim' experience allows me to discuss my failures as well as successes openly.

If the reader is looking for a technique to solve occlusal disorders, it does not exist. All occlusions are not created equal. Sometimes, the same patient undergoing major restorative dentistry using any of the five primary dental philosophies may experience a lifetime of beauty and comfort. That same approach on another patient results in havoc and pain in one case and clinical integrity and comfort in another. There is a very logical reason for this apparent success using any of the current occlusal philosophies. Simply stated," When there are no

repetitive habits or jaw motions that strain the existing occlusion, havoc is absent.'

The solution to occlusal disease is self evident by evaluating pieces of the system for signs or symptoms of disease. The whole is assessed by observing the extent of the current problems in relationship to the magnitude, direction and duration of the force created in multiple positions of tooth contact. More precisely, all the possible positions of tooth contact when the patient is either awake or asleep need be observed. Destructive forces never prevail in the rest position. Remember, there are no destructive effects to the teeth when one arch is fully restored and the other is edentulous!

In Summary

A careful evaluation, diagnosis, treatment plan and prognosis cannot be performed if the dentist doesn't view the whole by the sum of its parts.

Herein lies the root of the problem. If dentists are **unaware of function and anatomy of any of the parts**, there can be no confidence. Yet in many aspects of dentistry, confidence prevails. Consider performing a root canal for example. If there is a 90 degree curve in the mesial buccal root of an upper bicuspid, that specific **anatomical knowledge** influences clinical decisions to employ a particular technique. When the periodontium is deteriorating rapidly, consider how a **functional knowledge** of oral bacterium dictates a successful clinical approach. Once understood, a dentist could proceed confidently with treatment.

Contrast these examples to one which involves clinical decisions with an ailing TM Joint, limited jaw opening, loose and worn teeth within a healthy periodontal environment. How do you view, in your own mind, the possible approaches given your own visualization of **the anatomy and function of that joint and muscles?** How does the **lack of knowledge** affect confidence? Ask any colleague to describe the **anatomy** of the one and **only joint** we dentists should understand in its totality and you'll see an all too common blank stare of uncertainty.

While they're still uncomfortable, ask an easier question about the origin, insertion and **function** of the muscles that open, close and position the mandible. Be prepared to catch your colleague if they become pale. It is with great humility that I'm comfortable injecting this form of humor because I'm laughing at myself.

I was the very colleague I've described!

DR. Reid offers hands-on training in Lake Tahoe area and offers part or full day courses to study clubs and dental societies.

They are described in the 'Dentist Section' of his website.

www.TahoeDentalArtistry.com

His BiteFx software can be acquired at

www.BiteFx.com

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