Meet The Doctor

Reconstructive Dental Specialist

Kevin C Lin, DDS, FACP

Prosthodontist

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 a mock-board examiner for the UCSF Postgraduate Prosthodontic Residency Program.

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, UCDavis

Postgraduate Credentials

- Diplomate, American Board of Prosthodontics
- Fellow, American College of Prosthodontists
- Fellow, International Congress of Oral Implantologists
- Mock-board Examiner, UCSF Postgraduate Prosthodontics Residency Program
- 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

When should you consider referring to a prosthodontist?

Prosthodontists are specialists in esthetic, implant, and reconstructive dentistry.

1. Treatment complexity is beyond your typical practice.
Vertical dimension discrepancies, severely resorbed ridges, limited restorative space, poor implant angulation, TMJ dysfunction, severe bruxism, traumatic tooth loss, or congenital abnormalities.

2. Patient has extensive needs and is draining too much of your chair time!
If your patient requires treatment from multiple specialists, we can help sequence and manage the interdisciplinary treatment plans.

3. Patient wants a perfect smile!
If the patient has a gummy smile, thin gum and susceptible to recession, or extremely picky!

4. You want to discuss a case with a colleague to ease your mind.
We are an excellent resource for you to ask questions about complex treatments. We can work with you or complete the treatment for you to achieve the best in both function and esthetics for your patients.

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Board Certified Prosthodontist

Reconstructive Dentistry Updates

Oct/Nov 2023

Evidence Based Clinical Practices in Prosthodontics

Do you have a challenging patient case because of a failing long-span bridge, worn dentition, compromised esthetics, and poor periodontal health?

Your patient may present with ***recurrent decay around a long-span bridge, uneven tooth wear, compromised periodontal health, and an unsatisfactory smile***. You are not sure if you could take care of his/her treatment expectations and manage your clinical time effectively…

This is a patient who was referred to us for comprehensive evaluation and rehabilitation…

Here is the story of my patient Y.L. She has a lower anterior long-span bridge with recurrent decay and chronic persistent periodontal infection that could not be treated and maintained predictably. The upper front teeth also have wear and compromised esthetics…

- continue next page

Do you want to chat about a complex patient case? Would you like to meet and share ideas?

It could be daunting to have to manage a patient's dental complications and unforeseen prosthetic breakage especially if you are a solo practitioner or a non-restorative dental specialist.

I would like to work with you on challenging patient cases and share knowledge and experience. With your reputation for quality dental service and my experience in addressing complex dental needs, we can work together and serve our patients to the best of our ability. Let's exceed patient expectations and build our practice synergistically! I look forward to talking to you over the phone or meeting with you in person!

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Inside This Issue

COMPREHENSIVE DENTAL REHAB

WITH ORTHODONTIC ALIGNER THERAPY, PORCELAIN CROWNS, AND COMPOSITE RESIN RESTORATIONS

Initial worn dentition and deep bite

The case was challenging because:

- Compromised upper incisal edge position and uneven occlusal plane
- Long-span bridge with recurrent decay and unknown restorative and periodontal prognosis at the time of the consultation
- Malocclusion, tooth wear, and deep bite
- Occlusal traumatism
- Sequence of treatment requires potential implant/dental surgeries, orthodontic therapy, esthetic composite bonding, and fixed prosthodontic rehabilitation

Mid-treatment:

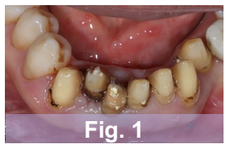


Fig. 1

Fig. 1: existing long-span lower anterior porcelain bridge was removed to assess the restorative and periodontal status of the underlying abutment teeth; #25 was hopeless periodontally

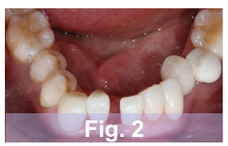


Fig. 2

Fig. 2: #25 was extracted; individual milled PMMA provisional crowns were fabricated and cemented on #21-27 in preparation for orthodontic aligner therapy

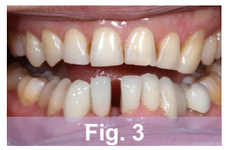


Fig. 3

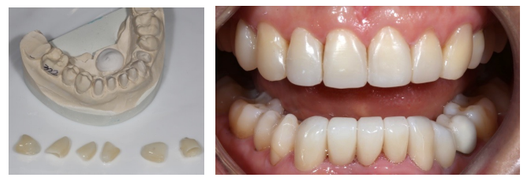
Fig. 3: front view of the dental alignment prior to orthodontic aligner therapy

Fig. 4

Fig. 4: front view of the dental alignment upon completion of the aligner therapy in 9 months

Treatment sequence:

- Comprehensive assessment and diagnostic treatment planning
- Patient discussion and review of the proposed surgical/prosthetic treatment options and limitations
- Removal of the lower long-span bridge to assess restorability and to finalize the treatment plan
- Management of the immediate splinted lower provisional crowns and conversion to lab fabricated individual milled PMMA crowns
- Proceed with aligner treatment planning and treatment
- Fabrication and delivery of lower ceramic crowns
- Upper anterior composite resin bonding to improve incisal edge position and esthetics
- Post-insertion and re-care maintenance



After

After

MY TREATMENT SUMMARY FOR Y.L.

a) Comprehensive evaluation and patient discussion
b) Removal of long-span bridge to assess restorability of the underlying abutment teeth and extraction
c) Collaboration with orthodontist for aligner therapy
c) Completion of a combination of definitive ceramic restorations and composite resin bonding
d) Return to referring general dentist for post-insertion and re-care maintenance

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ORTHODONTIC TREATMENT WITH REMOVAL OF ONE MANDIBULAR INCISOR: OUTCOME DATA AND THE IMPORTANCE OF EXTRACTION SITE PREPARATION

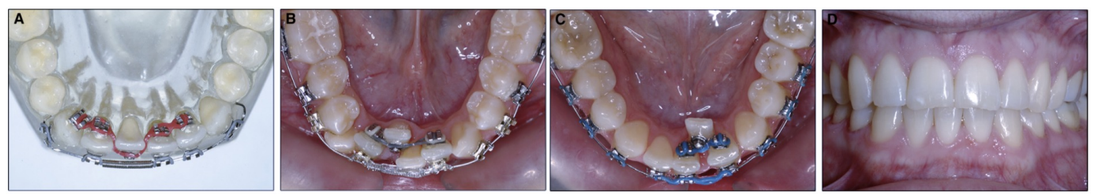
VILHJALMSSON, G., ZERMENO, J. AND PROFFITB, W.
J ORTHOD DENTOFACIAL ORTHOP 2019. OCT;156:453-63

Introduction:
Extraction of one mandibular incisor in adolescents and adults can simplify orthodontic treatment in 2 major circumstances: (1) severe crowding of the mandibular but not the maxillary incisors, and (2) mild anterior crossbite with good alignment in both arches. Despite its potential advantages, this method has had limited use in most practices. There have been 3 major objections: (1) the possibility of unsightly black triangles because of loss of interdental papilla height, (2) a possible tooth size discrepancy that would affect occlusal relationships, and (3) patient concerns about a visible extraction site. All 3 objections now can be overcome.

Methods:
For 37 consecutively treated single-incisor-extraction patients, preparation of the extraction site for the tooth to be extracted was done by tipping it lingually while simultaneously closing the space in front of it. Treatment outcomes and the effect of age at the time of treatment were evaluated.

Results:
In patients below age 20, this approach eliminated post-treatment black triangles and almost eliminated partial loss of the interdental papilla. It reduced the previously reported prevalence of these problems in patients aged 20-40 years and did not seem to be helpful in those aged over 40 years. This positive effect was achieved because of maintenance of alveolar crest height that supports the interdental papillae. Tooth size discrepancy caused by incisor extraction was largely compensated by the different labio-lingual orientation of maxillary and mandibular anterior teeth. The extraction space quickly disappeared during extraction site preparation.

Conclusions:
The new procedure of extraction site preparation described in this paper offers more favorable outcomes for post-treatment prevalence of black triangles in younger patients but shows limited efficacy in older patients. Camouflage of a mild skeletal Class III problem is the major indication for this extraction pattern. About 3% of Icelandic orthodontic patients appear to be good candidates for this treatment, and this finding should be reasonably generalizable to other populations of European descent.



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!

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