

Exploring the World of Bioesthetic Dentistry

In this exclusive written interview for Dentistry Today, Dr. Damon Adams, our editor-in-chief, asks Dr. James Benson about some of the core concepts and principles that Bioesthetic Dentistry offers to the profession. Dr. Benson, the president and director of education of the Optimal Biology International (OBI) Foundation for Bioesthetic Dentistry, has taught Bioesthetic dentistry throughout the United States, Canada, Europe, Mexico, and South America since 1994.

Would you briefly describe what Bioesthetic dentistry is, and what is it based on?

Dr. Benson: Bioesthetic dentistry is a process that accepts optimal biologic form as the basis for comprehensive diagnosis and treatment planning.¹ Optimal biologic form is the term that dentists trained in the principles and techniques of bioesthetics use to describe healthy, beautiful, unworn, and highly functional mastication systems. Through the study and observation of superb unworn dentitions (Figures 1a and 1b) that have survived in prime condition for decades, we have been able to define the attributes of optimal biologic form. Contrary to most breakthroughs, which have been technical, this subject demands attention to “discovery” over “invention.” Although an ideal biologic system goal is rare in the health arts, Bioesthetic dentistry has one. As the discovery process evolves, the qualities of optimal health biology continue to be clarified. Our knowledge of optimal nature is not yet complete, however, finding out *what* to study in order to per-



James R. Benson, DDS

form predictable and effective comprehensive dental system treatment has been enlightening.

So, why bioesthetics?

Dr. Benson: Until the creation of the Bioesthetic philosophy, no specific biologic basis had been developed for the clinical practitioner in dental diagnosis and treatment. OBI (formerly known as Orogathic Bioesthetics International) Foundation for Bioesthetic Dentistry has been formed to teach the principles of optimal dental system biology as it pertains to patient care. It provides intellectual empowerment and tools for the avid and curi-



Figures 1a and 1b. Example of optimal natural form—frontal centric and left lateral cuspid guidance view of the maxilla and mandible.

ous dentist. It is for the professionals who are seeking to fill the gap in their education and continuing education experiences. On a personal note, a course on “how the chewing system works” was not included in my dental school curriculum, and the majority of postgraduate studies in the area of occlusion were confusing, illogical, mystical, or all of the above. We know that many others can describe having had a similar experience.

Bioesthetic dentistry is a logical path to identifying and helping patients with dentitions in need. It takes the long-term approach to diagnosis and treatment. Skillful diagnosis is not only about what is happening now, but what will happen 10, 20, and 30 years from now. A thorough understanding of the principles, guidelines, and techniques that Bioesthetic dentistry offers enables dentists to deliver a level of care that is truly exceptional and enduring. Bioesthetic dentistry challenges the disease-based treatments of the status quo and teaches that patients with naturally healthy dentitions hold the answers. With Bioesthetic education and training, the clinician can accurately diagnose and treat each willing patient with optimal dental system health as the goal. With knowledge of optimal biologic form, Bioesthetic dentists are able to move their patients toward the top of the diagram (Figure 2).²

What are the fundamental attributes of optimal dental system health, and how have these elements been determined?

Dr. Benson: To initially pursue the issue of optimal dental system health, mature people (the older the better)—who exhibited healthy- and unworn-appearing teeth—were selected and carefully examined to find out why they were not experiencing wear on their teeth. Why is wear so important? We have found that asymptomatic wear on teeth is one of the earliest signs of pathology in a dental system. Tooth wear can be extreme, or absent, regardless of a person’s age. The present literature relegates most

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Exploring the World...

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tooth wear to varying psychological conditions.³ Bioesthetics has years of clinical evidence to show orthopedic misalignment as the main cause. Subjects with unworn dental systems were measured in the following manner:

Open bite centric registrations (CR) and ear-bow recordings were taken in order to mount the patient's dental casts on Panadent articulators enabling:

- Quantification of the cranial base to mandible relationship
- A dynamic functional analysis (Figures 3a and 3b).
- *Boley gauge measurements were made of tooth lengths, vertical dimension of occlusion (cemento-enamel junction [CEJ] to CEJ of central incisors) and the amount of vertical and horizontal overlap.*
- Casts were examined for wear on the teeth.
- Close-up dental and full-

face photographs were taken to assess form.

The findings showed that subjects with *unworn* chewing systems were closely similar in their functional relationships regardless of age, size, race, or gender. Three aspects—which can be called the *optimal biologic principles*—were in common in all groups.

First Principle—All these mounted dental systems demonstrated that the condyles were seated and the teeth were in, or very close to, maximum interdental occlusion. Centric relation equaled centric occlusion, naturally (Figures 4a and 4b).

Second Principle—The vertical and horizontal overlaps of the incisors and cuspids provided sufficient proprioceptive protective guidance and clearance for the mandible to return to full

occlusion without premature posterior contact.

Third Principle—The teeth displayed genetic form with convex interocclusal contacts enabling maximum chewing

efficiency. All subjects in this group showed full anatomy with very little wear, which had been the very reason for selecting them.

In general, these individuals all demonstrated healthy periodontal tissues, relaxed muscles, asymptomatic temporomandibular joints (TMJs) with good facial form and esthetics. People older than age 50 years and demonstrating the 3 principles had dental systems splendidly withstanding the test of time.

We can conclude that patients with natural dental systems (in “centric”) demonstrating these optimal biologic principles have few signs of pathology.

Can healthy natural dental systems serve as a model for diagnosis and corrective treatment?

Dr. Benson: The answer, reached throughout the last 20 years of clinical experience from among 200-plus clinicians, is a resounding YES!⁴

Rationally, what other than exceptional biology should be our guide? Intimate knowledge of great health readily reveals pathology and deformity, in addition to providing the form and function to correct it!

This study also uncovered, by deduction, a most relentless cause of dental system wear and attendant problems: *Destructive parafunction in patients with “out of centric” systems during sleep.* The signs of parafunction precede the symptoms, facilitating early diagnosis and treatment. Pathologic phenomena, such as recession, abfractions, tooth mobility, periodontitis, cracked tooth syndrome; and attendant symptoms in the muscles, TMJs, and tissues of the head and neck; begin to make sense once the state of dentally mis-

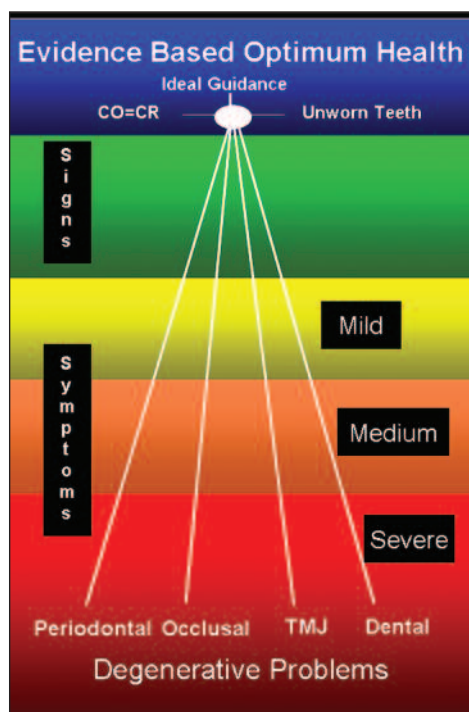


Figure 2. Conceptual convergence diagram representing the optimum dental system health goal.



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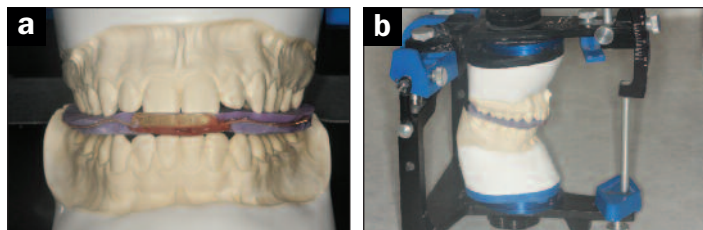
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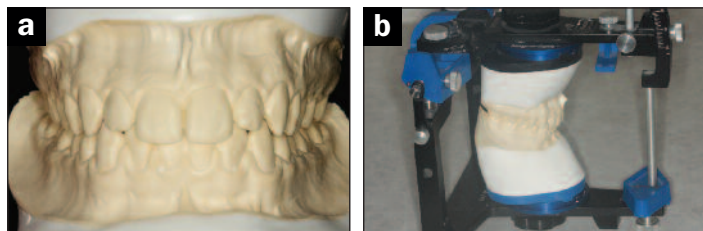
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Figures 3a and 3b. Right lateral and frontal views of a mounted optimal case with an open centric bite registration.



Figures 4a and 4b. Frontal and right lateral views of previous case showing case with bite registration removed, illustrating that centric relation equals centric occlusion naturally.

aligned jaws are compared to the ideal. Most patients are unaware of the activity and damage in the early stages; therefore, the identification must be made by the clinician. It is hoped that the findings presented here will alert practitioners to be more inquisitive about optimal dental systems in order to be able to see the contrast.

The optimal biologic dental system model (optimal model) comprises the 3 principles, thereby providing a template for diagnosis and a treatment destination for each dental chewing system—that is the essence of Bioesthetic dentistry.

It seems that Bioesthetic dentistry has an extreme focus on diagnosis. Is that perception correct?

Dr. Benson: Yes. In traditional disease-based medicine, the term “diagnosis” is defined as the analysis of signs and symptoms of disease and/or deformity that depart from “normal.” “Normal,” while implying “well,” does not translate to optimum health, nor does it establish a standard of health goal for treatment in dentistry. Bioesthetic diagnosis utilizes the *optimal biologic principles* as a standard for comparison and critical analysis relative to all human dental systems. It determines the problems as well as the possibilities for treatment. Systems that depart from the optimal health principles commonly have problems that eventually require treat-

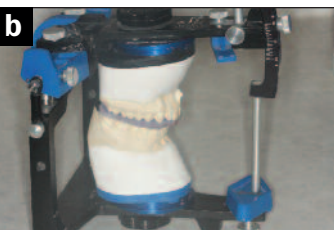


Figure 5. Example of occlusal contacts developed on a maxillary anterior guided orthosis (MAGO).

ment. Recognition of early signs and symptoms of challenged health can “jump-start” effective preventative care. The bioesthetic diagnostic process demands that the relationship between the patient’s cranial base and the mandible be established precisely with stable and seated condyles *prior* to making a final diagnosis.

Exactly what does it take to make a “bioesthetic diagnosis” with stable and seated condyles?

Dr. Benson: We do not find that a manually manipulated CR (“CR *du jour*”) in a threatened system produces the necessary alignment. People who have had an adaptive malocclusion for years require a more exacting process to achieve a stable and seated condylar position.

Following an in-depth clinical examination and documentation of pretreatment conditions (patient history, baseline records, necessary radiographs/scans, and photographs), the diagnostic process is initiated using a bioesthetically designed and adjusted maxillary anterior-guided orthosis (MAGO). This

process brings new precision and meaning to the embattled subject of “splint therapy.” Properly managed, the MAGO will deliver the benefits of the optimal model with the exception of cuspal anatomy. The primary objective for this “24/7, eat-and-speak-with” appliance is to calm the neuromusculature⁵ and to guide the condyles into stable, seated positions in the glenoid fossae replicating the best of nature (Figure 5).

Customized, periodic adjustments can take from 2 to 9 months, depending on the severity of the malocclusion, tissue damage, and misalignment. Multiple criteria are used to judge whether a case is stable enough to diagnose, ie, when the MAGO centric contacts remain the same and the condyles have not changed position for 3 weeks. At that time, accurate dental models are mounted on a jaw movement simulator (Panadent) via axis transfer instrumentation and open CR interjaw registrations. It is then that the diagnostic questions of “What is happening?” “Why is it happening?” and “What can be done about it?” can be answered.

With the first principle of stable and seated condyles achieved, mounted models can be evaluated with the goal of incorporating the remaining 2 principles of incisal and cuspid guidance and full, genetic dental anatomy into the solution (Figures 6a to 6d).

Treatments can include the thoughtful implementation of the full spectrum of general and specialty dental techniques; being as minimal as a limited joint seating subtractive coronoplasty; or as complex as a combination of orthodontics, orthognathic surgery, and/or full-mouth rejuvenation.

How is esthetics related to function in Bioesthetic dentistry?

Dr. Benson: In bioesthetics, we accept that esthetics and function are interdependent components of optimal biology. The bioesthetic process provides numerous possibilities for achieving an esthetic

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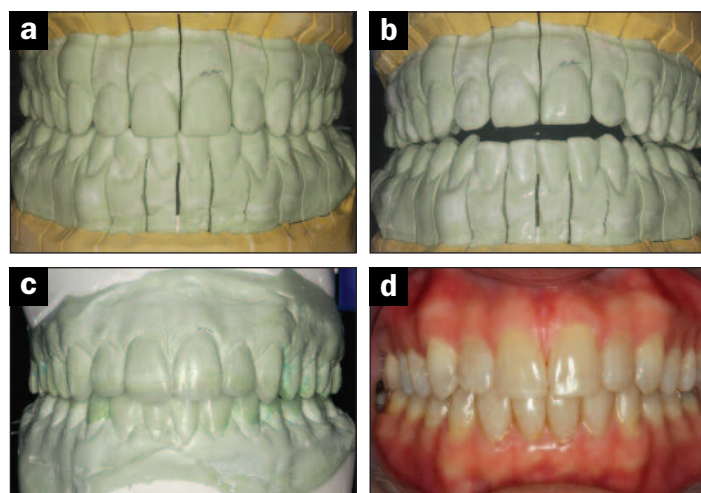
outcome. One of the keys to dental system esthetics is the ability to adjust dentofacial vertical dimension for the best appearance. This can be accomplished after the first principle of stable, seated condylar position has been established with MAGO splint therapy. The case is then ready for diagnosis and discovery of applicable treatment options. In the majority of cases, interocclusal space will be restored to compensate for the reduction of facial vertical dimension due to previous tooth wear or loss. Increasing anterior vertical dimension with stable joints can be a very esthetic event, since it provides a dentoskeletal facelift plus space for beautiful unworn tooth form (Figures 7a and 7b). Relaxed facial musculature is also a byproduct of this treatment. Different vertical dimensions of occlusion are analyzed by photographing the patient with jigs of various thickness

placed on the anterior teeth, observing how each affects the face and profile view. Once the most favorable form is determined, the attendant positions and functions of the teeth at that vertical dimension can be validated with mounted models using trial functional coronoplasty and wax-up techniques.

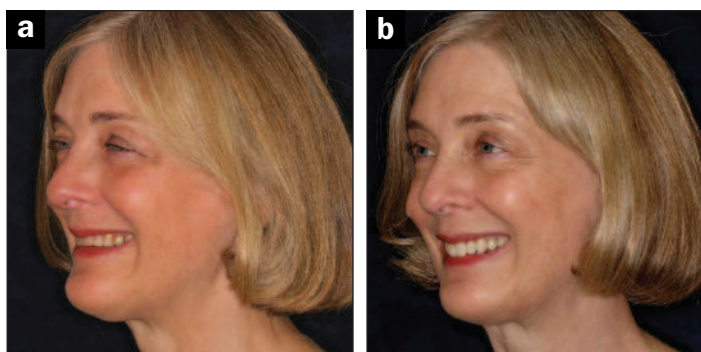
Working with an established center of mandibular rotation also allows multiple choices in fulfilling the second principle, incisive and lateral guidance, and the third principle, ideal, occluded tooth anatomy. After the most esthetic facial height is selected, the length and thickness of the teeth complementary to the lips and tongue are developed. Then, the remaining variables of tooth shape and color can be considered.

Bioesthetics has been simplistically characterized as “painting by the numbers.”

In severely worn down and mutilated dentitions,



Figures 6a to 6d. Pre-MAGO centric occlusion (a); post-MAGO seated and stabilized condylar position (b); proposed subtractive and additive coronoplasty restorative solution (c); and 10-year postoperative appearance (d).



Figures 7a and 7b. Pre- and post-treatment views. Note that increased anterior vertical dimension with alignment of the temporomandibular joints produces a neuromuscular release and a dentoskeletal facelift.



Figures 8a and 8b. Anterior views of a deciduous and a mixed dentition with very little wear in a 5-year-old and a 9-year-old, respectively.

dental landmarks appear to be lost. Knowledge of the optimal dental system can provide guidelines (numbers) that are helpful. As the hardest tissue in the body, teeth are readily measurable. For example, if one determines the lengths of the healthiest unworn dentitions in nature, one will find that the length of the maxillary central incisors often is in a range between 11 and 13 mm⁶ with mandibular central incisors 9 to 11 mm. Occlusal vertical dimension of central incisors from CEJ to CEJ in maximum contact is regularly between 16 and 19 mm with 3 to 5 mm of vertical overlap.⁷ These are just a few of the guidelines of optimal health that serve as starting points in deformed and challenging cases.

Following a bioesthetic wax-up on mounted models, a preview try-in guide can help the patient visualize the esthetics and form. During treatment, the wax-up is the source of bioprovisionals that provides a positive “biologic response” plus facilitating critique and contouring to the most esthetic form before moving to the final restorations. The patient is informed and included in all of the esthetic decisions along the way.

The above process also provides a treatment differential diagnosis for precisely determining whether orthodontics or orthognathic surgery should be considered to best serve the patient. Aesthetic form and ideal function are seamless coordi-

nated entities in bioesthetics just as they are in optimal nature.

What kind of patients can be best served with Bioesthetic dentistry, and is it recommended for everyone?

Dr. Benson: Bioesthetic dentistry, being based on optimal dental system health principles, can be of benefit to every human being. It defines the necessary elements for an esthetic, long-lasting, trouble-free dental system. Moving a person’s dental form and function toward the optimal health principles, even minimally, has invariably proven to be good therapy. Simply wearing a MAGO at night can neutralize overload and prevent primary causes of wear and torque on the system.

Bioesthetics is *not* merely about full-mouth rejuvenation, it is looking at every patient with the optimal model in mind to see how it can be helpful. Of course, bioesthetic diagnosis and treatment is also exceptionally effective in the most difficult, diseased, deformed, and painful cases.

Children and adolescents are also a part of the treatment mix. As stated earlier, the incredibly good news is that when recording excellent, unworn, deciduous and mixed dentitions, once again the 3 principles are present (Figures 8a and 8b).

This finding of relational consistency suggests the possibility of diagnosis and beneficial treatment of young systems that are “out of centric” because occlusal contact tolerances are very sensitive at all ages. A small prematurity can activate the neuromuscular avoidance pattern characterized by clenching, bruxing, and anterior mandibular repositioning. Therefore, early treatments can be minimal and effective. Originally, bioesthetics was discovered in the quest to understand how stomatognathic systems functioned optimally, so that care could be provided for patients suffering from severe occlusal problems with predictable, long-lasting restorative treatment. Paradoxically, the great-

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INTERVIEW



Figures 9a and 9b. Interactive, hands-on clinical courses in progress.

est gift will eventually be its contribution to preventative dentistry.

What is the difference between Bioesthetic dentistry and occlusion as taught in other disciplines?

Dr. Benson: Bioesthetic dentistry is the only discipline that uses optimal natural dental system biology as the guide for comprehensive diagnosis and treatment. The best human dental systems are not random. The scientific validity of this approach has been proven at the clinical level with quantifiable, existence-based, living morphology. The optimal model of exceptional biology is not exclusive and is available to anyone interested in its study. Very little formal academic research has been done on optimal dental system health. It is a fertile field for continued endeavor.

Logically, for a living system to have a well-grounded diagnosis, it should require an optimal health standard for comparison. Historically, there has been no specific biologic basis for comprehensive dental system diagnosis and/or treatment. For example, the most predominant activities in comprehensive dental system care today are found in the prosthodontic and orthodontic specialties. An extensive literature review shows that prosthodontics evolved from inventing denture solutions for edentulous patients. Those denture technologies were subsequently applied to people with teeth.⁸ The form and mechanics of that effort are embodied in what is known today as the prosthetic model.

It appears that a large number of orthodontists have also embraced some aspects of the prosthetic model demonstrated by the many finished

orthodontic cases considered ideal with overbites of 2 mm or less.⁹

The optimal model brings organization to the chaotic atmosphere that presently surrounds comprehensive restorative dentistry and orthodontics so practitioners can consider full mouth problems on a sound biologic foundation. It could serve as the universal standard for dental system care uniting all disciplines and specialties to a common philosophy. Techniques may be different, but the objectives would be the same.

An optimal biologic basis for comprehensive care has been discovered, tested, and applied for 20 years. It is now available to the profession as an excellent alternative to the status quo. The great benefit for our patients would be that most confusion about occlusion among the dental community would be resolved!

Is there a curriculum available for learning Bioesthetic dentistry for those doctors who might be interested?

Dr. Benson: The OBI Foundation for Bioesthetic Dentistry offers a stimulating learning experience by challenging the disease-based approach to diagnosis and treatment. Upon completion of the clinical courses, each participant will have applied the principles of Bioesthetic dentistry to living patients and acquired dental photography, case organization, and presentational skills. All classes have a 4:1 participant-to-faculty ratio, with unlimited access to faculty during, between, and after the sessions (Figures 9a and 9b). All participating doctors follow each case in the class through the

diagnostic process and all phases of treatment giving everyone an exponential learning experience. A basic introductory lecture can be found online (at the Web site obifoundation.org).♦

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Dr. Benson is a graduate of University of Illinois College of Dentistry. He maintains a private practice with an emphasis on restorative dentistry in Ashland, Ore. He is a graduate and past faculty member of the Dr. Robert Lee Institute. In 1994, he was appointed faculty of OBI International; appointed co-director in 2002; and he is currently president and director of education for OBI Foundation for Bioesthetic Dentistry. Dr. Benson has taught Bioesthetic dentistry throughout the United States, Canada, Europe, Mexico, and South America since 1994. He is a member of Omicron Kappa Upsilon, the International Academy of Gnathology, AGD, the American Academy of Cosmetic Dentistry, and is a Fellow in the International College of Dentists. He can be reached at (541) 482-1746 or at obi@bioesthetics.com.

Disclosures: Dr. Benson is President of OBI Foundation for Bioesthetic Dentistry and receives compensation for teaching OBI classes. The OBI Foundation for Bioesthetic Dentistry is a 501.3C charitable educational institution that teaches the biology and clinical practice of bioesthetic dentistry to dentists and dental technicians.

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