



give back a
SMILE™

AACD CHARITABLE FOUNDATION



by John L. Ames, D.D.S.

Dr. John Ames earned his dental degree in 1956 from Indiana University. Following dental school graduation, he served for three years with the U.S. Coast Guard and Merchant Marine as Chief Dental Officer, U.S. Public Health Service in Portland, Oregon. Dr. Ames has been practicing dentistry in Northwest Indiana for 48 years and is currently building a new office. He attributes much of his direction and enthusiasm to Dr. Ross Nash and Debra Englehardt Nash.

In addition to the AACD, Dr. Ames holds memberships in the American Dental Association, Indiana Dental Association, American Association of Functional Orthodontists, Indiana University School of Dentistry Academy of Continuing Education, and American Equilibration Society. He is a Fellow of the Academy of General Dentistry.

A True Testament

The AACD Charitable Foundation's Give Back A Smile™ (GBAS) program, in cooperation with the National Coalition Against Domestic Violence, restores the smiles of domestic violence survivors at no cost.

We have received many success stories and thanks from GBAS volunteers and recipients. This section shares the triumphs of the GBAS program.

Jennifer* first visited our office in July of 2002. She had been the victim of severe domestic violence seven years earlier, having received a blow to the mouth with the butt of a shotgun. She had not received dental treatment for several years and explained that her broken anterior teeth hurt so badly that she could not eat food that had any substance without causing a great deal of pain (Fig 1). To sustain herself for the last few years she had turned to "sugary beverages."

Her mouth was badly debilitated, with many broken and severely decayed teeth, and I thought it would take at least a year to do all the necessary root canal therapy.

It was obvious that Jennifer was in dire straits, both physically and emotionally. She was taking several across-the-counter pain medications and smoked heavily. She also related a history of headaches, earaches, and jaw pain in both temporomandibular joints. She said that her teeth were very sensitive when she bit and to foods that were hot. She also said that she had several broken fillings, some loose teeth, and areas in her mouth where food collected consistently.

Upon examination, I found that both left and right temporomandibular joints exhibited partial subluxation and both joints popped consistently on opening and closing, as well as in protraction-retrusion. Her mouth was badly

debilitated, with many broken and severely decayed teeth, and I thought it would take at least a year to do all the necessary root canal therapy. There were some retained roots and a few teeth that would need extracting as there wasn't enough tooth structure left to rebuild them even with root canal therapy. We concluded our initial visit with a complete series of x-rays and photos (Figs 2 & 3).

After studying the photos and radiographs, I decided to first rid Jennifer of as much pain as possible. I wanted to extract those teeth and roots that could not be saved and start root canal therapy on the upper right lateral incisor, as it had a periapical abscess and was causing her a great deal of pain.

By the end of her second visit, in late July 2002, we had started root canal therapy on the upper right lateral incisor and removed the lower right second bicuspid retained root, which also exhibited infection on the radiograph and was causing Jennifer significant pain. Within the next two weeks, we completed the root canal therapy for the upper right lateral incisor and removed the retained roots for the mandibular left first and second molars, as well as extracted the maxillary right second molar and the mandibular right second molar. Jennifer was beginning to feel better and was more relaxed for her dental visits. She said that she was now virtually pain-free despite all the severely decayed teeth that remained.

Over the next three months, I systematically removed the decay from her remaining teeth, expecting all kinds of pulpal involvement and possible root canal therapy. To my amazement, we did not have to do any more root canal therapy; there was sclerotic dentin under all of that soft decay. I placed Vitremer® (3M ESPE; St. Paul, MN) liners over many of the pulpal floors and temporized them as we went along, hoping for the best. We placed a ceramic post for the upper right lateral incisor and temporized it.

Although the primary purpose of this treatment was the restoration of Jennifer's smile, it was equally as important to pay attention to her temporomandibular joints because of her initial complaint of discomfort and popping in both joints.

For the small cervical cavities, we placed Class V composites. In the posterior, we placed a few stainless steel temporary crowns on some of the teeth and used Duralon (3M ESPE) as a luting cement. In the anterior, I did some direct bonding freehand build-up to try to give Jennifer a better appearance—again, only to temporize the case (Fig



Figure 1: Pretreatment, full smile, July 2002.

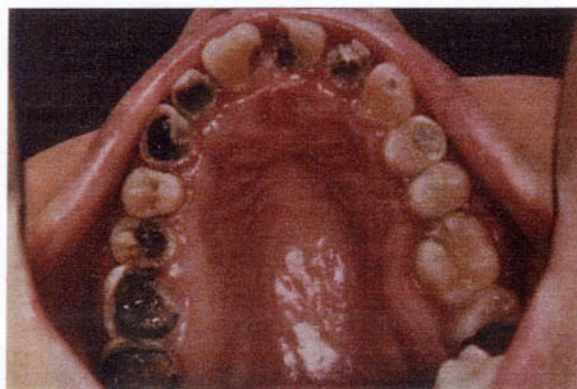


Figure 2: Pretreatment, maxillary arch, occlusal view, July 2002.



Figure 3: Pretreatment, mandibular arch, occlusal view, July 2002.

4). Although I didn't think it looked great, Jennifer was very pleased with her new appearance and she began to open up, smile, and laugh again.

My staff was as involved and invested in Jennifer's treatment as I was. In November 2002, I took some impressions for diagnostic casts and mounted the casts via an estimated hinge axis facebow on a SAM II articulator (Great Lakes Orthodontics; Tonawanda, NY). For the next two

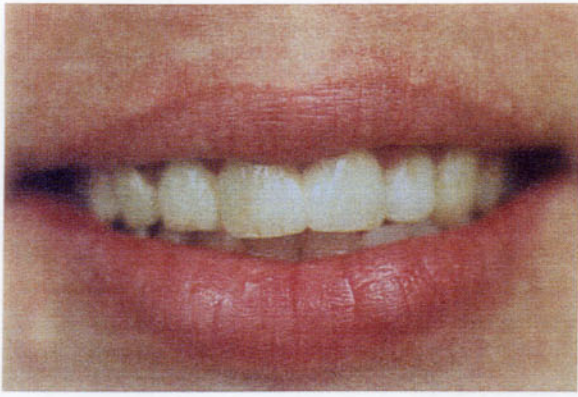


Figure 4: Temporization, November 2002.

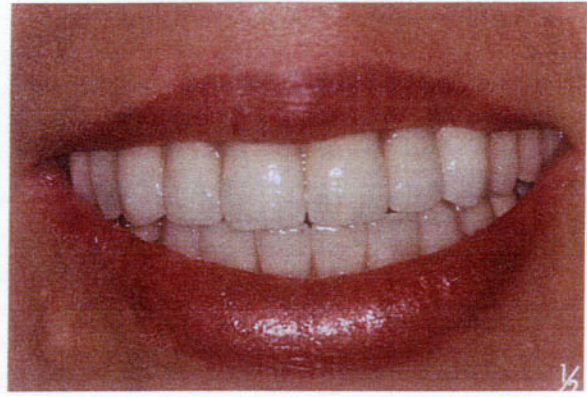


Figure 7: Post-treatment, full smile, June 2003.

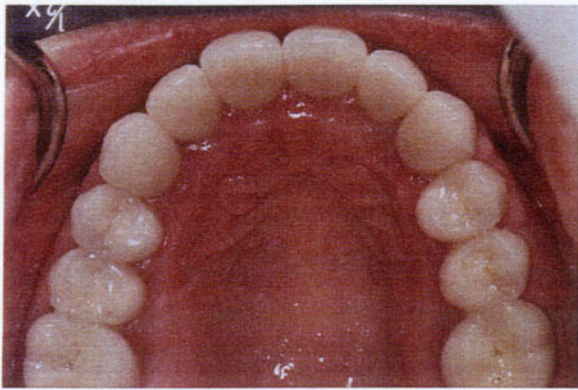


Figure 5: Post-treatment, maxillary arch, occlusal view, June 2003.

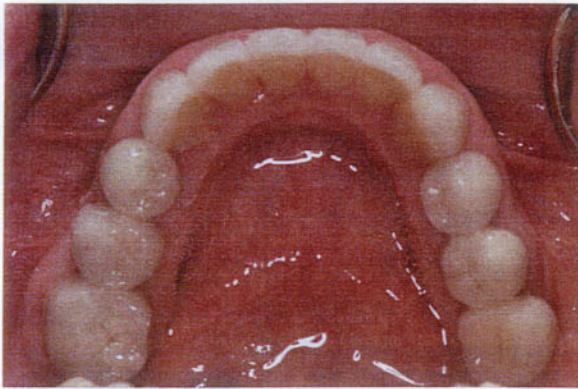


Figure 6: Post-treatment, mandibular arch, occlusal view, June 2003.

and a half months, Jennifer spent most of her time with Laurie, our hygienist, who worked diligently with her; and on more than one occasion, Lillian, our office manager, picked her up for appointments, as Jennifer does not own an automobile.

In mid-January 2003, all of Jennifer's teeth were responding well to treatment and we decided to proceed with the reconstruction. Our approach was to start with the lower arch posteriorly. I wanted to open the bite approximately 3.0 mm because of the collapse in the posterior due to the loss of teeth and severe decay. Jennifer's overbite was rather deep and I felt that she could handle that much opening. It also would help with the overall esthetics, and we could level the occlusal plane nicely.

We prepared and later sealed a cantilever fixed bridge for the lower left quadrant, with the first molar being the cantilever pontic and the abutments being the first and second bicuspids. The first molar pontic was kept the size of a bicuspid. Both left and right mandibular fixed bridges were done with full-coverage porcelain fused to gold and both were seated or placed at the same time. Because I do not do implants, a cantilever bridge was placed in the mandibular left posterior (an implant for the lower left second molar would be an excellent option and is still possible at some later date). To complete the lower arch and the leveling of the occlusal plane and also to maximize the esthetics of the new smile, I placed porcelain laminate veneers on the six lower anterior teeth in April 2003. We were now ready to restore the upper arch.

During the next month, we prepared the upper right and left first molars for porcelain fused-to-gold crowns and the upper left second molar for a full-cast gold crown even though it has no opposing tooth in the lower arch (it can be used later in conjunction with an implant in the lower left second molar area). This would give good sup-



Figure 8: Jennifer*, July 2003.

port for the posterior occlusion and ease any compression in the left temporomandibular joint.

Finally, it was time to complete the case by restoring the upper anterior arch from the left second bicuspid through the right second bicuspid. This was accomplished in mid-June 2003, with all-ceramic crowns for each of these teeth. The upper left and right cuspids as well as the upper left bicuspid were built out facially at the incisal or occlusal one-half, as they were inclined somewhat lingually. This better filled the smile zone on the left side and enhanced the cuspids esthetically (Figs 5 & 6).

Although the primary purpose of this treatment was the restoration of Jennifer's smile, it was equally as important to pay attention to her temporomandibular joints because of her initial complaint of discomfort and popping in both joints. I constructed a myopathic mandibular nightguard for Jennifer with the SAM instrumentation and decompressed it 0.3 mm using the SAM Variator as suggested by Dr. Rudy Slavicek of the University of Vienna, Austria. This would help address the loose ligament situation that existed in both joints and give good posterior occlusal support should there be any nocturnal bruxism.

It has been almost one year since we completed the work and returned Jennifer's smile to her (Fig 7). She is a true testament to the possibilities and success that the Give Back A Smile program brings to the lives of domestic violence survivors. She has quit smoking and her temporomandibular joints are without pain because of better occlusion. Her teeth and tissues are responding well, and now she is a beautiful person in every way. Her two children are very happy with their "new" mother, who has



Figure 9: Dr. John L. Ames and his staff.

regained not only her smile, but also her personal dignity, self-esteem, and self-confidence. Jennifer is a new person on her way to a better life (Fig 8).

I am grateful to my office manager Lillian Arena, hygienist Laurie Waugh, and chairside assistants Jodi Spencer and Jackie Soohey, who were all instrumental to the success of Jennifer's case; never have I had such a hard-working, compassionate team (Fig 9). Thanks also go to William "CK" Kim, C.D.T., of Americus Dental Labs (Jamaica, NY) for his beautiful ceramics. Finally, my heartfelt gratitude and appreciation go to Jennifer for being such a superb, cooperative patient and for the trust she had in me. *StB*

**The patient's name has been changed to protect her privacy.*

If you have a story to tell about your participation in the GBAS program or would like to submit a GBAS clinical case, please send your submission to: Kristin Klinkner, Give Back a Smile, 5401 World Dairy Dr., Madison, WI 53718.



The American Academy of Cosmetic Dentistry is an organization of many of the world's leading cosmetic dentists. It's membership includes many from the entertainment industry in Hollywood and New York City and dentists from South America, Europe, and the Far East.

Within the Academy of 5000+ cosmetic dentists, there is a group of approximately 1000+ cosmetic dentists who volunteer to serve in the AACD Charitable Foundation's "Give Back A Smile" (GBAS) program.

This program in cooperation with the National Coalition Against Domestic Violence, restores the smiles of domestic violence survivors at no cost.

Each year the Board of Trustees of the AACD awards one individual volunteer to the GBAS program their "Partners In Peace" award for the outstanding contribution of the year. The 2004 award was given to Dr. John L. Ames of Schererville, Indiana.

