

20 TIPS

THE SPECIALISTS

When you Refer, What Does your Specialist Need from You?

Are you giving your specialists the critical information they need when you refer a patient to them? In the spirit of interdisciplinary collaboration—and with the ultimate goal of improving patient care—the *JCD* asked respected clinicians and educators in the field, representing five different specialties (periodontics, prosthodontics, oral surgery, orthodontics, and endodontics), to provide readers with tips about what they need most from their referring general practitioners. You will find in the next few pages a total of 20 tips that will help you develop a better relationship with the specialists to whom you refer your patients.



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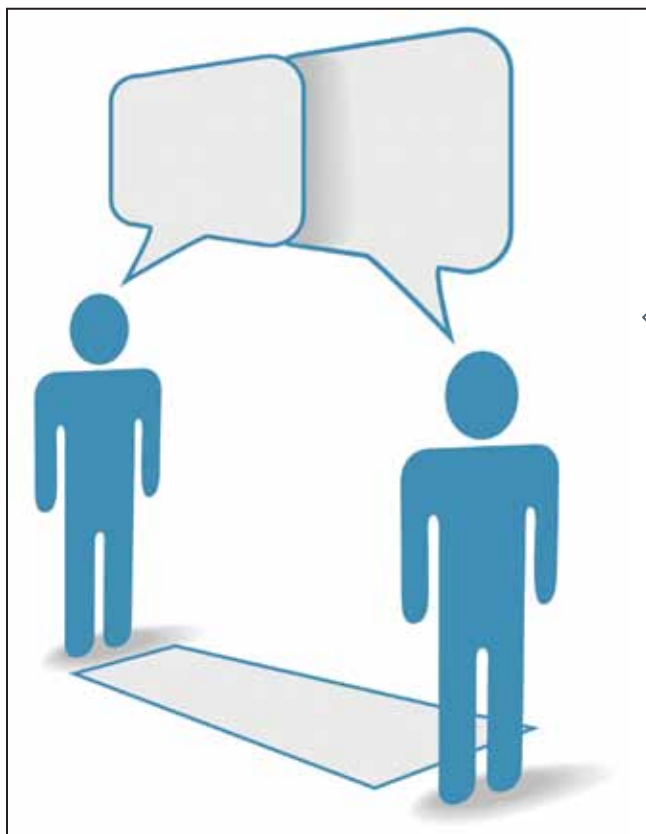


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Tips from a Periodontist

by Dan Holtzclaw, DDS, MS

Periodontics has a very intimate relationship with restorative dentistry. In many cases, one cannot function properly without the other. Communication is one of the most critical factors in the dentist-periodontist referral process. Although time-consuming and sometimes cumbersome, open lines of communication are one of the most important facets of my practice. All too often, the communication I receive from referring dentists is a simple one-sentence explanation of what they want. The tips below will help to improve communication with your periodontist and thereby help to improve patient outcomes.



1. Consider communicating to your periodontist by sending them a letter that fully explains your treatment plan. All too often, the communication I receive from referring dentists is a simple one-sentence statement of what they want. For example, a letter may simply say, "Evaluate maxillary anterior teeth" or "Crown lengthen #19." While this does provide some very basic information, it leaves much to be desired and often results in the periodontist needing to assume certain things the referring provider wants. A detailed letter explaining your plan will provide a much higher level of communication and better explain your desires. Provide as much detail

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as you can, otherwise you may end up with a completely different result from what you envision. Whether it is by letter, e-mail, fax, or phone, communicate!

2. Send us images! Most of you take images of your patient; please share them with your referring specialist. It will help us envision where you are and where you want to be. E-mails also provide the ability to send attachments such as photographs and diagrams. Most cosmetic dentists have computer programs that manipulate photos to show a patient prospective "before and after" images for certain treatments. Both clinical and simulated images are helpful. It is simple, effective, and visual...a great combination.

3. If at all possible, have a face-to-face meeting. This type of communication is very effective in that dentist and specialist can share ideas, evaluate radiographs together, handle models, etc. In terms of sheer effectiveness, this is probably the best manner of communication. However, meeting face to face is often difficult in light of the busy schedules most providers maintain. Try to make time.

4. Avoid failures. Periodontists and restorative dentists have an intimate relationship. In many cases, we cannot function without each other. A fixed partial denture placed on teeth with moderate to severe periodontal disease is often doomed to fail. Communicating with your periodontist could avoid this. No matter which form of communication you settle upon, the important thing is to not allow the communication process to break down. Do not become complacent—once the communication lines have been established, keep them open!

Editor's Note: For more detailed information about communicating with your periodontist, see Dr. Holtzclaw's article, "Periodontal Referral Tips for Cosmetic Dentists," on page 90.

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Periodontal
Referral Tips
Full Article

Tips from a Prosthodontist

by Ernesto A. Lee, DMD, DCD

A study conducted by the American College of Prosthodontists¹ revealed that only 9% of the general dentists surveyed referred to prosthodontists, compared to 69% that refer to oral surgeons, 63% to endodontists, 44% to periodontists, and 26% to orthodontists. The primary reason for not referring patients to prosthodontists was that 70% of general dentists said that they do the work themselves. There are certain cases however, that are better managed when referred to a prosthodontist. Although referrals often are made on the basis of case complexity, additional consideration should be given to factors such as patient expectations, potential liability, and the efficiency of delivering prosthodontic therapy within a general practice model.

Specialists are the general dentist's partners in the delivery of interdisciplinary care, and prosthodontists are no exception. Following are considerations to help optimize prosthodontic referrals.



Figure 1



Figure 2



Figure 3

Specialists are the general dentist's partners in the delivery of interdisciplinary care, and prosthodontists are no exception.

1. Do not attempt to take additional diagnostic records for the sake of the referral. The reality is that most specialists have their own standards when it comes to diagnostic records, and mutual emphasis should be made to avoid redundant procedures and charges to the patient.

2. Patient education is perhaps the most important contribution to the referral process. By making sure the patient understands the reasons why they are being referred, you will become their advocate. Invest some time in explaining the scope and potential costs associated with prosthodontic therapy. Even if patients opt not to pursue it, you will still be perceived as a knowledgeable and caring practitioner.

3. Treat the types of cases that are within your level of comfort. Although the dental laboratory may assist in navigating through a difficult situation, by law (at least in the U.S.), technicians follow instructions from the dentist, therefore making you solely responsible for the outcome. Patients exhibiting certain risk factors are best referred to a prosthodontist. These risk factors include parafunctional habits (**Fig 1**), occlusal disharmonies, inadequate vertical dimension (**Fig 2**), complex implant reconstructions (**Fig 3**), and patients with high esthetic demands. Your referral is based on your scope of practice, and is not a reflection of knowledge or technical ability. If a prosthodontist makes you feel otherwise, then refer elsewhere.

4. Referrals should be made as soon as possible. However (except for emergency procedures), treatment should not begin until a prosthodontic treatment plan has been developed. Co-treatment arrangements can then be made; this may avoid saving teeth subsequently deemed nonrestorable, or the premature extraction of teeth that could be utilized to support an interim prosthesis. Situations where the patient is referred with temporary restorations following completion of crowns or bridges should be avoided.

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Explain prosthodontic therapy to the patient.

Tips from an Oral Surgeon

by Joel L. Rosenlicht, DMD

When referring a patient to your oral surgeon, there are many details for you to keep in mind beyond the usual (e.g., sending x-rays, referral notes, and the patient's health history). The following tips highlight ways in which you can aid the oral surgeon(s) to whom you refer your patients.



1. Recognize that, many times, having an abundance of tissue is advantageous and once the soft tissue has healed, manipulating the tissue to maximize esthetics can enhance the final restoration. Discuss with the surgeon in advance the exact procedure that is going to be done in conjunction with either soft tissue augmentation at the time or separate from implant placement so that maximum

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healing and augmentation of the soft tissue can take place. This should be followed by the development of the site with either an ovate pontic, or the reduction of soft tissue with burs or lasers to form the central portion of the emerging crown.

2. Teeth often are removed by a variety of practitioners and the future plan for the restoration may or may not be discussed. Discuss with patients all their options prior to the removal of their teeth. If a final decision cannot be made at that time, consider socket grafting so that options in the future can be preserved. By maintaining the established ridge, either a fixed conventional prosthesis and/or implants can be placed into that site. Socket grafting, also known as ridge preservation, involves placing bone graft material into the socket immediately following tooth extraction. Healing will remodel the graft over time to maintain the maximum amount of both hard and soft tissue in these situations.

3. Discuss, when impacted teeth such as canines, bicuspid, or even second molars need to be exposed for orthodontic traction for proper position, whether "Wilckodontics" (selectively performing monocortical corticotomies adjacent to teeth in conjunction with full orthodontic treatment) is a possibility. This could be done in conjunction with the exposure of the crowns of those teeth, as it does sometimes appear to significantly facilitate the movement in these very challenging orthodontic cases.

4. Congenitally missing teeth often have overlying deciduous teeth. This appears to be beneficial for the patient in order to maintain space and develop a good occlusion. The potential for ankylosis or the migration over submerged deciduous teeth needs to be considered. If any deciduous teeth appear to be submergent or ankylosed in bone, they must be removed at the earliest possible opportunity.

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Many times, having an abundance of tissue is advantageous.

Tips from an Orthodontist

by David M. Sarver, DMD, MS

How many times have you stopped in the middle of a procedure, slapped your forehead, and wondered, "Why am I doing it this way?" Usually it is because we were taught that way, or it is the way everyone does it, or the way we have always done it.

This case addresses the orthodontic preparation of the patient with an undersized or peg-shaped maxillary lateral incisor. For many years, when placing my orthodontic appliances, I would place a bracket on the undersized lateral, and used active coil springs to position the tooth between the canine and central (Fig 1), going back and forth as my dental colleague instructed me, "I need it 1/4 mm to the mesial." This often was followed at the next visit by the directive, "No, now 1/8 mm back to the distal!" It was very frustrating.



Figure 1: In preparation for the restoration of an undersized lateral incisor, or to make space for emergence profile in cases of attrition, needed space may be orthodontically created.



Figure 2a: The patient had excellent incisor display, transverse smile dimension, and consonant smile arc.



Figure 2b: She had a deep bite with a midline diastema and small maxillary lateral incisors.

1. Do not bother with the lateral until ample space has been prepared around it; then have the lateral temporarily restored to ideal dimensions—the size and shape desired for the final restoration. The orthodontist simply places the lateral bracket as he or she would for any lateral incisor. This way, ideal placement is relatively straightforward and much more accurate, theoretically delivering to the dentist a tooth in an ideal restorative position.

In my assessment of the functional and esthetic goals of treatment for this case I noted that the smile arc was consonant¹ and incisor display excellent (Fig 2a). The teeth were generally spaced (Fig 2b), with incomplete passive eruption²⁻⁵ on the lateral incisors and the canines unerupted.

Communicate with the orthodontist your new approach to space allotment. If possible, the undersized tooth should be temporized to ideal dimension before orthodontic appliances are even placed.

2. I recommend simple composite bonding material, which is easily manipulated and modifiable during treatment, and a relatively good material on which to adhere an orthodontic bracket.

Encourage the orthodontist to keep a periodontal probe in the office (the orthodontist may actually have a diode laser in the office for use in these types of cases).^{6,7}

After initial orthodontic alignment, extra space was created on the mesial and distal aspects of the lateral, and the lateral intruded to attain better vertical gingival relations (Fig 3). I recommend that the orthodontist create more room than needed so the temporary can be made to ideal dimension.

The lateral incisor bracket was removed so that excess gingival tissue could be removed with a diode laser so the height-to-width ratio could be visualized (Fig 4).

3. The lateral was then temporized to ideal size and contour (Fig 5) and the lateral bracket was placed in order to finalize tooth position and close the remaining space (Fig 6). Orthodontic treatment was finished and the provisional restorations were replaced with the final, more esthetic restorations and a beautiful smile (Figs 7a-7c).

4. Ideally, you should be sure to see the patient for final approval before orthodontic appliances are removed.



Figure 3: The laterals were intruded orthodontically and extra space was created for ideal tooth dimension for the temporary restoration.



Figure 7a: Final occlusal and restorative result.



Figure 4: The bracket was removed and a diode laser used to remove excess gingival tissue.



Figure 7b: Final smile.



Figure 5: The lateral was bonded to the appropriate dimension.



Figure 7c: Final full-face smile.



Figure 6: The bracket was placed to ideal position and closure of the remaining space was begun.

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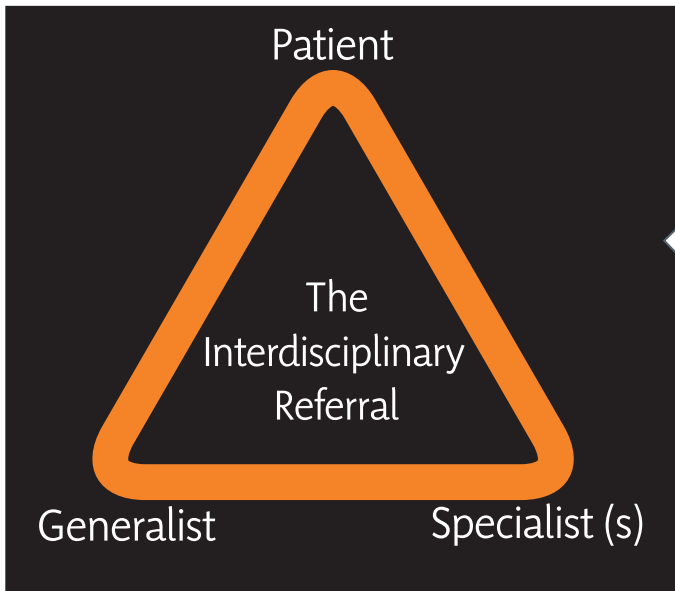
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Tips from an Endodontist

by John D. West, DDS, MSD

The most favorable interdisciplinary dental outcomes often occur when a trusted team treatment plans together in order to solve complex challenges. This “what do you do with this?” exchange enables the dentist to deliver responsible and successful treatment options. Collaborative dentistry requires impartiality, planning, and proper sequencing while presenting the patient with the optimal and alternative treatment plans. Remember, while there is only one diagnosis, there may be several treatment plans. The tips below will get you started in the right direction with your endodontist, patient, and team when the next challenging endodontic patient presents in your practice.



1. Trust and responsibility are critical. The patient has granted trust to the restorative dentist. In the referral to the endodontist, the dentist must accept responsibility for a successful referral and must recognize the profound nature of that transfer of patient trust to the endodontist. The dentist must inform the endodontist about the patient’s “dental IQ” and dental values so that the endodontist can purposefully affirm and support the treatment plan.^{1,2}

2. Equality and confidence are vital. The referring dentist must not be fearful of exposing treatment inadequacies to the endodontist. Do not be afraid that the endodontist might believe they have more knowledge in a particular discipline. Remember, the endodontist knows a great deal about a very specific subject. The general dentist is the treatment “quarterback” and understands the big picture.^{3,4}

3. Teamwork and leadership are key. The general dentist knows the patient best and is responsible for teaching the endodontist² the preferred treatment sequence, expectations, and outcomes.

Remember, while there is only one diagnosis, there may be several treatment plans.

None of these responsibilities can nor should be delegated. Sit down with your endodontist, share your practice philosophy, and learn how he or she can support your purpose. Have a two-way conversation before the referral process ever happens and learn what each of you needs and wants in order to produce a successful referral for patient, dentist, and endodontist.⁵

4. Determine whether endodontics or implants are more appropriate. Any endodontically diseased tooth can and should be saved if the root canal system can be sealed either nonsurgically or surgically, if the tooth is periodontally sound or can be made so⁵ and the tooth is restorable (i.e., 4 mm of 1-mm thick ferrule from height of bone to height of ferrule), and if doing so does not compromise dental esthetics. This is an objective and measurable treatment plan thought process. The best way to decide how to advise the patient about their choice is to think, “What would I do if it were me?” No one member of the interdisciplinary team should make a unilateral decision about endodontics versus implants unless the best interests of the patient are carefully evaluated by all relevant dental disciplines.⁶⁻⁸

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