

**MEET THE DOCTOR:
KEVIN C LIN, DDS, FACP
PROSTHODONTIST**

RECONSTRUCTIVE DENTAL SPECIALIST

Dr. Kevin Lin is a board-certified specialist in prosthetic dentistry. He has extensive clinical training and experience rehabilitating patients with complex dental problems using composite resin, dental implants, veneers, crowns, bridges, and dentures. He is an expert in creating and maintaining partials and dentures for older adults. Moreover, he has restored thousands of dental implants and related fixed and removable dental appliances.

Dr. Lin has published numerous papers in peer-reviewed journals, written book chapters, and presented in international and national professional conferences and regional study club meetings on issues concerning prosthetic dentistry.

He actively participates in local study clubs to learn and share new clinical knowledge and techniques; he works tirelessly with specialists, general dentists, and lab technicians to provide the best quality patient care possible. He currently serves as an ad-hoc journal reviewer for the Journal of Prosthetic Dentistry and the Journal of Prosthodontics.

Kevin C. Lin, DDS



EDUCATION

Board Certification, American Board of Prosthodontics
Certificate in Prosthodontics, UCSF Postgraduate Prosthodontics
Doctor of Dental Surgery, UCLA School of Dentistry
B.S. Biological Sciences in Medical Microbiology & B.A. Psychology, UC Davis

POST-GRADUATE CREDENTIALS

Diplomate, American Board of Prosthodontics
Fellow, American College of Prosthodontists
Fellow, International Congress of Oral Implantologists
Ad-hoc Journal Reviewer, Journal of Prosthetic Dentistry and Journal of Prosthodontics
Former Assistant Professor, University of the Pacific,
Arthur A. Dugoni School of Dentistry
Volunteer Faculty, Pre-doctoral Prosthodontic Clinic,
University of California, San Francisco

RECONSTRUCTIVE DENTISTRY UPDATES

JAN/FEB 2023

Evidence Based Clinical Practices in Prosthodontics

DO YOU HAVE A PATIENT PRESENTING WITH A DEFECTIVE LONG-SPAN BRIDGE AND LOOKING TO IMPROVE HIS SMILE AND CHEWING FUNCTION?



The patient may present with a **gummy smile, defective long-span bridge, compromised chewing function, and unsatisfactory smile esthetics**. You are not sure if you could take care of his/her treatment expectation and manage your clinical time effectively...

This is a patient who was referred to me for esthetic evaluation and an interdisciplinary treatment approach

Here is the story of my patient P.L. He had a long-span bridge done for his upper front teeth years ago, although he was never satisfied with the esthetics and the open-bite, he was not ready to pursue a replacement treatment until recurrent decay developed underneath the bridge margins...

CONTINUE NEXT PAGE



DO YOU WANT TO CHAT ABOUT A COMPLEX PATIENT CASE? OR WOULD YOU LIKE TO MEET AND SHARE IDEAS?

With your reputation for quality dental service and my experience with complex treatments, we can work together and benefit as a team. We simply want to do what is best for the patients.

I would like to work with you on challenging patient cases and share knowledge and experience. I would love to meet you for lunch, over a coffee break, or at your office to discuss a difficult patient case or to share ideas.

Please don't hesitate to reach out to me. I'm looking forward to talking with you on the phone or meeting in person.

Inside This Issue

CASE REPORT

Do you have a patient presenting with a defective long-span bridge and looking to improve his smile and chewing function?
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CLINICAL DENTAL RESEARCH

Efficiency of Upper Arch Expansion with the Invisalign System
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RECONSTRUCTIVE DENTAL SPECIALIST

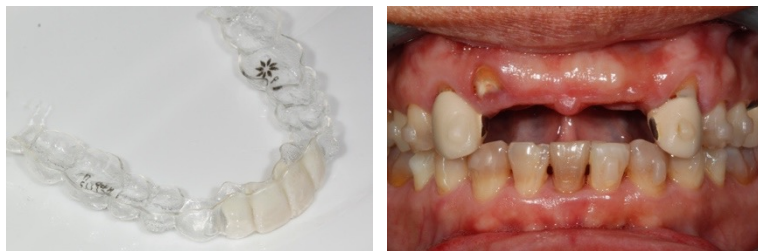
About Dr. Lin
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initial presentation

The case was challenging because:

- Gummy smile (high gingival display)
- Narrow arches, uneven gingival margin, and anterior open-bite
- Anterior crown/bridge tooth size discrepancy
- Recurrent decay on bridge abutment teeth, and poor restorative prognosis of the upper right lateral incisor
- Multiple missing teeth
- Sequence of treatment requires interdisciplinary coordination (orthodontics, oral surgery, and prosthodontics)



aligner therapy to expand the narrow arches



ceramic restorations and cantilevered screw-retained splinted implant crowns

MY TREATMENT SUMMARY FOR P.L. :

- ❖ Comprehensive evaluation and diagnostic denture set up
- ❖ Team collaboration with the orthodontist and oral surgeon on obtaining ideal orthodontic alignment and surgical implant planning
- ❖ Completion and insertion of the interim fixed restorations and definitive ceramic restorations
- ❖ Post-insertion and re-care maintenance

completed upper ceramic crowns
intraoral views



Treatment sequence:

- Comprehensive assessment and diagnostic treatment planning
- Patient discussion and review of the proposed surgical/prosthetic treatment options and limitations
- Collaboration with the orthodontist on aligner therapy to improve dental arch form and gingival margin esthetics
- Collaboration with the surgeon for extraction, soft/hard tissue grafting, and implant placement
- Fabrication and modification of the provisional restorations to monitor soft tissue changes
- Fabrication and insertion of the definitive ceramic restorations
- Post-insertion and re-care maintenance



final patient front & profile views

EFFICIENCY OF UPPER ARCH EXPANSION WITH THE INVISALIGN SYSTEM

ZHOU N, AND GUO J. ANGLE ORTHOD (2020) 90 (1): 23–30.

Objective:

To investigate the efficiency and movement pattern of upper arch expansion using Invisalign aligners. The correlation between the amount of designed expansion and the efficiency of bodily expansion was evaluated, as were the initial molar torque and efficiency of bodily expansion.

Materials and Methods:

Twenty Chinese adult patients who underwent arch expansion with Invisalign aligners were included in this study. Records of pretreatment (T0 stage) and immediately after completing the expansion phase (T1 stage) were collected, including digital models and cone-beam computed tomography. Dolphin 3D, Geomagic Studio 12.0, and Measure software were employed to measure data and calculate differences between the expected and actual outcomes.

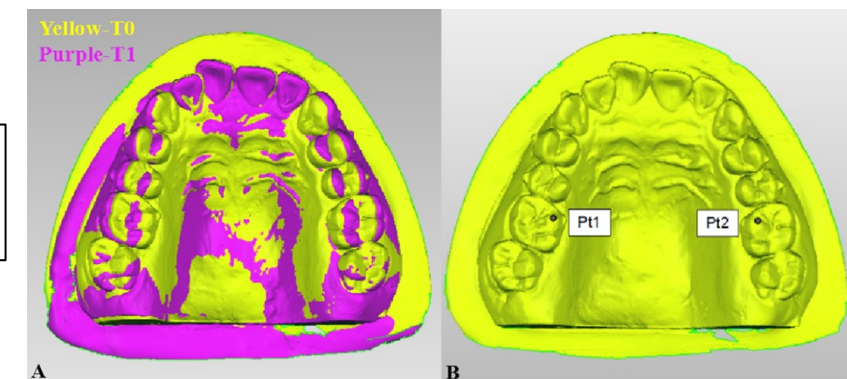
Results:

There were significant differences between the expected and actual expansion amounts ($P < .05$). The average expansion efficiencies of the upper canine crown, first premolar crown, second premolar crown, and first molar crown were $79.75 \pm 15.23\%$, $76.1 \pm 18.32\%$, $73.27 \pm 19.91\%$, and $68.31 \pm 24.41\%$, respectively. The average efficiency of bodily expansion movement for the maxillary first molar was $36.35 \pm 29.32\%$. Negative correlations were found between preset expansion amounts and the efficiency of bodily expansion movement ($P < .05$), and between initial maxillary first molar torque and efficiency of bodily expansion movement ($P < .05$).

Conclusions:

Aligners could increase the arch width, but expansion was achieved by tipping movement. The evaluation of initial position and preset of sufficient root-buccal torque of posterior teeth were necessary due to the lower efficiency of bodily buccal expansion by the Invisalign system.

Analysis of expansion movement for individual maxillary first molars
(A) Superimposition of digital models at T0 and T1
(B) Determination of coordinate point for the mesiolingual cusp tip on the maxillary first molar



Clinical Relevance

Aligners could increase the arch width, but expansion was achieved by tipping movement.

WOULD YOU LIKE TO STAY UP TO DATE WITH THE MOST CURRENT CLINICAL DENTAL RESEARCH?

You are not alone for continuing education! You have the opportunity to join like-minded clinicians in the community and challenge yourself to learn in a friendly non-judgmental atmosphere. We would love to have you for study club events, lecture presentations, and treatment planning seminars. For more detail on future events, please contact us!