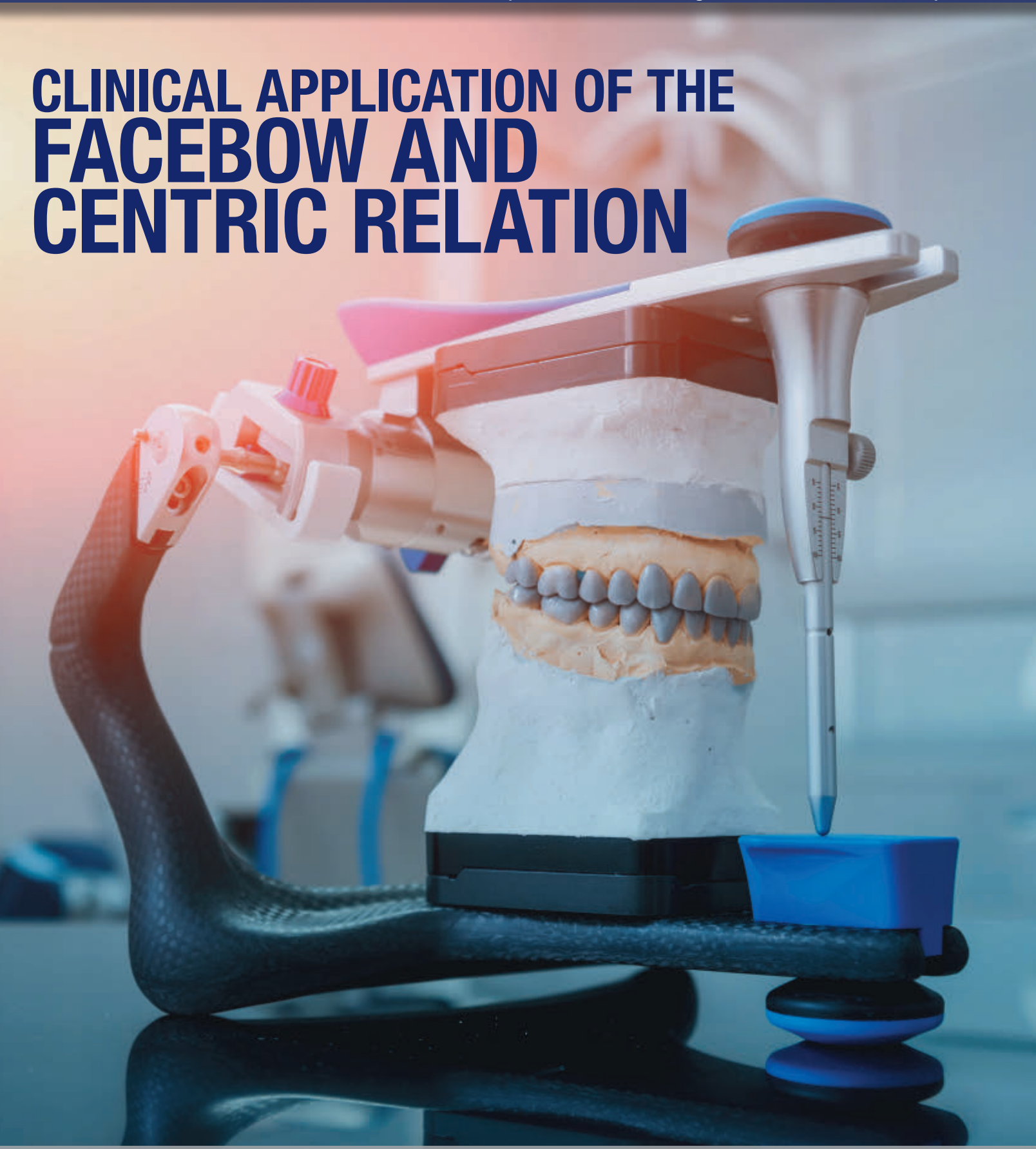
oregon dental ASSOCIATION

Membership Matters

A publication of the Oregon Dental Association • April 2019

CLINICAL APPLICATION OF THE FACEBOW AND CENTRIC RELATION



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Volume 24, Issue 8 | April 2019

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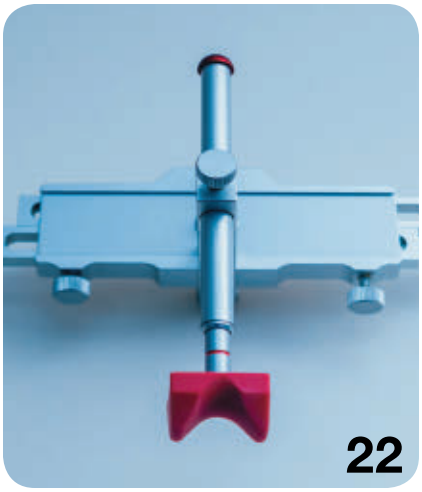

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Membership Matters is an official publication of the Oregon Dental Association in support of its core purpose to advance the dental profession and promote the highest standard of oral health and oral health care.

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FROM THE EDITOR

Women in Dentistry

By Alayna Schoblaske, DMD
Editor of *Membership Matters*

ON MY MOST RECENT 5 A.M. FLIGHT from Medford to Portland for an ODA board meeting, it struck me that, when it came to gender, the flight crew was equal. There was a female captain, a male first mate, a male lead flight attendant, and his lone female assistant. This equality is rare in aviation, and it is also rare in dentistry. As a proud woman and a proud dentist, I want to take this editorial to explore gender dynamics in dentistry in 2019. First, I want to provide two caveats. I will rely heavily on data because I believe that knowledge is power and allows us to act in an evidence-based manner. (I'm also the daughter of an engineer-turned-math-teacher, so numbers are my jam.) Second, gender identity is a spectrum. I apologize for oversimplifying the conversation to only males and females in this piece.

To be sure, I have personally experienced corners of the dental world that exemplify both ends of the gender equality picture. The ODA Board of Trustees is currently 67 percent male (12 out of 18), while the team of dentists I work alongside in Medford is 73 percent female (8 out of 11). Our profession as a whole more closely resembles the Board. According to the ADA's Health Policy Institute (HPI), in 2018, 67.7 percent of all dentists were male and 32.3 percent were female.[1] To be sure, national female representation has increased. In 2001, the split was 84 percent male and 16 percent female.[2] The HPI last evaluated individual states in 2016, when Oregon had 73.2 percent male dentists (compared to 70.5 percent nationally).[3] Our specialties have a wide degree of variability. For the 2017-18 school year, the specialty training program with the most men was oral & maxillofacial surgery, with 85 percent male residents. The programs with the most women were pediatrics and dental public health, tied at 65 percent female residents.[4] And what does our country look like as a whole? According to the U.S. Census Bureau, the civilian labor force between 2013 and 2017 was 58.2 percent female, while the overall population in 2018 was 50.8 percent female.

Phew! That was a lot of numbers. Why do they matter? I believe that the people caring for a population should reflect that population, and dentists are a long way from that benchmark. I believe that our patients better trust their dentists when they relate to them as people. I believe that aspiring dentists seek out mentors who look like them. I believe that women and men bring unique qualities to the dental field. The *Journal of the American Medical Association* explained that female physicians are more likely to provide preventive care, use patient-centered communication, and provide psychosocial counseling.[5] I would posit that the same is true for many female dentists. We need equal representation of both women and men's unique attributes so that our profession can be at its best.

What can be done to move toward equality? The ODA is leading the way by prioritizing recruitment and retention of female members (we exceeded our 4 percent increase goal by achieving a 15 percent increase in female membership in 2018). Organizational-level change like this is important. So are small individual actions that empower female dentists and advocate for more women to join the profession. Encourage a woman who is interested in dentistry: Welcome her into your office to shadow, invite her to an informational interview, and be honest with her about our profession, including our continued need for diversity. Prioritize women's voices during meetings. Ask a woman in your office — a fellow dentist or a member of your team — her opinion before making a decision. Intentionally register for CE courses taught by female dentists. If you determine compensation, examine your practice's salaries to ensure that commensurate female and male employees are paid equally. These small actions will have a large cumulative impact over time.

Finally, to my fellow female dentists, share your stories. We are a powerfully diverse group. We have different strengths, and different motivations for becoming dentists. We have different passions and we experience different realities. By sharing our stories and lifting each other up, we will enhance our beloved profession.

References

1. American Dental Association — Health Policy Institute. Supply of Dentists in the U.S.: 2001-2018. © 2019.
2. American Dental Association — Health Policy Institute. Supply of Dentists in the U.S.: 2001-2018. © 2019.
3. American Dental Association — Health Policy Institute. Dentist Profile Snapshot by State: 2016. © 2018.
4. American Dental Association — Health Policy Institute and Commission on Dental Accreditation. 2017-18 Survey of Advanced Dental Education. © 2018.
5. Y Tsugawa, et al. Comparison of Hospital Mortality and Readmission Rates for Medicare Patients Treated by Male vs Female Physicians. *JAMA Intern Med*. 2017;177(1):206-213.

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Board Meeting Highlights

Friday and Saturday, January 25-26, 2019

- Dr. Amberena Fairlee, Dr. Britta Martinez, and Dr. Sita Ping were appointed to the New Dentist Council.
- Dr. Terrence Clark was appointed to the Annual Meeting Council.
- The Beta Test Facebook group was opened to all ODA members.
- Mr. Michael Castro was appointed to the Moda Inc. Board, to replace Mr. Anthony Barth as a non-dental director.
- The 2020 ODA House of Delegates will be held September 25-26, in Sunriver.
- Board Policy on ODA Affiliation Agreements was approved.

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CONTINUING EDUCATION

Events & Education Component CE Calendar

Calendar provided by Mehdi Salari, DMD

Date	Host Dental Society	Course title	Speaker	Hours CE	Location	More Information
04/23/19	Clackamas	Customized Surgery: 3D Printing	Stacy Geisler, DDS, PhD	2	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@clackamasdental.com
04/26/19	Lane	Pediatric Dentistry	Dr. Greg Psaltis	6	Eugene (LCC Downtown)	www.lanedentalsociety.org or office@lanedentalsociety.org
05/07/19	Lane	Systems, Teams & Technology	Laci Phillips	2	Eugene (LCC Main Campus)	www.lanedentalsociety.org or office@lanedentalsociety.org
05/07/19	Washington	TBA	TBA	1.5	Beaverton (Stockpot Restaurant)	wacountydental.org or contact@wacountydental.org
05/14/19	Marion & Polk	The "Standard of Care" in Dental Treatment of Sleep Apnea	Michelle Aldrich, DMD & Kimberly Ross, DDS	1.5	West Salem (Roth's)	Contact Sabrina H. — marionpolkdentalsociety@gmail.com
05/22/19	Multnomah	Table Clinics	N/A	2	Portland (MAC Club)	multdental@aol.com or lora@multnomahdental.org
05/28/19	Clackamas	Digital Marketing	Ian McNickle — WEO Media	2	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@clackamasdental.com
07/19/19	Central Oregon	Safety and Simplicity in Root Canal Instrumentation	Dr. Anne Koch	6	Sunriver (Sunriver Resort)	Register through OHSU Dental CE Dept.
07/20/19	Central Oregon	Current Status & Future Advances for Dental Composites	Dr. Jack Ferracane	3	Sunriver (Sunriver Resort)	Register through OHSU Dental CE Dept.
10/15/19	Lane	Temperomandibular Joint Disorders	Dr. James X. Rapson	2	Eugene (LCC Main Campus)	www.lanedentalsociety.org or office@lanedentalsociety.org
10/16/19	Multnomah	Digital Dentistry	Samantha Jones & Kristen Minto	2	Milwaukee (MODA Plaza)	multdental@aol.com or lora@multnomahdental.org
10/28/19	Clackamas	Digital Marketing	Ian McNickle — WEO Media	2	Oregon City (Providence Willamette Falls Comm. Center)	www.clackamasdental.com or executivedirector@clackamasdental.com
11/08/19	Lane	New Generation of Hybrid Dentures	Dr. Marco Brindis	6	Eugene (LCC Main Campus)	www.lanedentalsociety.org or office@lanedentalsociety.org
12/06/19	Multnomah	Risk Management & Medical Emergencies	Chris Verbiest & Normund Auzins, DDS, MD	7	Portland (McMenamins Kennedy School)	multdental@aol.com or lora@multnomahdental.org
02/18/20	Lane	Infection Control	Dr. Monica Monsantofils	2	Eugene (LCC Main Campus)	www.lanedentalsociety.org or office@lanedentalsociety.org

Find this calendar online at **www.oregondental.org**. Click "Meetings & Events" > "Calendar of Events".

oregon dental ASSOCIATION

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COMPLIANCE CORNER

Health Professional Incentives Available to Oregon Dentists

AN IMPORTANT TOOL TO INCREASE ACCESS to care across the state, provider incentive programs help support underserved communities in recruitment and retention of high-quality providers. These programs help ensure there are adequate healthcare services for all Oregonians, particularly for underserved populations and in rural communities. There are many incentive programs available to Oregon clinicians. Check out a few of the options available for dental providers below.

	NHSC Loan Repayment Program	Oregon Partnership State Loan Repayment Program (SLRP)	Healthcare Provider Incentive Loan Repayment
Program Commitment	Work at an NHSC-approved site in a high-need urban, rural or frontier community in a designated Health Professional Shortage Area (HPSA) for at least two years (likely threshold HPSA score for 2019 is 17 or higher)	One year of clinical service at an approved site for each year of loan repayment	One year of clinical service at an approved site for each year of loan repayment
Minimum Commitment	2 years	2 years	3 years
Eligible Practice Site Must	Provide outpatient, ambulatory, primary health services in Health Professional Shortage Areas (HPSAs)	Nonprofit, offer discount to patients below 200 percent FPL, no patient asset testing, HPSA, and approved by ORH	Serving Medicaid and/or Medicare patients, HPSA, and approved by ORH
Eligible Practice Type	High-need NHSC-approved site in urban, rural or frontier community	Outpatient primary care	Outpatient primary care
Patient Criteria	Must see all patients regardless of ability to pay	Must see all patients regardless of ability to pay	Must see Medicaid and/or Medicare patients
Maximum	No limit	$35,000 per obligation year, with a lifetime max of $100,000	$35,000 per obligation year
Program Website	**https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program.html**	**https://nhsc.hrsa.gov/loan-repayment/state-loan-repayment-program/clinician-eligibility-requirements.html**	**https://www.oregon.gov/oha/HPA/HP-PCO/Pages/HC-Provider-Incentive.aspx**

THROUGH THE LOUPES

Questions for ODA Member and Council Spotlights

An interview with Kevin Prates, DDS

What Three Accomplishments, Personal and/or Professional are You Most Proud of?

I feel that my family and work balance that dentistry has given me is the best accomplishment I have achieved. I look forward to improving that, with my second accomplishment being transitioning from working at a Federally Qualified Health Center into private practice and the challenge that brings. My third accomplishment would have to be the ODA Presidential Citation I received in 2016 for the work I was able to do in reviving the Mid-Columbia Dental Society after it had been dormant for a number of years with the amazing help from ODA staff.

How Does the ODA Support You, Your Practice and Your Patients?

The ODA staff is always available for help when I have questions either about specifics for the local dental society or for when I have questions about getting the most out of my membership. They make me feel like we have a small dental community and are always excited to help me engage my benefits, making things easier for me and allowing me to focus more on patient care.

How Has the ODA Contributed to Your Leadership Skills and Experience?

The leadership teams that ODA has available and allowed me to be a part of have given me great insight into issues that are affecting dentists locally, in Oregon, and nationally. They're always inclusive and encouraging to get younger dentists involved in whatever capacity you are able, which is great experience to also help improve your own leadership skills.

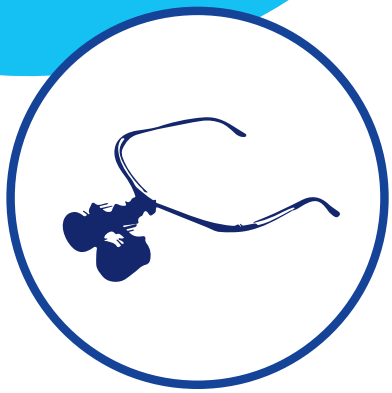
What Do You Enjoy Most about Dentistry?

With a background in art before going into dentistry I have really enjoyed the blending of art/science that dentistry has given me. The fulfillment of being able to do this and then help someone have a great smile and their gratitude is what I enjoy the most about it.

If You Could Impart Any Wisdom to New Dentists (Pre-doctoral Students, or Pre-dental Students Depending on the Member), What Would It Be?

Don't be overburdened by student loans. It's easier said than done,

THROUGH THE LOUPES



as I can tell you from personal experience. It's an elephant that you just have to eat one bite at a time, and with sound planning you will be able to balance your work/life and eventually pay them off. Focus on why you went into dentistry and be flexible. Work will be work sometimes, but remember to take joy in why you went into this great profession. Life doesn't go to your plans sometimes, but putting your patients first will always be the best investment you can make for them and in turn also yourself.

What Do You Foresee for the Profession of Dentistry in the Next 10 Years?

It will be interesting to see how the burden of student loans will change the landscape of dentistry. I think we are seeing some of the changes happening with group practices and FQHCs being more attractive options. Purchasing a private practice is not as simple as it used to be but still a great option as well. I had a few years of experience before the right opportunity was available. With the integration as well as whole person care keeps coming up and even hospitals becoming more involved with dental care, it will be interesting to see how that develops as well for the future of dentistry.

What Would Your Colleagues Be Surprised to Learn about You?

Most people are surprised that I enjoy brewing my own beer. But I'm a part of an amazing group of homebrewers known as the "Brewers of the Gorge" (B.O.G.). We have many local brewery brewmasters involved with us as well, which allow me to apply all the organic chemistry and microbiology I studied for dental school in a different way so I get to maximize the money spent on my student loans at least.

OHSU SCHOOL OF DENTISTRY

ASDA and ODA Team Up for Another Successful National Signing Day

ADA'S NATIONAL SIGNING DAY (NSD) is a national program aimed at engaging and encouraging dental school seniors to apply for ADA membership. National Signing Day brings together dental schools, state and local dental societies, and ASDA chapters to welcome new dentists to the profession. In partnership with ODA DS4 representative Paul Lamoreau and OHSU's ASDA chapter, Oregon was able to sign 100 percent of the DS4 class into membership for the fourth consecutive year! OHSU Alumni and ODA volunteers Britta Martienz, DMD, and Eddie Ramirez, DMD, led the program, sharing their personal insight and journey after dental school with the class of 2019.

Legislative Update

THE 2019 LEGISLATIVE SESSION BEGAN IN JANUARY, and ODA staff and members have been in Salem working on behalf of organized dentistry. Check out some updates on ODA's legislative agenda below:

House Bill 2220: This bill would allow dentists to administer vaccines, creating increased access to care across the state. The bill had a public hearing on March 12th, and three member dentists testified on behalf of the ODA: Dr. Patrick Hagerty, Dr. Phil Marucha, and Dr. Jim Smith.

Senate Bill 824: This bill clarifies that the Oregon Board of Dentistry may accept alternative examinations (such as the OSCE: objective structured clinic examination) as minimum requirements for licensure. The bill had a hearing in the Senate Health Care Committee on March 13th. Dr. Bruce Burton, Dr. Phil Marucha, and OHSU 4th year dental student Tysa Judd all testified for the ODA.

Senate Bill 834: This bill would allow licensees under the Oregon Board of Dentistry to explain an error to a patient without the threat of that conversation being used against them in court. Dr. Bruce Burton and Dr. Leah Hickson testified on behalf of the ODA on March 13 in the Senate Health Care Committee.

A huge thank you to all our members who have been involved in the legislative process this session! Interested in getting involved? Join our ODA Action Team! You can sign up and learn more about ODA's Legislative Agenda on our website at oregondental.org!

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Join Us for the ODA Mentor Dinner

Share your advice and experience with dental students. We invite you to be a mentor at the annual mentor dinner sponsored by the ODA New Dentist Council.

The mentor dinner provides dental students with a chance to meet with practicing dentists who can answer students' questions about "life after dental school."

Date: Thursday, May 9th
Location: OHSU School of Dentistry, Room 3A001
Time: 5:30-7:30 p.m.
Dinner is provided.

Register today: **http://bit.ly/19mentordinner**

Questions? Contact *Kristen Paul,* ODA Membership Manager, at 503-218-2010.

OCCLUSION

Facebow and Occlusion

By Carlos Jurado, DDS, MS

FACEBOWS

History

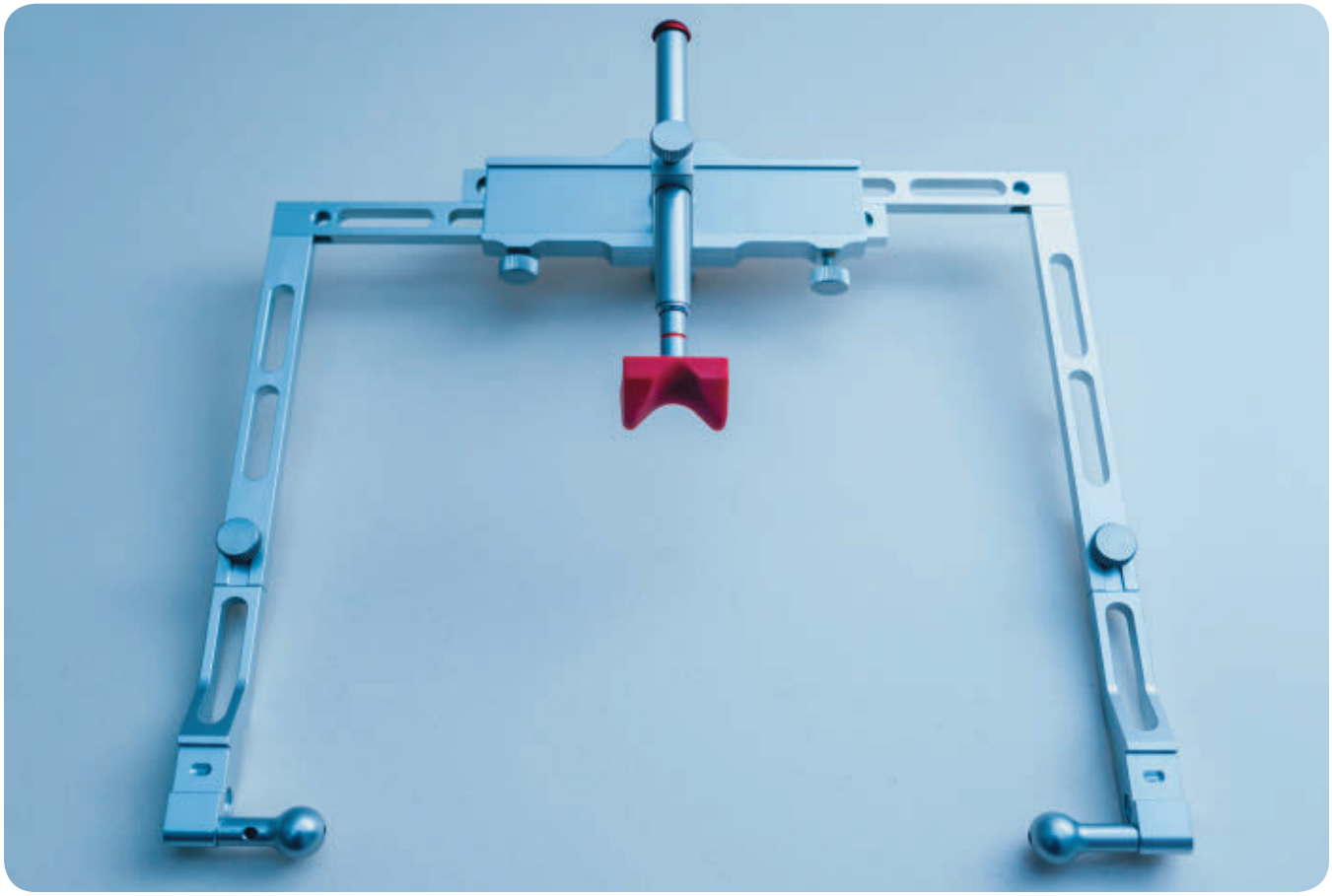
In 1892, Gilmore Thomas, an oral surgeon, was the first to suggest the use of a facebow. William Walker in 1896 used a head strap as a research tool, and it was the first type of facebow. George Snow in 1899 is known as the inventor of the current concept of the facebow, a maxillary bow, "The Snow Bow." Alfred Gysi in 1910 fabricated a mandibular bow to register hinge axis position, horizontal and sagittal movements. Rudolph Hanau in 1923 improved the Snow Bow using aluminum alloy and an anterior locking device. In 1925, Beverly McCollum fabricated several designs of mandibular bows and developed the concept of gnathology.

Definitions

The definition of facebow and its parts has been published in the "Glossary of Prosthodontic Terms" in the *Journal of Prosthetic Dentistry*.

-Ninth edition (2017):

Facebow: *An instrument used to record the spatial relationship of the maxillary arch to some anatomic reference point or points and then transfer this relationship to an articulator; it orients the dental cast in the same relationship to the opening axis of the articulator; customarily the anatomic*



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references are the mandibular transverse horizontal axis and one other selected anterior reference point.

Facebow Fork: *That component of the facebow used to attached the occlusion rim to the facebow.*

Facebow Record: *The registration obtained by means of a facebow.*

Facebow Transfer: *The process of transferring the facebow record of the spatial relationship of the maxillary arch to some anatomic reference point or points and transferring this relationship to an articulator.*[1]

Most current facebows utilize the Frankfort Horizontal Plane; however, some use Camper's Plane (Ivoclar). Frankfort Horizontal Plane is defined as an eponym for a plane established by the lowest point on the margin of the right or left bony orbit and the highest point on the margin of the right or left bony orbit and the highest point on the margin of the right or left bony auditory meatus.

Facebows use three points of reference: maxillary teeth, hinge axis and a third point. This third point varies from system to system; the most common are the orbitale (Hanau and Denar) and Nasion (WhipMix and SAM). Currently, most facebows arbitrarily choose average left and right points located toward the ears for an estimated hinge axis.

OCCLUSION

Gnathology

In 1926, McCollum defined gnathology as the science that treats the biologics of the masticatory mechanisms; that is, the morphology, anatomy, histology, physiology, pathology and the therapeutics of the oral organ, especially the jaw and teeth and the vital relations of the organ to the rest of the body. The early goals of gnathology included to establish a hinge axis locating rotational centers of the condyles, and record 3D border movements of condyles via the mandibular recorder (ultimately developed into the pantograph). Stallard and Stuart proposed to eliminate balancing contacts by having the cuspids disclude the posterior teeth in eccentric motion. Peter K. Thomas contributed to the cusp to fossa occlusion concept. Niles Guichet simplified gnathology by introducing a new instrument (Denar articulator accepting the Dental Pantograph) and provided extensive continuing education about it.

Goals of Occlusion

- No interferences between centric occlusion (maximum intercuspation) and centric relation.
- Cusp-to-fossa occlusal scheme.
- A minimum of one contact per tooth.
- No posterior contacts with protrusive jaw movements.
- No cross-tooth balancing contacts.
- Eliminate all possible fremitus.
- No balancing contacts.
- Canine guidance or group function.

Conclusions

Treatment goals for the musculoskeletal stable position.

For a variety of conditions such as muscle disorder, inflammatory disorder, or severely debilitated dentition, the clinician should provide optimum functional occlusion when the condyles are in the most musculoskeletal stable position (centric relation).

1. Condyles are resting in their most superioanterior position against the slopes of the articular eminences.
2. The articular discs are properly interposed between the condyles and fossae. This does not apply to disc derangement disorders.
3. When the mandible is brought into closure in the musculoskeletal stable position, the posterior teeth contact evenly and simultaneously. All contacts occur between centric cusp tips and flat surfaces directing occlusal forces through the long axes of teeth.
4. When the mandible moves eccentrically, the anterior teeth contact and disocclude the posterior teeth.
5. In the alert feeding position the posterior tooth contacts are more prominent than the anterior tooth contacts.

Because these goals are beneficial treating functional disturbances, they also become the goals in permanently restoring the dentition.

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OCCLUSION

Centric Relation: A Review of Concept

By Carlos Jurado, DDS, MS

Abstract

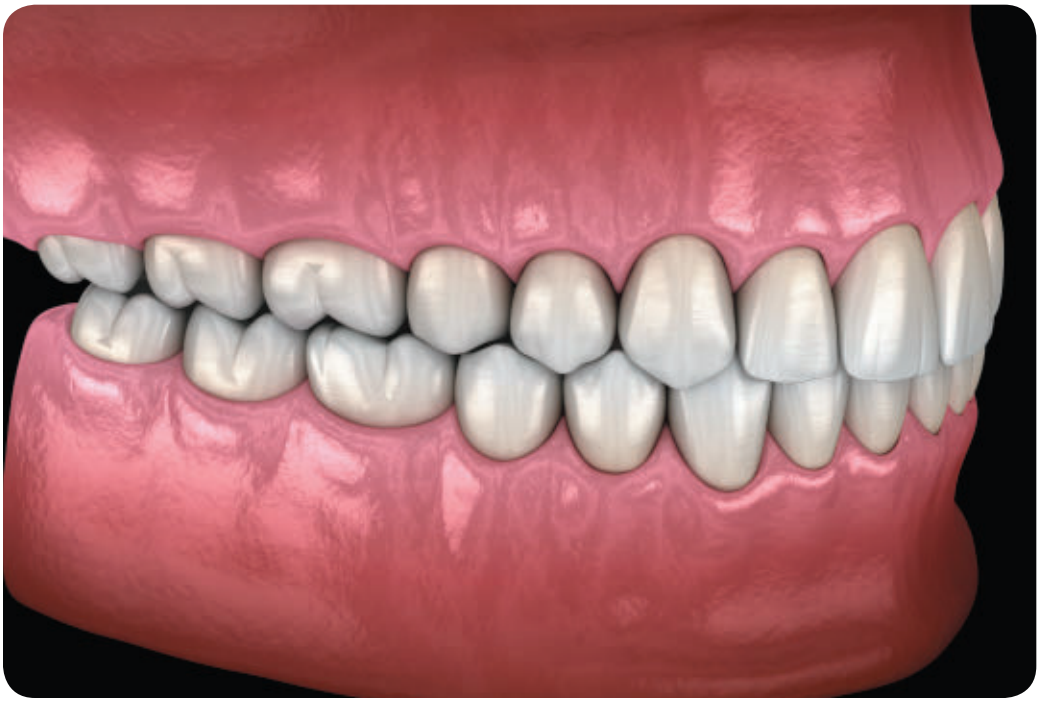
Mechanics and function constitute the proper bases for dentistry. A good masticatory function depends on the correct physic and mechanic of all parts of the masticatory system, particularly the correct intercuspation of teeth. It is very important to understand the whole mechanism of occlusion, and changes to the teeth should be made by dentists versed in the science and art of treating the masticatory apparatus. Unfortunately, the definition of centric relation (CR) has changed repeatedly over the years. Numerous definitions for CR have been given; however, no consensus exists, and the definition given by the glossary of prosthodontic terms may be confusing. The aim of this report is to review, from historical concepts based on literature, some of the most controversial topics in occlusion. Centric relation is clinically significant since it is the only clinically repeatable jaw relation, the starting joint position and the logical position to fabricate prosthesis.

Introduction

The concept of centric relation (CR) is without a doubt one of the most important and controversial in contemporary dentistry. This is a concept that has been changing through the years based on personal opinions, occlusal philosophies, and success and failure in clinical care.

Historical Aspects

The first important concept to describe is from Sears in 1925. He defined equilibrated occlusion; this concept consisted in having bilateral balance during all lateral movement and protrusion.[1] The equilibrated occlusion was developed for complete dentures, and it is based in bilateral contact to stabilize the denture during mandibular movements. The



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concept was widely accepted, and it was employed in fixed prosthodontics by Young in 1926 and Meyer in 1933.

Centric Relation

Centric relation is a classic term in dentistry; however, its definition is still considered an enigma, as is demonstrated by several different definitions in the literature. It has been defined as a maxilo-mandibular relation, as cranial-mandibular and as a mandibular posture. Related to space, Celenza in 1978 positioned as a completely retruded location,[2] Dawson in 1979 as the most superior,[3] and Stuart in 1969 as the most posterior superior and medial.[4]

Winberg in 1984 defined this as a tridimensional position,[5] and the controversy goes on. Centric relation is usually defined by describing an anatomic point, and other types of definitions are based on neuromuscular mechanisms.

In 1956, Moyers defined CR as the mandibular position determined by neuromuscular reflexes learned to control the mandibular position when primary teeth are in occlusion.[6] He defined centric occlusion as relationship of teeth during centric relation.

P. Saizar in 1971 mentioned the three theories developed to explain centric relation. The three widely accepted theories are: muscular theory, ligament theory and osteofibrous theory.[7]

Iraj Shafagh in 1975 found changes in position of CR; he pointed out that CR follows a position that could change based on the fluid of the temporomandibular joint.[8]

Peter Dawson mentions that there are many misconceptions related to the term of centric relation. It has been defined in so many different ways that it has lost its importance. A basic point of this misconception is the confusion between the terms CR (centric relation) and CO (centric occlusion). Moreover, the standard definition of CR as the most retruded is not correct from the anatomic point of view, and many methods to register the centric relation do not place the mandible in a physiological position within the articular cavities. The most retruded position is not a physiological position and also could damage the alignment of the condyle-disc and can affect the muscles. Positioning the mandible at the most retruded position could constitute the most common error in dentistry. Unfortunately, it is one of the most used procedures. Dawson defines CR from the anatomical function point of view. It is good to remember that CR is referred to the position of the temporomandibular joints, so it is a maxillary-mandibular relationship. This is an axial position, meaning the joint can rotate to open and close the mouth without losing the centric relation position; the mandible can keep this position even when teeth are not in occlusion. Only in CR can the mandible rotate on the same axis without the need to use the pterygoid muscles. Based on the previous information, we can define centric relation as the relation of the mandible regarding the maxilla when the disc is aligned, in the post superior position against the articular tubercle, and it is independent on the teeth position and vertical dimension. Centric occlusion (CO) is referred to the relation between the mandible to the maxilla when teeth are in maximum occlusion, and it is independent of the position or alignment of the condyle-disc relation, and it is also called maximum intercuspation position. The goal for occlusal treatments is to have maximum intercuspation in harmony with the condyle-disc complex, and coinciding the CR and CO.[9]

Okeson in 1995 introduced the concept of a functional and optimal position, naming it as musculoskeletal position. He mentions that CR has been used in dentistry for several years, but it has many definitions; in general, this is a mandibular position in which the condyles are located in a functional position. As a summary, the optimal joint position determined by the muscle is when the condyles are situated in the most superior-anterior position in

relation to the fossas. However, we also need to consider the disc position, so the optimal position is when articular discs are in adequate position between condyles and articular fossas. Therefore, the complete definition of the optimal joint position is when condyles are in the most superior anterior position in relation to the articular fossas, when they lean on the posterior slopes of the articular eminence, with the articular discs intercalated correctly, and this position is considered a musculoskeletal stable position of the mandible.[10]

William McHorris in 1986 tried to describe and define CR, and considered that this position has some anatomic and physiological requirements in order to maintain the position. He also discussed this as a therapy. He defined CR as the physiological relation of the mandible to the maxilla and the cranial base when both condyles are properly aligned to their articular discs, and the condylar disc is stable against the posterior eminence of the glenoid fossa. He believes that CR is a border position, and this position usually has no coincidence with maximum intercuspation, but whenever this happens it is known as occlusion in centric relation.[11]

Different definitions of centric relation have been published in the "Glossary of Prosthodontic Terms" in the *Journal of Prosthetic Dentistry*:

-First edition (1956):

Centric Relation: *The most retruded relation of the mandible to the maxillae when the condyles are in the most posterior unstrained position in the glenoid fossae from which lateral movement can be made, at any given degree of jaw separation.*[12]

Centric Occlusion: Not defined.

-Third edition (1968):

Centric Relation: *The most retruded physiological relation of the mandible to the maxillae to and from which the individual can make lateral movements. It is a condition which can exist at various degrees of jaw separation. It occurs around the terminal hinge axis.*

Centric Occlusion: *The centered contact position of the lower occlusal surfaces against the upper ones; a reference position from which all the other horizontal positions are eccentric.*[13]

-Ninth edition (2017):

Centric Relation: *A maxillomandibular relationship, independent of tooth contact, in which the condyles articulate in the anterior-superior position against the posterior slopes of the articular eminences in this position, the mandible is restricted to a purely rotatory movement; from this unstrained, physiologic, maxillomandibular relationship, the patient can make vertical, lateral or protrusive movements; it is a clinically useful, repeatable reference position.*

Centric Occlusion: *The occlusion of opposing teeth when the mandible is in centric relation this may or may not coincide with the maximal intercuspal position.*[14]

Melvin Moss in 1975 suggested the bases of the TMJ biomechanics, and mentioned that CR is never a functional position nor common. The current knowledge about the TMJ suggests that it adapts to the oral function as needed, and it adapts whenever it is needed in real time.[15] Dr. Moss provided conclusions without evidence.

In 1978, Moffett wrote an opinion article considering the biology of the CR. Defining it as the most posterior superior and medial position, he concludes that the joints adapt to function, especially the joint capsule and ligaments as active structures and not just as mechanical parts; therefore, there is no biological complication for using CR as a reference point in occlusion.[16] However, the author does not provide any evaluation of his explanation.

In 1987 and 1989, doing a rigorous methodological study, Jimenez concluded that it is more the dental stability than the antero-posterior position of the mandible. He also concluded that the CR is not an optimal position, and therefore the occlusal scheme is more important than the mandibular position.[17,18]

Tarantola in 1997 evaluated the reproducibility of the condylar position with different techniques; he has shown CR records that capture condylar positions

with a maximum variation of 0.1 mm. He concluded that CR can become a predictable, repeatable starting point for occlusal therapy.[19]

Discussion

The definition of CR has been changing over the past century from being a posterior-superior position to an anterior-superior position of the condyle in relation to the glenoid fossa. Before 1987, centric relation was considered a retruded condylar position. This concept of the more retruded the better was still used in the mid 1980s, and many authors were reporting this method of positioning the mandible more posteriorly.

The TMJ is a biological structure capable to adapt and remodel according to extrinsic factors by muscle and ligament response. Then an impetus for the shift in thinking was introduced with the TMJ imaging that led to the change in the definition of CR from a posterior-superior to an anterior-superior position. The argument for anterior-superior positioned condyles was the belief that distally displaced condyles can cause anterior and medial displacement of the TMJ discs.

Ismail in 1980 conducted a radiographic study of condylar position and concluded that in CR position, both condyles were placed in a more posterior and superior position in their fossa. The evidence available suggested that there is no ideal position of the condyle in the glenoid fossa, but there is a range of normal positions. Celenza concluded that there might be several acceptable CR positions. The change of definition of CR from posterior-superior to an anterior-superior position logically has eliminated or reduced the magnitude of centric slides.

Conclusions

As you can see, the definition of centric relation has been changing through the years from a posterior and superior position to finally an anterior and superior. We cannot compare CR with CO, because the first one is condylar position and the second one is a dental-occlusal position. From the clinical point of view, what is important is the way that the patient responds to the dental treatment based on the knowledge of the CR as a functional position rather than a reference point for diagnosis. The temporo-mandibular joint is a biomechanic structure capable to adapt and remodel according to extrinsic factors affecting muscles and ligaments.

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DENTAL FOUNDATION OF OREGON

The Dental Foundation of Oregon

DFO Partners with Moda Health

For the second year, the Dental Foundation of Oregon has partnered with Moda Health as part of its February Dental and Health Heart initiative. As a featured nonprofit partner to Moda Health, the DFO hosted an information table at the February 13, 2019, Portland Trail Blazers game, where they distributed more than 100 dental kits filled with toothpaste, a toothbrush and dental floss to youth and their parents who attended the game.

Spirit Mountain Community Fund Grant

The Dental Foundation of Oregon is pleased to announce a one-year grant in the amount of $50,000 from the Spirit Mountain Community Fund. The grant will be used to support the Tooth Taxi in its ongoing efforts to provide dental care to low-income and economically disadvantaged youth ages 5 to 18 years of age throughout Oregon.

DFO staff and board leadership joined other Oregon nonprofit leaders on March 13th at the Confederated Tribes of Grand Ronde government office, where they were presented with the grant check by Spirit Mountain Community Fund leadership and tribal leaders.

2019 Texas Hold'em Event

On behalf of BnK Construction, Columbia Bank and The Dental Foundation of Oregon (DFO), we extend our deep appreciation to the 100 players and our team of volunteers for their support at the 10th Annual Texas Hold'em Poker Tournament! Together, we raised $26,000.

Special thanks to our friends at Moda Health for hosting the tournament at their southeast Portland facility, and to Harry Barmon — In Your Face Photography for sharing these photo images from the event.

Top 8 finishers at this year's tournament were: Doug Shepherd 1st Place; David Greenberg 2nd Place; Brad Siever, DMD, 3rd Place; Rick Sennet 4th Place; Luke Kapper 5th Place; Matt Malone 6th Place, Ben Gaunt 7th Place; and Brandon Posey 8th Place. Rounding out the list were Stacey Bagent — Last Woman Standing; and Aaron Raasch — First Person Out.

2019 Chip for Teeth Golf Tournament

The 15th Annual Chip for Teeth Golf Tournament will be held Friday, June 14, 2019, at Langdon Farms, consistently recognized as one of Oregon's top-rated golf courses. Register your foursome here: **https://app.etapestry.com/onlineforms/OregonDental/2019ChipForTeeth.html**

The Tooth Taxi

The Tooth Taxi started the year by spending two weeks in Marion County serving kids from Cloverdale, Turner and Aumsville Elementary schools. We had the help of district Executive Assistant Cheryl Harmon, who not only transported kids back and forth but made sure we didn't go hungry by supplying snacks!

Dr. Sita and the team worked with several families to schedule before and after school appointments, allowing for some of our more apprehensive patients to have a familiar face present for treatment.

In Aumsville, we had a kindergartener come on for a cleaning. I noticed right away that she was unsure, but she climbed up in the chair, letting me get her X-rays. As I set her back in the chair to start, I noticed she was visibly shaking, so much so that her teeth were chattering. I asked her if she was cold and she said, "No, I'm just scared." I made sure to take extra time, telling and showing her everything I was going to do, having her hold my hand that was using the prophy angle so she could help me polish her teeth. Each step of the way, I could see her relax a little more, and by the end of the appointment she was back to being a chatty six year old telling me about her ability to do cartwheels and how much fun she was having on the Tooth Taxi. A big part of our job is easing fears, educating and helping teach kids to become good patients. This girl left with a smile on her face, feeling good about her experience at the dentist, excited about taking care of her teeth and for her next checkup.

Story by Carrie Peterson, Tooth Taxi

TOOTH TAXI STATISTICS (September 2008 – January 25, 2019)

21,867 students screened

12,533 appointments in the van

22,860 students received oral hygiene education in the classroom

$7,277,009 value of free dental care provided

Realities from the Road

Sometimes you get to enjoy the scenery around you. The Tooth Taxi team was able to get out after work for a quick hike at Silver Falls State Park.

Kid Quotes

While getting X-rays taken on the Tooth Taxi, a young girl asked, "Do my teeth look pretty?" After getting treatment done, she asked, "Do they look even prettier now?"

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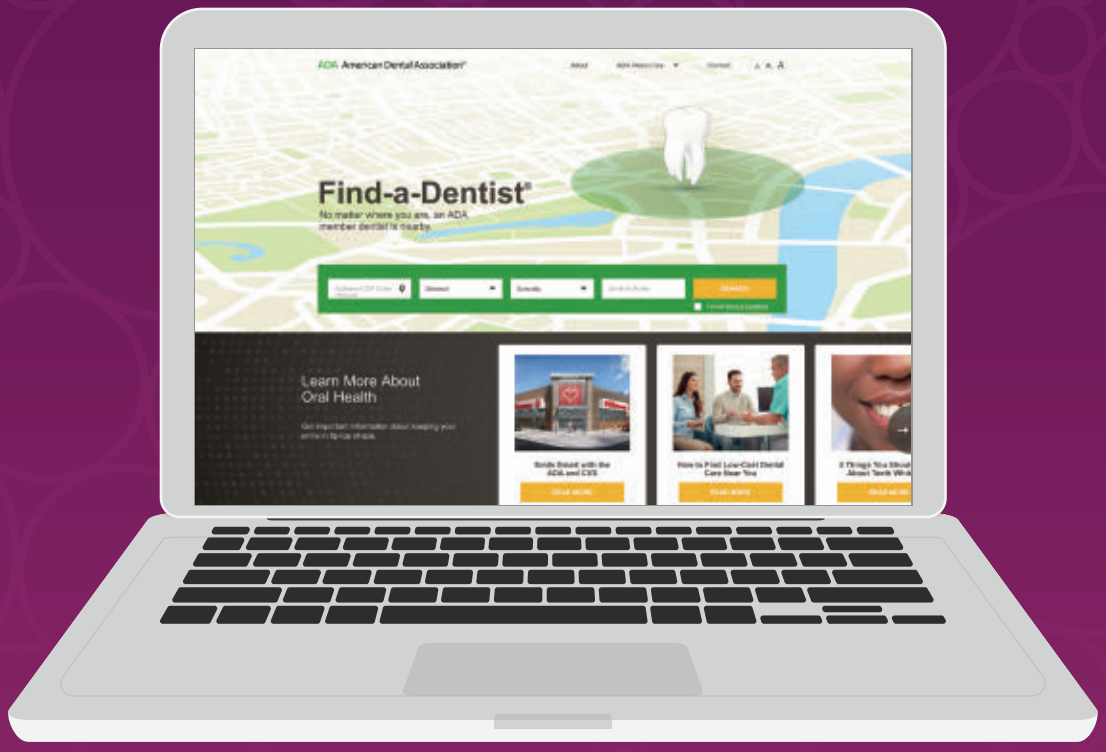

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Associate positions in Salem, Albany and Roseburg. FFS, well-established 2 locations expanding the brand to Salem, Albany Roseburg. Beneficial to confidently perform endo, oral surgery, surgical implants. Contact Megan@omni-pg.com, 503-830-5765. (OD122)

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Albany - 4 op building for sale in Albany near hospital and related services. Parking, street signage exposure. 2,025 square feet. Has been dental office 43 years. Contact Megan@omni-pg.com for more information. (OD108)

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Donna Carlson Lowell
Co-Founder

I thrive on guiding practices to reach their potential and equipping the dentist with the leadership skills needed to build an environment which creates loyal employees and patients.

Denise Jones
Client Coordinator

I have been working with dentists for over 20 years and I understand your business model. Allow me to help coordinate your optimal transition.

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