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DAVID A. WRIGHT
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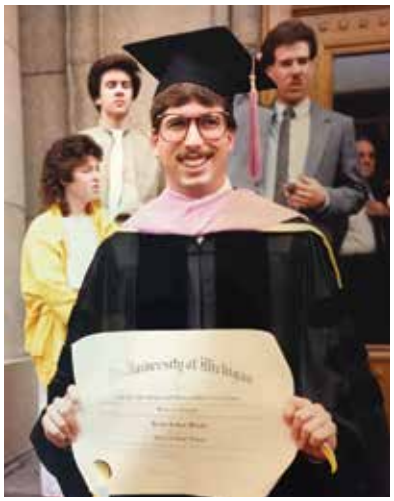
New patients welcome

Summer 2017

Thirty Years a Dentist!



Thirty years ago this past May, a young man with an awful mustache matriculated from the University of Michigan School of Dentistry. After eight years in Ann Arbor, I was off to face the real world. Fiancé and soon-to-be-wife Peggy tried to get me to take a month to backpack across Europe. After all, I took my boards in mid-May and was not allowed to start practicing until late July (when all of the schools had completed boards). However, I was too excited about beginning practice, and too worried about the $33,000 in school loans that I had taken, so I continued working at my bartending job that I was about to quit after six years, and got ready for our July 11th wedding. This year, 7-11 meant 30 years of Peggy putting up with me…amazing!

Somehow we managed to have three kids, who had the gall to grow up and go to college. My middle kid, Daniel, graduated in May from The Ohio State University (why do some schools insist on capitalizing the "The"?). It was surreal because 1.) I was watching my only boy GRADUATE FRIGGIN' COLLEGE, and 2.) I was still trying to figure out how the child of two Michigan grads went to OSU. To enhance the uneasiness, various speakers referred to "that school up north" or "that state up north" no fewer than ***four times*** during the ceremonies. Yep, they DO NOT like us folks down there. In spite of all that, Daniel had a great experience there, made wonderful friends, and got out in four years. I am very proud of him…and I will be VERY, VERY proud once he lands a job and is off the family payroll. ☺

(continued on page 3)

What Is 'Cosmetic Dentistry'?

There is no such specialty, or official area of dentistry, as "cosmetic dentistry." Occasionally I'll read about a dentist who gets in trouble with the State Board, in Michigan or elsewhere, because they claim to "specialize in cosmetic dentistry." State boards really frown on dentists just making stuff up, and yet there is no doubt that many areas of dentistry involve esthetic, or cosmetic, changes. Most dentists are not trained in orthodontics, so one of the main ways to improve someone's smile is not available to them. These dentists may choose to use what skills they DO have, like using crowns or porcelain veneers, when orthodontics might have been preferable. Most general dentists do not place dental implants, so another way to improve their smile is not part of their practice. They have to refer that out to another dentist, like me, who routinely places implants.

In our office we have pretty much all of the options for cosmetic dental changes, except for radical jaw surgery (which is RARELY indicated), available to us. Orthodontics and dental implants are everyday treatments for us, and whitening, bonding, and veneers are a regular part of our options as well. I think this makes us uniquely qualified to plan the best, ***most affordable treatment*** for patients needing this care. Yes, because we keep all of this "in house," we often can provide excellent treatment at a reduced fee—faster, less costly, and, I really believe, better treatment.

(continued on page 2)

Thank you for all your referrals. We appreciate them!

Sugar Blues

In the mid-1980s, while in grad school, I came across a 10-year-old book called *Sugar Blues*. I really should go back and reread it, but it described the modern addiction to simple sugars, especially sucrose, and attributed many of America's medical ills to this substance. Those ideas, revolutionary at the time, SHOULD BE old hat now, 40 years later. In fact, most of the weight-loss books and articles that I have read since that time have basically rewritten *Sugar Blues*. And yet today's America struggles even more with sugar-related problems such as obesity, cardiovascular disease, diabetes, and, yes, tooth decay.

While I have not had a cavity since I was 16, since I do the things that I preach, like avoiding between-meal sugars and rotapointing three times daily, I still have managed to slowly gain weight for the past 30 years. This year, at my annual physical, my key numbers jumped out of the "normal" range. I have decided that it is time to do something.

One month ago I followed the lead of my workout partner and next-door neighbor, Todd. He had lost a ton of weight over the past year and has maintained the loss by using a no-simple-carb approach. I am following his lead (I call him "my diet Sherpa[1]"), and the first month has gone well. I have lost 20 pounds and feel fine. My goal is to be at my weight goal by January 1, 2018.

If you are curious, here is what I am doing. I will continue to exercise a fair amount, as I always have. My diet will consist entirely of complex carbs: vegetables, lowish-sugar fruit (like strawberries and melon), nuts, and proteins. I eat mostly chicken and fish, and try to keep red meat to once a week or less. Gone are beer and wine, soda (I still have an occasional diet soda), fruit juice, bread, pasta, potatoes, and rice. Breakfast is an egg, lunch a salad, and dinner a protein, vegetables, and a little fruit.

I absolutely, positively, DO NOT cheat. You see, diets that allow a "cheat day" or a "reward cheat" forget that the key element of the weight loss is reprogramming the insulin metabolism, and therefore eliminating the psychological "sweet tooth" cravings. That is the theory, in short, behind many of the successful diets of the past three decades, such as "Atkins," "Protein Power," and "South Beach," to name a few. I found all of these diets successful in the past, but then I would blow it by having "one little cheat," "one piece of birthday cake," etc., and I would be back to my same old habits. The problem was not the diet; it was me and my underlying poor choices. Was the actual problem linked to Insulin? At least in part, I believe that to be true.

By the way, I so far have found this diet super-easy. It is far simpler, for me, to know that certain foods are "verboten," off-limits, in no way allowed. There is no rationalizing how I can "do this in order to do that." It simply "is what it is." It takes the calorie counting and hunger pains out of it; just eat the proper foods and don't cheat. Best of all, there are no payments to make and no clubs or businesses to subscribe to. It literally costs nothing.

Sherpa Todd is trying to understand what his "new normal" will be and how he can safely introduce the occasional simple carb back into his diet. Once at my target weight, I need to learn how to live differently and not begin the weight climb back up. Hopefully he will have good insights for me. My hope is that I am successful, and then perhaps I can be a "Sherpa" to those of you who might be looking for a way up the weight-loss mountain. Wish me good fortune!

[1]For those who don't follow mountain climbing in the Himalayas, a "Sherpa" is of a people who have lived in very high elevations for hundreds of years and have made physiologic adaptations to this harsh environment. As a result, they possess a great ability to remain healthy at high elevations, and are often used to guide climbers up mountains such as K2 and Everest.

What Is 'Cosmetic Dentistry'?

(continued from page 1)

Most of us are aware that the British have long been famous for having "bad teeth." You even run into Brits who seem to be proud of the fact that their teeth are black and look like an unkempt garden. Why is that? Well, for generations the U.K. has had national healthcare, which SOUNDS great until you realize that in that system, most modern treatment, like orthodontics, was severely rationed. The average Brit received the most rudimentary of care, even if they could afford better care. Teeth were sometimes removed that would have been saved here. Amazingly, there was an "awakening" in dentistry in the U.K. about 15 years ago, and most dentists threw off the shackles of national healthcare and created private practices like mine. And guess what. Cosmetic dentistry is BOOMING in England, and many of the biggest cosmetic practices in the world are in London. These English patients finally understand that it is OK to want to look nice, and they are lining up to correct the neglect of the past. *They are happy to pay for it themselves and happy to be free of the socialized controls.* I also think that this is a good parable to think about when "the government" is going to provide something new for us.

A few weeks ago I had a longtime patient, a wonderful gentleman around my age, describe his distaste with all of the teeth whitening and cosmetic dentistry that is occurring in the world. (We had not tried to interest him in this; he brought it up out of the blue.) I listened politely and smiled. I didn't really affirm or argue his point; I just let him talk. I should have told him that cosmetic dentistry is booming because it is, well, kind of fun. Many parts of our body are looking a little older, so if someone wants to improve the smile to a "younger-looking" smile, what is the harm in that? Moreover, many of these changes actually improve the bite and/or strengthen the teeth and prevent further problems. No one is all that excited when we do a nice filling, but I get lots of high-fives and hugs following cosmetic treatment. The comment that I hear over and over and over, is "Why did I wait so long? I wish I had done this YEARS ago!"

If you have any areas of your smile that you are considering changing, please let us know and we will help you understand the options for treatment. Oftentimes people are surprised that the treatment is easier and less costly than they had imagined. You may have British DNA, but that doesn't mean you have to look like a Brit. ☺ ***—Dr. Dave***

BLOOD PRESSURE SCREENING—
What Business Does a Hygienist Have Taking My BP?

Blood pressure (BP) is such a common medical reading that I think we lose sight of its importance. No other easily obtained measurement gives so much information. Moreover, there are rarely any signs of high blood pressure, and people who subscribe to the "I feel fine, so everything must be fine" mantra often are surprised that their BP is elevated.

The first- and third-leading causes of death (heart disease and cerebrovascular disease) for American males, also the first- and fifth-leading causes of death for American females, are tied closely to BP. Many other diseases and disorders affect BP, and vice versa. The important point is that while it remains pretty constant in most folks, a change in BP is rarely random; usually something is causing this variation.

A year ago we decided, as an office, to begin taking blood pressure at every hygiene visit. The American Dental Association (ADA) encourages this, as does the American Medical Association (AMA), and the American Heart Association, as do virtually all health organizations. Now, here's the rub: We would be using our valuable time, without any reimbursement, simply to help our patients. We hoped that people would appreciate us volunteering our services to help them. We invested in excellent equipment, including a $2,000 operating room–quality pulseoximeter that is highly accurate, to make sure that we could do this quickly and accurately. (Please note that less costly units are often our first line of screening, since we need one in each of our six rooms.)

Not surprisingly, over 90 percent of our patients have BP readings right where they expected them to be, and where they fall when they get their physicals at their physician visits. There certainly have been, however, some folks who had much higher readings than they were anticipating.

Reviews from patients have been all over the place on this new service. Many have not blinked, since they associate BP readings with quality health care, and they appreciated the service. Some have been overly grateful, as we turned up an undiagnosed problem and it allowed them to seek treatment before a calamity occurred. But there have been, surprisingly, a few individuals who were pretty negative. One longtime patient even walked out of the office, essentially saying, "I don't have time for this crap." Frankly, I am intrigued by this.

I have to believe that these folks either don't think that BP readings are any of our business (I'll call this the ***Leave it to the REAL doctors*** philosophy), or they think that we are not competent to obtain a proper reading (often these are the ***Your equipment isn't any good; I'm usually fine*** folks).

I also think that people know when a medical physical is coming, and they often change their diet ahead of time, take their meds as required, avoid caffeine, etc., to make sure that they get a good BP reading at the physical. Is this, then, an ACCURATE portrayal of their day-to-day BP? Not if they act differently when they don't have an upcoming physical. In those cases we are MORE LIKELY to get an accurate reading on the days people are visiting us, and therefore our readings are MORE INDICATIVE of their cardiovascular risk. It doesn't matter to your body what your BP CAN BE when you are doing things perfectly. What matters to your body is what your BP is day in and day out. And so I believe that the reading that you get on a truly "random" reading is the MOST accurate reading.

Other folks note that "I check it at home and it is fine." If it is high at our office but "fine at home," that is either because of the equipment or technique used at home (some monitors, especially wrist monitors, are very technique sensitive) OR because once this person gets into their (stressful) day, their BP soars. This likely needs treatment, and these findings should be discussed with their physician, because the daytime elevated BP is stressing their cardiovascular system. Our readings would hopefully help this person discover an undiagnosed, or misdiagnosed, problem.

I have noticed that people in my age group, the 55-and-over group, often have a high BP when they come into the office, but it often drops 10 to 20 points after they relax for 5–10 minutes. They clearly go through much of the day with higher BP than the reading that is considered their "normal." My gut feeling is that this should be discussed with one's physician to see if that is acceptable or if it suggests new or different medications.

In any case, I want you to know that we are going to continue to provide this service for you. I hope that you appreciate that we are not doing it because we "have to," but because we are part of the medical team that cares for you. We also will continue to not do elective treatment on someone who has a diastolic reading (the lower number) over 100. We are following the standard of care in dentistry as suggested by the ADA and leading experts. Your safety and your health are our highest concerns. As always, I thank you for allowing us to care for you! ***—Dr. Dave***

Thirty Years a Dentist!

(continued from page 1)

Oldest daughter Natalie is still working at Mathnasium, teaching the kids of type-A parents advanced math (I tease). She also is well along writing her first novel. She won't tell us anything about it, so I have to assume it deals with the horrors of being raised by a dentist and a speech pathologist…kind of like *Oliver* meets *Silence of the Lambs*. (OK, comments like that are probably why she won't tell us what it is about.) Julia just finished her first year of college, at the University of Michigan. Like about half of the freshman class, she is pre-med. She missed us so much that she decided to get a job and stay in Ann Arbor this summer. She seems to know that college is serious business, but you need to enjoy it, too. Hopefully next year living in the ADPi Sorority won't be SO enjoyable that she has a new major. In any case, it is fun to have a child up in Ann Arbor again; it makes me look brilliant for keeping my football tickets during all of the dark years.

Recognizing that it might be our last chance for a trip with all of us together, a couple of days after Daniel graduated we took a two-week trip to the former Yugoslavia, exploring Slovenia (we saw Melania Trump's high school…insert your own sarcastic comment), Croatia, Bosnia and Herzegovina, and Montenegro. A few new photos from the trip are hanging in the office, if you like that sort of thing. If this is the last of the Wright family trips, it was a great ending.

Last night we had three couples, some of our closest friends, over for dinner. As the eight of us were chatting, it suddenly hit me that the other three males were retired. Darn, that is strange! All three left corporate jobs when it wasn't fun anymore. My main mentor in dentistry, Gordon Christensen, just turned 80, and he still can't wait to get to the office each day. I am pretty darn lucky to be able to do a job that allows such passion and enjoyment. Thank you for being among the patients who make this possible. Have a great "rest of the summer" and a blessed autumn! I may be old, but I ain't going anywhere!

Very much yours,
Dr. David

'Thanks!' to My Implant Patients!

For nearly 30 years I have been involved in implant dentistry. I took my first surgical training in Toronto, Canada, in 1989. That was well before Peggy and I had children, and I still remember that she accompanied me on that trip and we explored Toronto extensively over those five days. I also remember the excitement of being introduced into a whole new world, where missing teeth could be replaced by something far, far better than what dentistry had beforehand.

Flash-forward to today, where it is an unusual day in the office when we are not seeing at least one implant patient. Today I even teach in this area, mostly at the PCC Dental training center in Provo, Utah. I have also been asked to speak at a meeting in October before about 400 dentists. My topic concerns motivating general dentists to get into implant dentistry (most U.S. GPs still do not do implant surgery, although in many other developed countries, GP dentists overwhelmingly place implants).

Recently there has been an emphasis on getting "credentialed" in the implant arena. This means that you pass written, oral, and "case" exams (where you show some of your cases), and experts decide your fate. I have begun this process, passing the written exam last year with the AAID (American Academy of Implant Dentistry). Next spring I will attempt the oral and case portions of the first level of credentialing.

To prepare for this arduous process, I need new photos and radiographs (X-ray pictures) of many patients. I will have my staff call patients who are prospective cases and ask them if they would mind us updating these images. Of course, there will be no charge for this, and I really appreciate those of you who are willing to do this for my good, and the good of the practice. You are the best; thanks for letting me take care of all your dental needs. ***—Dr. Dave***

Dr. Wright Named Top Doc (Again)

Dr. David Wright has once again been named a "Top Dentist" in the Detroit Metro Area. This award was voted on by his peers and was announced in February of 2017. Dr. Wright has won this award every one of the 10 years that it has been in existence. It is nice to know that others appreciate the hard work that Dr. Wright puts in to remain current and effective.

Office Hours

Monday	**10 a.m.-7 p.m.**
Tuesday	**8 a.m.-5 p.m.**
Wednesday	**8 a.m.-5 p.m.**
Thursday	**8 a.m.-2 p.m.**
Friday	**8 a.m.-2 p.m.**
Saturday	**8 a.m.-1 p.m.**

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Front Desk:
Barb

Hygienists:
Mary, Elizabeth, Michele, Heather, Nichole, Amelia, Ashley, Marisa

Dental Assistants:
Heather, Caitlyn, Marisa

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Dr. Wright and Team Train with the Inventor of the Pinhole Technique

A few months ago, **Dr. Wright,** office manager **Kara,** and clinical manager **Heather** went to the office of Dr. John Chao in Pasadena, California, for a three-day training in pinhole surgery. Dr. Chao invented this surgery as a means to have a much less invasive way to treat gum recession. Traditional surgery, as done by Dr. Wright, harvested tissue from the patient's palate and transplanted it to the recession area. This treatment usually worked well but was uncomfortable or even painful at both of the surgical sites.

Untreated recession causes tooth sensitivity, cosmetic concerns, and, untreated, can even result in tooth loss. Many people would like gum recession treated but were intimidated by the traditional surgery that was required.

The pinhole technique does not have a second surgery site, and the primary site is done through one or more small "pinholes." Patients report that there is only mild discomfort, and the areas heal nicely as long as the patients follow the post-treatment instructions.

Our initial surgeries in our office are using family, staff, and long-term patients in order to observe the results for ourselves. Once we see that this is predictable, we will offer this service to all our patients. As always, we are forever learning so that we can provide our care in more effective, more comfortable ways!