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- We All Get Older (Hopefully!) Is It Our Age, Our Genes, or Something Else? Do Telomeres “Tell It All”?
- Template Fabrication for Tomographical Diagnosis in Implant Dentistry: Two Clinical Cases
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Mission Statement:
"The New Jersey Dental Association serves and supports its members and fosters the advancement of quality, ethical oral healthcare for the public."

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Cover
Telomeres, located at the ends of chromosomes. iStockphoto.com

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Dear colleagues, I hope that your summer months have been gratifying and that it was time well spent enjoying the outdoors with friends and family.

As we embark on the change of season we look forward to a more nurturing time with our loved ones, with special emphasis on the approaching holidays, and the ushering in of a new year filled with hope and optimism.

This fall we will witness the election of our next US President, undoubtedly a ground-breaking year, unique and a first of its kind in so many ways. The two major political parties attempting to position themselves with the electorate; their challenge more than ever is to appeal to all, regardless of age, race, gender, sexual orientation and religious beliefs. Inclusion of all is the Republican or Democratic Parties’ only chance of winning this election. The notion that no matter who you are, you have a “voice.” The majority of voters, believing that one party heard their message more clearly than the other, will decide. But regardless, both parties need to appeal to everyone if they are to prevail. Times have indeed changed.

Change and evolution is fundamental to any member organization, whether political or professional, and organized dentistry is no different. More than ever, with all of the external forces that surround our profession attempting to influence, change and impose themselves on us, we must be united to protect the interests of our patients first and foremost, and then our own.

My friends and colleagues, inclusion is key to a vibrant organization. Allowing NJDA to increase our membership and retain our present members so that — as a profession — we can move forward and continue the legacy handed to us by our predecessors. On the national, state and component level we must communicate more effectively that our doors are open to everyone, demonstrating that organized dentistry has indeed many faces. Broadening the base also allows the opportunity for new leadership. We are one voice regardless of our individuality. Embrace it, and help continue to grow this well-respected profession, safeguarding it for everyone.

Extend a personal invitation to a non-member to come to one of your component meetings, communicate to them the value in belonging, roll out the welcome mat, make them feel that they are part of the NJDA family.

Simply stated ....“together we can.”

Thank you for your commitment and trust in organized dentistry, and know that we have your backs. Wishing you and your families the very best.

Giorgio
In Memoriam

We note with sadness the passing of the following members:

**Essex**
Ronald A. Hausman
2016

Jerome M. Horowitz
May 8, 2016

Daniel Robert Korb
April 8, 2016

Saul P. Lee
March 6, 2016

Murray J. Plishtin
February 15, 2016

**Mercer**
William C. Penney
December 14, 2015

**Middlesex**
Martin J. Moran, III
January 25, 2016

**Passaic**
Ben T. Adler
December 10, 2015

**Southern**
Preston J. Elkis
April 8, 2016

**Tri-County**
Melvin Hebel
November 16, 2015

**Union**
Arnold J. Levine
March 26, 2016

Leonard R. Moore
April 9, 2016

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We all have a need to find purpose in life. Some people find a way to express their purposes in their jobs, while others seek opportunities outside their daily work.

Our purpose in life may be something grand and complicated, or it may be as simple as dispensing love and kindness wherever we go. Just as we eat healthy foods and exercise to take care of our bodies, seeking a meaningful life of purpose nourishes the spirit and, as contemporary research shows, improves our emotional and physical health as well.

According to a recent study by Drs. Randy Cohen and Alan Rozanski and colleagues at Mt. Sinai St. Lukes – Roosevelt Hospital, New York, possessing a high sense of purpose in life is associated with a reduced risk of mortality and cardiovascular events.1 While the mechanisms behind the association remain unclear, the findings suggest that approaches towards strengthening a sense of purpose might lead to improved health outcomes.

Researchers pooled data from all previous studies until June 2015 investigating the relationship between purpose in life, risk of death and cardiovascular events. The analysis included data on more than 136,000 participants from 10 studies, mainly from the US and Japan. The US studies evaluated a sense of purpose or meaning in life, or "usefulness to others." The Japanese studies assessed the concept of ikigai, or "a life worth living/a reason for being."

The study participants, with an average age of 67, were followed for about 7 years. After adjusting for other factors, mortality was about one-fifth lower for participants reporting a strong sense of purpose, or ikigai. A high sense of purpose in life was also related to a lower risk of heart disease and stroke. Both associations remained significant on analysis of various subgroups, including country, how purpose of life was measured, and whether the studies included participants with pre-existing cardiovascular diseases.

According to the study authors, there is already a well-documented link between negative psychological risk factors and adverse health outcomes, including heart attack, stroke and overall mortality. This analysis now provides confidence that psychological factors can promote healthy physiological functioning and greater longevity.

Although researchers are currently unable to pinpoint the relevant biological mechanisms, the association might be explained physiologically, such as by a lessening of harmful responses to stress; or behaviorally, such as by a healthier lifestyle (physical or psychological).

Although having a strong sense of life purpose has long been thought to be an important dimension of life, providing people with a sense of vitality, motivation and resilience, the medical implications of living with a high or low sense of life purpose have only recently caught the attention of investigators. These current findings are important because they may open new potential interventions for helping people to promote their health and sense of well-being. ©

Reference
1. Cohen, R., MD, MS; Barishi, C., MD, MPH; Rozanski, A., MD; Purpose in Life and Its Relationship to All-Cause Mortality and Cardiovascular Events: A Meta-Analysis. Psychosomatic Medicine; Feb/March 2016; Vol. 78 – Issue 2: pp 122–133.
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Editor's note: Recent changes to state and federal regulations regarding the practice of dentistry were announced to our members in weekly email alerts during the month of August. Below is a summary of the changes and information on how to obtain required notices and posters for your office.

We urge our members to read the weekly email alerts to receive timely notifications of these regulations and other announcements that affect you and your profession.

If you are not currently receiving the Monday morning emails, please contact AnnMarie Varga in our membership department, avarga@njda.org or 732-821-9400.

Additionally, the quarterly newsletter, The Advocate, also includes recaps of our weekly emails. The Advocate is mailed toward the end of each quarter and includes email alert information from the prior three months.

State Board Requires Written Emergency Protocol
Effective July 18, 2016, the New Jersey State Board of Dentistry adopted a regulation that requires each dental office, facility, dental clinic or institution at which there is patient contact to: "1. Have a written protocol for managing medical or dental emergencies; 2. Have equipment to maintain adult and pediatric airways; 3. Have an ambu bag (bag-valve-mask resuscitator); and 4. Ensure that all staff are trained upon hire, and at least annually thereafter, to implement the emergency protocol."

State Board Adopts Regulation Governing General Supervision of Dental Hygienists
In the same notice that imposed “emergency protocols,” the State Board adopted a regulation (1) expanding and clarifying the procedures that can be performed by dental hygienists under direct supervision and (2) governing the scope of practice of licensed dental hygienists under general supervision. It also lists the procedures that can be performed under general supervision.

HHS Requires Covered Entities to Post Notice of Consumer Civil Rights
In a regulation which became effective July 18, 2016, the United States Department of Health and Human Services (“HHS”) required all “covered entities,” including doctors who accept Medicaid, to post a notice of consumer civil rights.

Also, it requires covered entities with 15 or more employees to adopt a civil rights grievance procedure and to designate an employee to coordinate its compliance efforts.

Further, covered entities must post information telling consumers with disabilities and consumers with limited English proficiency about the right to receive communication assistance, and to post taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business, advising consumers of the availability of free language assistance services. The regulation applies to every health program or activity that receives HHS funding, every health program or activity administered by HHS and every health program or activity administered by an entity created by Title 1 of the Affordable Care Act.

Sample notices and other relevant documents are provided by the US Office for Civil Rights, the Department of Health & Human Services and related agencies. To access any of these documents, please visit the NJDA website, www.njda.org and read the article on our home page entitled: New State and Federal Regulations in Effect July 18, 2016. The article includes links to the above mentioned regulations, posters and frequently asked questions.

As always, NJDA members are encouraged to call the Association whenever in need of clarification or further explanation of the regulations that involve the practice of dentistry. ☎
New Log In Instructions for Members

The upgraded NJDA website features a new log in protocol that allows members to access their NJDA and ADA member information with just one log in.

To log in to the NJDA website, www.njda.org:

- Your user name is your ADA#, no dashes or spaces.
- Password is the password you created for your ADA account.
- If you do not remember your password:
  1. Click on the reset password button.
  2. Re-enter your ADA# to access your security question.
  3. After you correctly answer your security question, you will be able to create a new password.
  4. After creating a new password, you’ll be able to log in to the NJDA website. **You may need to close your web browser and re-open it in order to log in after password reset.**
  5. If you have never created an ADA log in, follow the instructions provided in the FAQ section of the ADA password reset page.

Need help? Contact us at 732-821-9400 or Email: avarga@njda.org.
What If I’m Asked to Refund a Payment Sent by an Insurance Carrier?

Joan Monaco, DMD
Director of Dental Benefits, NJDA

It happens, possibly more than you’d care to acknowledge. You treat a patient and now you’re being asked to return all or part of the payment received from an insurer. What are you obligated to do?

From a Regulatory Perspective
There are different types of plans—self-funded (also known as ERISA plans), insured and hybrid. Hybrids are plans where a carrier only acts in the capacity of a third party administrator. Depending on the type of plan, different regulations apply. Self-funded plans are regulated under ERISA. Those that are insured or risk plans are regulated by the state. The type of plan involved will determine which state or federal regulations apply.

Contractual Obligations
If you have agreed to participate with an insurance carrier, then you are contractually obligated to abide by the contract’s provisions. Most contracts—if not all—have a provision that says when/if the carrier requests a refund due to overpayment or error on their part, you must comply. If you don’t comply the carrier will withhold funds from subsequent bulk payments or withhold benefits to the insured patient. They may also report you to the State Board of Dentistry for a violation of the contract, which is an “ethical violation” subject to disciplinary action.

Best Practices
If you participate with a carrier and receive a refund request:
• Verify that you did see the patient and did receive the benefit.
• Verify the circumstances of the carrier’s request and understand what you are refunding and why, so that you can pass this information on to your patient when you invoice or bill them for the service you provided.
• Make adjustments to the patient ledger, copy the check prior to refunding and send the check along with a copy of the request and a brief explanation (on your own letterhead), back to the carrier.

Disputing a Request
If you would wish, voice your discontent and dissatisfaction to the carrier and to the patient, but if you participate with the carrier, you are obligated to issue the refund.

If you do not participate, you must first identify what type of plan the patient has, as described above, and then submit a letter citing “the laws of restitution” in response to their request. NJDA is able to assist you in drafting a letter to the carrier. Your office should notify the patient of the discrepancy, explain that the carrier feels benefits were issued in error, and explain what you are doing in response. All charts and ledgers should be documented to reflect any actions taken.
New Look for NJDA Website

JDA’s updated website went live in July. Visit www.njda.org for the latest in state, local and national dental information, including regulatory changes that have recently gone into effect. See Executive Director Art Meisel’s message on page 6 for a summary of these recent developments.

In addition to finding member benefits and CE opportunities, you are encouraged to link your website to www.njda.org to provide your patients with easy access to consumer-friendly oral health information.

To include items in Members in the News, please contact Dr. Harvey S. Nisselson, editor, at hn3@cumc.columbia.edu or Lorraine Sedor, managing editor, at lsedor@njda.org or 732-821-9400.
The main objectives of root canal treatment are to provide function, prevention of reinfection, long term comfort and esthetics.\(^1\) There is considerable evidence to support long term survival rates for teeth initially treated by means of nonsurgical root canal treatment without intervention.\(^2\) Patients also choose nonsurgical root canal treatment to retain teeth and preserve the natural esthetics of their smile and relief of pain.\(^3\)

Overall satisfaction ratings are high for root canal treatment. Cost effectiveness and benefit of root canal treatment compared well with the alternatives, involving replacement using a fixed dental prosthesis or single tooth implants. Long-term postoperative complications appear to be lower than for single tooth implants and fixed dental prosthesis. It is critically important that the initial root canal treatment is performed carefully so that the risk of failure will be minimized.\(^4\)

Typical endodontic complications include swelling and the need for retreatment. The ten year complication rates for retained teeth treated by means of root canal treatment are approximately 4% in comparison to 18% for retained single tooth implant restorations.\(^5\)

The high survival rates of dental implants have created a paradigm shift in treatment planning that sometimes resulted in needless extraction of these teeth, which were not patient centered treatment options.\(^6\)

Nonsurgical retreatment cases have a survival rate of 93% in the prospective study.\(^7\)

Nonsurgical retreatment cases have a survival rate of 93% in the prospective study. If an endodontic failure is retreated with conventional nonsurgical means, the success rate is high, especially in teeth without periapical lesions and when the cause of failure has been identified and corrected.\(^8\)

Endodontic surgical outcomes have improved substantially because of the use of the microscope, angled ultrasonic surgical instruments and new root end filling materials. Results from long term follow up studies of modern endodontic microsurgery show high success rates. Modern microsurgical endodontic treatment is superior to traditional surgical endodontic treatment in that microsurgically treated teeth tend to be lost at low rates over time.\(^9\)

Tooth replacement is the insertion of a tooth into its own alveolus after the tooth has been extracted for the purpose of performing treatment, such as root end filling or perforation repair.\(^2, 3\) A mean survival rate of 88% for replanted teeth has been reported after systemic review and meta analysis.\(^10\)
Transplantation is the transfer of an embedded, impacted or erupted tooth from one site to another socket or surgically prepared socket either in the same or another person. Transplantation has a place particularly in younger patients with an appropriate donor tooth, whose ongoing craniofacial growth would allow an implant to become deeply buried and misplaced.11

Conclusion
Survival rates of teeth treated by means of root canal treatment are high and patient benefit is great. It is important that initial root canal treatment be performed to high standards to reduce the risk of future failure. The first treatment option after failure of root canal treatment may not be extraction of the tooth and replacement by using a fixed prosthesis or a single tooth implant. There is value in retaining an otherwise sound natural tooth. ○

References:

About the Authors
Haritha Mikkilineni, MDS, is a prosthodontist practicing in Hyderabad, India.

Deepika M. Reddy, DDS, is an associate dentist at Signature Smiles in Atlantic City, New Jersey, and a member of NJDA and Monmouth-Ocean County Dental Society.
Oral Pathology Quiz #92

Presented by Rutgers School of Dental Medicine Biopsy Service

The Rutgers School of Dental Medicine oral pathology and oral medicine faculty members are showing the clinical presentation of some relatively common lesions for readers to self-evaluate their skills in clinical differential diagnosis. You are expected to choose the most likely clinical diagnosis on the basis of history and clinical or radiographic appearance with the appreciation that definitive diagnosis requires microscopic examination of the specimen.

Case Number 1  
Figure 1: Courtesy Dr. Eric Weiss, Livingston

A 52-year-old white female presented with extensive white lesions on her left mandibular alveolar mucosa and vestibule. Changes on the alveolar mucosa extended from the left mandibular central incisor to the alveolar ridge distal to second molar. (The third molar was absent). The lesions extended from the interdental papillae into the vestibule and onto the buccal mucosa. The entire region appeared white and the mucosal surface layer was not removable with stretching or application of gentle pressure. The changes ranged from a thin white plaque, to thicker plaques and a verrucous appearance. Erythematous areas adjacent to the white component were noted. Biopsies taken several years earlier revealed epithelial dysplasia. The patient was a cigarette smoker and had a history of Crohn’s disease. Which of the following is the most likely diagnosis?

A. White sponge nevus  
B. Squamous cell carcinoma  
C. Lichen planus  
D. Leukoedema

Case Number 2  
Figure 2: Courtesy Dr. Joseph T. Mormino, Staten Island, NY

A 60-year-old healthy white female presented with an asymptomatic, solitary lesion on her anterior palate. The well-defined sessile papule was located about 3 mm from the palatal gingival margin of the maxillary left canine and first premolar. It was covered by mucosa of normal color, firm in consistency and measured approximately 5 mm by 3 mm. There was interdental alveolar bone loss between adjacent teeth, but they were vital. Which of the following is the most likely diagnosis?

A. Pleomorphic adenoma  
B. Canalicular adenoma  
C. Necrotizing sialometaplasia  
D. Benign neural neoplasm

Case Number 3  
Figure 3: Courtesy Dr. Joseph D’Amore, Englewood

A 33-year-old healthy white female presented with a solitary enlargement on her left buccal mucosa. The pink, round, sessile nodule projected above the adjacent mucosa. It was firm in consistency and measured approximately one cm in diameter. The patient smoked one pack of cigarettes per day and had a cheek-biting habit. Her mucosa showed a white film and several papules on the mucosa surrounding the exophytic lesion. Which of the following is the most likely diagnosis?

A. Peripheral ossifying fibroma  
B. Pyogenic granuloma  
C. Irritation fibroma  
D. Peripheral giant cell lesion
Radiographs of the mandible of a healthy, asymptomatic 24-year-old Hispanic female revealed a well-defined, non-corticated, unilocular radiolucency. It was located around the apices of the right mandibular premolars and measured approximately 1.2 cm in maximum dimension. Both teeth were vital and there was no evidence of expansion. There were no other significant radiologic changes. Which of the following is the most likely diagnosis?

A. Focal cemento-osseous dysplasia  
B. Radicular cyst  
C. Dental granuloma  
D. Apical scar

Answers on page 16
Radiographic orthodontic records are typically taken to diagnose malocclusions. Often they provide information that may have been completely missed otherwise. The cephalogram provides information not only of the jaws and the dentition, but other structures including the airway passage. The same is true for the panoramic radiograph.

A healthy nine-year-old boy presented to the orthodontic office for treatment of crooked teeth. A cephalogram and panorex were taken as part of the orthodontic records. An opaque circular object was evident in the posterior aspect of the nasal passage. The panorex also identified an unusual object. The patient had no symptoms and did not remember anything unusual in the past. A posterior anterior radiograph was taken to help with the relocation and identification of the object.

The patient was referred to an ENT specialist who was able to retrieve this object uneventfully. It was identified as a coin. Neither the patient nor the parents could recall how this occurred.

The orthodontist was able to play an important role and provide an additional service to the patient. In conclusion, the clinician should be cognizant of anything atypical on the radiographs. Orthodontic and dental radiographs can play a useful role in identifying pathology in the head and neck area that may otherwise remain undiscovered.

About the Author
Anil Ardeshna, DMD, MDS, is a diplomate of the American Board of Orthodontics and an associate professor and director of Postgraduate Orthodontics in the Department of Orthodontics, Rutgers School of Dental Medicine.
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Oral Pathology Quiz #92 Answers

Answers from page 12

Case Number 1  
**Answer:** B. Squamous cell carcinoma

Oral mucosal squamous cell carcinoma (B) may present as leukoplakia (suspicious white lesion), erythroplakia (suspicious red lesion), erythroleukoplakia, ulceration, cratered enlargement or as a verrucous (warty or papillary) lesion. The patterns seen in this case included leukoplakia (both plaque and verrucous forms) and erythroplakia. Incisional biopsies revealed areas of well-differentiated invasive squamous cell carcinoma, epithelial dysplasia and verrucous hyperkeratosis. The changes coupled with previously diagnosed lesions constitute a clinicopathologic entity known as proliferative verrucous hyperplasia (PVL).

PVL is a high risk form of leukoplakia in which there are multiple white plaques, some of which have a roughened (verrucous) surface. Lesions begin as homogeneous leukoplakia without dysplasia and go through the stages of verrucous leukoplakia with dysplasia, verrucous carcinoma and conventional invasive squamous cell carcinoma. Such patients must be carefully monitored and biopsied as new lesions appear. This is because the malignant potential of PVL is greater than that of any other form of oral mucosal premalignant condition.

White sponge nevus (A) is inherited as an autosomal dominant trait with a high degree of penetrance and variable expressivity. There are bilateral and symmetrical, asymptomatic, white (or gray-white), thickened, velvety or corrugated (sometimes deeply folded) plaques. Lesions are sometimes spongy in consistency. They usually appear early in life and may also affect the nasal cavity, larynx, esophagus, and ano-genital region. It is excluded because here because lesions began in middle-age and because previous biopsies were positive for epithelial dysplasia.

Lichen planus (C) is a chronic immunologically-mediated disease. Oral mucosal lesions may be white and/or erosive. White lesions may be reticular striae (interlacing white lines), plaques or papules. They tend to occur bilaterally and a verrucous component would be very unusual.

Leukoeclasia (D) is a gray-white, bilaterally symmetrical, appearance of the buccal mucosa, which does not rub off but is reduced by stretching the mucosa. It occurs in most adults and some authorities regard it as a variation of normal. It is excluded in this case because lesions did not subside when the mucosa was stretched.

---

Case Number 2  
**Answer:** D. Benign neural neoplasm

Palisaded encapsulated neuroma is one of several benign neural tumors (D) that occasionally occur on the oral mucosa. It is probably traumatic in origin. Most cases are found on the face. It is histologically distinguishable from neural neoplasms (schwannoma and neurofibroma) and from the traumatic neuroma. All lesions clinically resemble irritation fibromas. Other lesions presenting as solitary, firm, normal-colored papules or nodules on the oral mucosa include gingival reactive lesions (fibroma, peripheral ossifying fibroma), leiomyoma and early benign salivary gland tumors. Pleomorphic adenoma (A) and canalicular adenoma (B) are, however, very unlikely to develop on the hard palate because minor salivary glands are absent in this area. Necrotizing sialometaplasia (C) is a reactive condition that is also limited to sites where there is salivary gland tissue.

---

Case Number 3  
**Answer:** C. Irritation fibroma

Irritation fibroma (C) is a very common reactive lesion. It presents as a dome-shaped, firm, painless papule or nodule, with well-defined borders. Its surface is intact and it is similar to, or paler than, adjacent normal mucosa. Fibromas are more often sessile than pedunculated. They are attached to the connective tissue from which they arise. They may develop from pyogenic granulomas.

Peripheral ossifying fibroma (A) and peripheral giant cell lesion (D) are excluded because they occur only on the gingivae. Pyogenic granuloma (B) is excluded because it is red in color.

The differential diagnosis of solitary dome-shaped, firm, nodules with well-defined borders includes mesenchymal tumors (leiomyoma, traumatic neuroma, neurofibroma and schwannoma).
Case Number 4  

**Answer: A. Cemento-osseous dysplasia**

Cemento-osseous dysplasia (A) is an abnormal remodeling of periapical bone in response to undetermined factor(s). It is unrelated to tooth vitality. The vast majority of cases occur in women. Lesions go through lucent, mixed and opaque stages. The focal form of this condition presents as a solitary lesion, most often in the posterior mandible. It appears as a well-defined, relatively small, usually non-expansile, asymptomatic lesion. In some cases, borders are slightly irregular.

The differential diagnosis of well-defined apical radiolucencies is extensive. When teeth are vital, inflammatory apical lesions, such as radicular cyst (B) dental granuloma (C) and apical scar (D) are very unlikely. In the radiolucent stage of focal cemento-osseous dysplasia, the differential diagnosis includes developmental odontogenic cysts (including keratocyst), odontogenic tumors (e.g. ameloblastoma and early cementoblastoma), benign non-odontogenic tumors (central ossifying fibroma, central giant cell lesion, mesenchymal neoplasms, and hemangioma) and Langerhans cell disease. Distinguishing focal cemento-osseous dysplasia from these lesions, especially from central ossifying fibroma, may be difficult. Some clinicians perform biopsies to obtain an immediate diagnosis. Most of these diagnoses will cause expansion of the mandible. Since focal cemento-osseous dysplasia has limited growth potential and usually does not cause expansion, the alternative is to monitor the lesion as it becomes increasingly opaque. Some patients with the focal form of cemento-osseous dysplasia may later develop the periapical and/or florid forms. It is, therefore, important to monitor patients because inappropriate management of the florid form of the disease may result in a secondary osteomyelitis.

The Oral Pathology Quiz is presented by faculty of the Rutgers University – Rutgers School of Dental Medicine, Drs. Lawrence C. Schneider, Joseph Rinaggio and Mahnaz Fatahzadeh. Clinicians who have clinical pictures and/or radiographs of cases suitable for future quizzes should call Dr. Schneider at (973) 972-4375. E-mail: Lawenschneider@aol.com

Biopsy kits may be obtained without charge by calling (973) 972-1646. Faculty members are available to answer questions Monday through Friday, from 8:00 a.m. to 4:00 p.m.

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Abstract
As healthcare professionals, we deal daily with “aging” factors relating to our patients’ dental treatment planning (and to ourselves). We are all are expressions of our DNA—the long molecules in our cells’ nuclei that contain our genes which determine how proteins will be made to express who we are. Although genetics can be a confusing subject to understand, when trying to understand DNA, perhaps consider that you Do Not Abandon learning some of the basics of genetics.

In today’s evolving world of medical science, there is a major focus on genetics and genomics; analyzing one’s genetic makeup to help in diagnosing and managing disease, and prescribing of medications (pharmacogenetics/pharmacogenomics). One aspect of interest is what we call “aging” or getting older, an expression of cellular “senescence”—most of our cells are programmed to commit suicide (apoptosis) over time. So we get wrinkles, our stomach sags and our hair goes gray. As described below, a normal physiologic process takes place at the end of your chromosomes to protect them. Over many years, this process can no longer protect your chromosomes and the cells die. However, if normal processes are not functioning correctly, the chromosomes continue to reproduce—if this is a cancer cell, the lack of cell suicide allows tumors to grow.

Your Chromosomes
In the nucleus of your cells are your chromosomes, the DNA molecular structures that contain your genes—the directors of the information about you (who you are, what you look like, what might be passed on to your children, what diseases you might get, how you might respond to a medication, etc.). Genes are sections of these linear chromosomes. Each chromosome is made up of DNA tightly coiled many times around proteins called histones that support its structure (Fig. 1).

What is a Telomere?
Telomeres are the end parts of chromosomes that do not carry usable genetic information (Fig. 1, 2, 3).

Telomeres have been compared with the plastic tips on shoelaces, because they keep chromosome ends from fraying and sticking to each other, which would destroy or scramble an organism’s genetic information. Each time a cell divides, the telomeres get shorter. Telomeres do not have genetic information, so as they shorten our functioning remains stable. However, as they get much shorter, functioning gene information on the chromosome is not protected and the cell becomes inactive (senescent) or dies by a suicidal process of programmed cell death called “apoptosis.” This shortening process is associated with aging.

When they get too short, the cell can no longer divide; it becomes inactive or “senescent” or it dies. This shortening process, in addition to causing aging, is associated with a higher risk of death. So, telomeres also have been compared with a bomb fuse.1

But wait a minute! If this occurred on a regular basis, we would not grow after birth and our hair would stop growing so we would become bald in our first few years of life. Fortunately, body cells have an enzyme called telomerase which, in certain replicating cells, lengthens the chromosome after it divides by adding back the non-
functioning DNA. However, telomerase has very low activity in the
great majority of our cells, so these cells keep dividing until they are
too short and they cannot function any more….thus we age in certain
tissues (skin, blood, cardiovascular, etc.). Fortunately, telomerase is
found in high levels in important tissue cells which have to function
well over many years (egg, sperm, stem, intestinal lining, immune,
platelets, etc.). Thus the “aging” process is delayed in certain body
systems which is an important aspect of our genetics and our health.

Telomeres and Cancer—A Bad “Marriage”
As potentially cancerous cells shorten, if there is a genetic change
(e.g., mutation) the shortening telomeres will be rescued. Telomerase
will become active, maintaining chromosome length and the cells
will then have the ability to keep replicating to form tumors.3
Research is looking at medications to retard telomerase activity, but
there is a risk factor in simultaneously retarding survival of important
proliferative cells that we need to aid in function when aging
(fertility, wound healing, and production of blood cells and immune
system cells).1

Summary
This article is a brief overview of one aspect of aging as other
factors may be involved such as oxidative stress and glycation.
Telomere shortening in certain cancer cells is a developing focus of
the potential for future therapy.4 Results of a study done in 2015
showed that using genetics to create telomere extension turns back
the aging clock in cultured human cells—so it is possible to make
the telomeres “younger.” This could lead to new research findings
relating to aging and disease and perhaps develop treatments
for disorders of accelerated aging.5 As stated above, genetics and
advances in genetics and genomics—the future of healthcare—dental, medical, our patients,
ourselves and our families.

References
1. Learn Genetics http://learn.genetics.utah.edu/content/chromosomes/
telomeres/ June 20
3. Telomeres, Telomerase and Cancer, Scientific American Magazine,
Scientific American .com, Jul 2016
4. Are Telomeres the Key to Aging and Cancer? Genetic Science Learning
Center, University of Utah, http://learn.genetics.utah.edu, 2014
5. Telomere extension turns back aging clock in cultured human
cells, study finds- Helen Blau PhD, professor of microbiology and
all-news/2015/01/telomere-extension-turns-back-aging-clock-in-
cultured-cells.html, accessed July 2016

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Division of Oral Medicine at Rutgers School of Dental Medicine.
Template Fabrication for Tomographical Diagnosis in Implant Dentistry: Two Clinical Cases

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Kelvin I. Afraشتھefar, DDS, MSc, FADFE, FADI

Editor’s Note: All figures appear on page 25.

Introduction
Endosseous implants can be applied to a wide variety of treatments, from replacing a single tooth to treating a completely edentulous patient with either fixed or removable prosthodontics. In order to complete the diagnosis and to select a proper treatment plan, it is necessary to use a bi-dimensional (i.e., orthopantomography) and more often tri-dimensional (3-D) radiographic technique (i.e., computerized tomography) in the pre-surgical assessment of implant sites. When the patient has selected a treatment that will employ endosseous implants, the radiographic technique must complement the anatomic findings and the planned rehabilitation by using a radiographic template. The anatomic findings include taking into account the maxillary sinus, adjacent teeth or implants, alveolar ridge, etc. The planned rehabilitation includes a diagnostic wax-up duplication through a radiographic template. A correctly developed radiographic template will help to ensure the correct position of the dental implants and thus to provide a predictable outcome.

The “All-on-Four” protocol provides a fixed or removable method of rehabilitation (with an over-denture supported by a bar) utilizing the placement of four implants within the edentulous pre-maxilla or interforaminal region of the mandible. With the use of a radiological or tomographic template and computerized axial tomography (CAT), a surgical guide is fabricated to assist with the precise placement of the implants during the potential flapless surgical procedure. Several mistakes have been detected in the treatment planning stage while using this type of surgical guide. Factors related to incorrect fabrication include the following:

1. Misfit during the tomographic procedure. Since the guide is a duplicate of the template, any misfit (retention, support or stability) will be transferred to a surgical guide during the virtual planning.
2. Lack of template support while taking CAT scan. Both the template and surgical guide support may be dental, mucosal or combined. However, it is important to note that hard tissues provide the most stable support. The choice of support depends on many factors, such as the number of teeth remaining in the arch, whether the mandibular or maxillary arch is being treated, and the anatomy of the edentulous or partially edentulous maxillae. The seating of the template could be incorrect when it is placed in the patient, even if it appears to be well adapted.
3. Not knowing the protocol for tomographic study: NobelClinician recommends using gutta-percha as a contrast medium, digital imaging and communications in medicine (DICOM) as the format file, and tomographic images (virtual 'slices') of 0.5mm.
4. Insufficient anchor pins. These pins are placed virtually during the planning phase and must have a buccal flange in the template to place the pins and anchor over the ridge bone. These have to be placed properly to guarantee stability during the drilling phase.
5. Insufficient radiopaque elements. These are created by gutta-percha points.
6. Insufficient thickness of the guide. This guide could fracture during the surgery.
7. Lack of knowledge of the anatomical structures involved. During planning, it is necessary to consider the anatomy of nerves, arteries and the Schneiderian membrane, along with parameters such as tooth-implant distance, implant-implant distance, apical-coronal depth and thickness of the osseous plates, in order to avoid negative clinical outcomes.

The keywords “Nobel Clinician” and “NobelClinician” were searched in the Medline database through the Pubmed search engine on May 15, 2015, retrieving 27 articles. Of these retrieved hits, only one article presenting one clinical case was related to the guided-surgery system we searched. Therefore, further information and training about this technique is highly recommended for clinicians involved in the planning of dental implants. The aim of this article is to present the basic components of diagnostic templates for tomography in the cases of two partially-edentulous patients.

The Diagnostic Template
First, the template could be a duplicate of a proposed prosthesis, a provisional restoration in the case of a fixed partial denture or a removable prosthesis in the case of a complete denture. Then, these templates are modified and a radiopaque element (metallic pellets, guide tubes, gutta-percha, barium sulfate) is integrated into their structure during manufacture to complement the radiographic information (2-D or 3-D) of the remaining bone and anatomic structures related to prosthetic information. The template could also be used as a surgical guide for the dental implant placement. In addition, the software is applicable to most implant systems.
A Tomographic Template Must Fulfill the Following Conditions:

1. In the case of a completely edentulous patient, the template has to be fabricated with a rigid material (i.e., acrylic resin) with enough width to guarantee structural resistance, in order to be stabilized and to be supported by subjacent structures during the tomographic procedure.

2. For a partially edentulous patient, the rigid base of the template supported by adjacent teeth must have a window to visually verify the correct placement. Once the surgical guide is available, and since it is a duplicate of the template, adjustment is usually necessary before the actual surgical procedure.

3. It is necessary to have an interocclusal registration to ensure stability with the opposing arch.

4. It is necessary to have radiopaque elements as a reference of the definitive restoration during software planning. In the Nobel protocol, cases should contain at least six gutta percha points (1.5mm diameter and 1mm deep) placed on the vestibular flange, and at least three points at the palate surface to facilitate the virtual overlap of the template itself and the template placed in the mouth of the patient.

5. The tomographic template must be easy to manipulate and insert in position, in case the patient by him- or herself has to place the template.

6. The template must have in its design vestibular flanges in order to place attachment pins at the guide during software planning to ensure bone subjacent support during the surgical procedure protocol.

7. The template has to have enough pins and has to be placed as a tripod to guarantee the absence of movement during surgery.

The Authors in this Article used two Alternatives to Fabricate Tomographic Templates

1. Duplication of a diagnostic wax model and the creation of flanges for the template.

2. Utilization of a provisional restoration in the edentulous space where the implants can be placed.

First Clinical Case

Patient 1 was a systemically healthy woman who visited our dental department with the complaint, “I’ve been informed I will lose my teeth. Is there any solution with fixed teeth for me?” The patient was diagnosed with generalized periodontal disease and deficient periodontal support of remaining maxillary teeth (Fig. 1). She was informed that the teeth mobility and periodontal disease would lead to extraction of her maxillary teeth.

Potential maxillae treatments plans:

1. Immediate denture placement after teeth extraction and surgical modification of the alveolar process.

2. Extraction of remaining teeth, alveolar osteotomy, alveolar bone preservation, maxillary sinus lift, placement of 4 implants for an “All-on-Four” implant-supported overdenture.

3. Extraction of remaining teeth, surgical modification of the alveolar process, alveolar bone preservation, and placement of 4 implants for an “All-on-Four” implant-supported fixed prosthesis. The patient preferred this last option for avoiding the sinus lift surgery, since it was less costly and provided her a fixed rehabilitation solution.
For the technique, the primary casts were obtained in order to fabricate an individual impression rim for a physiologic cast. An interocclusal record made of silicon diminished the degree of movement of the remaining teeth and the casts were transported to the semi-adjustable articulator (SAA) (Figs. 2A–2C).

For the template fabrication, a trial arrangement was made considering the upper lip support and maxillary teeth incisal borders. A mock-up trial was made to increase the predictability (Figs. 2D and 2E). The extractions were simulated in the cast and the trial arrangement was completed in order to explain the expected outcomes to the patient.

Then, the vestibular flanges were waxed for the template fabrication (Figs. 2F–2H). Finally, the gutta-percha points were placed in order to test the template in the patient’s mouth for the first tomographic scan. The second scan was done for the template alone (Fig. 3). The dental implants were placed virtually and, accordingly, the surgical guide was manufactured by transferring this information to the NobelClinician software.

Second Clinical Case
Patient 2 was a 53-year-old woman who was referred to our dental department with the following complaint: “I would like a new denture or something that has firmer denture stability.” She presented maxillary edentulism and mandibular partial edentulism class II modification 1 (Kennedy classification). Thus, the proposed maxillae treatment plans were:
1. A new complete denture.
2. Placement of two implants for an implant-supported overdenture.
3. Placement of four implants for a bar-retained overdenture.
4. Placement of four implants for a fixed implant-supported denture and a maxillary sinus lift.
5. Placement of six implants for a fixed implant-supported denture.

The fourth alternative was the patient’s choice to avoid paying for two extra implants and to avoid the maxillary surgical procedure of the fifth alternative, which was the other fixed option.

For the mandibular scenario, the patient rejected the removable option and accepted two implants in each posterior side in order to place implant-supported fixed partial dentures.

Treatment began by fabricating one conventional complete denture. Anatomic impressions had to be taken for fabrication of an individual rim. Then, a physiologic impression with polyvinyl siloxane was taken to obtain study casts. Next, maxillomandibular relations were recorded, aided by a graphic intraoral tracer (Figs. 4A–4E).

The diagnostic trial arrangement was done over acrylic covers to try them directly on the patient. Once approved, they were duplicated for provisional fabrication (Figs. 4F–4M). As mentioned, maxillary template fabrication was conducted by duplicating the denture trial
arrangement with silicon, as well as adding six vestibular gutta-percha points and at least three on the palatal side (Figs. 5A–5E). 

The mandibular template was achieved by constructing a cover above the provisional restorations. The template design must have some openings as windows in the anterior zone for visual confirmation of the template and surgical guide sitting. While the design was being virtually planned, it was also decided to add vestibular flanges for anchorage pins to maximize stability during the surgical phase (Figs. 5F–5G).

Both maxillary and mandible templates were stabilized with an interocclusal register for the CAT scan.

Virtual implant planning was achieved with NobelClinician software considering anatomic structures related to the implant angulation, diameter, size and final position (Fig. 6). The surgical guide was fabricated during treatment planning. The surgical phase could even be considered for conducting a flapless intervention and completely guiding the drilling sites. 

**Conclusion**

Two clinical cases were presented to report the fabrication of radiological diagnostic templates for tomography in order to ensure proper positioning of the dental implants during treatment planning. Having a correct fabrication of a tomographic template is essential to avoid mistakes such as the template coming off due to lack of stability and support. This procedure will also aid in the virtual planning with software to duplicate accurate contours for the final prosthesis and predictable positioning of the dental implants.

**Conflict of interests:** There is no conflict of interest.

**References**

7. Rocci A, Martignoni M, Gottlow J. Immediate loading in the maxilla using flapless surgery, implants placed in predetermined positions, and

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Legends
Figure 1. Initial picture of the first case.
Figure 2. A–C. Silicone roll to obtain jaw relationships. D, E. Trial arrangement of incisors for conducting mock-up prior to extractions of remaining teeth. F–H. Diagnostic trial arrangement completed with attached gingival edges placed over the points of gutta-percha during virtual manufacturing of the surgical guide.
Figure 3. A, B. Finished templates, which will have gutta-percha points placed for the virtual junction and planning with NobelClinician. C–E. Acrylized trial arrangement used for the template confection and for the immediate load provisionals.

Figure 4. Second Case. A–E. In the mandibular cast, the ball retainers are bent and adjusted to retain the plate which will host the Gothic arch tracing. F–K. A trial arrangement is created and is duplicated in acrylic for fabricating the provisional restoration, which remains in the mouth at the time of tomography. The tomographic template is designed with vestibular holes to place the gutta-percha. L. The trial arrangement on acrylic copings is tried in. M. The provisional restoration is fabricated, tried in and cemented.

Figure 5. A, B. The antagonists are tested and a silicone interocclusal record is made over them. C–E. Maxillary teeth placed, scalloped denture and creation of palatal rugae. F–H. Sheath of template and CAT scan. I. Planning is performed by NobelClinician software.

Figure 6. A, B. Planning is conducted by placing four implants in the maxillae. C. The bone volumes with the prosthesis shown by the template are associated. D. A surgical guide is fabricated virtually from the template design. E, F. The virtual placement of the mandibular implants shows the relationship of the implant platform with the tooth contours on the template.

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