Canadian Journal of Restorative Dentistry & Prosthodontics
The official publication of the Canadian Academy of Restorative Dentistry and Prosthodontics

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Esthetic Dentistry
Dentisterie esthétique

Implant Dentistry
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Standardization in Oral Implantology

Dr. Ron Zokol, D.D.S., FCARDP
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We are not only dentists, we are also scientists. We strive to better understand our field and increase our knowledge base in order to hone our skills and provide the best possible services to our patients. But despite our good intentions we are also limited by that which we do not know.

The field of oral implantology for one, is in critical need of dispassionate, cold appraisal. Information has been coming to my attention regarding a growing number of malpractice suits or cases that are under the scrutiny of authoritative bodies. In my practice alone there has been a 400% increase over the last 3 years of patients coming to the Pacific Implant Institute for revision implant and implant related treatments due to compromised clinical results. The costs to our profession to administrate and prosecute complaints are mounting sharply. Such costs are both financial and moral.

So how should we manage this situation effectively? Up until now, we've been providing our individual services as best we can, as we watch the bigger picture of standardization go into a tailspin. It has become apparent that too few dentists know the field of oral implantology well, in both the scientific and clinical spheres.

Those charged with policy making on our behalf are attempting to solve our problems using ineffective means. For example, some colleges have chosen to disallow the term "Implant" in their description of the practitioners using them and the services they provide. Semantics. Others have chosen to restrict the provision of implant services unless the practitioner can prove he/she has accumulated between 30 to 150 hours of continuing education in oral implantology.

Neither solution is satisfactory. If advanced continuing education in oral implantology provides approximately 300 hours of training for entry level competence, then how can 30 or even 150 basic continuing education hours in spotted areas of oral implantology be a solid foundation for certification?

Oral implantology services encompass some of the most sophisticated interventions in clinical dentistry today, combining knowledge and skills in several specialties, with spotlights on prosthodontics, periodontics and oral surgery. Yet, for many young dentists, providing oral implantology services amounts to sticking a titanium screw into a piece of bone, with the hope for high financial return. Unforeseen complications will eventually cause many of those dentists to hang up their surgical tools when they find themselves faced with ramifications they were not trained to handle. Others might brace themselves and jump into the unknown, thereby causing significantly greater problems still, for their patients, themselves and, unfortunately, our profession.

The crux of the matter is that we, as a profession, have not produced a valid standard of care pertaining to oral implantology, and attempting to bring the specialties under a single canopy simply won't do the job. It is unusual to hear a prosthodontist assert that oral implantology belongs within the periodontal specialty or to hear a periodontist declare that oral implantology belongs to the realm of prosthodontics. As for oral surgeons, they've given up on this controversy altogether. Yet, oral surgeons contribute services in oral implantology that are beyond the scope of the average periodontist or prosthodontist. No single specialty can provide comprehensive dental implant services. How can we therefore reconcile the competencies in both the surgical and prosthodontic fields?

Is the development of an oral implantology specialty the answer? There are strong arguments pro and con this contentious issue. Universities insist there is no specialty so why bother developing a program that looks like a specialty? Colleges contend that there is no adequate educational process in order to recognize

such a specialty. Finally, many dentists fear a reduction of referrals, ergo, income, if oral implantology were a specialty.

Turning to another solution, we could recognize the peer examination process supervised by the American Board of Oral Implantology/Implant Dentistry. This body is comprised of periodontists, oral and maxillofacial surgeons, prosthodontists and general dentists. Each of these individuals must pass a written and an oral examination equivalent to the board certification of other specialties in the U.S.A. and Canada. The validity of these examinations was challenged by the ADA as well as 2 States: California and Florida. After many years of litigation, including appeals to the supreme courts in both jurisdictions, it was determined that the uniqueness of knowledge, plus the extensive range of the examination process, met the standards to allow dentists to use the credentials issued by those bodies.[1,2] Colorado has now endorsed AAID and ABOI credentials as well.[3] It's a starting point.

Ours is not a perfect world and whatever solution we elect will not be perfect either. Still, we are scientists with the responsibility to put the needs of the public above ours. As a profession, we should be able to get a handle on this field of oral implantology. But in order to do so, we need individuals who are trained in both surgery and prosthetics. It is time to set aside our self-interests and develop educational programs specific to oral implantology, thereby setting the standards for our profession.

As scientists, let's look beyond what we are doing today and investigate what is possible tomorrow. Your comments are most welcome on our journal blog: www.cardp.ca

Dr. Ron Zokol
Guest Editor, CJRDP

References:

1) Case Number CR38833 State of California and the ADA vs Michael Edward Potts in San Diego on September 19, 1994; Final ruling October 15, 2011.
2) State of Florida vs Francis DuCoin 2009
3) AAID News, October 2008

Standardisation en implantologie orale

Nous ne sommes pas seulement des dentistes, nous sommes aussi des scientifiques. Nous nous efforçons de mieux comprendre notre travail et d'améliorer notre base de connaissances afin d'aiguiser nos performances et fournir les meilleurs services possibles à nos patients. Mais malgré nos bonnes intentions, nous sommes également limités par ce que nous ne savons pas.

Pour ce qui le concerne, le secteur de l'implantologie orale a cruellement besoin d'être évalué de façon objective et impartiale. J'ai eu connaissance d'un nombre croissant de litiges ou de cas de fautes professionnelles ayant été soumis à l'examen des autorités compétentes. Dans mon seul cabinet, il y a eu une augmentation de 400% sur les trois dernières années, de patients venant au Pacific Implant Institute pour une révision de leurs implants et des traitements liés aux implants, à cause de résultats cliniques insatisfaisants. Les frais pour notre profession concernant la gestion et les poursuites judiciaires progressent sévèrement. Ces coûts sont à la fois financiers et moraux.

Alors, comment pouvons-nous gérer cette situation efficacement? Jusqu'à présent, nous avons fourni nos services individuellement du mieux possible, alors que nous nous rendions compte que le sujet de la standardisation nous mène nulle part. Il est apparu que trop peu de dentistes avaient une bonne connaissance du secteur de l'implantologie orale, qu'il s'agisse des domaines scientifiques ou cliniques.

Ceux-ci accusés d'élaborer des politiques en notre nom, tentent de résoudre nos problèmes à l'aide de moyens inefficaces. Par exemple, certains collègues ont choisi de rejeter le terme "implant" dans la description des praticiens qui les utilisent et des services qu'ils fournissent. De la sémantique. D'autres ont choisi de limiter leurs services liés aux implants à moins que le praticien puisse prouver qu'il/elle a accumulé entre 30 et 150 heures de formation continue en implantologie orale.

Aucune de ces solutions n'est satisfaisante. Si la formation continue avancée en implantologie orale

dispense environ 300 heures de cours pour acquérir un niveau de base, alors comment 30 ou même 150 heures de formation continue de base dans certains domaines d'implantologie orale peuvent-elles constituer une base de certification acceptable?

Aujourd'hui l'implantologie orale inclut des interventions très complexes en dentisterie clinique, combinant des connaissances et des compétences dans de nombreuses spécialités, avec des études approfondies en prosthodontie, parodontie et chirurgie buccale. Maintenant, pour beaucoup de jeunes dentistes, fournir des services d'implantologie orale revient à placer une vis en titane dans un morceau d'os, en espérant un important retour financier. Des complications imprévues peuvent alors obliger certains de ces dentistes à raccrocher leurs instruments chirurgicaux lorsqu'ils se trouvent face à des ramifications qu'ils n'ont pas l'habitude de gérer. D'autres retroussent leurs manches et se lancent dans l'inconnu, au risque de provoquer davantage de problèmes à la fois pour leurs patients, pour eux-mêmes et malheureusement, pour notre profession.

Le nœud du problème est que, en tant que professionnels, nous n'avons pas produit de norme de diligence valide se rapportant à l'implantologie orale, et le fait d'essayer de regrouper les spécialités dans un seul ensemble ne marchera pas. Il est inhabituel d'entendre un prosthodontiste affirmer que l'implantologie orale fait partie de la parodontie ou d'entendre un parodontiste déclarer que l'implantologie orale appartient au domaine de la prosthodontie. Quant aux chirurgiens buccaux, ils ont complètement délaissé cette controverse. Aujourd'hui, les chirurgiens buccaux offrent des services d'implantologie orale qui vont au-delà des compétences de la plupart des parodontistes ou prosthodontistes. Aucune spécialité ne peut fournir à elle seule des services d'implantologie dentaire complets. Comment pouvons-nous alors réconcilier les compétences des secteurs de la chirurgie et de la prosthodontie?

La création d'une spécialité "implantologie orale" est-elle la réponse? Il y a de nombreux arguments pour et contre ce sujet litigieux. Les universités insistent pour dire qu'il n'y a pas de spécialité, alors pourquoi s'évertuer à développer un programme qui ressemblerait à une spécialité? Les collèges soutiennent qu'il n'existe aucune procédure d'enseignement adaptée afin de reconnaître ce type de spécialité. Enfin, de nombreux dentistes craignent une diminution du nombre de référents, et par conséquent de revenus, si l'implantologie orale devenait une spécialité.

Comme autre solution, nous pourrions reconnaître la procédure d'examen collectif supervisée par l'American Board of Oral Implantology/Implant Dentistry (conseil américain d'implantologie orale / implantologie dentaire). Cette commission se compose de parodontistes, spécialistes en chirurgie buccale et maxillo-faciale, prosthodontistes et dentistes généralistes. Chacun d'entre eux doit passer un examen écrit et oral équivalant à la certification d'autres spécialités aux Etats-Unis et au Canada. La validité de ces examens a été contestée par l'ADA et par 2 états: Californie et Floride. Après plusieurs années de litige, incluant des appels auprès des cours suprêmes des deux juridictions, il a été établi que le caractère unique des connaissances, plus l'étendue de la procédure d'examen, répondaient aux standards permettant aux dentistes d'utiliser les références obtenues par ces commissions.[1,2] Aujourd'hui le Colorado a également validé les références AAID et ABOI.[3] C'est un début.

Notre monde n'est pas parfait et quelle que soit la solution que nous retiendrons, elle ne sera pas non plus parfaite. Néanmoins, nous sommes des scientifiques avec la responsabilité de placer les besoins du public au-dessus des nôtres. En tant que professionnels, nous devons être capables d'appréhender ce secteur de l'implantologie orale. Mais pour cela, nous avons besoin de personnes formées à la fois en chirurgie et en prothèse. Il est temps de laisser de côté nos intérêts personnels et de développer des programmes de formation spécifiques à l'implantologie orale, et ainsi établir des standards pour notre profession.

En tant que scientifiques, voyons plus loin que ce que nous faisons aujourd'hui et examinons ce qu'il est possible demain. Vos commentaires sont les bienvenus sur notre blogue: www.cardp.ca

Dr. Ron Zokol
Rédacteur invité, JCDRP

Références:

1) Case Number CR38833 State of California and the ADA vs Michael Edward Potts in San Diego on September 19, 1994; Final ruling October 15, 2011.
2) State of Florida vs Francis DuCoin 2009
3) AAID News, October 2008

Smile Design and The Pink Hybrid Restoration

The prosthetic solution for ridge deficiency

Le design du sourire et la restauration hybride rose

La solution prothétique en cas de déficience de la crête

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Abstract

Complex anterior reconstructions where bone and soft tissue has been lost or damaged has been very difficult to manage and usually has been the focus of multiple implant, grafting and other rehabilitative procedures attempting to re-establish normalcy of tooth and gingival architecture. Many times the result has not been successful in reconstructing these tissues and the final esthetic outcome has still remained significantly impaired. An alternative approach is to use pink ceramic as a prosthetic soft tissue replacement supplemented with an intra-oral direct application of superimposed pink composite. The planning for this type of reconstructive approach is best made with digital photography and digital smile design (DSD). Preplanning on a computer screen can provide definitive guidance on symmetry, tooth outline form and the form of a harmonious scalloped gingival interface. Outstanding results many times can be achieved prosthetically, without subjecting patients to the morbitity and unpredictability of repetitive and complex osseous and soft tissue surgery.

The "new world" of esthetic dentistry has created a great burden for the practicing clinician. Media-centered advertising would have one believe that anyone and everyone can buy the "perfect" smile. Although most dental restorative providers recognize that this is not the case, this global hype has created a number of negative consequences:

- Patients present for treatment with unrealistic expectations.
- Many dentists are misguided into thinking that they should be able to meet or exceed patient esthetic expectations in all cases. Many of these clinicians feel inadequate if they cannot achieve the results that they see in monthly dental journals and magazines and online resources.
- Some "cosmetic dentists" are focusing more on patient "wants" than on patient "needs" and are not availing themselves of a comprehensive approach to treatment.

This case illustration was chosen because it is does not exemplify ideal treatment. It is not a treatment plan that the present-day cosmetic dentist would necessarily want to implement. And, it is not a plan that most treating clinicians would consider as a first or even second choice of therapy. However, it is a very realistic and practical approach, considering the amount of bone loss that was present in the esthetic zone of this particular case. The treatment protocol is novel in its design and is relatively straightforward in implementation. This plan was simple in concept, was minimally invasive and the final treatment outcome was esthetically gratifying.

Résumé

Les reconstructions antérieures complexes en cas de perte ou de dégradation de l'os et des tissus mous sont très difficiles à gérer et consistent habituellement en des implants multiples, des greffes et autres procédures de réhabilitation visant à redonner un aspect normal aux dents et à l'architecture gingivale. Souvent le résultat n'est pas satisfaisant en termes de reconstruction de ces tissus et l'aspect esthétique final reste vraiment médiocre. Une approche alternative consiste à utiliser de la céramique rose comme tissu mou prothétique de remplacement accompagnée de l'application intra-buccale directe d'un composite rose en surface. La mise en place de ce type d'approche reconstructrice est encore plus satisfaisante grâce à la photographie numérique et au digital smile design (DSD). La préparation préalable sur un écran d'ordinateur permet de fournir une indication définitive de la symétrie, de l'alignement externe des dents et de la forme arrondie harmonieuse de l'interface dent-gencive. Des résultats incroyables peuvent souvent être obtenus au moyen de prothèses, sans faire subir aux patients le caractère morbide et imprévisible de chirurgies répétées et complexes au niveau de l'os et des tissus mous.

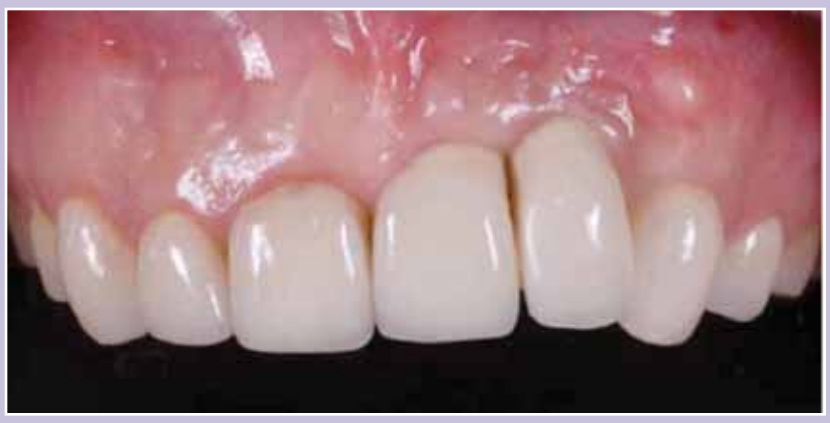
Case Presentation:

The Treating Clinicians:

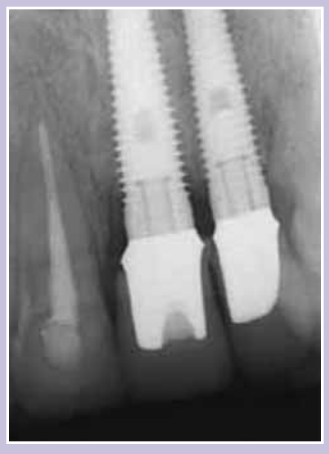
Prosthodontist, periodontist, and implant surgeon: Eric Van Dooren, DDS Orthodontist: Ralph Lemmens, DDS Dental laboratory and smile designer: Christian Coachman, DDS, CDT

The Situation:

A 42-year-old woman presented with an esthetic problem associated with a failing implant restoration. The previous treatment, which was necessitated by trauma resulting from a car accident, was performed 7 years prior to the initial examination. Extensive bone grafting was performed at that time in order to restore the anterior ridge defect. Two implants had been placed in the areas of the missing teeth nos. 9 and 10. This patient's main complaint was an unpleasing smile. She was not in favor of re-treating the area surgically but stated that she might consider this option if it was minimally invasive. She also insisted that any solution be relatively simple and limited to as few procedures as possible.



Intraoral frontal view of maxilla.



Radiograph of implants.

Facial view of smile.

Treatment-planning considerations

- This patient was very apprehensive about treatment because of negative past dental experiences and expressed interest in a non-invasive, non-surgical approach to treatment. She qualified her wishes by stating that if surgery was absolutely unavoidable to achieve a successful

esthetic result, it should be minimal and limited to a single surgical procedure.

- The patient expressed some concerns about her smile, especially regarding the midline, inclination of the incisal plane, and lack of symmetry in the length and form of her anterior teeth.
- This patient wanted to focus on the failing implants and did not want any of her other teeth to be treated. On the other hand, she understood that in order to improve tooth proportions and to create more esthetic harmony and balance, additional teeth may require treatment.

Summary of concerns

1. Even if the patient consents to surgical soft and hard tissue augmentation, are there any surgical techniques that would predictably and fully restore the anterior ridge to its original state? Is it advisable to propose surgery, even with qualifications, and possibly create unrealistic expectations?
2. Considering that this patient is hesitant to proceed with any surgical treatment, if a decision is made to replace the existing crowns and to try to restore harmony and balance to the face and smile, how can this be accomplished with minimally invasive procedures?
3. Recognizing that we may be limited in the amount of vertical ridge augmentation that can be achieved, how will we be able to compensate for this restoratively to meet or exceed the patient's treatment expectations?

Proposed Treatment Plan

Goals/objectives of treatment

- Accomplish a fixed method of rehabilitation without involving non restored teeth
- Achieve optimal esthetics

Phase I: Data gathering and digital planning

1. Intraoral and full-face digital photos are captured in order to establish:
   a. Proper incisal edge position
   b. Appropriate midline position and angulation
   c. Ideal tooth proportions and gingival contours

Photographic documentation is transferred to the computer for digital planning. The first step would be to relate the full-face smile photo to the horizontal reference line. The most common reference line used is the interpupillary line; however, the nasal or commissural lines can also be used. The midline is then projected onto the horizontal line, and digital planning is initiated. The treatment plan is evaluated, modified, and related to the DSD.

Phase II: Transfer of digital wax-up to the master cast

2. The digital plan is transferred to the master cast.
3. Tooth form is copied from the digital forms.
4. White esthetics are optimized.
5. Pink esthetics are optimized.
6. The 3D defect around the implants is filled with pink wax, which allows us to evaluate the vertical and horizontal components of the ridge deficiency.

Phase III: Fabrication of intraoral mock-up and provisional partial denture

7. The digital project or intraoral smile design is evaluated.
8. Old restorations are removed, and tooth locations and form are evaluated. Anterior provisional partial denture is fabricated.
9. DSD is evaluated and minor changes in form are made, if necessary, by applying flowable composite. The size of the anterior ridge defect is visualized by both the patient and the dentist.
10. Decisions are made as to whether and to what extent the anterior defect can be managed and how this will affect the definitive restoration. Much of the decision making occurs based on careful 3D evaluation of the soft tissue contours, with special focus on the papilla heights and volume.
11. Esthetic and functional evaluation is performed to establish incisal edge position, soft tissue contours, altered midline inclination, lip support, and tooth form, which should provide overall facial balance and harmony.
12. Patient approval is obtained.
13. The treatment plan is finalized.

Phase IV: Establishing the definitive treatment plan

14. Any final changes to the treatment plan are made, taking into consideration patient preferences. Final adjustments are also made to maximize soft tissue harmony, gain optimal soft tissue contours (compensating for the ridge deficiency), and optimize selection of prosthetic materials.
15. The definitive digital and intraoral concept is translated into the definitive treatment plan.

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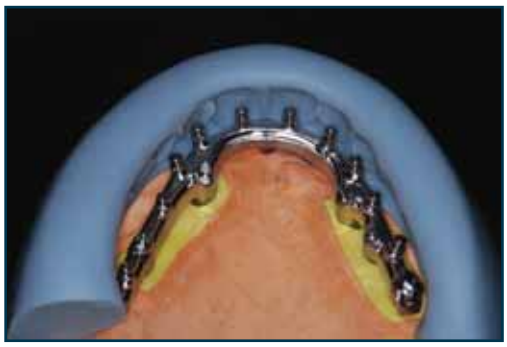
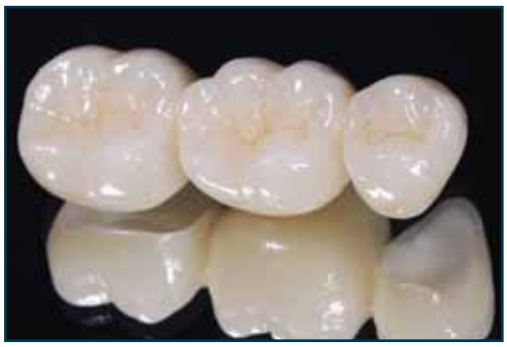


Maxillary Bar with Silicone Index

Ivobase



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Phase V: Orthodontic therapy

16. Orthodontic treatment is initiated in the mandibular arch to realign the mandibular anterior teeth and to intrude the incisors to aid in reducing the existing vertical overlap.

Phase VI: Surgical treatment

17. Surgical therapy is performed, including possible clinical crown lengthening to attain adequate biologic width in the maxillary anterior segment.
18. Connective tissue grafting is performed where indicated to augment the anterior ridge.
19. Postoperative care is provided, and healing is allowed to occur.

Phase VII: Definitive restorations

20. Minimally invasive definitive tooth preparation is performed.
21. Final impressions are taken, and the master cast is fabricated.
22. Definitive restorations are fabricated.
23. All restorations are tried in.
24. The definitive restoration is cemented.

Clinical Treatment

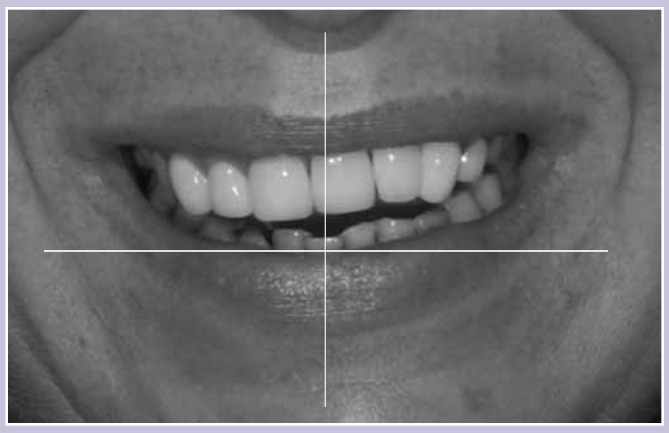
Review of the goals/objectives of treatment

- The goals and objectives of treatment for this patient were to accomplish a fixed method of rehabilitation with- out involving non-restored teeth and to achieve optimal esthetics. The patient limited possible therapeutic options by insisting that treatment be performed with the fewest number of minimally invasive procedures.
- Digital treatment planning would be used in designing the most practical approach to achieving esthetic success considering the extent of the anterior alveolar ridge deficiency present.

Phase I: Data gathering and digital planning

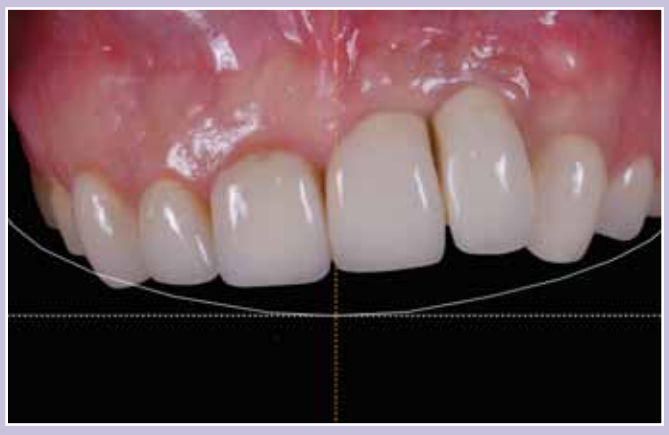
A protocol was established to be able to transfer the clinical and digital findings into a digital treatment plan.

Digital determination of the facial midline and horizontal reference plane on the facial photogragh.

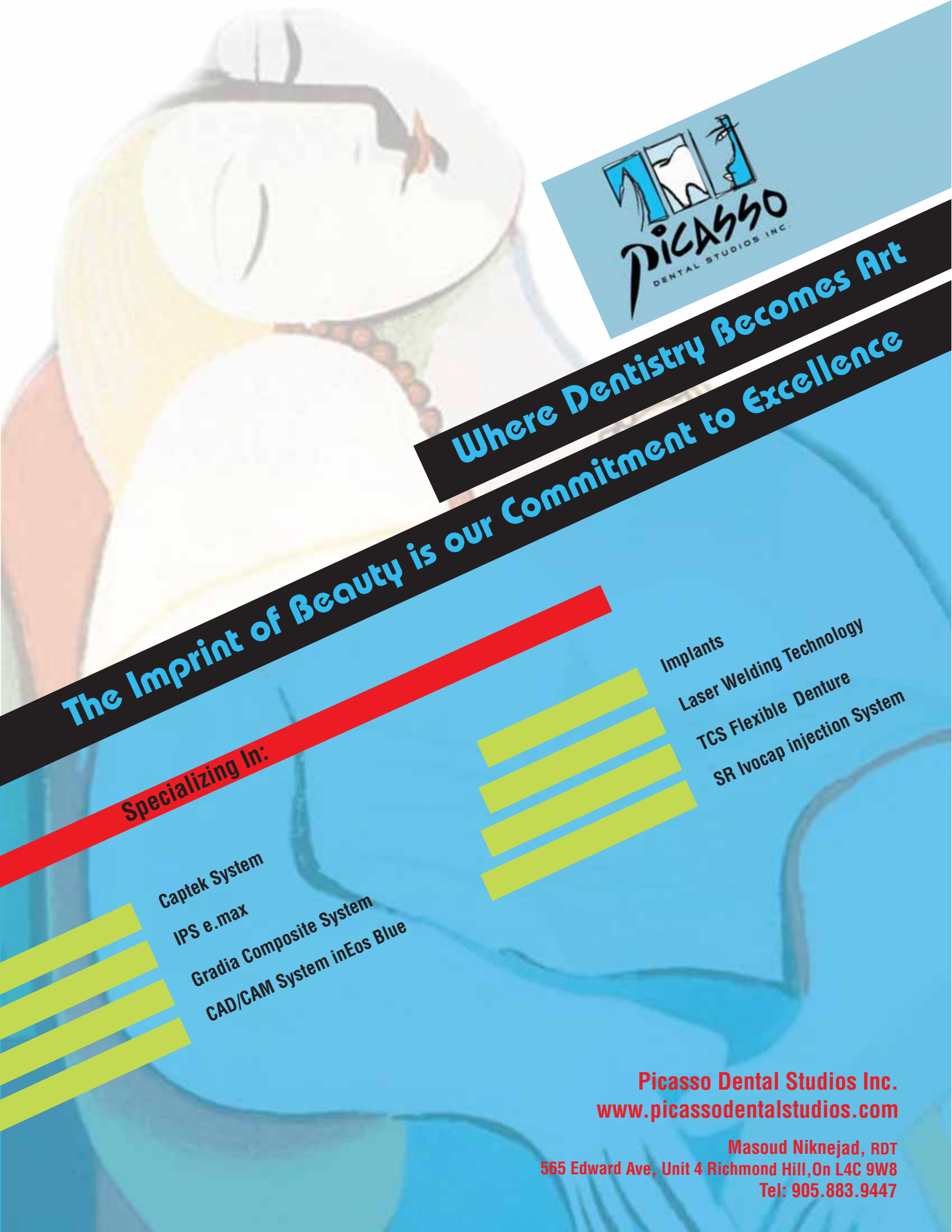


Close-up of smile from facial photograph with facial reference lines.

Transfer of the reference lines to the intraoral situation.



Incisal edge guideline.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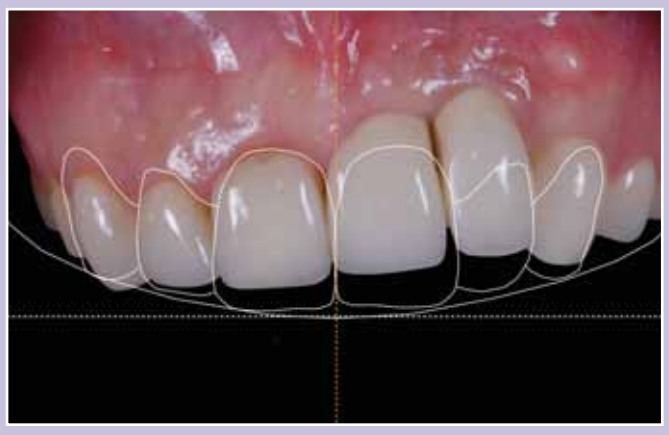
Photographic and dynamic video data were gathered on the patient. Intraoral and full-face smile images were taken. This data would be important for establishing proper incisal edge position, midline position and angulation, tooth preparation, and gingival contours.

The photographic information was transferred to a computer so that digital planning could be initiated by relating the full-face smile image to the horizontal reference line. It was evident that digital planning with only an intraoral photo would make it extremely difficult to correctly analyze these parameters because of the lack of any facial horizontal reference.

Photograph of the patient taken before the accident with the natural dentition intact.



Outlines of the teeth accomplished using Keynote software.

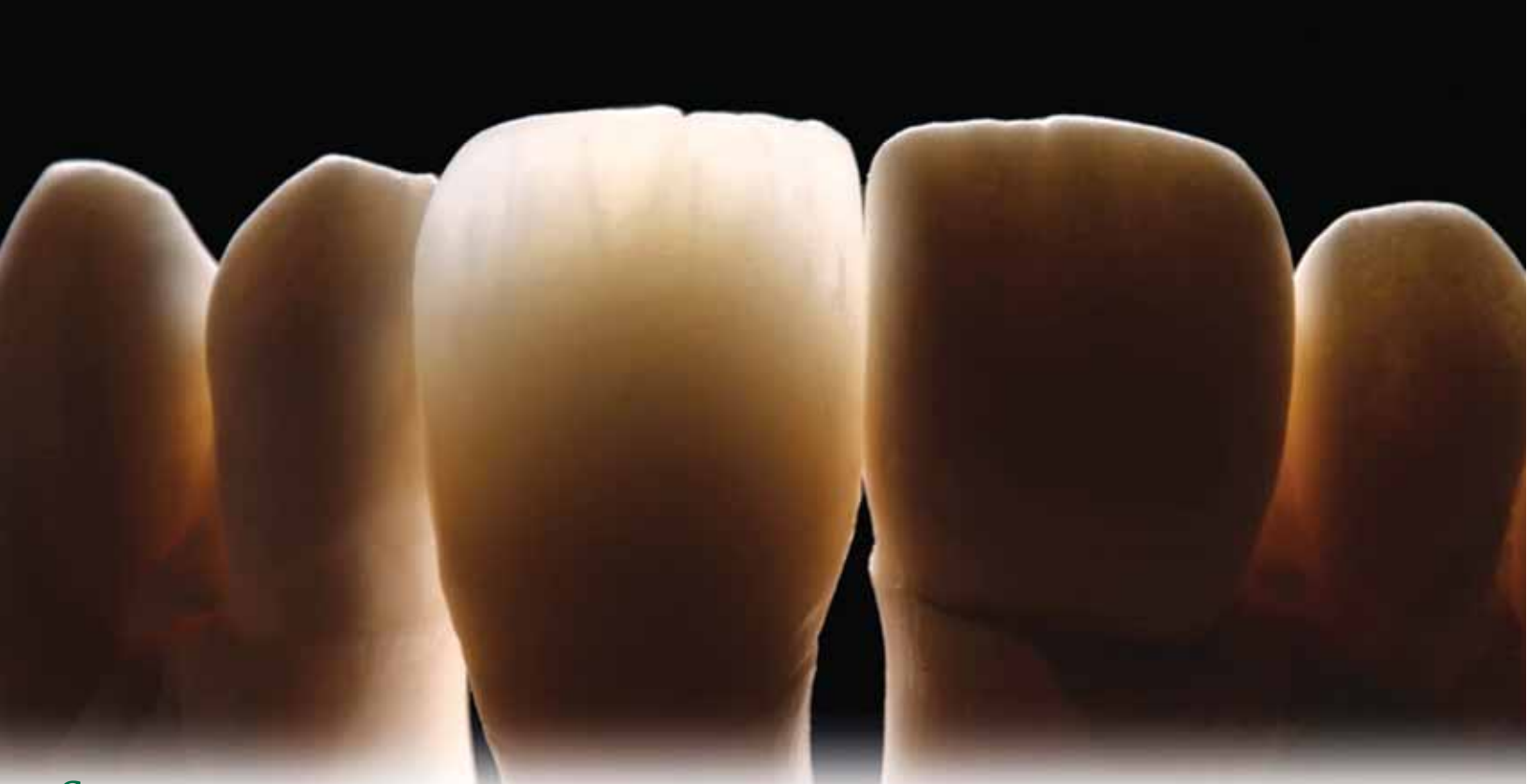
Digital ruler used to make initial measurements.

The inter-pupillary line should be the first reference used to establish the horizontal plane, but it should not be the only one. We have to analyze the face as a whole and then determine the best horizontal reference that will result in the most harmonious facial outcome. Other facial lines, such as the nasal line, commissure line, and mandibular angle, should be analyzed. Determining the horizontal plane of reference is a much more subjective and artistic decision than an objective exercise. We have found that it is easier to determine this esthetic reference digitally rather than relying on a facebow or any other device. The static image of the patient on the computer screen and the addition of the lines is the most precise way to determine this horizontal plane. Then this digital information must be transferred to the master cast, which is accomplished using the digital ruler and a real caliper. Once the horizontal reference has been established, the midline can then be projected onto the horizontal line.

It became quite evident that in this particular case the midline was significantly canted and the incisal edge position and length were incorrect. Tooth no. 6 appeared disproportionately long, and excessive gingival display was present around teeth nos. 4 to 7, 12, and 13.

After relating the intraoral to the full-face photograph, keeping the same angulation, we initiated digital planning. First the incisal length of one of the central incisors was determined digitally by outlining the correct tooth proportions and ideal form. This image was then mirrored, and from this point a digital setup could be completed. A facial photo that was taken before the accident was very helpful at this stage. We considered this a virtual mock-up, allowing us to relate the digitally created forms to the existing clinical situation and the face. At this point, the clinical treatment plan for the patient needed to be adjusted and related to the DSD.

By evaluating the distance from the digitally determined ideal incisal edge position of tooth nos. 9 and 10 to the existing marginal soft tissue level, it was apparent that surgical ridge augmentation would not accomplish what was necessary to significantly improve the esthetic outcome. After evaluating the buccal soft tissue level of tooth no. 10 as it related to the buccal placement of the implant (followed by apical soft tis- sue shifting) and the papilla height defect between teeth



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nos. 9 and 10, it became clear that this area was not surgically restorable. Limitations of vertical augmentation procedures, especially for papilla augmentation, should be recognized early and then assessed to determine the most prudent treatment approach if compromise is going to be accepted.

By designing the incisal contours, relating them to the horizontal line, and correcting the inter-incisal line, it became evident that the patient would benefit from plastic periodontal surgery and surgical crown lengthening.

Phase II: Transfer of digital wax-up to the master cast

At this point, we needed to transfer the digital plan to the master cast. It was important to position the cast in the articulator with the same inclination as was established in the digital planning. Digital measurements are made on the computer and then transferred to the cast with a caliper. First the horizontal plane and then all other measurable information are transferred from digital form to the cast with a pencil. The information transferred to the cast will act as a guide in the wax-up procedure. Drawing a horizontal line, keeping the cast in hand, and comparing it visually with the digital inclination aided in accomplishing this. Tooth form was copied from the digital forms. At this point, the dental technician focused on ideal tooth form.

After white esthetics was optimized, ideal pink esthetics were established by filling the 3D defect around the implants with pink wax. This would again allow us to evaluate the vertical and horizontal component of the ridge deficiency. With careful pre-evaluation of an ideal white and pink wax-up by the surgical team, there would be a better understanding of the 3D topography of the ridge defect and its effect on smile design. From this wax-up, we could produce a silicone index that would enable us to intraorally fabricate an exact copy of the wax-up.

Phase III: Fabrication of intraoral mock-up and provisional partial denture

In the next phase, we evaluated the DSD intraorally. The old restorations were removed. It became evident that the implant in tooth position no. 10 was in significant labio-version. A silicone index (related to the final tooth forms on the wax-up) guided the preparation of the provisional restorations. At this point, an acrylic material (Outline, Anaxdent) was injected in the silicone index and applied intraorally. The provisional partial denture was seated and adjusted.

At this stage, the digital plan was evaluated, and a flowable composite was used to visualize the size and extent of the soft tissue and bony defects. As previously anticipated, the defect was going to be unmanageable surgically, and we would not be able to restore the ridge to its original dimensions.

To better conceptualize the size of the defect, a pink composite provisional material was applied to the provisional partial denture. While the optimal tooth form was the guide for this provisional pink application, care was taken to establish the ideal 3D soft tissue contours, focusing on the papilla heights and volume. This step led to the conclusion that the defect was affecting not only the vertical and horizontal components of the ridge but also the papilla height and volume on the mesial aspect of tooth no. 8 and distal aspect of tooth no. 11. At this time, it was apparent that the most optimal esthetic and functional restoration would be an artificial prosthetic gingival restoration.

Information and measurements transferred to the study cast.

Addition of pink wax to create the ideal gingival outline.

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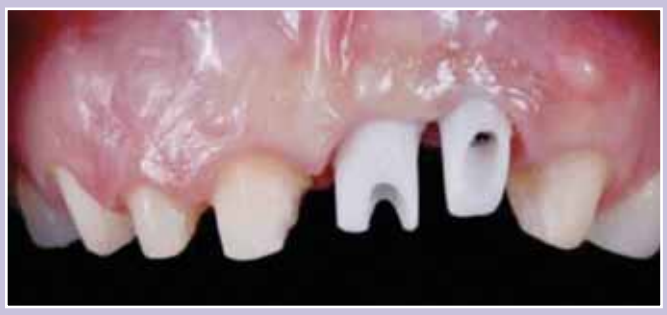
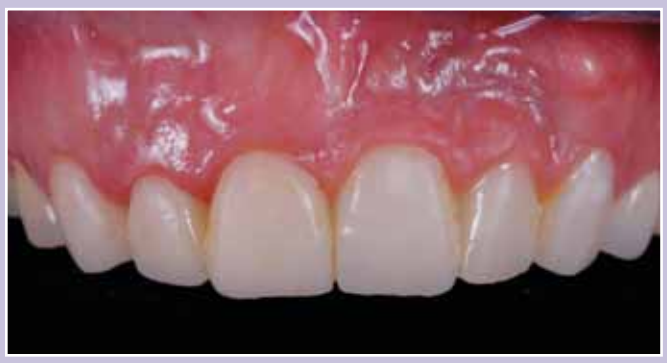
The papilla height of the natural teeth on the contralateral side was used as a reference in order to establish proper gingival contours in the area of the defect. Many times it is easier to establish the papilla design digitally first by taking a photograph of the provisional partial denture and designing the soft tissue contours on the computer screen in an Apple Keynote presentation. This makes it easier to transfer the DSD concept to the oral environment.

At this time, we performed an esthetic and functional evaluation. The objective was for the incisal edge position, soft tissue contours, altered midline inclination, lip support, and tooth form to create an overall balance and facial harmony. Once the projected esthetic outcome was approved by the patient, the final treatment plan was established.

Hygiene instruction was provided because it is crucial for all artificial prosthetic gingival restorations, including the provisional restorations.



Intraoral view after removal of the old crowns.



Intraoral view of provisional partial denture with pink composite.

Smile view of provisional partial denture.

Phase IV: Establishing the definitive treatment plan

When it was time to translate the digital intraoral concept into a final treatment plan, we contemplated what we could do to maximally enhance the definitive esthetic and functional out- comes, considering that the patient wanted little or no surgery and that the existing ridge deficiency could not be restored surgically if we wanted any symmetry in soft tissue levels and papilla heights.

The following ideas were considered:

- We would improve soft tissue harmony and achieve a better balance in soft tissue levels by performing surgical clinical crown lengthening on teeth nos. 4 to 8, 12, and 13. The patient was reluctant but willing to undergo this procedure.
- We would fabricate a pink hybrid restoration to compensate for the extremely compromised ridge. There were two options considered to achieve this:

1. Use the two natural teeth (nos. 8 and 11) as abutments for a four- unit fixed partial denture. With this approach, the implants would be submerged or eventually removed.
2. One or both implants would be incorporated into the hybrid restoration.
   - Using the natural teeth as abutments for a fixed partial denture would not be ideal because the pink interface between natural and artificial gingiva would not be esthetically pleasing. Moreover, there would be limited retrievability should the restorative material need to be replaced in the future. Therefore, the hybrid concept was chosen.

The decision was also made to incorporate only one implant as an abutment in supporting the hybrid restoration because it would provide easier access for hygiene maintenance. Also, with a cantilever it would be easier to achieve optimal esthetics with the artificial gingiva. We decided to use the implant in the no. 9 position and to submerge the implant in the location of tooth no. 10. A connective tis- sue graft procedure was performed to augment the buccal aspect of the ridge defect at the time that the implant was submerged. This resulted in easier and better adaptation of the artificial gingiva material.

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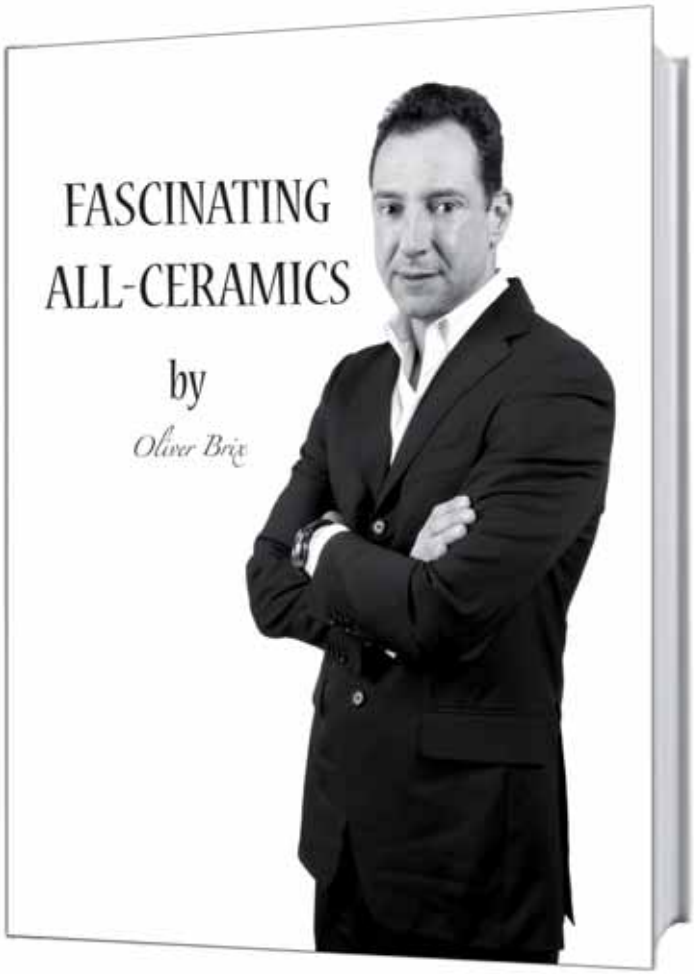

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- We would endeavor to optimize the prosthetic materials. All-ceramic single crowns (e.max Press, Ivoclar Vivadent) were to be fabricated on teeth nos. 6 to 8, 11, and 12. A PFM, two-unit, palatally screw-retained, cantilevered partial denture would be fabricated on the implant at site no. 9. The challenge for the technician would be to match the two-unit, PFM partial denture to the all- ceramic, single- tooth restorations.

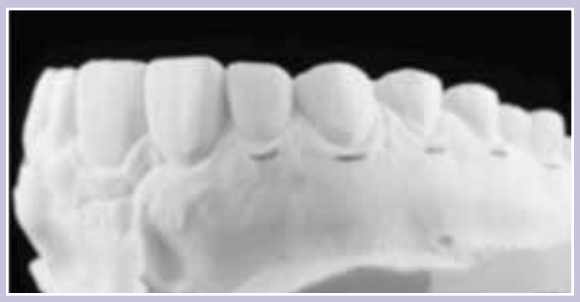
Phase V: Orthodontic therapy

Once the treatment plan had been finalized, orthodontic therapy was initiated to intrude and align the mandibular anterior teeth. This took approximately 6 months to complete, was uneventful, and did not interfere with any treatment being performed simultaneously in the maxillary arch.

Phase VI: Surgical treatment

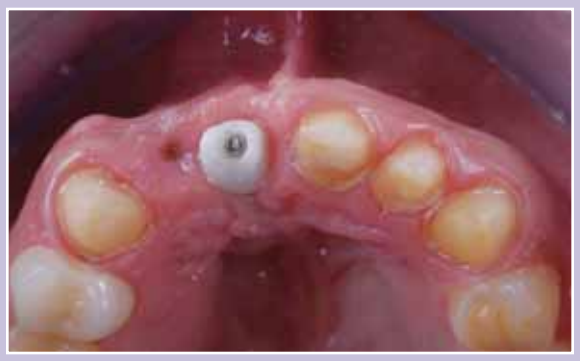
Surgical treatment was guided by a surgical stent designed and fabricated from the cast made with the approved provisional fixed partial denture.

Clinical crown lengthening via osseous resection was performed on teeth nos. 4 to 7 and 11 to 13, making sure that at least 3 mm of functional, attached gingiva was maintained. Adequate biologic width was also created. A connective tissue graft was placed as an onlay to the ridge (covering the implant) and in a buccal pouch at site no. 10. Healing was uneventful, and sutures were removed after 1 week.

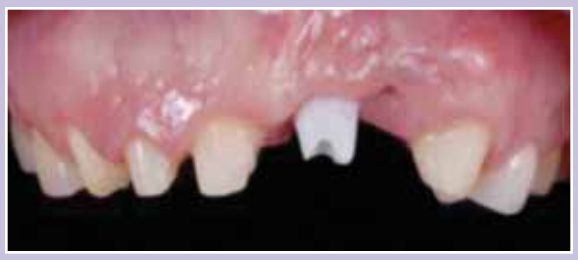


Crown lengthening suggested on the digital design transferred to the cast for fabrication of surgical stent.

Crown lengthening surgical stent.

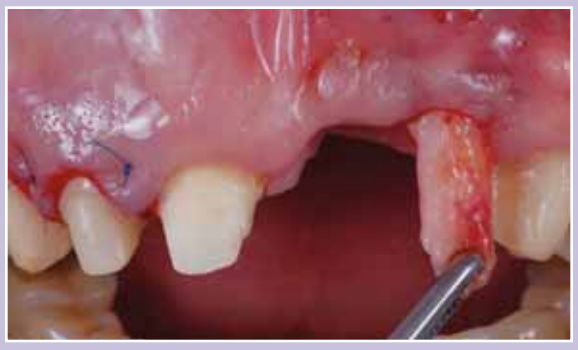


Occlusal view of anterior maxilla before surgery.



Intraoral frontal view of maxilla before surgery and after removal of the zirconia abutment of tooth no.10.

Marking the soft tissue with the explorer with the crown lengthening surgical stent in place.



Connective tissue graft for submergence of the implant at site no. 10 and to improve the horizontal aspect of the defect.

Phase VII: Definitive restorations

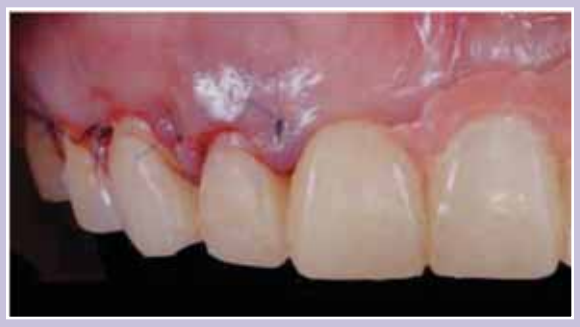
At 4 months postoperative, final tooth preparation was initiated. Care was taken to maintain a minimally invasive approach and to achieve biologically compatible preparations and impressions. A silicone index (related to the tooth forms of the provisional design) was used to guide our final preparations. Impressions were taken, and the master cast was fabricated.

Ideally, for the pink hybrid restoration,[5-8] an implant-sup- ported restoration should be retrievable. Because the implant in site no. 9 was placed buccally, a custom abutment was required to allow for adequate retention of the palatal screw. All-ceramic single crowns and a two-unit PFM partial denture (IPS d.Sign, Ivoclar Vivadent) were fabricated. The two-unit partial denture was already provided with a palatal layer of pink porcelain, which allowed for intraoral application and finishing with pink composite material (Anaxgum, Anaxdent).

At this stage, all prosthetic components and crowns were tried in, and minor modifications were made. Tight adaptation with some light ischemia was visible around the pink porcelain at the try-in.

All single e.max crowns were adhesively cemented, which was followed by intraoral application of the pink composite layer. Prior to this, in the lab, the usual protocol of steaming, sandblasting, etching, silanization, bonding, and application of the first layer of flowable pink composite was used to ensure effective and strong bonding between the pink porcelain and the first layer of pink composite.

The color of the gingiva on the right side was used to select the most ideal color of pink composite. Different shades and tints were used to enhance the esthetic outcome. Surface texture and polish of the pink composite were optimized, and after final polymerization and polishing in the lab, the two-unit partial denture was cemented. Occlusion and hygiene were checked. The patient was seen on a 6-month maintenance program.

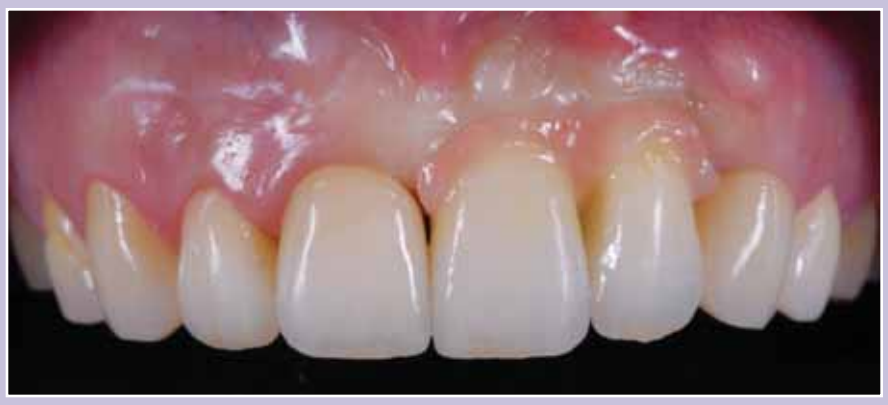


Intraoral lateral views of the maxilla after the crown lengthening

Intraoral frontal view of maxilla prior to final impression taking.

Definitive restorations on the cast.

Placement of palatal screw.



Intraoral frontal view of maxilla at try-in.

Intraoral application of the pink composite layer.

Partial denture with finished pink composite removed for final shaping, polishing and glazing.

The 18-month postoperative pictures demonstrate a very acceptable and pleasing esthetic and functional result. When comparing the before and after pictures, a dramatic change could be observed. It is clear that diagnosis and treatment planning, using digital technology, can assist in evaluating ridge deficiencies, visualizing potential treatment solutions, and achieving predictable esthetic and functional outcomes.

At this stage, all prosthetic components and crowns were tried in, and minor modifications were made. Tight adaptation with some light ischemia was visible around the pink porcelain at the try-in.

All single e.max crowns were adhesively cemented, which was followed by intraoral application of the pink composite layer. Prior to this, in the lab, the usual protocol of steaming, sandblasting, etching, silanization, bonding, and application of the first layer of flowable pink composite was used to ensure effective and strong bonding between the pink porcelain and the first layer of pink composite.

The color of the gingiva on the right side was used to select the most ideal color of pink composite. Different shades of pink composite were then applied by trial and error along with the addition of different pink stains to create a final illusion of natural gingival tissues specific for this patient.

Post-treatment

Benefits of utilizing the DSD Concept:

Communication

The dental literature has highlighted the importance of the smile design, although it has been vague regarding how the information ideally should be gathered and implemented. The importance of gathering the diagnostic data through forms and checklists[9-14] is emphasized. However, many of these pieces of information may be lost if their real meaning is not transferred in an adequate way to the design of the rehabilitation.

Traditionally, the smile design has been instituted by the dental technician, who performs the restorative wax-up, creates shapes and arrangements in accordance with limited information, and follows instructions and guidelines pro- vided by the clinician in writing or by phone. However, in many cases, the technician is not given enough information to use his or her skills to their maximum potential, and the opportunity to produce a restoration that will truly satisfy the patient is missed.

When the treatment coordinator or another member of the restorative team who has developed a strong personal relationship with the patient takes the responsibility for the smile design, the results are likely to be far superior. This individual has the ability to communicate the patient's personal preferences and/or morpho-psychologic features to the laboratory technician, providing information that can elevate the quality of the restoration from one that is adequate to one that is viewed by the patient as exceptional.[14,15]

With this valuable information and that from the 2D DSD in hand, the dental technician will be able to develop a 3D wax-up more efficiently, focusing on developing anatomical features within the parameters provided, such as planes of reference, facial and dental midlines, recommended incisal edge position, lip dynamics, basic tooth arrangement, and the incisal plane.

Transferring this information from the wax-up to the test- drive phase is achieved through a mock-up or a provisional restoration.[11,13,16] The design of the definitive

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- Lab retrofitting Technique and Components
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- Post Op Instructions, Patient Protocol, and Follow Up
- Final Impressions
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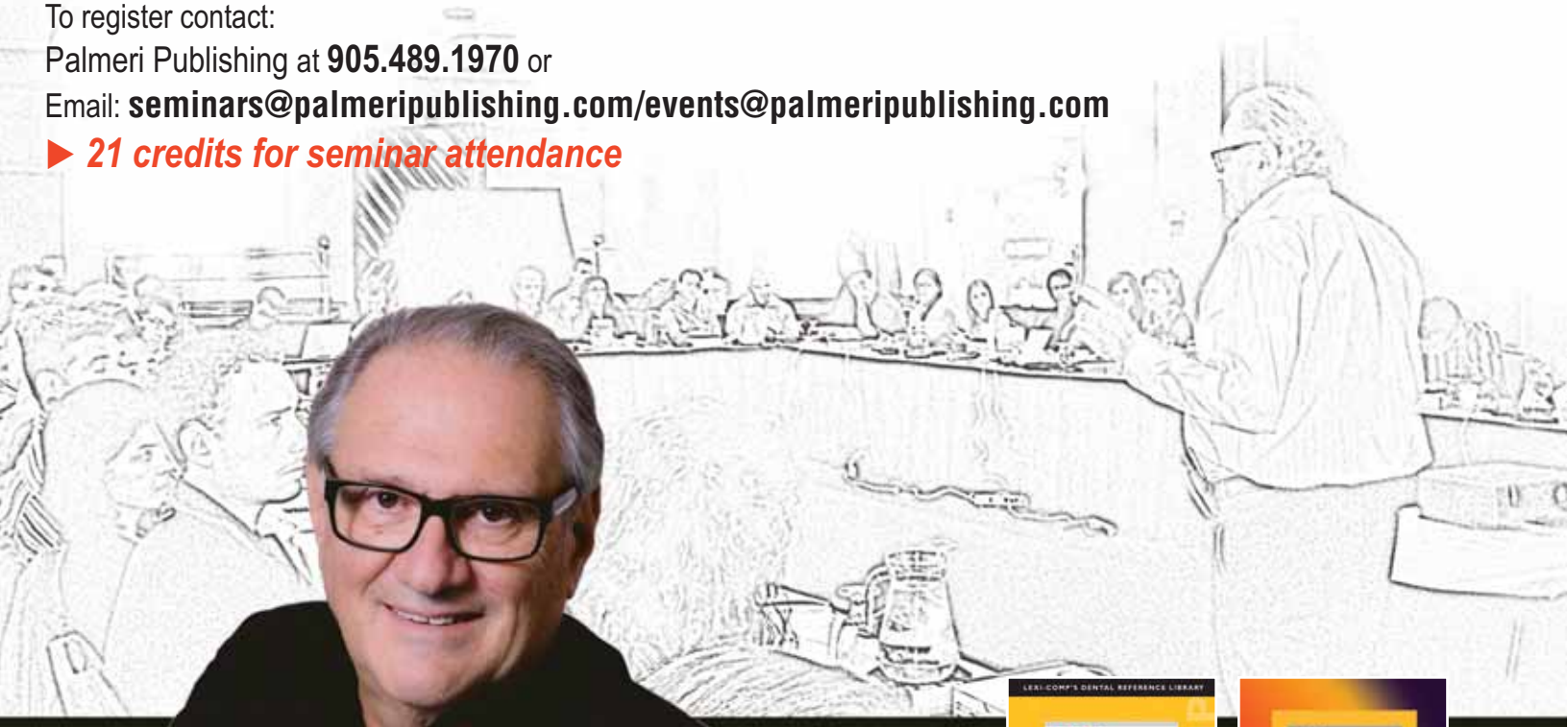

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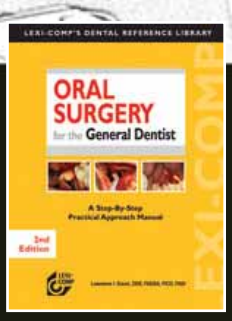

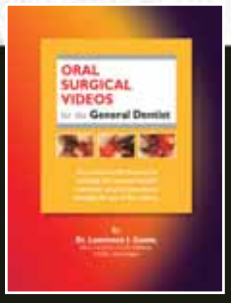

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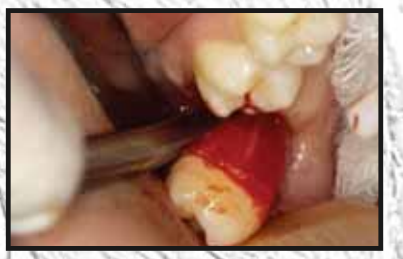

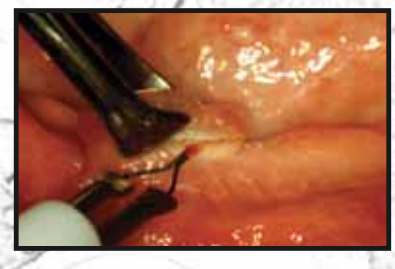

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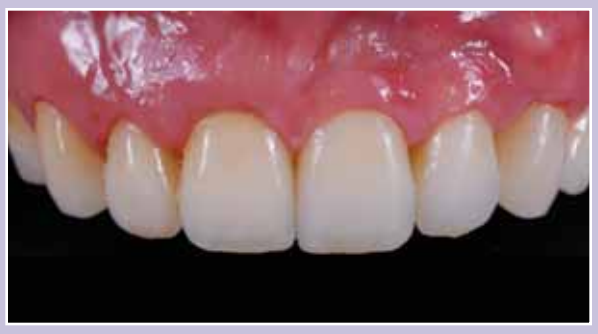
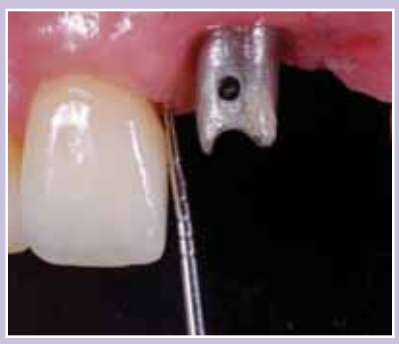
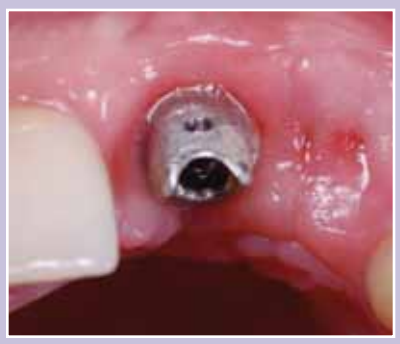


Intraoral frontal view of maxilla at the end of treatment.

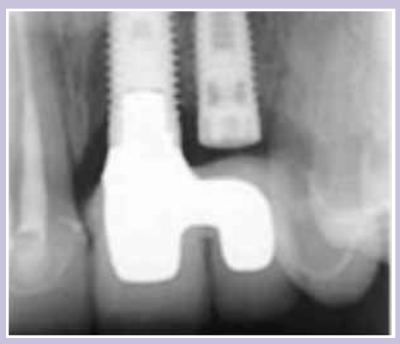
Intraoral frontal view of maxilla 18 months after treatment.



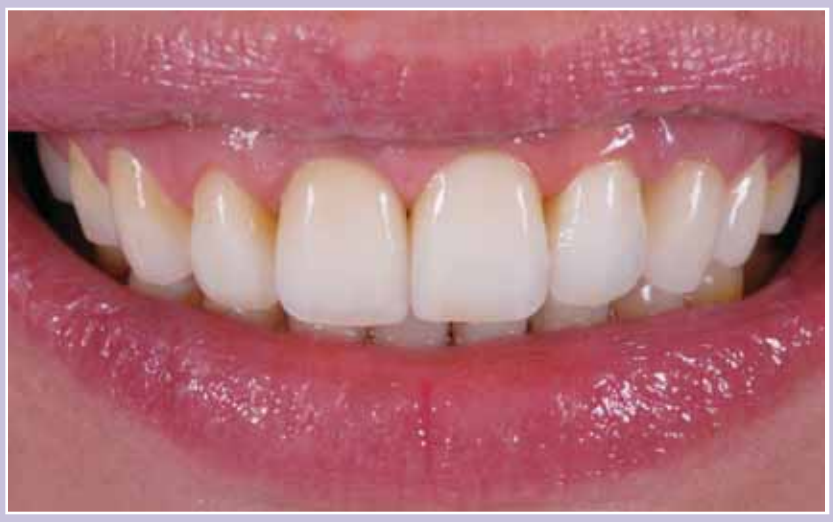
Removal of partial denture to check the soft tissue condition at 18-month checkup.



Occlusal view of healthy soft tissues at 18-month recall.



Radiograph at 18-month recall.



Intraoral frontal view of maxilla at the end of treatment.

esthetic restorations should be developed and tested as soon as possible, guiding the treatment sequence to a predetermined esthetic result. Efficient treatment planning results in the entire treatment team being able to better identify the challenges they will face and helps expedite the initiation and completion of treatment.[1]

Assessment, feedback, and learning

The DSD allows a precise re-evaluation of the results obtained in every phase of treatment. With the drawings and reference lines created, it is possible to perform simple comparisons between the before and after pictures, determining if they are in accordance with the original planning or if any other adjunctive procedures

are necessary to improve the outcome. The dental technician also gains feedback related to tooth shape, arrangement, and color so that definitive refinements can be made. This constant double-checking of information ensures that a higher-quality product will be delivered from the laboratory and also provides a great learning tool for the entire interdisciplinary team.

Education

In many cases, patients are not satisfied with their appearance but really do not understand which contributing factors are responsible. When the clinician is able to clearly illustrate the elements present that deviate from ideal esthetic principles, the patient is more likely to appreciate the treatment challenges ahead and the potential compromises that may ensue. In an educational presentation, the clinician can explain the severity of the case, introduce strategies for treatment, discuss the prognosis, and make case management recommendations.

Conclusion

The concept of compromise sometimes can be hard to swallow, and yet the treatment outcomes in the case suggest that falling short of the ideal should not necessarily be taken as defeat. Treatment success is most important and is subject to the interpretation of the patient. Patient satisfaction trumps the clinician's view of the ideal outcome every time that the two are not the same.

Smile Design should be the primary principle of a treatment plan and the team should use tools to improve the visualization of all the esthetic issues before defining the ideal treatment plan.

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Dr. Christian Coachman *graduated in Dental Technology in 1995 and in Dentistry at the University of São Paulo/Brazil in 2002. He is a member of the Brazilian Academy and Society of Esthetic Dentistry. Moreover, Dr. Coachman attended the Ceramic Specialization Program at the Ceramoart Training Centre, where he also became an instructor.*

In 2004, Dr. Coachman was invited by Dr. Goldstein, Garber, and Salama, of Team Atlanta, to become head ceramist of their laboratory, a position he held for over 4 years.

Dr. Coachman has been working with many leading dentists around the world as Dr Van Dooren (Belgium), Gurel (Turkey), Fradeani (Italy), Bichacho (Israel), Ricci (Italy) and Calamita (Brazil).

Dr. Marcelo Calamita*: Brazil in 1988. He obtained his certificate, MS, and PhD in prosthodontics from the same University, were he worked as clinical instructor in the Department of Prosthodontics for 17 years. He was associate professor of prosthodontics at University Braz Cubas and University of Guarulhos, both in Sao Paulo.*

Dr. Calamita is the former President of the Brazilian Academy of Esthetic Dentistry and maintains a full-time private practice focusing on comprehensive restorative and implant dentistry.

In addition, he has lectured nationally and internationally, published numerous articles and chapters in textbooks on treatment planning, implants and aesthetic restorative dentistry.

Dr. Eric van Dooren *attended the Katholieke Universiteit Leuven, Belgium, where he received his dentistry degree in 1982. After graduating, he opened a private practice in Antwerp, Belgium, which is limited to periodontics, fixed prosthodontics, and implants. Currently, Dr. Van Dooren is an active member of the European Academy of Esthetic Dentistry. In addition, he is a member of the editorial staff of Teamwork (Germany) and a member of the Belgian Dental Society. Dr. Van Dooren lectures nationally and internationally, mainly on aesthetics, implants and aesthetic periodontal surgery. He has published several articles in international journals and is co-author of The Art of Smile.*

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Cemented Implant Restorations and the Risk of Peri-Implant Disease: Current Status

Les restaurations implanto-portées cimentées et le risque de maladies péri-implantaire: La situation actuelle

Chandur Wadhwani, BDS, MSD

Abstract

Dental implants have changed the way many dentists work and have improved the lives of countless patients. However, along with these positive changes some issues have surfaced. One such example is the link between luting cements used for cement-retained implant restorations and peri-implant disease. How and why these materials cause an issue specifically with implants is currently under investigation. This article presents what we currently know about the interaction of cements, implants and peri-implant diseases. By providing a better understanding of their relationship to each other it may be possible to reduce or even eliminate many of the problems that are occurring.

Résumé

Pour de nombreux dentistes, les implants dentaires ont changé leur façon de travailler et ont amélioré les conditions de vie d'un grand nombre de patients. Mais ces changements positifs ont également fait émerger quelques problèmes. Comme par exemple le lien entre les ciments de scellement utilisés pour les restaurations d'implants scellés et les maladies péri-implantaires. Le comment et le pourquoi de ces matériaux qui posent problème spécialement avec des implants sont aujourd'hui à l'étude. Cet article présente les informations dont nous disposons actuellement concernant l'interaction entre les ciments, les implants et les maladies péri-implantaires. Grâce à une meilleure compréhension de leur relation les uns avec les autres, il sera alors possible de limiter voire même d'éliminer de nombreux problèmes auxquels nous nous voyons confrontés.

Introduction:

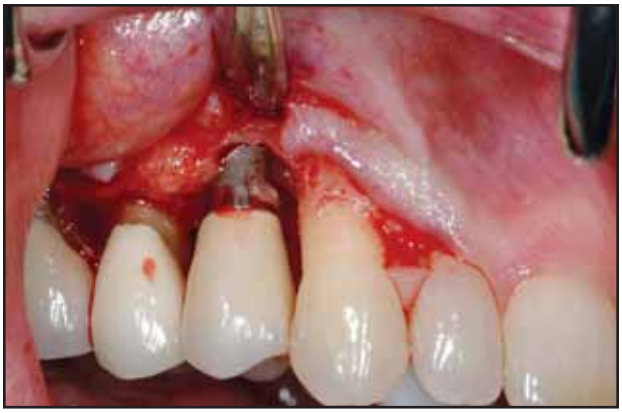
The American academy of periodontology recently released a report into peri-implant disease and risk factors.[1]

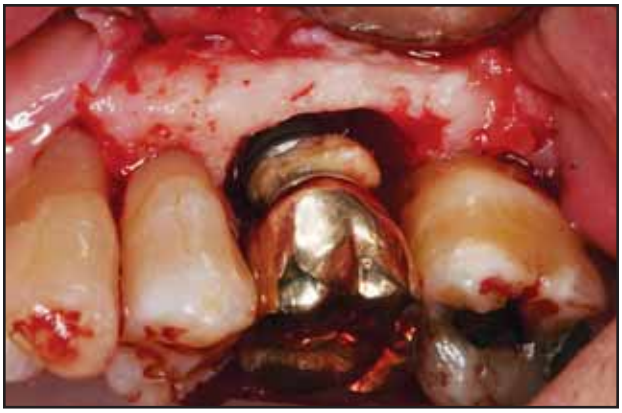
Risk factor for peri-implant disease :

- Previous Periodontal Disease
- Poor Plaque Control/Inability to Clean
- Residual Cement
- Smoking
- Diabetes
- Occlusal overload
- Potential emerging risk factors

List of risk factors related to peri-implant disease stated by the American Academy of Periodontology 2013

When the list is critically reviewed it is clear that some of these risk factors are within the control of the restorative dentist, especially providing a reconstruction that is accessible to cleansing adequately, and more importantly the complete elimination of residual excess cement when a cement–retained restoration is used.





Figures 1a & 1b — These 2 examples show residual excess cement and how it relates to the destruction of the implant supporting tissues.

Cement-retained restorations for implants were introduced over 20 years ago[2], with many claimed advantages such as; control of esthetics, occlusion, reduced cost, ease of fabrication, and passive fit.[3] However, it is more likely that this type of restoration became popular because dentists were familiar with the cementation process, it being a part of traditional tooth form dentistry.[2] What is interesting to note is that most patients when surveyed do not mind whether they receive a screw-or cement -retained restoration[4], therefore it appears predominately the clinicians choice to use a cement retained restoration.

Wilson in 2009 is credited with being the first researcher to positively link peri-implant disease to residual excess cement.[5] He noted that in over 80% of the peri-implant disease cases studied residual excess cement was found located around the implant restoration. The study also evaluated the time period between the restoration being cemented and the detection of the disease process. This ranged from 4 months to almost 9.3 years, with an average of 3 years before any clinical signs or symptoms were detected.

Controversies exist about this disease process, and the aim of this article is to present what is currently known about peri-implant disease and why are implants (compared to cementing restorations onto natural teeth) so susceptible to a procedure which dentistry has been using for over a hundred years with great success?[6]

Peri-Implant disease is now considered to be comprised of 2 general categories. Peri-implant mucositis and Peri-implantitis.[1] Some authorities consider peri-implant mucositis to be similar in nature to gingivitis, in that it is restricted to the soft implant supporting tissues and is considered reversible if treated early. In contrast, peri-implantitis is a non-reversible disease process that affects the supporting bone tissues, and although considered similar to periodontitis it is noted to be far more aggressive and difficult to control.

Although peri-implant disease process have several risk factors, where residual excess cement is concerned, it may be that the cement has an active etiological role rather than simply behaving as a mechanical trap for bacteria such as an overhang. (Figure 1) Peri-implant disease may be caused by the presence of residual excess cement due to: Bacterial interaction, allergic response, foreign body reaction to cement or by the cement altering the surface of the implant resulting in inflammation around the site.[7]

Microbial interaction:

Wilson speculated the time delay before the peri-implant disease became detectable may be a related to a bacterial growth threshold on or near the excess cement. The cement may actually provide a substrate or an environment for bacteria to grow on. The causative organisms of peri-implantitis are considered the gram negative anaerobes. Examples of these bacteria include: Aggregatibacter actinomycetemcomitans, Fusobacterium nucleatum, Porphyromonas gingivalis. They are known pathognes involved in producing destructive effects around both teeth and implants. How these bacteria react in the presence of cements is currently being evaluated and should give direction to cement selection in patients that may have susceptible sites, such as deep implants. An active or perhaps a previous history of periodontal disease may also give rise to careful implant cement selection, where adjacent tooth sites may harbor these bacteria, which may migrate and then infect the implant sites. It is highly likely that some cements may have a negative effect on bacterial colonization, while others may act as a seeding agent for bacteria.

Allergic responses:

Many of the adhesive cements used in dentistry contain chemicals such as HEMA (2-hydroxyethyl methacrylate), a known skin irritant.[8] Leaching out of these chemicals, especially in their unset form in unprotected sites must be considered problematic. Although there is documentation that barrier protection in the form of rubber dam or PTFE material may help[9], these are not widely used during cementation of an implant restoration. Cements in their fluid state must be used cautiously as they can behave as hydraulic systems when placed within a crown and seated under load onto an abutment. The soft tissue attachment mechanism of the body to the implant is very fragile. This hemi-desmosomal attachment is very different to that of a tooth where super-crestal collagen fiber bundles provide immense protection from trauma. In contrast the implant soft tissues can readily be disrupted and torn, resulting in an exacerbation of the problem by providing a pathway for cement to flow even deeper into the tissues.[10]

Foreign body reaction:

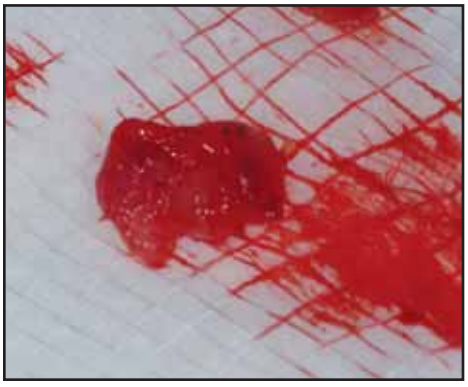
The soft tissues around a peri-implantitis cases have been surgically harvested from diseased sites and histologically evaluated (Figure 2). Foreign body reactions including giant cell formation have been recorded.[11] Emerging reports on cement getting within the soft tissues suggest this may be an etiological factor for peri-implant disease. What is interesting is that investigators are now evaluating how much cement gets displaced both onto and within the sulcular soft tissues during the action of cementating the implant restoration.[12] What is a concern is that some cements have very thin film thickness within the order of red blood cells dimensions. If blood cells can come out of the tissues it seems highly likely that these thin cements may be pushed into the tissues when excessive amounts are loaded into the crown prior to seating and this may be a potential portal for the disease process to occur. Surveys on how much cement is loaded into a crown intended for seating on an implant abutment show the vast majority of clinicians use far in excess of the amount of luting cement ideally needed and there is no consensus on how to apply the cement.[13]

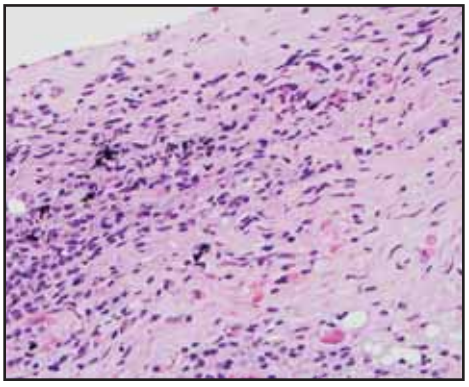
Ionic activation of Titanium:

Some cement manufacturers (for example Durelon 3M-ESPE,) clearly state that their product is not suitable for use with titanium superstructures. Even given this information some clinicians advocate use of these products “off label” and use them for cement-retained implant restorations.[14,15] It is believed these materials when used with titanium result in chemical surface changes that render the titanium active with the removal of the titanium oxide layer. This is of concern as our studies have shown that cement clearly gets to the level of the implant itself. Activation of the titanium would not be desirable. (Figure 3)

Appropriate cements for implant restorations:

There is no ideal dental cement, most if not all have been designed for the natural tooth and frequently include properties for adhesion to hard dental tissues, or have agents that reduce the susceptibility to caries. However it should be noted that implants are not teeth, and while the addition of say fluoride is an obvious benefit for the natural tooth it has no benefit for the implant restoration, in fact it may be detrimental as described above. In 2010 Tarica surveyed US dental schools as to which cement they select for implant restorations and how that differed from what is used for the natural dentition





Figures 2a & 2b — Soft tissue mass removed from around an implant that had residual excess cement. Histopathological report indicates foreign body inclusions in the soft tissues and these can also be seen as dark spots within the tissue specimen (Courtesy of Dr. Goitchi Shiotsu).

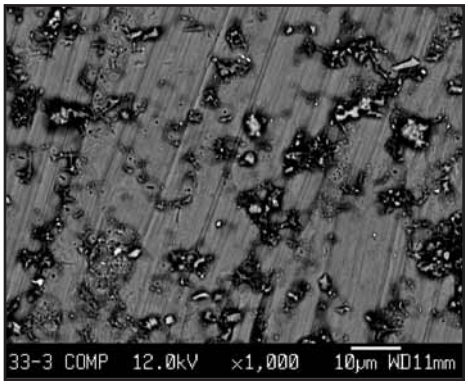


Figure 3 — This SEM at 1000 times magnification shows the effect of Durelon on titanium. There is an etching type pattern.

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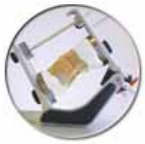

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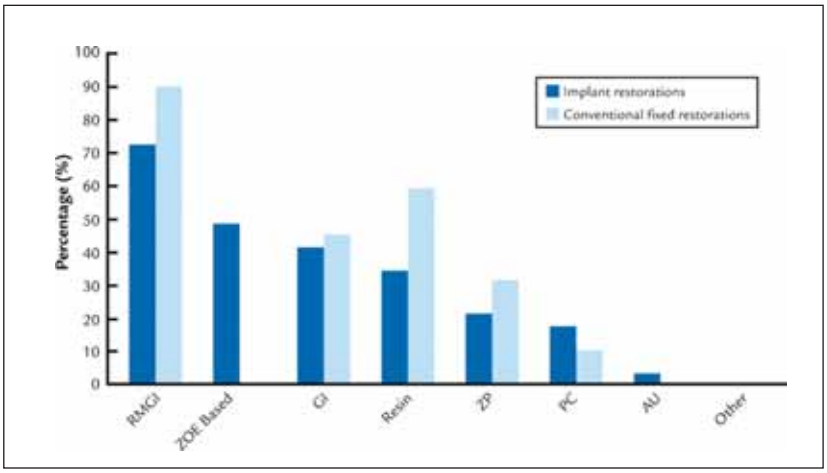
Table 1 — Cement selection for restoration type-

(Tarica 2010 Published in the Journal of Prosthetic Dentistry)



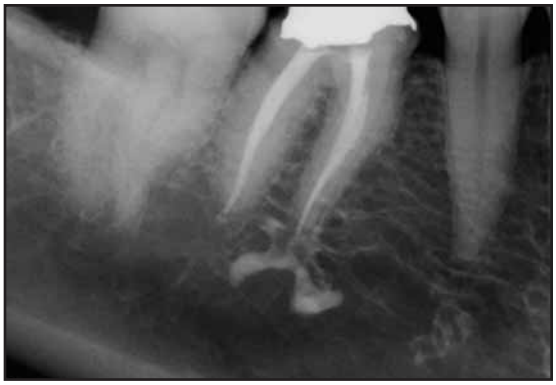


Figure 4 —
This radiograph of a root canal filled tooth demonstrates the alveolar (little cavities) nature of the bone in which implants are placed.

Table 2 — Some considerations for material selection specific to teeth and implant cemented restorations

(Wadhwani and Schwedhelm – 2013 – Dentistry Today)

	Implant restoration	Natural tooth restoration
Substructure	Metal, Ceramic, Acrylic	Dentine, Enamel
Biologic tissue association	Peri-implant tissues	Periodontal tissues, pulp
Primary disease issue	Peri-implant disease	Caries, Pulpal, Periodontal
Restoration finish line	1-2 mm below the gingival crest -often deeper. Implant deeper than this commonly	1 mm below in anterior aesthetic sites, often above free gingival margin elsewhere.
Cement margin	May or may not follow scallop of gingival tissues	Preparation follows gingival Tissue
Need for cement seal	questionable	Desired (prevent caries)
Anti-caries agents	May be detrimental	Desirable
Corrosion	Titanium may be corroded	Not applicable
Radiopacity	Should be highly radiopaque	Similar to dentine
Microbial challenge	Bacteria found in peri-implant sites	*Strep. Mutans, Lactobacillus* (caries producers)

(Table 1). The conclusion was that many schools use the same cements in both cases. This must be considered a complete oversight and misunderstanding of the needs of these very different situations. A list of some of the differences in needs of teeth and implants is shown in (Table 2).

The discerning clinician will realize that many cements must exist within the armamentarium as required for different situations. Also, knowing little about the way the cements could cause peri-implant disease suggests that clinicians must be extremely careful in what materials they use and how they use them.

Mechanisms of cement expression around a dental implant?

One comment that is frequently cited is “if the cement got onto the implant surface then the implant cannot have been fully integrated”.

This statement indicates a complete lack of understanding of the bone into which implants are placed. The term actually describes the bone’s characteristics, it is labelled Alveolar bone. This means “cavity or hollow” and the bone we place implants into is hollow, with marrow spaces, and a highly vascular blood supply. The amount of mineralized tissue touching an implant surface of what is considered a well integrated implant is only 35-40%. Therefore, the remaining 60-65% is un-mineralized and likely to afford little if any resistance to the flow of cement under pressure. This is a common finding when post endodontic treatments are reviewed radiographically. Cement is seen highlighting the marrow spaces. (Figure 4)

A recent examination of failed and returned implants

Figure 5 – (a) This implant had cement one third along the body length.

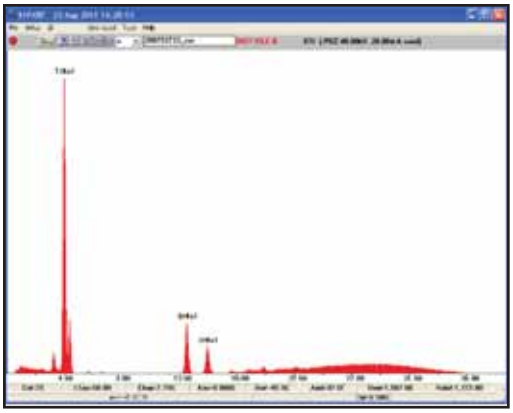


Figure 5 – (b) Evaluation by spectrometer file confirmed chemical properties that are consistent with cement.

to Nobelbiocare (Yorba Linda, CA) attested to the depth along the implant surface that some cements had reached. Using an X-ray spectrometer (Bruker) the materials could be readily identified from their chemical composition. This provided a means of evaluating where the cement had extruded to. (Figure 5)

Solutions:

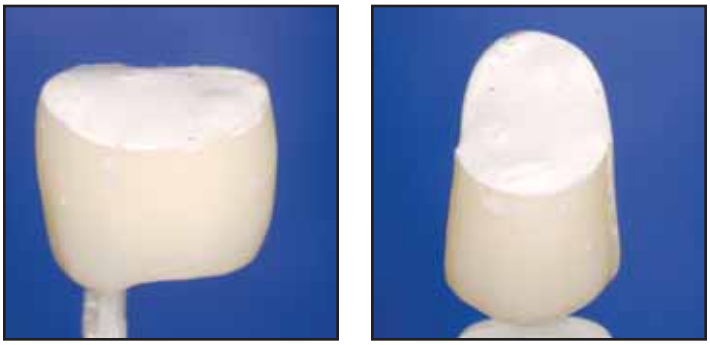
Cement selection must be carefully scrutinized according to requirements for implant health. It should be re-iterated, there is no ideal cement, the clinician must understand there are limitations and take these into account.[16]

Cement application, must be considered, understanding how much is needed and that there is an optimum site for placement to control the cement flow.[13,21] Although this seems obvious, a recent survey of over 400 dentists revealed a lack of consensus on both how much cement was required as well as where the most appropriate application site was. Examples of some of the ways dentists loaded implant crowns are shown. (Figure 6)

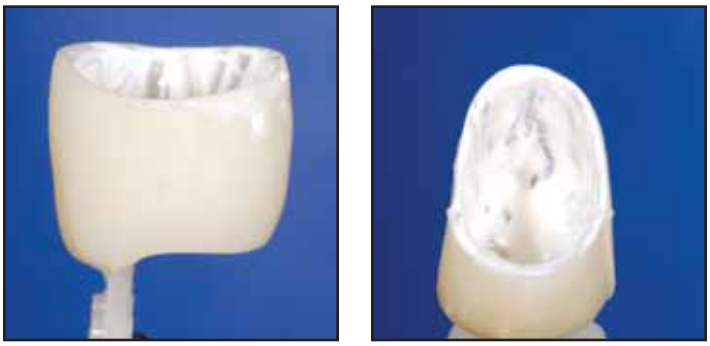
One method to minimize excess cement, especially when using an abutment that has a screw access channel closed off, such as a solid abutment, is to fabricate a custom copy abutment to extra-orally, pre-extrude the cement and leave a cement film coat of about 50 microns on the inside of the crown. (Figure 7)

Using a screw-retained restoration does eliminate the cement issue with techniques that have been developed to overcome the proposed limitations such as esthetics and occlusion (Figure 9).[17] In reality this is not always likely to fulfill the aesthetic requirements, especially in the anterior dentition, so cemented restorations will remain with us for the foreseeable future.

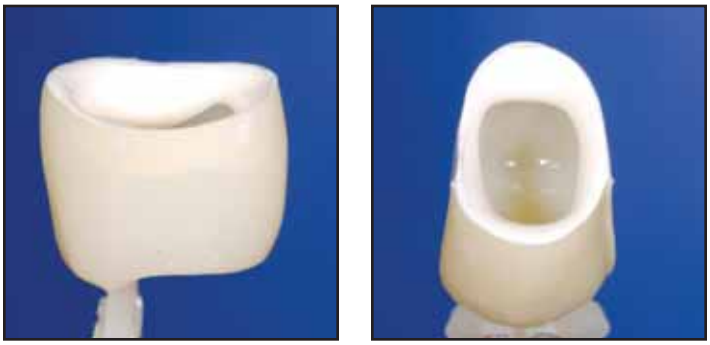
Abutment form and designs: the cement extrusion site is a consideration. Not only should the cement margin position[12,18] of the restoration be judiciously controlled, the abutment can be designed in a manner that "internalizes



Example of "gross application" of cement



Example of "Rim application" of cement



Example of "brush application" of cement

Figure 6 – Three main methods of loading an implant crown with cement recorded in a recent survey. Over 400 clinicians were surveyed. 28% Gross applied cement, 55% Brush application, 17% applied cement to the Rim. (Wadhwani and Chung, Courtesy Dentistry Today 2013).

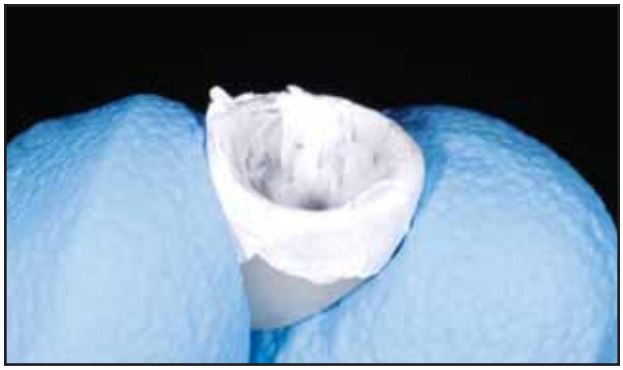


Figure 7a — The inside of the crown is lined with a spacer (Teflon "plumbers" tape is ideal it is 50 microns thick).

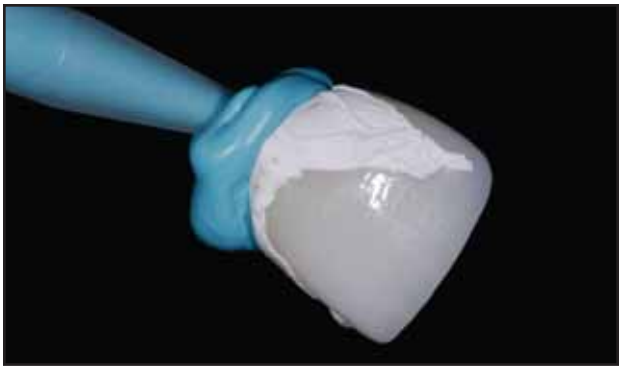


Figure 7b — A fast setting polyvinyl siloxane (Blu-Mousse by Parkell works well) is placed into the crown. The custom copy abutment is removed along with the teflon tape which is disposed of.

Figure 7c — The copy abutment resembles the actual abutment, and is approximately 50 microns smaller in all dimensions.

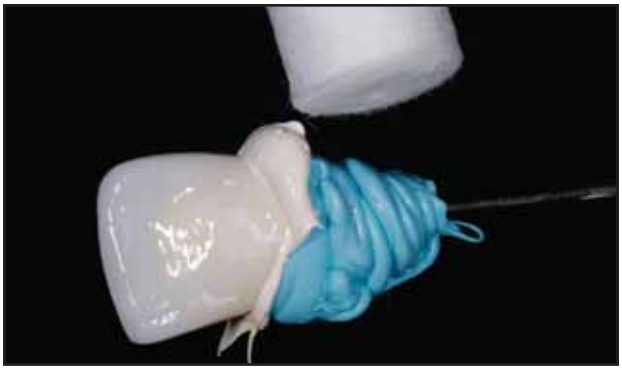
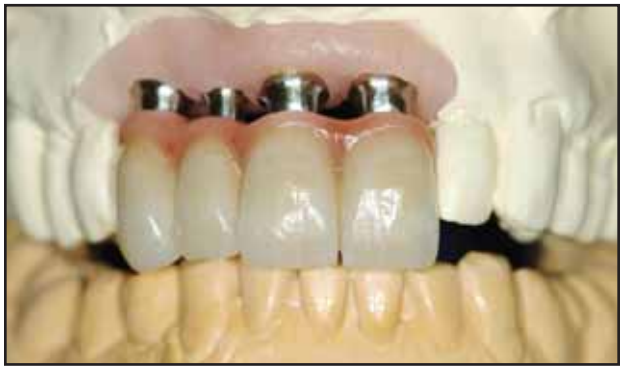


Figure 7d — The cement is placed in the crown, the copy abutment is used to express out cement, leaving a 50 micron cement layer pre-loaded on the walls of the crown.



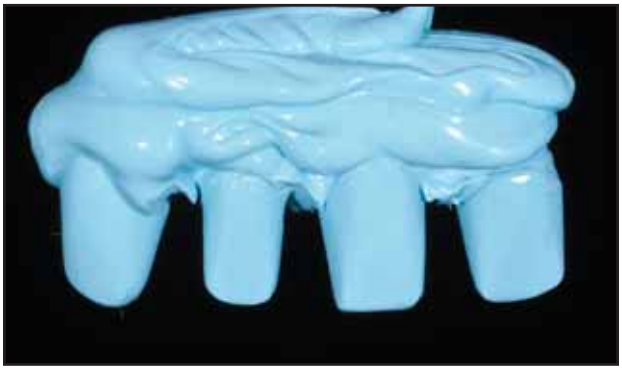


Figure 8 — (a) For multiple abutment cemented restorations the custom copy abutment technique can also be useful (b) (Wadhwani, courtesy Dentistry Today)

the cement" so less material is potentially pushed under the tissues.[19] The author has devised new abutment designs such as Internal venting and abutment inserts[20] that provide flow features which direct cement within the hollow abutment. (Figure 10)

In conclusion:

The process in which cement may lead to peri-implant diseases is still unknown. A link is apparent and residual excess cement is considered a real issue. The restoring clinician is responsible for how and where cement flows, when it remains within the peri-implant tissues and a disease process results it must be considered iatrogenic. The clinician must be aware of why implant restorations in particular have vulnerabilities and how to best control them.

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Dr. J. Wellington (Skip) Truitt B.S., D.D.S. received his Bachelor of Science degree from Texas Christian University and his Doctor of Dental Surgery degree from Baylor University. He has maintained a private dental practice in Gainesville, Texas, since 1967. He also acts as a consultant to other private medical and dental practices in Australia, Thailand, Singapore, South Africa, Mexico, Ireland, Norway, Germany, the United Kingdom, Canada, and the United States.

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Figure 9a — A full contour wax up and wax inlay plug are formed onto the metal UCLA abutment.

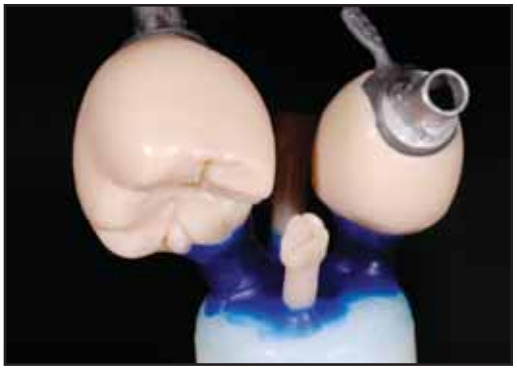

Figure 9b — The wax plug and UCLA wax up can be invested simultaneously, placed into a porcelain pressing oven and porcelain pressed onto the metal.

Figure 9c — Once pressed the porcelain screw access orifice and plug can be etched with Hydrofluoric acid and silane conditioned.

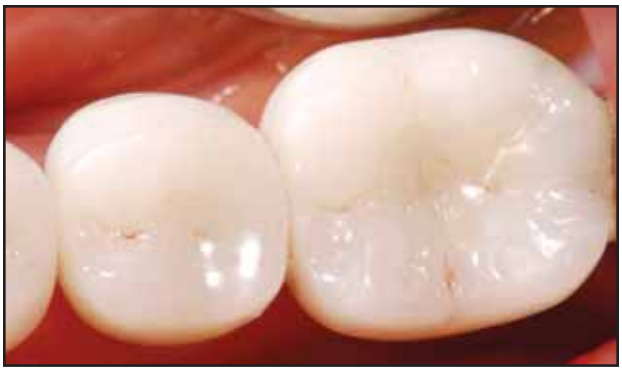

Figure 9d — The porcelain plug is cemented into the screw access channel of both molar and premolar implant crowns, providing an esthetic solution that also gives control of the occlusion.
(Technician: Jurijs Avots)

Figure 10a — The internal vented abutment changes cement flow by channelling it within the screw access chamber. This is readily achieved in metal structures.

Figure 10b — With ceramic abutments, this type of modification could damage them, so an insert is provided to force cement internally.

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Welcome Message from CARDP / Message de bienvenue de l'ACDRP

Dear Colleagues,

On behalf of the 2013 CARDP executive and the organizing committee for the annual scientific meeting, it gives me great pleasure to welcome you to Vancouver, British Columbia: A province and a city, that is "beautiful by nature".

The theme for this year's meeting is "The Art of What We Know" and the program and speakers that we offer will exemplify this enunciation. The collaborative efforts of Drs. Dennis Nimchuk, Ron Zokol, Myrna Pearce, Les Kallos and Allan Jerrof have guaranteed a scientific and social program that will appeal to all.

To kick off our meeting, there will be a hands-on session on Wednesday on composite dentistry, led by Dr. David Clark, from Tacoma Washington. Thursday will focus on an outstanding social/sporting program followed by an array of speakers taking the podium on Friday and Saturday. On Friday evening, we will enjoy a dinner boat cruise of English Bay and the famous Lions Gate Bridge. I highly recommend it: you will not be disappointed.

Vancouver is a vibrant multi-cultural city and I encourage you to arrive early and stay late, in order to enjoy the best that we have to offer. September is an especially beautiful time in Vancouver, with so much to see and do. Within walking distance of our hotel you'll find some world class restaurants, our sea wall and Stanley Park. For those who would like to do a little shopping, Pacific Centre and Robson Street shops are nearby.

The 2013 meeting promises to be an exciting, enriching experience, set in one of the world's most beautiful cities. I look forward to seeing you in September.

Ash Varma
President CARDP, 2013

Chers/chères collègues,

Au nom du conseil d'administration de l'ACDRP 2013 ainsi que du comité organisateur du congrès annuel, il me fait énormément plaisir de vous accueillir à Vancouver, Colombie-Britannique: une province et une ville naturellement belles.

Le thème du congrès cette année porte sur l'Art du savoir, énoncé qui sera appuyé par notre programme et nos conférenciers. Les efforts des Drs Dennis Nimchuk, Ron Zokol, Myrna Pearce, Les Kallos et Allan Jerroff nous assurent un programme scientifique et social qui plairont à tous.

Pour démarrer ce congrès, une session pratique du mercredi, sur les composites en dentisterie, sera dirigée par Dr. David Clark, de Tacoma Washington. Le lendemain, jeudi, sera un jour d'activités sportives et sociales exceptionnelles, suivies, les deux jours suivants, d'un assortiment de conférenciers éminents. En soirée du vendredi, je vous recommande fortement la croisère/souper sur English Bay. Vous ne serez pas déçus.

Vancouver vibre au son de toutes les cultures qu'elle héberge et je vous encourage de la mieux connaître en arrivant avant et en quittant plus tard que le congrès. Septembre est un mois splendide à Vancouver, pour profiter des choses à voir et à faire. À pied de notre hôtel vous trouverez moult restaurants gastronomiques, le parc Stanley, ainsi que du lèche-vitrines au Pacific Centre ou la rue Robson.

Notre congrès 2013 promet de stimuler et d'enrichir dans une ville parmi les plus magnifiques au monde. Au plaisir de vous y retrouver.

Ash Varma
Président ACDRP 2013

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Congrès annuel 2013
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2013 Annual Scientific Meeting

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Wednesday, September 25th

9:00 am - 5:00 pm	Dr. David Clark *"Better, Faster Prettier Composites, The Art and Science. Hands on Course"*

Friday, September 27th

8:15 am	Dr. Ashok Varma – CARDP President
8:23 am	Dr. Dennis Nimchuk – Scientific Program Chair
8:26 am	Dr. Ron Zokol – Clinic Chair
8:30 am	Dr. David Clark - *Injection Molded Composite Dentistry: The Dawn of a New Era*
9:30 am	Dr. Charles Schuler - *What are these drugs our dental patients are taking?*
10:30 am - 11:00 am	Refreshment Break with Sponsors – Exhibit Hall
11:00 am	Dr. Leslie David - *Questions and Realities in Contemporary Oral Surgery and Implant Care*
12:00 Noon - 1:30 pm	Luncheon with Sponsors – Exhibit Hall
1:30 pm	Dr. Harold Baumgarten - *Dental Implants in the Aesthetic Zone – Achieving and Maintaining Long Term Aesthetic Results*
2:30 pm	Dr. Christian Coachman - *Improving Dentist/Technician Communication for Optimum Smile Design and Ceramic Restorations*
3:30 pm - 4:00 pm	Refreshment Break with Sponsors – Exhibit Hall
4:00 pm - 5:00 pm	Dr. David Sweet - *How do I kill you? Let me count the ways.*

Saturday, September 28th

8:30 am - 8:50 am	Dr. Mike Racich – *TMD Evaluation and Management in Everyday Practice*
8:50 am - 9:10 am	Dr. Don Anderson - *Success or Failure in Implant Dentistry and how it affects your Practice*
9:10 am - 9:30 am	Dr. Roxanna Saldarriaga - *The Challenge of Restoring the Anterior Tooth*
9:30 am - 9:50 am	Dr. Ben Pliska - *What Every Dentist Should Know About Obstructive Sleep Apnea*
9:50 am - 10:30 am	Refreshment Break with Sponsors – Exhibit Hall
10:30 am - 10:50 am	Dr. Kim Kutsch - *Dental Caries: Not the Usual Suspects*
10:50 am - 11:10 am	Dr. Chris Wyatt - *Marginal fit of ceramic crowns using digital and conventional techniques*
11:10 am - 11:30 am	Dr. Allan Burgoyne - *Use of technological advances to navigate through tight spots*
11:30 am - 11:50 am	Dr. Chandur Wadhwani - *Residual Excess Cement and Dental Implants- An inconvenient truth.*
11:50 am - Noon	Dr. Ashok Varma - Meeting Conclusion Dr. Jay McMullan - Montreal 2014 Conference Announcement & Video
12:00 Noon - 2:00 pm	CARDP Members Luncheon
2:00 pm - 5:00 pm	Table Clinics

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Mercredi 25 septembre

09h00 – 17h00	Dr. David Clark - *Technique de moulage par injection pour la dentisterie moderne des composites*

Vendredi 27 septembre

08h15	Dr. Ashok Varma – Présidente ACDRP
08h23	Dr. Dennis Nimchuk – Président programme scientifique
08h26	Dr. Ron Zokol – Président des cliniques
08h30	Dr. David Clark - *Moulage par injection de composites en dentisterie*
09h30	Dr. Charles Shuler - *Quelles sont ces drogues que prennent nos patients?*
10h30	Pause dans le salon des exposants
11h00	Dr. Leslie David - *Les questions et les faits concernant les soins en chirurgie buccale et en implantologie*
12h00	Repas du midi avec les commanditaires – salon des exposants
13h30	Dr. Harold Baumgarten - *Les implants dentaires dans la zone esthétique – leur exécution et leur maintien à long terme*
14h30	Dr. Christian Coachman - *Améliorer la communication entre dentiste et technicien dans le but d'optimiser les restaurations* de céramique et la physionomie du sourire
15h30	Pause dans le salon des exposants
16h00	Dr. David Sweet - *Comment puis-je te tuer?*

Samedi 28 septembre

08h30	Dr. Michael Racich - Les dysfonctions temporomandibulaires en pratique quotidienne
08h50	Dr. Donald Anderson - Le succès ou l'échec en implantologie dentaire: comment cela affecte votre pratique
09h10	Dr. Roxana Saldarriaga - Le défi de restaurer une dent antérieure
09h30	Dr. Benjamin Pliska - Ce que tout dentiste doit savoir au sujet l'apnée du sommeil obstructive
09h50	Pause dans le salon des exposants
10h30	Dr. Kim Kutsch - La carie dentaire, cette inconnue
10h50	Dr. Chris Wyatt - L'adaptation marginale des couronnes céramiques à l'aide de techniques conventionnelles et numériques
11h10	Dr. Allan Burgoyne - La technologie au secours des espaces réduits
11h30	Dr. Chandur Wadhwani - Le ciment résiduel excédentaire et les implants dentaires
11h50	Dr. Ashok Varma - Clôture du congrès Dr. Patrick Arcache - Montreal 2014 – annonce et vidéo
12h00	Repas du midi pour les membres de l'ACDRP
14h00	Démonstrations de tables

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TIME			LOCATION
Wednesday, September 25, 2013			
9:00 AM	5:00 PM	Hands On Course	Salon F (Level A)
6:30 PM	11:00 PM	CARDP Executive Dinner Meeting	Port of Vancouver
Thursday, September 26, 2013			
7:00 AM	4:30 PM	Sturgeon or BC Salmon Fishing	Meet in Lobby Renaissance Harbourside Hotel 6:45 am
8:30 AM	4:30 PM	Golf at Shaughnessy Golf Course	Meet in Lobby Renaissance Harbourside Hotel 8:15 am
11:00 AM	3:00 PM	Cooking Vancouver	Meet in Lobby Renaissance Harbourside Hotel 10:30 am
12:00 AM	11:59 PM	Scientific Set-up	Harbourside Ballroom I
8:00 AM	6:00 PM	Trade Show Set-up	Harbourside Ballroom II & III
11:00 AM	8:00 PM	Registration	Harbourside Foyer
3:00 PM	Finish	Journal Meeting (TBC)	Presidents Suite
6:00 PM	10:00 PM	Eat, Meet & Greet, Welcome Buffet with Sponsors	Harbourside Ballroom II & III
Friday, September 27, 2013			
7:00 AM	5:00 PM	Registration	Harbourside Foyer
7:00 AM	8:30 AM	Breakfast with Sponsors	Harbourside Ballroom II & III
8:15 AM	5:00 PM	Scientific Sessions	Harbourside Ballroom I
9:30 AM	3:30 PM	Partner's Program – Vancouver Highlights	Meet in Lobby Renaissance Harbourside Hotel 9:15 am
10:30 AM	11:00 AM	Break with Sponsors	Harbourside Ballroom II & III
12:00 PM	1:30 PM	Lunch with Sponsors	Harbourside Ballroom II & III
3:30 PM	4:00 PM	Break with Sponsors	Harbourside Ballroom II & III
6:30 PM	10:30 PM	Yachting In Vancouver - Sunset Bay II	Meet in Lobby Renaissance Harbourside Hotel 6:00 pm
Saturday, September 28, 2013			
7:00 AM	12:00 PM	Registration	Harbourside Foyer
7:00 AM	8:30 AM	Breakfast with Sponsors	Harbourside Ballroom II & III
7:00 AM	8:30 AM	CARDP Member Breakfast	Tuscany Ballroom (Main Floor)
8:30 AM	12:00 PM	Scientific Sessions	Harbourside Ballroom I
9:50 AM	10:30 AM	Break with Sponsors	Harbourside Ballroom II & III
12:00 PM	2:00 PM	CARDP Members & Guests Lunch	Tuscany Ballroom (Main Floor)
2:00 PM	4:00 PM	High Tea (Partner's Program)	Fairmont Pacific Rim Hotel
2:00 PM	5:00 PM	Table Clinics	Vistas Ballroom (Top Floor)
6:30 PM	7:30 PM	President's Reception	Vistas Ballroom (Top Floor)
7:30 PM	12:00 PM	President's Gala - Dinner Dance	Tuscany Ballroom (Main Floor)
Sunday, September 29, 2013			
9:00 AM	12:00 PM	Clinic and Essay Meeting	Port of Vancouver

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L'ART DU SAVOIR

TRAVAILLER – JOUER – APPRENDRE

TIME		Wednesday, September 25, 2013	LOCATION
9:00 AM	5:00 PM	Cours pratique	Salon F (Level A)
6:30 PM	11:00 PM	Dîner-réunion CA de l'ACDRP	Port of Vancouver
		Thursday, September 26, 2013	
7:00 AM	4:30 PM	Pêche esturgeon ou saumon	Rassemblement foyer 06h45
8:30 AM	4:30 PM	Golf au Shaughnessy	Rassemblement foyer 08h15
11:00 AM	3:00 PM	Cuisiner Vancouver	Rassemblement foyer 10h30
12:00 AM	11:59 PM	Préparation salle de conférence	Harbourside Ballroom I
8:00 AM	6:00 PM	Mise en place des exposants	Harbourside Ballroom II etIII
11:00 AM	8:00 PM	Inscription	Foyer de l'hôtel
3:00 PM	Finish	Réunion du Journal (TBC)	Suite du Président
6:00 PM	10:00 PM	Buffet de bienvenue	Harbourside Ballroom II etIII
		Friday, September 27, 2013	
7:00 AM	5:00 PM	Inscription	Foyer de l'hôtel
7:00 AM	8:15 AM	Petit déjeuner + commanditaires	Harbourside Ballroom II et III
8:15 AM	5:00 PM	Conférences	Harbourside Ballroom I
9:30 AM	3:30 PM	Reliefs Vancouver – pour invités	Rassemblement foyer 09h15
10:30 AM	11:00 AM	Pause avec commanditaires	Harbourside Ballroom II et III
12:00 PM	1:30 PM	Repas avec commanditaires	Harbourside Ballroom II et III
3:30 PM	4:00 PM	Pause avec commanditaires	Harbourside Ballroom II et III
6:30 PM	9:30 PM	Dîner-croisière sur Sunset Bay II	Rassemblement foyer 18h00
		Saturday, September 28, 2013	
7:00 AM	12:00 PM	Inscription	Foyer de l'hôtel
7:00 AM	8:30 AM	Petit déjeuner + commanditaires	Harbourside Ballroom II et III
7:00 AM	8:30 AM	Petit déjeuner membres ACDRP	Tuscany Ballroom
8:30 AM	12:00 PM	Conférences	Harbourside Ballroom I
9:50 AM	10:30 AM	Pause avec commanditaires	Harbourside Ballroom II et III
12:00 PM	2:00 PM	Repas membres + collègues	Tuscany Ballroom
2:00 PM	4:00 PM	High Tea – pour invités	Fairmont Pacific Rim Hotel
2:00 PM	5:00 PM	Démonstrations cliniques	Salle Vistas
6:30 PM	7:30 PM	President's Reception	Salle Vistas
7:30 PM	12:30 AM	Réception du Président	Tuscany Ballroom
		Sunday, September 29, 2013	
9:00 AM	12:00 PM	Réunion comités organisateurs	Port of Vancouver

Wednesday, September 25, 2013 — mercredi le 25 septembre, 2013

Hands-on Course (LIMITED ATTENDANCE)

ADA C·E·R·P® Continuing Education Recognition Program

Presenter: David Clark, DDS

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Hotel Room – Salon F – Level A

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Direct composite restorations are under-promoted and under-appreciated in today's world of implants and computer assisted ceramics. Yet direct composites can be the least invasive, most biomimetic and wonderfully aesthetic of all restorations. The challenge is that we must rely on our own hands to create that magic.

Dr. Clark will present creative solutions to overcome the major clinical impediments to modern resin dentistry. This hands-on course will include the introduction of the "Injection Molding" composite placement technique with the use of the anatomic Bioclear Matrix. At the completion of this course the participants will:

- Restore deep anterior caries
- Restore a peg lateral
- Predict Diastema Closure
- Close black triangles
- Prepare and restore minimally invasive posterior cavity preparations predictably and quickly:
  The Clark Class II
- Achieve a mirror finish and invisible margins in a minute or less.

Dr. David Clark founded the Academy of Microscope Enhanced Dentistry, an International association formed to advance the science and practice of microendodontics, microperiodontics, microprosthodontics and microdentistry. He is a course director at the Newport Coast Oral Facial Institute in Newport Beach, California, and is co-director of Precision Aesthetics Northwest in Tacoma Washington. He lectures and gives hands-on seminars internationally on a variety of topics related to microscope-enhanced dentistry. He has developed numerous innovations in the fields of micro dental instrumentation, imaging, and dental operatory design. Dr. Clark is a 1986 alum of the University of Washington School of Dentistry. He maintains a microscope-centered restorative practice in Tacoma and can be reached at drclark@microscopedentistry.com

Présentateur: David Clark DDS

Technique de moulage par injection pour la dentisterie moderne des composites

Salon F – Level A

(inscriptions contingentées)

Crédits EC: 7

Micro-latérale restaurée utilisant Filtek™ Supreme Ultra Flowable et un composite universel

Les restaurations directes en composites sont sous utlisées et sous estimées dans un monde préconisant les implants et les céramiques assistés par ordinateur. Toutefois, les composites directs peuvent être les moins invasifs, les plus biomimétiques et les plus esthétiques de toutes les restaurations. Le défi de cette magie dépend principalement sur notre dextérité.

Dr. Clark présentera des solutions créatrices dans le but de surmonter les entraves cliniques majeures associées à la dentisterie contemporaine des résines. Ce cours pratique inclut l'initiation à la technique de placement des composites utilisant le «moulage par injection» au moyen des matrices anatomiques Bioclear. À la fin de ce cours les participants pourront:

- Restaurer une carie profonde antérieure
- Restaurer une micro-latérale
- Anticiper la fermeture de diastèmes
- Fermer les triangles noirs
- Tailler et restaurer de manière conservatrice, prévisible et efficacement des cavités postérieures: la classe II Clark
- Obtenir des surfaces miroirs lisses et des marginations imperceptibles en une minute ou moins

Le Dr Clark a fondé the Academy of Microscope Enhanced Dentistry, une association internationale pour l'avancement de la science et de la pratique de la microendodontie, de la microparodontie, de la microprosthodontie et de la microdentisterie. Il est directeur du cours offert au Newport Coast Oral Facial Institute à Newport Beach, Californie et co-directeur du Precision Aesthetics Northwest à Tacoma, Washington. Il donne des conférences et des cours pratiques au niveau international sur une variété de sujets reliés à la microscopie en dentisterie. Il a développé de nombreuses innovations dans les domaines de l'instrumentation dentaire, de l'imagerie et de l'ergonomie des cabinets dentaires. Dr Clark fut promu en 1986 de l'École de Dentisterie de l'Université de Washington. Il maintient une pratique restauratrice centrée sur la microscopie à Tacoma et peut être rejoint à drclark@microscopedentistry.com

Scientific Meeting Speakers
CARDP Vancouver

Friday, September 27th Program – 55 min presentations

Dr. David Clark, Tacoma, Washington
Topic: Injection Molded Composite Dentistry: The Dawn of a New Era
8:30 am – 9:30 am

Synopsis:
You are invited to experience a unique approach to modern resin dentistry. Learn how to create magical artistic effects with direct composite restorations particularly under the beautiful view of a clinical microscope. Direct Composite restorations are under-promoted and under-appreciated in today's world of implants and computer assisted ceramics yet direct composites can be the least invasive, most biomimetic, and wonderfully esthetic of all restorations. The challenge is that we must rely on our own hands to make the magic. Dr. Clark will present creative solutions to overcome the major clinical impediments to modern resin dentistry.

Learning objectives:
1. Know the optimal mix of flowable and paste composite and the injection molding technique
2. Discern the modern model of crack initiation and propagation
3. Identify and treat early tooth fracturing
4. Combine anatomic matrices, emergence profile, and composite techniques for delivering esthetic dentistry

Biography:
Dr. David Clark founded the Academy of Microscope Enhanced Dentistry, an international association formed to advance the science and practice of microendodontics, microperiodontics, microprosthodontics, and microdentistry. He is a course director at the Newport Coast Oral Facial Institute in Newport Beach, CA, and is co-director of Precision Aesthetics Northwest in Tacoma, WA. He lectures and gives hands-on seminars internationally on a variety of topics related to microscope-enhanced dentistry. He has developed numerous innovations in the fields of micro dental instrumentation, imaging, and dental operatory design and authored several landmark articles. Dr. Clark is a 1986 graduate of the University of Washington, School of Dentistry. He maintains a microscope-centered restorative practice in Tacoma, WA.

Dr. Charles Shuler, Vancouver
Topic: What are these drugs our dental patients are taking?
9:30am – 10:30 am

Synopsis:
Many dental patients take medications for a medical condition. The numbers and types of medications available have increased dramatically over the years. The drugs prescribed for a patient can provide considerable insight into their systemic conditions and could require a patient management adjustment during dental care. Some of the medications also have side effects that either alter oral conditions or predispose to oral disease. As our patients are living longer with their teeth, knowledge of the drugs and an understanding of their impact on oral health is a critical component in dental treatment.

The electronic oral health record at the University of British Columbia Faculty of Dentistry listed more than 3500 different entries in the records of medications taken by patients. The drugs can be grouped into categories such as frequency prescribed, the organ system that is targeted, the medical condition being treated, the specific type of medication and the specific considerations during dental treatment.

Learning Objectives:
1. Identify the drugs most commonly prescribed for dental patients
2. Link the drugs with the medical conditions for which they were prescribed
3. List the types of side effects associated with medications
4. Determine the appropriate modification to dental care for patients taking these drugs
5. Identify the ways a dentist can obtain information about a medication prescribed for a patient

Biography:
Dr. Shuler is Dean of the Faculty of Dentistry of the University of British Columbia. Prior to being appointed at UBC he was a faculty member at the University of Southern California for 18 years where he served as Director of the Center for Craniofacial Molecular Biology as well as Director of the Graduate Program in Craniofacial Biology. He was Associate Dean for Student and Academic Affairs at the USC School of Dentistry. He received his B.S. from the University of Wisconsin, his D.M.D. from Harvard, his Ph.D. in Pathology from the University of Chicago and his Oral Pathology education at the University of Minnesota and the Royal Dental College in Denmark. He has been active in assessing and managing clinical oral pathology patients with soft and hard tissue lesions. He also maintains a research program funded by the United States National Institute for Dental and Craniofacial Research.

Dr. Leslie David, Toronto
Topic: Questions and Realities in Contemporary Oral Surgery and Implant Care
11:00 am – Noon

Synopsis:
Advances have occurred in oral surgery and implant care over the years which greatly impact clinicians and patients alike. Options with regard to treatment and execution have become more advanced yet less invasive. A potpourri of frequently asked oral surgery questions pertaining to dental extractions, infections, and other basic oral surgery topics will be reviewed. In addition, the concept of immediate loading pertaining to the single tooth as well as the completely edentulous arch will be de-mystified.

Scientific Meeting Speakers
CARDP Vancouver
Friday, September 27th Program – 55 min presentations

Learning Objectives:
1. Review the implant oriented dental extraction technique and basic oral surgery questions pertaining to general practice
2. Understand the indications and contraindications of immediate implants and immediate loading in both the esthetic and posterior zones
3. Review treatment planning and execution regarding immediate implants and immediate loading

Biography:
Dr. Lesley David is an oral and maxillofacial surgeon who obtained her dental degree from McGill University and practiced general dentistry for 2 years prior to pursuing Oral and Maxillofacial Surgery. Dr. David graduated from OMFS at the University of Toronto. She is involved in teaching at the University of Toronto and is on staff at the Mt. Sinai, Credit Valley, and Trillium hospitals. She is a Fellow and examiner for the Royal College of Dentists of Canada. Dr. David has been involved in implant research, has various implant related publications, and lectures nationally and internationally on various topics in implant dentistry and oral surgery.

Dr. Harold Baumgarten, Philadelphia
Topic: Dental Implants in the Aesthetic Zone – Achieving and Maintaining Long Term Aesthetic Results
1:30 pm – 2:30 pm

Synopsis:
All too often, the aesthetics of an implant supported restoration look good on the day of insert but deteriorates over time. Success in the aesthetic zone requires the clinician to understand the many factors that must come together to achieve and maintain the aesthetic result for the long term. This lecture will discuss issues related to surgical and restorative techniques as well as implant design.

Learning Objectives:
1. Learn the 6 factors responsible for the preservation of bone and soft tissue levels around an implant
2. Know why immediate implant placement and immediate restoration can provide superior aesthetic results
3. Understand how digital restorative technologies can provide superior tissue support and aesthetics

Biography:
In addition to Advanced Restorative and Aesthetic Dentistry, Dr. Baumgarten's practice includes advanced dental implant procedures. He is a consultant to a global dental implant company, is involved in clinical research and product development and lectures regularly around the world. He is also the author of chapters in dental textbooks, and a number of articles in peer reviewed journals.

In 2010, Dr. Baumgarten was selected as one of "The Best Dentists in America" and "Philadelphia Magazine's Top Dentists 2010" by a vote of his peers, and continues to give his patients the benefit of over 30 years of experience.

Dr. Christian Coachman,
Rio de Janiero, Brazil
Topic: Improving Dentist/Technician Communication for Optimum Smile Design and Ceramic Restorations.
2:30 pm – 3:30 pm

Synopsis:
We need to keep abreast of the latest developments in dentistry and incorporate new techniques and materials into our armamentarium on an ongoing basis. It is also essential that all of the team members participate proactively in the treatment planning process so that consistent interaction among the members of the dental team is required. Technicians should have a basic understanding of clinical procedures and the development of target-oriented communication protocols are essential prerequisites for a smooth workflow and the provision of high-quality service. Crucial treatment steps such as the diagnostic wax-up, the fabrication of the mock-up, shade selection, material selection, prep design, and the fabrication of temporary restorations, etc. can be greatly improved by taking into account the technician's perspective.

Learning Objectives:
1. Plan ceramic restorations to fit the patients' esthetic and emotional needs
2. Improve team communication by utilising simple digital tools
3. Develop a Digital Smile Design and link it to the Esthetic Wax-up, Mock-up and Final Ceramic Restorations

Biography:
Dr. Christian Coachman graduated in Dental Technology in 1995 and in Dentistry at the University of São Paulo/Brazil in 2002. He attended the Ceramic Specialization Program at the Ceramoart Training Centre, where he also became an instructor. In 2004, Dr. Coachman was invited by Team Atlanta to become Head Ceramist of their laboratory, a position he held for over 4 years. He now works with many leading dentists around the world. He is currently the scientific coordinator of an e-learning website and serves as a consultant for dental companies and offices developing products and implementing concepts. He has lectured and published internationally in the fields of esthetic dentistry, dental photography, oral rehabilitation, dental ceramics and implants.

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Scientific Meeting Speakers
CARDP Vancouver
Friday, September 27th Program – 55 min presentations

Dr. David Sweet, Vancouver
Topic: How do I kill you? Let me count the ways!
4:00 pm – 5:00 pm

Synopsis:
A biography exists in each human tooth and bone under its armour coating. By examining these tissues, forensic scientists can deduce the events of a person's life and death. The BOLD Forensic Lab at The University of BC uses information gleaned from these examinations to assist in the legal investigation of deaths here in Canada and around the world. This presentation is designed to both inform and entertain you about the forensic sciences. Dr. Sweet will illustrate some of the things that he has experienced working on 1100 cases on six continents.

Learning Objectives:
1. Discover the role of forensic science in national and international systems of justice
2. Realize the complexity of the criminal mind and appreciate the oddity of certain behaviors
3. Appreciate the intensity and rigour with which criminal investigations are conducted

Biography:
With qualifications in dentistry, forensic dentistry and forensic medicine, Dr. Sweet is in a unique position to help police investigators solve the puzzles that are often present at crime scenes. His UBC laboratory has been involved in numerous high-profile criminal cases since its inception in 1996. Dr. Sweet developed new techniques that are now used internationally by investigators. He is a tenured professor at UBC Dentistry and director of North America's only laboratory dedicated to full-time forensic odontology research, teaching and casework. In 2008, Dr. Sweet was invested as an Office of the Order of Canada for his work as a forensic scientist, researcher, teacher and consultant. He was chief scientist for disaster victim identification at INTERPOL in France from 2005–2011 and a forensic advisor to the International Committee of the Red Cross in Switzerland from 2009–2012.

Reserve Essayist for Long Program

Dr. Ron Zokol, Vancouver
Title: Soft Tissue Options to Enhance Esthetic Solutions for Implant-Supported Restorations

Synopsis:
Expectations for high quality esthetic and functional implant-supported restorations to achieve that of the healthy natural tooth have continued to evolve. At every step during the surgical and prosthetic phases, the soft tissue factor needs to be evaluated as it affects the next stage of the restoration process. Technology and procedural options have greatly influenced our expectations for esthetic results.

Learning Objectives:
1. Optimize gingival esthetics
2. Review the technological advances that have increased our esthetic expectations
3. List the biologic influences that deteriorate esthetic gingival solutions

Biography:
Dr. Ron Zokol is the Director of Pacific Implant Institute International, established since 1996 in Vancouver and in Boca Raton, Florida since 2010. Dr. Zokol has been an international lecturer for more than 30 years. He is a member of the Faculty of Dentistry at UBC and sits as a member on its Dean's Advisory Council. Dr. Zokol has maintained a referral practice in advanced surgical and prosthetic rehabilitation in Vancouver.

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Conférenciers programme scientifique
ACDRP Vancouver
Programme du vendredi 27 septembre – 55 min presentations

Dr. David Clark, Tacoma, Washington

Sujet: Moulage par injection de composites en dentisterie

08h30 – 09h30

Synopsis:

Vous êtes invités à faire l'expérience d'un nouveau genre de dentisterie moderne utilisant les résines. Apprenez à créer des effets artistiques dans les restaurations de composite direct. Celles-ci sont sous-évaluées dans un monde d'implants et de céramiques assistées par ordinateur. Or les composites directs peuvent être les moins envahissants et les plus biomimétiques et esthétiques de tous les types de restaurations. Le défi provient du fait que nous devons nous fier sur nos propres mains pour produire cette magie. Dr. Clark présentera des solutions originales pour surmonter les obstacles cliniques à la dentisterie de résine contemporaine.

Objectifs:

- Connaître le ratio optimal des composites fluides et conventionnels ainsi que les techniques de moulage par injection
- Discerner les modèles contemporains d'initiation et de propagation des fêlures
- Reconnaître et traiter les fractures dentaires précoces
- Combiner les matrices anatomiques, les profils d'émergence, et les techniques de composite pour une dentisterie esthétique

Biographie:

Dr. David Clark a fondé l'Académie de la dentisterie microscopique avancée, une association internationale qui a pour but de faire valoir la science et la pratique de la micro-endodontie, la micro-parodontie, la micro-prosthodontie et la micro-dentisterie. Il dirige un cours au Newport Coast Oral Facial Institute à Newport Beach, Californie et est co-directeur d'Esthétique de précision à Tacoma dans l'État de Washington. Il donne aussi des conférences et des cours pratiques à travers le monde portant sur la dentisterie rehaussée au moyen de la microscopie. Il a développé plusieurs nouveautés en matière d'instrumentation, d'imagerie et de design de cabinets dentaires et est l'auteur de nombreux articles de pointe. Il fut promu en médecine dentaire de University of Washington en 1986 et maintient une pratique centrée sur les restaurations microscopiques à Tacoma.

Dr. Charles Shuler, Vancouver

Sujet: Quelles sont ces drogues que prennent nos patients?

09h30 – 10h30

Synopsis:

Plusieurs de nos patients prennent des médicaments pour raisons de santé. La quantité et les types de médications se sont multipliés au fil des ans. Les ordonnances du patient offrent un aperçu de sa condition systémique qui pourrait exiger un ajustement de ses soins dentaires. De plus, certains médicaments provoquent des effets secondaires qui modifient les conditions orales ou même prédisposent aux maladies buccales. Puisque nos patients vivent plus longtemps avec leur dentition, il devient essentiel de connaître les remèdes qui leur sont prescrits et l'impact de ceux-ci sur l'état de leur santé orale.

Le registre électronique de la santé bucco-dentaire à University of British Columbia a répertorié plus de 3 500 médicaments inscrits dans leurs dossiers patients. Ces médicaments se regroupent en catégories, telles leur fréquence de prescription, les systèmes ciblés, la maladie traitée, le type précis de la médication administrée durant les traitements dentaires.

Objectifs:

- Identifier les médicaments prescrits les plus communs
- Associer chaque médicament à la condition médicale traitée
- Dresser une liste des effets secondaires de ces drogues
- Choisir les rectifications à apporter aux soins dentaires s'il y a lieu
- Connaître les moyens de nous informer au sujet des médications de nos patients

Biographie:

Dr. Shuler est doyen de la faculté de Médecine dentaire à University of British Columbia. Avant ce rôle, il était membre de la faculté de University of Southern California pendant 18 ans où il dirigeait le Center for Craniofacial Molecular Biology en plus du programme de deuxième cycle en biologie craniofaciale. Il y occupait aussi le poste de vice-doyen aux études à l'École de Médecine dentaire. Il a mérité un B.S. de University of Wisconsin, son D.M.D. de Harvard, son Ph.D. en pathologie de University of Chicago et sa formation en pathologie orale de University of Minnesota et du Royal Dental College au Danemark. Il poursuit ses activités dans la gestion des patients en pathologie orale ayant des lésions aux tissus mous et durs. D'autre part, il continue à oeuvrer dans un programme de recherche subventionné par le United States National Institute for Dental and Craniofacial Research.

Dr. Leslie David, Toronto

Sujet: Les questions et les faits concernant les soins en chirurgie buccale et en implantologie

11h00 – 12h00

Synopsis:

Les progrès des dernières années en chirurgie buccale et en soins implantaires ont considérablement affecté les cliniciens et leurs patients. Les options de traitements et d'exécution sont à la fois plus avancées et moins envahissantes. Une foire aux questions portant sur les extractions dentaires, les infections, ainsi que d'autres sujets fondamentaux seront adressées. Nous tenterons aussi de démystifier le concept de la mise en charge des dents unitaires et de l'arcade complètement édentée.

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Conférenciers programme scientifique
ACDRP Vancouver

Programme du vendredi 27 septembre – 55 min presentations

Objectifs:
- Revoir la technique d'extraction d'une dent en prévision d'un implant ainsi que des questions portant sur la chirurgie buccale en dentisterie générale
- Saisir les indications et contre-indications d'implants immédiats et de la mise en charge immédiate dans les zones esthétiques et postérieures
- Revoir le plan de traitement et d'exécution pour les implants immédiats et leur mise en charge immédiate

Biographie:
Promue de McGill University, Dr. David a pratiqué la dentisterie générale pendant 2 ans avant de se spécialiser en chirurgie buccale et maxillofaciale à University of Toronto où elle enseigne présentement. Elle est aussi rattachée aux hôpitaux Mt. Sinai, Credit Valley et Trillium. Elle est Fellow et examinatrice du Royal College of Dentists of Canada. Elle est impliquée dans la recherche sur les implants, publiée dans divers ouvrages sur l'implantologie, et donne des conférences aux niveaux national et internationaux sur des sujets touchant la dentisterie implantaire et la chirurgie buccale.

Dr. Harold Baumgarten, Philadelphia
Sujet: Les implants dentaires dans la zone esthétique – leur exécution et leur maintien à long terme
13h30 – 14h30

Synopsis:
Trop souvent, une restauration implanto-portée paraît bien au départ mais son esthétique détériore avec le temps. Afin d'éviter ce problème, le clinicien doit se familiariser avec tous les facteurs qui entrent en jeu. Cette présentation discutera des techniques chirurgicales et restauratrices ainsi que du design des implants.

Objectifs:
- Connaître les 6 facteurs responsables de la préservation des niveaux de tissus mous et osseux autour de l'implant
- Comprendre pourquoi le placement immédiat d'un implant et la restauration immédiate donnent des résultats esthétiques supérieurs
- Comprendre comment les technologies numériques de restaurations fournissent un meilleur support des tissus et de l'esthétique

Biographie:
La pratique du Dr. Baumgarten, forte de 30 ans, comprend une dentisterie restauratrice, esthétique et implantaire. Consultant pour une multi-nationale, il fait aussi de la recherche clinique et le développement de produits, en plus de donner des conférences autour du globe. Il a signé des chapitres de textes dentaires et de nombreux articles dans des journaux dentaires revus par des pairs. En 2010 Dr. Baumgarten fut nommé par ses collègues et par Philadelphia Magazine l'un des meilleurs dentistes en Amérique.

Dr. Christian Coachman,
Rio de Janiero, Brésil
Sujet: Améliorer la communication entre dentiste et technicien dans le but d'optimiser les restaurations de céramique et la physionomie du sourire
14h30 – 15h30

Synopsis:
Nous nous devons de nous tenir à jour sur les derniers développements en dentisterie et d'incorporer de nouvelles technologies et matériaux dans notre arsenal de pratique. Pour ce faire, il s'avère essentiel que tous les membres de l'équipe dentaire participent aux plans de traitements en maintenant entre eux une constante interaction. Ainsi, les techniciens dentaires doivent posséder une connaissance de base des procédures cliniques, et la mise en place d'un protocole de communication avec ces derniers assurera leur meilleur service et une fluidité dans le déroulement des opérations. Les étapes indispensables des traitements, telles les cirages diagnostiques, la fabrication de maquettes, la sélection de la teinte et des matériaux, le design des tailles et la fabrication de restaurations temporaires, etc., seront considérablement améliorées en tenant compte de la perspective du technicien.

Objectifs:
- Planifier les restaurations selon les besoins esthétiques et affectifs des patients
- Améliorer la communication parmi l'équipe dentaire à l'aide de simples outils numériques
- Développer un design numérique d'un sourire et le lier aux cirages diagnostiques esthétiques, aux maquettes et aux restaurations en céramique

Biographie:
Dr Coachman a terminé sa technologie dentaire en 1995 et son cours de dentisterie à l'Université de Sao Paulo en 2002. Il a assisté au programme de spécialité en céramique au centre Ceramoart où il a enseigné par la suite. Puis en 2004 Team Atlanta a demandé au Dr. Coachman de devenir leur céramiste en chef, ce qu'il a fait pendant 4 ans. Présentement, il travaille avec plusieurs dentistes partout dans le monde et est le coordonnateur scientifique d'un site web de formation. Il est consultant pour des compagnies dentaires développant des produits, donne des conférences et contribue à des publications qui portent sur la dentisterie esthétique, la photographie dentaire, la réhabilitation orale, les céramiques dentaires et les implants.

Conférenciers programme scientifique
ACDRP Vancouver

Programme du vendredi 27 septembre – 55 min presentations

Dr. David Sweet, Vancouver

Sujet: Comment puis-je te tuer?

16h00 – 17h00

Synopsis:

Chaque dent et chaque os cache une histoire humaine. En examinant leurs tissus, les médecins légistes peuvent déduire les événements de la vie et de la mort d'un individu. Le laboratoire BOLD du Dr. Sweet prend les renseignements relevés des examens dans le but de contribuer aux investigations légales de mortalités ici au Canada et partout dans le monde. Cette présentation veut vous renseigner et vous divertir à l'aide d'exemples retenus parmi plus de 1 100 cas répartis sur 6 continents.

Objectifs:

- Découvrir le rôle de la médecine légale dans divers systèmes juridiques
- Comprendre la complexité du cerveau criminel et discerner certains comportements insolites
- Saisir l'intensité et la rigueur dans lesquelles les investigations criminelles se déroulent

Biographie:

Qualifié en matières dentaires, légales et médico-judiciaires, Dr. Sweet peut aider les investigations policières à résoudre des crimes. Son laboratoire à UBC, qu'il dirige depuis sa fondation en 1996, s'implique dans plusieurs cas criminels et les nouvelles techniques que le Dr. Sweet a developpées sont utilisées par les enquêteurs à travers le monde. Il est professeur à UBC tout en oeuvrant dans son laboratoire, le seul en Amérique du nord dédié à la recherche et l'enseignement de l'odontologie légale. En 2008 Dr. Sweet mérita l'Ordre du Canada pour l'ensemble de son oeuvre. De 2005 à 2011, il aidait Interpol en France à identifier les victimes de sinistres et entre 2009 – 2012 il était aussi conseiller médico-légal pour la Croix rouge internationale en Suisse.

Conférencier substitut

Dr. Ron Zokol, Vancouver

Titre: Les options au niveau des tissus mous afin d'améliorer les solutions esthétiques des restaurations implanto-portées

Synopsis:

Les attentes continuent d'évoluer quant aux restaurations implanto-portées de haute qualité esthétique qui s'apparentent aux dents saines naturelles. À chaque étape des phases chirurgicales et prothétiques, le tissu mou doit être évalué puisqu'il affecte la prochaine séquence de la restauration. La technologie fait en sorte que nos options de procédures influencent grandement nos expectatives des résultats esthétiques.

Objectifs:

1. Optimiser l'esthétique gingivale
2. Examiner les progrès technologiques qui influencent nos attentes sur l'esthétique
3. Énumérer les effets biologiques qui détériorent l'esthétique gingivale

Biographie:

Dr. Ron Zokol est directeur de Pacific Implant Institute International qui s'est établi à Vancouver en 1996 ainsi qu'à Boca Raton, Floride, depuis 2010. Il donne des conférences au niveau mondial depuis 30 ans. Il fait partie de la faculté dentaire à UBC et maintient une pratique en réhabilitation prothétique et chirurgicale à Vancouver.

Scientific Meeting Speakers
CARDP Vancouver
Saturday Speakers — September 28, 2013

ADA C·E·R·P Continuing Education Recognition Program

Dr. Michael Racich, Vancouver
Topic: TMD Evaluation and Management in Everyday Practice
8:30 am – 8:50 am

Synopsis:
Patients go to the dental office for reasons related to appearance, function and comfort. All three areas must be in harmony for overall patient satisfaction. Over the last decade and a half our knowledge in these areas has increased, especially in the field of orofacial pain and temporomandibular disorders (TMD). This evidence-based presentation will overview current concepts in TMD evaluation, diagnosis and management for everyday practice.

Learning Objectives:
1. Evaluate and diagnose TMD
2. Evaluate occlusion and orthotics
3. Include management considerations in one's practice

Biography:
Dr. Racich, a 1982 graduate of UBC, has a general dental practice emphasizing comprehensive Restorative Dentistry, Prosthodontics and TMD/orofacial pain. Dr. Racich has lectured nationally and internationally on subjects relating to patient comfort, function and appearance. He has published in peer-reviewed scientific journals and has authored books on Oral Rehabilitation, Occlusion and Facially Generated Treatment Planning. Currently he mentors the didactic/clinical FOCUS Dental Education Continuum.

Dr. Donald Anderson, Burnaby
Topic: Success or Failure in Implant Dentistry and How it Affects Your Practice
8:50 am – 9:10 am

Synopsis:
Success or failure in implant dentistry can affect the bottom line of your practice. Recent research in two areas of implant dentistry (CBCT Guided Surgery and Crestal Sinus Lifts) demonstrate how implant dentistry can become a hobby.

Learning Objectives:
1. View the risks of flapless surgery with the use of CBCT surgical guides and crestal approach sinus lift surgery
2. Maximize the success rate in these two modalities

Biography: Dr. Anderson received his BSc (1970) and DMD (1974) from UBC. His practice is limited to implant dentistry and he has trained over 500 dentists from around the world as a Faculty member of the Misch International Implant Institute in Toronto. Dr. Anderson mentors 3 implant study clubs in Vancouver and one in Calgary.

Dr. Roxana Saldarriaga, Vancouver
Topic: The Challenge of Restoring the Anterior Tooth
9:10 am – 9:30 am

Synopsis:
Research has shown that attractive people with radiant smiles are considered to be more trustworthy and more intelligent and have better success in securing jobs than people with unfavorable smiles. It is no wonder there is such emotion involved in restoring damaged or failed anterior teeth. In our profession the restoration of a single anterior tooth is considered to be one of the most challenging processes due to the difficulty in replicating the natural state when it is so obviously exposed. This presentation will illustrate some of the problems and solutions for restoring anterior teeth.

Learning Objectives:
1. Identify various problem situations for the anterior lab fabricated restorations
2. Discuss restorative material selections for developing a high esthetic result
3. Establish a communication protocol with the dental technician to achieve an optimum outcome

Biography:
Dr. Saldarriaga obtained her BA in 1994 and her first dental degree, both in Lima, Peru. In 2005, Dr. Saldarriaga obtained a DDS from the University of Western Ontario. She later entetered the three year Prosthodontic program at the University of Minnesota and graduated in 2010. In 2011 she qualified for her Canadian Royal College Certification in Prosthodontics. Dr Saldarriaga is a Prosthodontic Examiner for the Royal College of Dentists and is in full time private Prosthodontic practice in Vancouver.

Dr. Ben Pliska, Vancouver
Topic: What Every Dentist Should Know About Obstructive Sleep Apnea
9:30 am – 9:50 am

Synopsis:
Obstructive sleep apnea (OSA) is a serious and relatively common condition affecting both children and adults. This presentation will provide dentists with the latest evidence from the emerging overlap between dentistry and sleep medicine, providing clinicians with practical information to make better informed decisions in the care of their patients.

Scientific Meeting Speakers
CARDP Vancouver
Saturday Speakers — September 28, 2013

Learning Objectives:
1. Identify the health effects and common signs and symptoms of OSA in adult and pediatric populations
2. Describe the effectiveness and complications of oral appliance therapy
3. Describe the interaction between craniofacial morphology and OSA in children

Biography:
Dr. Pliska is an Assistant Professor at the University of British Columbia Faculty of Dentistry and maintains a private practice in Vancouver as a certified specialist in Orthodontics. He is a graduate of the University of Western Ontario School of Dentistry, and obtained his Certificate in Orthodontics and Master degree in Dentistry from the University of Minnesota. Dr. Pliska is an active researcher, publishing and lecturing in the areas of airway imaging and dental sleep medicine.

Dr. Kim Kutsch, Albany, Oregon
Topic: Dental Caries: Not the Usual Suspects
10:30 am – 10:50 am

Synopsis:
Dental caries are not a pathogen specific disease, but rather a pH specific disease. Recent studies have demonstrated that the selection pressure for this disease is an acidic pH in the biofilm. We will review the biofilm scientific literature, the current dental caries disease model, caries risk assessment and diagnosis, demin-remineralization chemistry, protocols for treating patients. Further discussions will include practical implementation of a system based on the risk assessment model into the clinical practice setting to be efficient, effective, and predictable.

Learning Objectives:
1. Describe how the dental caries biofilm disease model has evolved
2. Know the benefits of caries risk assessment in a private practice setting
3. Compare targeted therapeutic strategies

Biography:
Dr. Kutsch received his undergraduate degree from Westminster College in Utah and then completed his DMD at the University of Oregon in 1979. He is an inventor holding numerous patents in dentistry, as well as a product consultant and internationally recognized speaker. He has published dozens of articles and abstracts on minimally invasive dentistry, caries risk assessment, digital radiography and other technologies in both dental and medical journals and contributed to several textbooks. He acts as a reviewer for several journals. As a clinician he is a graduate and mentor in the Kois Center and maintains a private practice in Albany.

Dr. Chris Wyatt, Vancouver
Topic: Marginal Fit of Ceramic Crowns Using Digital and Conventional Techniques
10:50 am – 11:10 am

Synopsis:
It is now possible to make an intra-oral digital scan of prepared teeth, then design and mill crowns at the dental laboratory. Conventional methods for the creation of ceramic crowns all involve dimensional error. Elimination of the multiple steps with digital impressions and CAD/CAM dental laboratory processing should theoretically reduce error and improve marginal fit of the final crown. This presentation will show results of an in-vitro research project that can help clinicians decide whether to move to digital technology for crown fabrications.

Learning Objectives
1. Understand the process of intra-oral digital scanning of prepared teeth
2. Understand the process of dental laboratory CAD/CAM to create ceramic crowns
3. Compare conventional and digital fabricated ceramic crown marginal fits

Biography:
Chris Wyatt, BSc, DMD (1986), Dip. Prosthodontics (1995), MSc (1996), FRCD(C) is Professor and Chair of the Division of Prosthodontics and Dental Geriatrics at the Faculty of Dentistry at UBC. He is a founding member of the ELDERS group (Elder's Link with Dental Education, Research, and Service), and the director of the UBC Geriatric Dentistry Program. In 2010, Dr. Wyatt was appointed head of the new Graduate Prosthodontics Program at UBC.

Dr. Allan Burgoyne, Kitchener
Topic: Use of Technological Advances to Navigate Through Tight Spots
11:10 am – 11:30 am

Synopsis:
This is an introduction to strategies using existing and new technologies and implant macrogeometries to navigate tight spaces with dental implants. Tight spaces are identified as interradicular and buccolingual bone volume as well as vertical restrictions of anatomical constraints. We will review the literature associated with the clinical use of reduced diameter, small diameter and min implants. Cases will be presented showing examples of reduced diameter implants, short implants and CBCT for diagnosis and guided surgery.

Scientific Meeting Speakers
CARDP Vancouver
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Learning Objectives:
1. Identify current scientific documentation for reduced diameter implant systems
2. Identify available reduced diameter implant systems and indications for their use
3. Determine when CBCT can be of value in tight spaces for diagnosis
4. Determine when guided surgery can be of value in tight spaces

Biography:
Dr. Burgoyne received his DDS from the University of Western Ontario in 1984 and an MSc and his Certificate in Prosthodontics from the University of Washington in Seattle. Since 1991 he has been in full-time private practice in Kitchener, Ontario. He has lectured extensively on aesthetics, prosthodontics and implant dentistry in Canada and internationally. Dr. Burgoyne is a member of many professional associations and is the author of several scientific papers; he has also given over 150 continuing dental education seminars.

Dr. Chandur Wadhwani, Bellevue, WA
Topic: Residual Excess Cement and Dental Implants - An Inconvenient Truth
11:30 am – 11:50 am

Synopsis:
The American Academy of Periodontology now lists residual excess cement as a major factor in peri-implant disease. Why is this the case, when the techniques we use on the natural dentition have been so successful and do not directly relate to periodontal disease? This lecture will explore the differences between the natural dentition and dental implants, and explain why your patients may well suffer from this disease. It will also explain why cement selection is so important especially with patients who have or are actively suffering from periodontal disease are at significantly more risk of getting peri-implant disease.

Learning Objectives:
1. Discern why implants cannot be treated in the same way as the natural tooth when cementing restorations
2. Appreciate why selecting the wrong type of cement can harm a patient and lead to complications
3. Realize that patients who have periodontal disease have a 50/50 chance of getting peri-implant disease

Biography:
Dr. Wadhwani received his dental degree from the University College London in 1986. After 13 years of general practice and part-time teaching at UCL, he received his Prosthodontics certificate and Master degree from the University of Washington. He is currently in full time private practice limited to prosthodontics in Bellevue WA. He holds a faculty position at the UW. In his spare time he is a clinical researcher and is involved in research in the Prosthodontics, Periodontics, Endodontics and Microbiology departments. He also mentors graduate students from UCSF, UCLA and UW. He has published many articles and is an international speaker.

Reserve Presenter for Short Program

Dr. Dennis Nimchuk, Vancouver
Title: A New Paradigm Shift for Creating Occlusal Precision with Dental Porcelain

Synopsis:
Porcelain fused to metal restorations has reliably served the dental profession for over half a century providing restorations that are both strong and esthetic. However the PFM systems were never able to achieve the occlusal precision that cast gold provided. Now, contemporary ceramic systems have finally evolved to deliver all three elements of an optimum restoration: strength, esthetics and precision.

Learning Objectives:
1. Understand the failings of past ceramic systems
2. Recognize the desirability of occlusal precision

Biography:
Dr. Nimchuk is a Certified Prosthodontist in Vancouver. He has been a director and mentor to over 20 continuing education Study Groups in the field of Fixed, Removable and Implant Prosthodontics. He is an author and teaching clinician and has given over seven hundred presentations worldwide. He has been an Honorary Sessional Lecturer for the Faculty of Dentistry at the University of British Columbia for over 15 years.

14 CE Credits will be issued for Friday and Saturday Scientific Meeting Attendance

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Conférenciers du Samedi — 28 septembre, 2013

Dr. Michael Racich, Vancouver

Titre: Les dysfonctions temporomandibulaires en pratique quotidienne

08h30 – 08h50

Synopsis:

Un patient consulte pour des besoins reliés à l'apparence, la fonction et le confort. Pour qu'il soit pleinement satisfait, ces trois éléments doivent s'harmoniser. Depuis une quinzaine d'années, nos connaissances dans ces domaines se sont accrues, surtout au niveau des douleurs orofaciales et temporomandibulaires. Cette présentation basée sur les faits survolera l'évaluation, le diagnostic et la gestion de ces problèmes.

Objectifs:

1. Évaluer et diagnostiquer les problèmes temporomandibulaires
2. Évaluer l'occlusion et les orthèses
3. Tenir compte de la gestion dans une pratique

Biographie:

Dr. Racich, de la promotion de 1982 à UBC, a une pratique générale qui accentue la dentisterie restauratrice, prosthodontique et orofaciale. Il est conférencier international sur ce qui touche le confort, la fonction et l'esthétique du patient. Il est publié dans plusieurs journaux revus par des pairs et est l'auteur de volumes sur la réhabilitation buccale, l'occlusion et leurs plans de traitements. Il est aussi mentor pour FOCUS, un programme en éducation continue.

Dr. Donald Anderson, Burnaby

Titre: Le succès ou l'échec en implantologie dentaire: comment cela affecte votre pratique

08h50 – 09h10

Synopsis:

Le succès ou l'échec en implantologie dentaire peut avoir des répercussions sur votre revenu. Les dernières recherches dans deux régions de l'implantologie (chirurgie du type CBCT et les élévations sinusales) démontrent comment la dentisterie implantaire peut devenir un passe-temps.

Objectifs:

1. Constater le niveau de risques de pertes d'implants associés aux chirurgies CBCT et aux élévations sinusales sans lambeaux
2. Maximiser le taux de succès dans ces deux modalités

Biographie:

Dr. Anderson a un BSc (1970) et un DMD (1974) de UBC. Il limite sa pratique à la dentisterie implantaire et, en tant que membre de la faculté du Misch International Implant Institute à Toronto, il a formé plus de 500 dentistes à travers le monde. Il est aussi mentor de trois groupes d'étude à Vancouver et un à Calgary.

Dr. Roxana Saldarriaga, Vancouver

Titre: Le défi de restaurer une dent antérieure

09h10 – 09h30

Synopsis:

La recherche démontre que les gens qui possèdent de beaux sourires radieux sont considérés plus fiables et intelligents que ceux qui ne jouissent pas d'un sourire favorable, et qu'ils sont aussi plus aptes à trouver un bon emploi. Il ne faut donc pas s'étonner de la grande émotivité que suscite la restauration des dents antérieures. La restauration de la dent unique antérieure se veut un défi de taille en raison de la difficulté à reproduire son état naturel. Cette présentation illustrera quelques-uns des problèmes et solutions dans ce genre de restauration.

Objectifs:

1. Identifier des difficultés de fabrication des restaurations antérieures en laboratoire
2. Discuter du choix des matériaux pour arriver à des résultats hautement esthétiques
3. Établir un protocole de communication avec le technicien afin d'optimiser son rendement

Biographie:

Dr. Saldarriaga a obtenu son BA en 1994, suivi de son premier diplôme dentaire, à Lima au Pérou. Ensuite, en 2005, elle recevait un DDS de University of Western Ontario suivi d'un programme de trois ans en prosthodontie à University of Minnesota. En 2011, le Royal College du Canada lui conférait sa certification en prosthodontie. Dr. Saldarriaga est examinateur pour le Royal College of Dentists et pratique à temps plein à Vancouver.

Dr. Benjamin Pliska, Vancouver

Titre: Ce que tout dentiste doit savoir au sujet l'apnée du sommeil

09h30 – 09h50

Synopsis:

L'apnée du sommeil obstructive est une condition sérieuse assez répandue qui affecte adultes et enfants. Cette présentation offre les

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derniers résultats de la recherche portant sur la médecine du sommeil en relation avec la dentisterie, et aidera le praticien à faire des choix plus éclairés dans les soins de ses patients.

Objectifs:
1. Identifier les symptômes et effets de l'apnée du sommeil obstructive parmi les populations adultes et pédiatriques
2. Décrire l'efficacité et les complications de la thérapeutique des appareillages
3. Décrire l'influence réciproque entre la morphologie craniofaciale et l'apnée du sommeil obstructive chez l'enfant

Biographie:
Dr. Pliska est professeur adjoint à la faculté de dentisterie de UBC et mène aussi une pratique privée en orthodontie à Vancouver. Il a fait son premier cycle en dentisterie à University of Western Ontario suivi d'un certificat en orthodontie et de sa maîtrise de University of Minnesota. Dr. Pliska est aussi chercheur, auteur et conférencier dans le domaine de l'imagerie et de la médecine dentaire du sommeil.

Dr. Kim Kutsch, Albany, Oregon
Titre: La carie dentaire, cette inconnue
10h30 – 10h50

Synopsis:
La carie dentaire n'est pas une maladie pathogénique spécifique mais plutôt une maladie spécifique au pH. Des études récentes démontrent qu'une des causes principales de cette maladie réside dans le pH acidique du biofilm. Nous verrons la littérature portant sur le biofilm, le dernier modèle de la maladie des caries dentaires, l'évaluation des risques de caries et leur diagnostic, la chimie démin-réminéralisation, les protocoles de traitements. Nous discuterons aussi de la mise en place d'un système basé sur l'évaluation des risques dans le but de rendre une pratique plus efficace et prévisible.

Objectifs:
1. Décrire l'évolution du modèle biofilm de la carie dentaire
2. Connaître les avantages de l'évaluation des risques de caries en pratique privée
3. Comparer certaines stratégies thérapeutiques

Biographie:
Dr. Kutsch a fait un premier cycle à Westminster College dans le Utah et a complété son DMD à University of Oregon en 1979. Inventeur, il détient plusieurs brevets dentaires. Il est aussi consultant de produits et conférencier international. Il est publié dans de nombreux articles de journaux et textes dentaires, portant sur la dentisterie non invasive, l'évaluation des risques de caries, la radiographie numérique, et autres technologies. Il oeuvre, en tant que clinicien, comme mentor au Kois Center et mène une pratique privée à Albany.

Dr. Chris Wyatt, Vancouver
Titre: L'adaptation marginale des couronnes céramiques à l'aide de techniques conventionnelles et numériques
10h50 – 11h10

Synopsis:
C'est possible aujourd'hui de faire un balayage numérique intra-oral de dents préparées pour ensuite concevoir et usiner les couronnes en laboratoire. Les méthodes conventionnelles de fabrication des couronnes céramiques impliquent des erreurs de dimension. En principe, l'élimination de certaines étapes à l'aide d'empreintes numériques et de la CAO/FAO en laboratoire devrait améliorer l'adaptation marginale d'une couronne. Cette présentation montrera les résultats d'un projet de recherche in vitro qui peut aider les cliniciens à décider s'ils veulent avoir recours à la technologie numérique dans la fabrication des couronnes.

Objectifs:
1. Saisir le processus du balayage intra-oral des dents préparées
2. Comprendre le déroulement de fabrication CAO/FAO des couronnes céramiques en laboratoire dentaire
3. Comparer l'adaptation marginale des couronnes céramiques fabriquées de façon conventionnelle vs numérique

Biographie:
Chris Wyatt, BSc, DMD (1986), Dip. Prosthodontie (1995), MSc (1996) est professeur et directeur du département de prosthodontie et de la gériatrie dentaire à la faculté de médecine dentaire à UBC. Il est membre fondateur de ELDERS et directeur du programme de dentisterie gériatrique à UBC. En 2010 il fut nommé directeur du programme de prosthodontie au deuxième cycle à UBC.

Dr. Allan Burgoyne, Kitchener
Titre: La technologie au secours des espaces réduits
11h10 – 11h30

Synopsis:
Ceci est une introduction aux stratégies d'utilisation de technologies et de la macrogéométrie implantaire pour naviguer dans les espaces réduits. Ces derniers sont identifiés par le volume osseux inter-radiculaire et buccolingual ainsi que les restrictions verticales et anatomiques. Nous examinerons la littérature portant sur l'emploi d'implants de diamètres réduits, d'implants courts et du diagnostic ainsi que la chirurgie guidée au moyen de la CBCT.

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Objectifs:
1. Identifier la documentation contemporaine sur les systèmes d'implants aux diamètres réduits
2. Identifier les systèmes d'implants aux diamètres réduits disponibles avec leurs indications
3. Établir les conditions pour l'utilisation de la CBCT dans le diagnostic des espaces restreints
4. Évaluer l'applicabilité de la chirurgie guidée dans les espaces réduits

Biographie:
Dr. Burgoyne a reçu son DDS de University of Western Ontario en 1984 et son MSc et son certificat en prosthodontie de University of Washington à Seattle. Il maintient une pratique privée plein temps à Kitchener depuis 1991. Il donne des conférences sur l'esthétique, ainsi que la prosthodontie et la dentisterie implantaire au Canada et à l'international. Membre de nombreuses associations professionnelles et auteur de travaux scientifiques, il a donné plus de 150 séminaires en éducation continue dentaire.

Dr. Chandur Wadhwani, Bellevue, WA
Titre: Le ciment résiduel excédentaire et les implants dentaires
11h30 – 11h50

Synopsis:
La American Academy of Periodontology inclut maintenant le ciment résiduel excédentaire dans sa liste de facteurs importants des maladies péri-implantaires. Pourquoi en est-il ainsi puisque ce n'est pas le cas pour les dents naturelles? Nous explorerons les différences entre la dentition naturelle et les implants et expliquerons comment la sélection du ciment est primordiale, en particulier chez les patients qui souffrent de maladies parodontales et qui sont plus à risque de développer une maladie péri-implantaire.

Objectifs:
1. Constater pourquoi les implants ne peuvent pas être traités comme des dents naturelles dans la cimentation des restaurations
2. Comprendre que la sélection du mauvais type de ciment peut endommager le patient et entraîner des complications
3. Conclure que les patients ayant une maladie parodontale ont 50% de chances de développer une maladie péri-implantaire

Biographie:
Dr. Wadhwani a reçu son diplôme dentaire de University College à Londres en 1986. Après 13 ans de pratique générale et d'enseignement à temps partiel à UCL, il mérita sa maîtrise et son certificat en prosthodontie de University of Washington. Il pratique la prosthodontie à temps plein aujourd'hui à Bellevue, Washington. Il a un poste à la faculté de UW et est chercheur dans les départements de prosthodontie, parodontie, endodontie et microbiologie. Il est mentor pour les étudiants au deuxième cycle de UCSF, UCLA et UW. Il a publié de nombreux articles et offre des conférences à travers le monde.

Conférencier substitut du samedi

Dr. Dennis Nimchuk, Vancouver
Titre: Un nouveau paradigme dans la précision occlusale utilisant la porcelaine dentaire

Synopsis:
La porcelaine fusionnée aux restaurations métalliques a servi la profession dentaire de façon fiable depuis plus d'un demi siècle. Cependant, les système céramo-métalliques n'ont jamais pu atteindre la précision qu'offrent les coulées métalliques. Or aujourd'hui, les systèmes de céramiques ont évolué au point où les 3 éléments de la restauration sont optimisés, à savoir: la résistance, l'esthétique et la précision.

Objectifs:
1. Reconnaître les lacunes des systèmes passés
2. Connaître les avantages de la précision occlusale

Biographie:
Dr. Nimchuk est un prosthodontiste certifié à Vancouver. Il a dirigé et mentoré plus d'une vingtaine de groupes d'études dans les domaines de la prosthodontie fixe, amovible et implantaire. Auteur et clinicien enseignant, il a donné au-delà de 700 conférences globalement et depuis une quinzaine d'années il est professeur invité honorifique à UBC.

Table Clinics / Demonstrations Cliniques

Saturday, September 28th, 2013 – 2:00 PM – 5:00 PM (3 CE Credits Issued) / Samedi le 28 septembre 2013, 14h00 – 17h00 (3 crédits EC)

ADA C·E·R·P Continuing Education Recognition Program

Dr. Alan Jeroff

Oral Surgery for the General Dentist: a Simple and Predictable Approach to Minimally Invasive Oral Surgery

Learning Objectives:

1. Know the minimally invasive tooth removal techniques and instrumentation
2. Remove broken and difficult teeth with minimal flap
3. Identify various incision and flap designs for optimal end results

La chirurgie buccale pour l'omnipraticien: une approche simple et fiable

Objectifs:

1. Connaître les techniques et instruments pour extraire une dent tout en protégeant l'os
2. Enlever une dent fracturée ou tenace avec un minimum de lambeau
3. Identifier les incisions et modalités de lambeaux

Dr. Michael Racich

A Logical Approach to Occlusal Equilibration

Learning Objectives:

1. Understand the technique rationale
2. Grasp the equilibration technique
3. List the equilibration endpoints

Une approche méthodique de l'équilibration occlusale

Objectifs:

1. Comprendre la raison d'être d'une technique appropriée
2. Saisir la technique d'équilibration
3. Énumérer les buts visés de l'équilibration

Dr. Ian Tester

Provisionalization Techniques for Restorative Cases Requiring Verticalization

Learning Objectives:

1. Review the reasons for opening vertical dimension
2. Enumerate the records required prior to initiating treatment
3. View anterior and posterior indirect and direct provisionalization techniques

Les techniques de temporisation pour les restaurations nécessitant une augmentation de la dimension verticale

Objectifs:

1. Revoir les raisons pour augmenter la dimension verticale
2. Énumérer les données cliniques préalablement au traitement
3. Voir les techniques de temporisation antérieures et postérieures, directes et indirectes

Dr. Kevin Lin

A Novel Implant-locating Device for Abutment Retrieval and Predictable Radiographs to Evaluate Prosthetic Misfit and Health of Osseointegration

Learning Objectives:

1. Recognize the clinical challenges with maintenance and repair of cement-retained implant restorations
2. Understand the importance of obtaining diagnostic intraoral radiographs
3. Learn the advantages of using an implant-locating device to obtain accurate serial radiographs and retrieve implant screw access conservatively

Un nouveau dispositif de localisation d'implant pour la récupération de piliers et pour des radiographies prévisibles, afin d'évaluer les imprécisions prothétiques et l'état de l'ostéointégration

Objectifs:

1. Reconnaître les défis du maintien et de l'entretien des restaurations implantaires qui emploient le ciment
2. Saisir l'importance des radiographies diagnostiques intra-orales
3. Apprendre les avantages d'utiliser un appareil de repérage d'implants afin d'obtenir des radiographies précises et d'accéder aux vis des implants

Table Clinics / Demonstrations Cliniques

Saturday, September 28th, 2013 – 2:00 PM – 5:00 PM (3 CE Credits Issued) / Samedi le 28 septembre 2013, 14h00 – 17h00 (3 crédits EC)

ADA C·E·R·P Continuing Education Recognition Program

Dr. Kim Kutsch

Successful Caries Risk Assessment

Learning Objectives:

1. Explain a new approach to caries risk assessment
2. Describe critical elements of successful caries risk assessment
3. Profile patients in private dental practice regarding dental caries, disease, risks and attitudes

L'évaluation réussie des risques de caries

Objectifs:

1. Expliquer une nouvelle approche d'évaluation de risques de caries
2. Décrire les éléments critiques de cette évaluation
3. Tirer le profil des patients face aux risques de caries

Dr. Angela Wong

Review of Implant Surface Topography

Learning Objectives:

1. Review different types of surface topographies and how they are produced
2. Become familiar with the cells involved in osseointegration
3. Learn about current research on cell interactions in surface topographies

La topographie de surface de l'implant

Objectifs:

1. Revoir les différents types de surfaces topographiques et leur développement
2. Se familiariser avec les cellules de l'ostéointégration
3. Faire une mise à jour des dernières recherches sur les interactions cellulaires des surfaces topographiques

Dr. John Nasedkin & Mr. Bruce Adams

Occlusal Screening: There's an App for that!

Learning Objectives:

1. Provide simplified documentation of occlusal screening
2. Identify potential tm joint disk coordination anomalies
3. Enhance dental diagnostic validity
4. Effectively monitor occlusal or other treatments

Dépistage occlusal: Il y a une application pour ça!

Objectifs:

1. Procurer une documentation succinte du dépistage occlusal
2. Identifier les anomalies de coordination potentielles du ménisque
3. Accroître la validité du diagnostic
4. Contrôler l'efficacité des traitements occlusaux et autres

Mr. Mark Rotsaert & Mr. Paul Rotsaert RDT

Custom Implant Abutments: Interface, Fit, and Clinical Significance

Learning Objectives:

1. Explain the mechanical interface of the implant with the abutment
2. List the limitations of different design software and manufacturing methods
3. Describe, in this context, the clinical applications of the different systems.

Les piliers individualisés: leur interface, adaptation et rôle clinique

Objectifs:

1. Expliquer l'interface mécanique du pilier avec l'implant
2. Énumérer les limites de divers logiciels de conception et de méthodes de fabrication
3. Décrire, dans ce contexte, les applications cliniques des différents systèmes

Pre-Convention Social Activities

Sturgeon or Salmon Fishing on the Fraser River

Thursday, September 26 (7:00 am - 4:30 pm)
Meet in Hotel lobby 6:45 am

Sturgeon fishing in British Columbia with Cascade Fishing Adventures is an unforgettable experience. Sturgeon fishing guests swear that the Fraser River White Sturgeon "acipenser transmontanus" is by far the largest and most exciting freshwater sport fish to be found. Reaching weights exceeding 1,000 pounds, these sturgeon inhabit the murky waters of the mighty Fraser. Special tackle and gear is required for these great fish which is provided for you on your fishing adventure. A boat is a necessity as well and it must be rigged properly to fish for these giants.

Or

Try British Columbia Salmon fishing for the largest of the Pacific salmon, the Chinook, on the Fraser River, located in the heart of the beautiful Fraser Valley. Cast or fly fish for our fall run of Coho salmon. Whatever your choice, our team of Government licensed fishing guides are ready to show you what fishing in British Columbia is all about.

Included in your Fishing Package

- Exclusive boats for 4 guests each
- All fishing gear, tackle, bait, boat fuel, and waders (where needed)
- Transportation to and from the hotel and boat launches
- Luncheon and non alcoholic beverages
- Fishing license fee

Personal Requirements

To ensure your comfort, please bring appropriate clothing for the day. Dressing in layers is suggested with hat, boots and sunscreen. Don't forget your cameras – a point and shoot style digital camera or SLR are fine. The boats are covered enough to provide adequate protection for cameras that are not water resistant.
Website: http://www.bcsturgeon.com

Golf at Shaughnessy Golf Course

Thursday, September 26 (8:30 am - 4:30 pm)

Tee off 9:30 am (Meet in Hotel lobby 8:15 am)

About the Golf Course

Shaughnessy is a parkland style course overlooking the Fraser River and Strait of Georgia. The course was built in 1960 and many of its 150 species of beautiful trees were donated and planted by the members of the time. Shaughnessy's goal is for everyone to experience a very special day so guests and members are requested to follow certain rules:

Dress Code

- Wear tidy and appropriate attire for the various club areas (course, courts, fitness, clubhouse, etc.)
- Denim or denim like material is not accepted in any area of club property
- Bare midriffs are unacceptable
- Caps and clothing with commercial logos not related to golf or tennis are not allowed

Includes transfer to and from the Renaissance Vancouver Harbourside Hotel, green fees and carts, plus lunch in the Spruce Room (club rentals available on site)
Website: www.shaughnessy.org/

Cooking Vancouver

Thursday, September 26 (11:00 am - 3:00 pm)
Meet in the Lobby at 10:30 am

The Dirty Apron Cooking School is one of Vancouver's most unique venues and favourite culinary playgrounds. Everyone loves food, and absolutely nothing unites people quite like creating and sharing a meal. **Prepare to roll up your sleeves and get your apron dirty!**

Instruction focuses on popular regional cuisines as well as basic skill sets for ingredient-focused cooking, and students use only the best tools of the trade. Expert tutor chefs will guide the group as they create their own three course sumptuous meal. Then you'll sit and enjoy the dishes in a beautiful dining-room with a glass or two of selected wines.

Website: www.dirtyapron.com/

Eat, Greet & Meet - Welcome Dinner Buffet

Thursday, September 26 (6:00 pm - 10:00 pm)

Harbourside Ballroom, Second Level

Starting off this year's 21st Scientific Meeting will be our Opening Reception hosted in the Harbourside ballroom and foyer on the second level of the Vancouver Renaissance Harbourside Hotel. Join our meeting sponsors, other registrants and guests to rekindle old acquaintances and make new ones. A dinner buffet will be available for all to enjoy offering a variety of traditional, regional foods.

So plan to be in Vancouver early to join us for the 2013 Scientific Meeting.

Complimentary with registration

Dress Code – Business Casual

Pre-Convention Social Activities

Vancouver Highlights — Guest Event

Friday, September 27 (9:30 am – 3:30 pm)
Meet in the Lobby at 9:15 am

Departing the Vancouver Renaissance Harbourfront Hotel we will make our first stop at the Museum of Anthropology at UBC for a guided tour, followed by a visit to the gift shop. MOA, is a place of extraordinary architectural beauty, provocative programming and vibrant, contemporary exhibitions; a place of active exploration and quiet contemplation – of world arts and cultures.

Next you'll visit Seasons in the Park for an elegant luncheon in the beautiful gardens with spectacular views. Finishing off the day you'll board the coach for Afternoon Tea (or a glass of wine) and a Garden tour at Dr. Dennis and Lydia Nimchuk's home.

Evening Yachting & Dinner on the Sunset Bay II

Friday, September 27 (6:30 pm - 9:30 pm)
Meet in Hotel lobby 6:00 pm
Boarding commences at 6:00 pm and disembarks at 10:00 pm

Join us for a Reception and evening Dinner Cruise offering some of the most spectacular views of Vancouver and surrounding areas. We will gather in the Hotel lobby for a short walk (8 minutes) to the Sunset Bay II, specially docked for us next to the float plan dock to the left of the Convention Centre (West Cordova Street at Bute)

Award winning Executive Chef Natasha Harris and the Sunset Bay Yacht Group's culinary team will prepare a buffet dinner to start off the evening, completed by a relaxing water cruise.

Dress Code – Warm Casual

Signature High Tea at the Fairmont Pacific Rim Hotel — Guest Event

Saturday, September 28 (2:00 pm - 4:00 pm)
Walk on Own

Tea consumption increased dramatically in the early nineteenth century when Anna, the 7th Duchess of Bedford, is said to have complained of "having that sinking feeling" during the day. At the time it was usual for people to take only two meals per diem, breakfast, and a late dinner. The solution for the Duchess was a pot a tea and a light snack in the afternoon.

Friends were eventually invited to join her in her rooms at Woburn Abbey and this summer practice proved so popular that the Duchess continued it when she returned to London. So join your friends at the Fairmont Pacific Rim Hotel for a memorable afternoon. Please meet at the Fairmont Pacific Rim directly (near the Renaissance Harbourside Hotel), 1038 Canada Place, Lobby Lounge Terrace.

CARDP PRESIDENT'S GALA

Saturday, September 28 (6:30 pm – 12:30 am)
Vancouver Renaissance Harbourfront Hotel

In each city we meet, we try to improve on past galas, so they keep getting better due in great part to the friendships we've created along the way. Join us for this 21st President's Gala champagne reception on the top floor of the Renaissance Harbourside, with spectacular views from the Vistas Room. Then we'll move to the main level in the Tuscany Ballroom to feast on a marvellous Gala dinner, followed by dancing to the Blue Meanies, who have been playing music from the 50s onward in the Vancouver area for 20+ years, on big and small stages alike. The Blue Meanies offer diverse, no warm-up required, concentrated, big-sound entertainment.

Reception 6:30 pm – Vistas Room, top floor
Dinner/Dance 7:30 pm – Tuscany Ballroom, main floor
Dress: Black Tie Optional

Vancouver Average September Temperature (Low / High) - (10°C / 18°C) (50°F / 65°F)

Activités pré-congrès et sociales

Pêche à l'esturgeon ou au saumon sur la rivière Fraser

Jeudi 26 septembre (07h00 – 16h30)

Rassemblement au foyer de l'hôtel 06h45

Avec Cascade Fishing Adventures, la pêche à l'esturgeon en Colombie Britannique devient une expérience inoubliable. L'esturgeon blanc des eaux de la rivière Fraser, 'acipenser transmontanus' est, à peu de choses près, le poisson d'eau douce le plus impressionant et excitant à pêcher car son poids peut atteindre plus de 1 000 livres (453 kg). Cela nécessite donc un attirail tout particulier qui vous est fourni pour votre aventure, incluant une embarcation spécialement équipée.

OU

Lancez la mouche au plus grand saumon du Pacifique, le Chinook, sur la rivière Fraser, au coeur de la vallée du même nom. Le Coho s'y trouve en automne. Vos guides expérimentés et licenciés vous offriront une expérience unique de la pêche en Colombie Britannique.

Inclus dans votre forfait

- Embarcations pour 4 pêcheurs, essence
- Équipement, gréments, appâts, cuisardes (où requises)
- Transport aller-retour de l'hôtel et aux bateaux
- Repas du midi et breuvages non-alcoholisés
- Permis de pêche

Effets personnels

Afin d'assurer votre confort, les vêtements appropriés sont recommandés: plusieurs couches, chapeau, bottes, écran solaire. N'oubliez pas vos appareils photos.
Site web: http://www.bcsturgeon.com/history.htm

Golf au Club de golf Shaughnessy

26 septembre (08h30 – 16h30) - Départ à 09h30

Rassemblement dans le foyer de l'hôtel 08h15

À propos du parcours

Shaughnessy est un parcours qui surplombe la rivière Fraser et le détroit Georgia. Instauré en 1960, le terrain ressemble à un parc avec ses 150 espèces d'arbres splendides qui furent plantés par les membres de l'époque. Afin que tout le monde puisse jouir de leur expérience à Shaughnessy, membres et invités sont priés d'acquiescer à certaines règles:

Code vestimentaire

- Tenue soignée et appropriée pour les divers lieux du club (parcours de golf, courts de tennis, mise en forme, pavillon)
- Tissus en denim (jeans) ou qui ressemblent au denim ne sont aucunement acceptés sur la propriété
- Ventres exposés sont inacceptables
- Casquettes et vêtements avec des logos non reliés au golf ou au tennis ne sont pas permis

Le transfert aller-retour de l'hôtel Renaissance Vancouver Harbourside, les tarifs de parcours et voiturettes électriques, le repas du midi sont inclus (location de bâtons sur place)
Site web: www.shaughnessy.org/

Cuisiner Vancouver

Jeudi 26 septembre (11h00 – 15h00)

Rassemblement dans le foyer de l'hôtel 10h30

L'école Dirty Apron est parmi les attractions préférées de Vancouver car tout le monde aime manger et se rassembler autour d'un repas bien préparé et partagé avec convivialité. Alors roulez vos manches et salissez vos tabliers!

La cuisine régionale et les aptitudes culinaires de base sont les vedettes de la séance de formation où les élèves travaillent avec les meilleurs équipements qui soient. Des chefs d'expérience guident chaque groupe dans la préparation d'un délectable repas trois services, accompagné d'un ou deux verres de vin assorti, servi dans une belle salle à manger.

Site web: www.dirtyapron.com/

Buffet de bienvenue

Jeudi 26 septembre (18h00 – 22h00)

Salle de bal Harbourside – deuxième niveau

Notre 21ième congrès annuel débutera avec une réception d'ouverture à la salle de bal et au foyer du deuxième étage du Vancouver Renaissance Harbourside Hotel. Venez rencontrer commanditaires, collègues et invités, renouez avec vos amis puis faites de nouvelles connaissances. Un buffet vous sera offert, présentant plusieurs plats traditionnels de la région.

Arrivez tôt pour démarrer notre congrès 2013 à Vancouver.

Inclus avec votre inscription

Code vestimentaire - Décontracté

Activités pré-congrès et sociales

Reliefs de Vancouver —
offerts aux invités des participants inscrits

Vendredi 27 septembre (09h30 – 15h30)

Rassemblement dans le foyer de l'hôtel 09h15

Nous quitterons notre hôtel pour nous diriger au musée d'anthropologie de University of British Columbia et un tour commenté, suivi d'une visite à la boutique du musée. L'édifice, qui possède une architecture extraordinaire, offre une programmation vibrante et provocante dans ses expositions contemporaines. C'est un endroit de découverte active puis de contemplation tranquille – un monde d'art et de cultures.

Un élégant repas du midi nous attend à Seasons in the Park dans ses jardins avec vues imprenables. Pour clôturer la journée, nous sommes invités pour le thé (ou un verre de vin) et une visite des jardins de la demeure de Dennis et Lydia Nimchuk.

Soirée et dîner sur le Sunset Bay II

Vendredi 27 septembre (18h30 – 21h30)

Rassemblement dans le foyer de l'hôtel 18h00

Embarquement à 18h00 et débarquement à 22h00

Soyez des-nôtres pour ce dîner-croisière qui offre de surcroît des panoramas magnifiques de Vancouver et ses environs. À compter du foyer de notre hôtel, nous nous rendrons à pied (8 minutes) au Sunset Bay II qui nous attendra au quai à gauche du centre des congrès (West Cordova et Bute).

La chef de renommée Natasha Harris et l'équipe culinaire du Sunset Bay Yacht Group auront préparé un splendide buffet, repas qui sera agrémenté d'une croisière reposante.

Code vestimentaire - Chaud Décontracté

Le High Tea au Fairmont Pacific Rim Hotel —
offert aux invités des participants inscrits

Samedi 28 septembre (14h00 – 16h00)

La consommation du thé a connu une montée en flèche au XIXième siècle lorsque Anna, la septième duchesse de Bedford, qui avait des malaises causés par «un creux dans l'estomac» durant la journée, implanta la tradition du thé l'après-midi. Avant ce temps, les gens ne prenaient que deux repas par jour: le petit déjeuner et un souper tard dans la soirée. La duchesse invita des amis à se joindre à elle pour une tasse de thé et un goûter les après-midis quand elle séjournait à Woburn Abbey mais cette pratique est devenue vite si populaire qu'elle continua la nouvelle tradition à Londres. Joignez-vous à vos propres amis au Fairmont Pacific Rim pour une expérience inoubliable du High Tea. Rendez-vous directement à cet hôtel, situé près du Renaissance Harbourside au 1038, Canada Place, à la terrasse du foyer au rez-de-chaussée.

Gala du Président

Samedi 28 septembre (18h30 – 00h30)

Vancouver Renaissance Harbourfront Hotel

Chaque année, nous tentons de surpasser les galas précédents, ce qui veut dire qu'ils ne vont qu'en s'améliorant, et cette tendance est due, en grande partie, aux liens amicaux que nous entretenons d'une fois à l'autre. Ce 21ième gala ne fera pas exception. Réunissons-nous pour le champagne à la salle Vistas du Renaissance Harbourside, perché au dernier étage avec vues époustouflantes. Par la suite, nous nous rendrons au niveau principal de l'hôtel, à la salle de bal Tuscany pour un merveilleux festin et de la danse accompagnée des Blue Meanies. Cet orchestre joue de la musique des années 50 jusqu'à aujourd'hui depuis plus de 20 ans. Leur répertoire diversifié est un spectacle concentré à grand déploiement.

Réception: 18h30 Salle Vistas, dernier étage
Souper/danse: 19h30 – Salle de bal Tuscany, niveau principal

Code vestimentaire - Tenue de soirée Optionnelle

Température moyenne à Vancouver en septembre (Min / Max) - (10°C / 18°C) (50°F / 65°F)

Executive & Committees / Conseil d'administration et comités de l'ACDRP

2013 Committee Structure and Members/ Structure des comités et membres

COUNCIL

EXECUTIVE COUNCIL:

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Dr. Ashok Varma
Powell River, BC

President-Elect
Dr. Jay McMullan
St-Lambert, Qc

Vice President
Dr. Ian Tester
St. Catharines, ON

Past President
Dr. Maureen Andrea
Chester, NS

Secretary - Treasurer
Dr. Les Kallos
Burnaby, BC

COUNCILORS:

Atlantic Provinces
Dr. Scott McLean, Halifax, NS

Quebec/Nunavut
Dr. Jay McMullan, St. Lambert, QC

Ontario
Dr. Izchak Barzilay, Toronto, ON

Manitoba/Saskatchewan
Dr. Terry Koltek, Winnipeg, MB

Alberta/NWT
Dr. Deborah Schwartz, Calgary, AB

BC/Yukon
Dr. Alan Jeroff, Vancouver, BC

STANDING COMMITTEES

EXECUTIVE COMMITTEE:
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Dr. Ashok Varma, Powell River, BC
President-Elect
Dr. Patrick Arcache, Beaconsfield, QC
Vice President
Dr. Ian Tester, St. Catharines, ON
Past President
Dr. Maureen Andrea, Chester, NS
Secretary - Treasurer
Dr. Les Kallos, Burnaby, BC

ADMISSIONS COMMITTEE:
Dr. Myrna Pearce (Chair), Vancouver, BC
Dr. Denis Beauchesne, Georgetown, ON
Dr. Mark Norris, Vancouver, BC

NOMINATIONS COMMITTEE:
Dr. Emo Rajczak (Chair) Hamilton, ON
Dr. Kim Parlett, Bracebridge, ON
Dr. Stanley Blum, Montreal, QC

CONSTITUTION AND BY-LAWS COMMITTEE:
Dr. Dennis Nimchuk (Chair), Vancouver, BC
Dr. Gerald Skea, Thunder Bay, ON
Dr. Patrick Arcache, Beaconsfield, QC

PHOTO-ROSTER COMMITTEE:
Dr. Bruce Farlow (Chair), Peterborough, ON
Dr. Les Kallos, Burnaby, BC

PUBLICATIONS COMMITTEE:
Dr. Hubert Gaucher, Québec City, QC

PROMOTIONS AND COMMUNICATIONS COMMITTEE:
Dr. Maureen Andrea (Chair), Chester, NS
Dr. Myrna Pearce, Vancouver, BC
Dr. Joanne Thomas, Dartmouth, NS
Dr. Ed McIntyre, Edmonton, AB

CONTINUING EDUCATION COMMITTEE:
Dr. Rolf Kreher (Chair), Toronto, ON
Dr. Ed McIntyre, Edmonton, AB
Dr. Jim Donaldson, Thunder Bay, ON

HISTORIAN:
Dr. William Sehl, Waterloo, ON

Past Presidents / Présidents antérieurs

Canadian Academy of Restorative Dentistry and Prosthodontics / L'Académie canadienne de dentisterie restauratrice et de prosthodontie

Maureen Andrea	2012
Kim Parlett	2011
Vernon Shaffner	2010
Stanley Blum	2009
Mike Racich	2008
Dennis Nimchuk	2007
Gorman Doyle	2006
Alan Osborn	2005
William H. Sehl	2004
Cary D.L. Letkemann	2003
Brian Friesen	2002
Hubert Gaucher	2001
Bernard Linke	2000
Robert J. David	1999
Michael R. Roda	1998
Edward McIntyre	1997
Allan R. Mills	1996
Graham G. Matheson	1995
Anthony H. Sneazwell	1994
George K. Scott	1993

Canadian Academy of Prosthodontics / L'Académie canadienne de prosthodontie

Dennis P.A. Nimchuk	1992
Carl J. Osadetz	1991
David H. Charles	1990
Nasser Diabi	1989
Bruce M. Jackson	1988
Harry L. Gelfant	1987
Emmanuel J Rajczak	1986
Robert Hoar	1985
Andrew Tynio	1984
Michael W. Balanko	1983
Paul S. Sills	1982
Paul Jean	1981
Leon A. Richardson	1980
Arthur H. Irvine*	1979
Richard C. McLelland	1978
Francoise Michaud*	1977
Herbert Ptack	1976
Douglas V. Chaytor	1975
Georges A. Zarb	1974
W. Brock Love	1973
Jacques Fiset*	1972
A. Harris Crowson	1971
Donald Kepron	1970
Jean Nadeau	1969
Alan D. Fee	1968
William G. Woods	1967
Kenneth M. Kerr*	1966
James E. McCutheon*	1965
Wilfred D. Clark* (Charter Meeting)	1964
Charles H. Moses*	1963
R. Lawrence Twible*	1962

Canadian Academy of Restorative Dentistry / L'Académie canadienne de Dentisterie restauratrice

Craig Naylor	1992
Ernest R. Ambrose	1991
Leonard L. Kahane	1990
Andrew Tynio	1989
Stanley S. Kucey	1988
Vernon B. Shaffner	1987
Daniel C.T. MacIntosh	1986
Edward J. Abrahams	1985
Berl L. Mendelson	1984
J. Ivan Johnson	1983
B. Larry Pedlar	1982
Norman C. Ferguson	1981
E.S. Morrison	1980
Earl V. Gowda	1979
George K. Scott	1978
Owen J. Yule*	1977
Robert B. Telford	1976
Robert A. Clappison	1975
Emmanuel J. Rajczak	1974
Walter V. Grenkow*	1973
Douglas H. MacDougall	1972
D. Blake McAdam	1971
Sidney R. Katz*	1970
Jacques Fiset	1969
William R. Scott	1968
James D. Purves*	1967
J. Rod Fraser	1966
Harry Rosen	1965

CARDP Membership / ACDRP Membres

Active /Fellow Members

Adams	Dr. Jonathan M.	305 - 1830 Oak Bay Ave.	Victoria	BC	Active 08
Albert	Dr. Daniel	950 Bedford Hwy, Suite 203	Bedford	NS	Active 12
Andrea	Dr. Maureen	57 King Street, PO Box 299	Chester	NS	Fellow 00
Akkad	Dr. Samer	2810 - 25 Kingsbridge Garden Circle	Mississauga	ON	Active 07
Arcache	Dr. Patrick	1450 rue Talon est	Montreal	QC	Fellow 00
Barzilay	Dr. Izchak	905-2300 Yonge Street, Box 2334	Toronto	ON	Fellow 91
Beauchesne	Dr. Denis	12719 Tenth Line	Georgetown	ON	Active 10
Bergen	Dr. David	38 Dalhousie Ave	St. Catharines	ON	Active 10
Blair	Dr. David R.	Suite 231, 465 Victoria	St. Lambert	QC	Fellow 89
Blum	Dr. Stanley S.	8200 Decarie Blvd. #160	Montreal	QC	Fellow 84
Boccia	Dr. Aldo	2992 Dufferin Street	North York	ON	Active 04
Boucher	Dr. Denis	200 Champlain St., Suite 240	Dieppe	NB	Fellow 91
Brode	Dr. Donna	3075 Forest Glade Drive	Windsor	ON	Active 11
Carr	Dr. Heather	Atlantic Dental Ctr, 7001 Mumford Rd	Halifax	NS	Active 10
Coopersmith	Dr. Allan	245 Victoria, Suite 620	Westmount	QC	Fellow 89
Currie	Dr. Mary P.	315 Lakeshore Road	Pointe-Claire	QC	Active 03
Dabuleanu	Dr. Tudor	2 Finch Avenue West	Toronto	ON	Fellow 81
Davidson	Dr. Thomas	350 Oxford St., N	London	ON	Active 06
David	Dr. Robert J.	Ste. 626, 1414 Drummond Street	Montreal	QC	Fellow 66
Donaldson	Dr. James	Ste.703, W. Arthur Place, 1265 E.Arthur St	Thunder Bay	ON	Fellow 01
Doyle	Dr. Gorman	Faculty of Dentistry, Dalhousie University	Halifax	NS	Fellow 94
Ellis	Dr. David	85 East Avenue	Kitchener	ON	Fellow 83
Ennis	Dr. Leslie	205-1538 Foster Street	White Rock	BC	Active 08
Evans	Dr. Natalia	202-145 W. 15th Street	North Vancouver	BC	Active 08
Farlow	Dr. Bruce	201 Aylmer St., North	Peterborough	ON	Active 08
Filice	Dr. Elio	130 - 1685 Main Street. W	Hamilton	ON	Active 08
Flunkert	Dr. Michael	101-1197 W. 10th Ave	Vancouver	BC	Active 08
Fortin	Dr. Yvan	Suite 109, 3075 Chem des Quatre Bourgeois	Quebec City	QC	Fellow 87
Freeman	Dr. Rick	1433 Ontario Street	Burlington	ON	Active 08
Friesen	Dr. Brian N.	1295 Leila Avenue	Winnipeg	MB	Fellow 92
Gardner	Dr. Bruce	777 Guelph Line, Suite 213	Burlington	ON	Active 11
Garland	Dr. Wayne H.	503-6095 Coburg Road	Halifax	NS	Active 07
Gatchell	Dr. Greg	102-166 North St., South Shore Prof. Centre	Bridgewater	NS	Active 06
Gaucher	Dr. Hubert	2408, Saint-Louis Road	Quebec City	QC	Fellow 79
Goldberg	Dr. Perry V.	Suite 125, 8305 Walnut Hill Lane	Dallas	TX	Fellow 84
Goldenberg	Dr. Brian	1014 - 750 West Broadway	Vancouver	BC	Active 11
Gottschling	Dr. Gerd D.	Suite 201, 180 Nechako Centre	Kitimat	BC	Fellow 85
Gowda	Dr. Earl V.	Suite 204, 1571 Bellevue Avenue	West Vancouver	BC	Fellow 69
Hamilton	Dr. Douglas	1 Westmount Square, Suite 420	Westmount	QC	Active 08
Hess	Dr. Tim	1268 E Main Street	Auburn	WA	Active 12
Hoetten	Dr. Filiz	Ste 405 - 6155 North Street	Halifax	NS	Active 07
Hill	Dr. Steven	Suite 1901-805 West Broadway	Vancouver	BC	Fellow 04

Active /Fellow Members – continued

Hupfau	Dr. Peter R.	Suite 510, 2425 Oak Street	Vancouver	BC	Fellow 86
Isbister	Dr. Karyn Patricia	10070 - 105th Street	Edmonton	AB	Active 08
Jeroff	Dr. Alan	708-1160 Burrard Street	Vancouver	BC	Active 08
Kallos	Dr. Les	Suite 210, 7155 Kingsway	Burnaby	BC	Fellow 92
Kiproff	Dr. James	Suite 312, 2425 Bloor Street	Toronto	ON	Fellow 86
Klaiman	Dr. Howard	2300 Yonge street Suite 905	Toronto	ON	Active 12
Koltek	Dr. Terry	1111-233 Kennedy Street	Winnipeg	MB	Fellow 05
Koranyi	Dr. Alex F.	5775 Yonge Street, Suite 1000	Toronto	ON	Fellow 99
Kreher	Dr. Rolf	1244 Gerrard Street East	Toronto	ON	Active 04
Kutlesa	Dr. Marijana	605 Hwy 8	Stoney Creek	ON	Active 12
LaCouvee	Dr. Francis	101-183 Fern Road West	Qualicum Beach	BC	Active 07
Letkemann	Dr. Cary D.	19-54 Wilson Street West	Ancaster	ON	Fellow 94
Lobb	Dr. Douglas A.	#620, 10216-1244 Street NW	Edmonton	AB	Fellow 03
Lunn	Dr. Garry	#402, 1338 West Broadway	Vancouver	BC	Fellow 04
MacLean	Dr. Scott	Trimac Dental Ctr, 6950 Mumford Rd, Ste 1	Halifax	NS	Active 06
Mancuso	Dr. Antonio	2-547 Thorold Road	Welland	ON	Active 06
Mansbridge	Dr. Bruce	18 – 800 Queenston Road	Stoney Creek	ON	Active 10
Mazgaj	Dr. David	1616 Abbott Road	Lackawanna	NY	Active 11
McMullan	Dr. Jay	17112 Chemin Ste-Marie	Kirkland	QC	Fellow 01
Miller	Dr. Robery J.	16244 S. Military Trail, Suite 260	Delray Beach	FL	Active 12
Modi	Dr. Pio Zacharias	299 Wayne Gretzky Parkway, Unit 1	Brantford	ON	Active 12
Nette	Dr. Andrew	9 Gaspereau Ave	Wolfville	NS	Active 12
Nord	Dr. Brian	5715 Canal Road	Pender Island	BC	Fellow 86
Norris	Dr. Mark	310, 5970 East Boulevard	Vancouver	BC	Active 04
Parlett	Dr. Kim	PO Box 1387, 48 Anne Street	Bracebridge	ON	Fellow 88
Pate	Dr. John	Suite 2, 530 Willow Road	Guelph	ON	Fellow 87
Pearce	Dr. Myrna	2203, 2850 Shaughnessy Street	Port Coquitlam	BC	Fellow 04
Pedlar	Dr. Patrick	310 Plains Road East	Burlington	ON	Active 11
Pepper	Dr. John	206, 105 King Street West	Dundas	ON	Fellow 05
Poon Woo	Dr. Carolyn	2259 Bloor Street	Toronto	ON	Active 05
Potluri	Dr. Ajay	Suite 101, 15252-32nd Ave.	Surrey	BC	Active 08
Pudritz	Dr. Ronald	201 - 1760 Marine Drive	West Vancouver	BC	Fellow 04
Racich	Dr. Michael J.	1085 Palmenston Ave	West Vancouver	BC	Fellow 00
Rawas	Dr. Charles	2100 Marlowe, #244	Montreal-Nord	QC	Active 11
Rhodenizer	Dr. Ken	Suite 195, 6960 Mumford Road	Halifax	NS	Active 06
Richard	Dr. Roger	59 rue Notre Dame	St. Louis-de-Kent	NB	Fellow 04
Robertson	Dr. David	575 Upper James Street	Hamilton	ON	Active 04
Roda	Dr. Michael	5657 Spring Garden Road, Suite 600, Comp 201	Halifax	NS	Fellow 83
Rotondo	Dr. Joseph	3613 Fleury Est	Montreal-Nord	QC	Active 10
Saldarriaga	Dr. Roxanna	1901-805 Broadway	Vancouver	BC	Active 11
Savoie	Dr. Joseph	477 Rue Paul	Dieppe	NB	Fellow 04
Schwartz	Dr. Deborah	101-747 Lake Bonivista Dr. SE.	Calgary	AB	Active 08

CARDP Membership / ACDRP Membres

Active /Fellow Members – continued

Scott	Dr. David	14007-52 Avenue NW	Edmonton	AB	Fellow 92
Seddon	Dr. Nicholas	2461 Bellevue Ave	West Vancouver	BC	Active 11
Sehl	Dr. William	187 Erb Street West	Waterloo	ON	Fellow 77
Shah	Dr. Paresh	6-3421 Portage Ave	Winnipeg	MB	Active 08
Skea	Dr. Gerald	136 Edward Street South	Thunder Bay	ON	Fellow 91
Soo	Dr. Lange	210 15321 16 th Ave,	Surrey	BC	Active 12
Soordhar	Dr. Anil Rick	9030 Derry Road West, Suite 2	Milton	ON	Active 11
Stewart	Dr. Malcolm	10070-105 Street, Main Floor	Edmonton	AB	Fellow 81
Struguescu	Dr. Michael	Suite 309, 745 Danforth Avenue	Toronto	ON	Fellow 95
Sutherland	Dr. Mark	1528 Robie Street	Halifax	NS	Fellow 06
Taylor	Dr. Peter	401-345 Lakeshore Road East	Oakville	ON	Fellow 04
Tejani	Dr. Abbas	2354 West 41st Avenue	Vancouver	BC	Fellow 05
Tester	Dr. Ian	305 Glendale Avenue	St. Catharines	ON	Fellow 92
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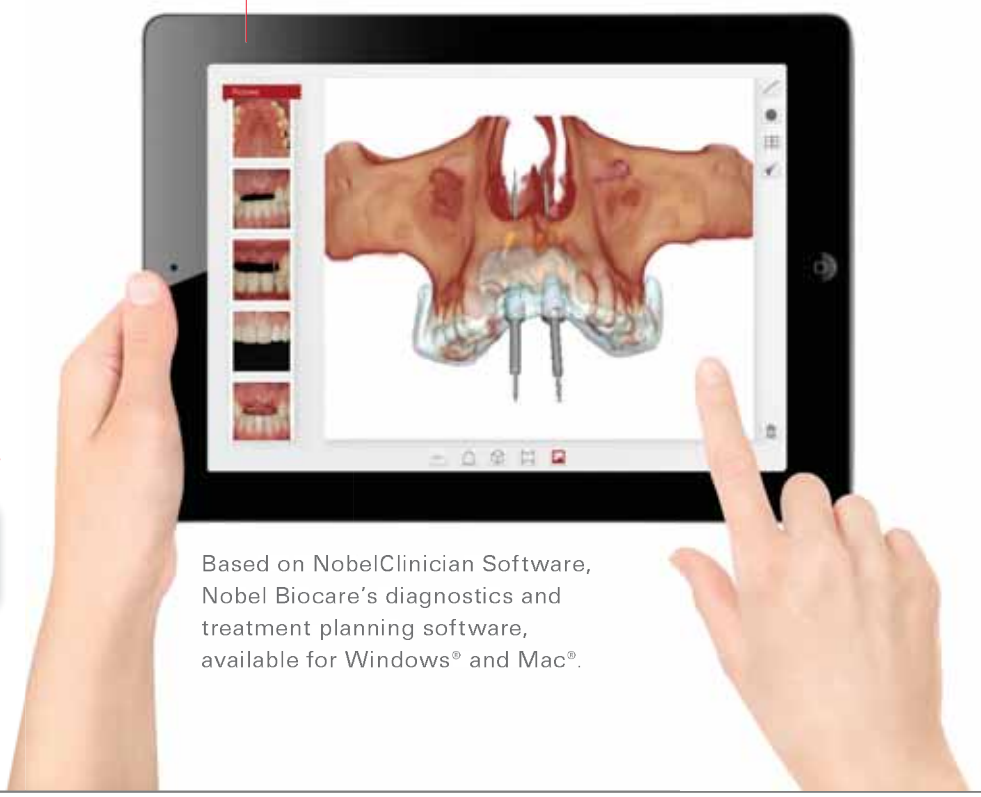

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