★ STAR EDITION

SPRING 2026

THE journal

OF THE GREATER HOUSTON DENTAL SOCIETY

SALVAGING MAXILLARY FORM AND FUNCTION AFTER FREE TISSUE TRANSFER FAILURES:

Successful Use of an IPS® Custom Subperiosteal Implant.

LEARNING TWICE:

Why Teaching as a Junior Dental Faculty has been impactful

STAR OF THE SOUTH
GREATER HOUSTON DENTAL SOCIETY
DENTAL CONFERENCE

SEPTEMBER 25-26, 2026
HOUSTON, TEXAS

STAR OF THE SOUTH GREATER HOUSTON DENTAL SOCIETY

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Spring 2026 | Volume 98 | Issue 2 | Est. 1929

FEATURES

COLUMNS

All scientific articles submitted to the GHDS Journal undergo peer review by the GHDS Editorial Review Board. The GHDS Journal is a member-centric publication dedicated to highlighting the expertise of its members and sharing research, insights, and updates impacting the Greater Houston dental community.

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JOEL J. VELA, DDS

A Message

FROM OUR PRESIDENT

IF WE BUILD IT, WILL THEY COME?

If those words sound familiar then I suspect either you're a baseball fan, a Kevin Costner fan or perhaps both? Of course I'm paraphrasing "If you build it they will come" from the 1989 film *Field of Dreams*. Nominated for three Oscars, I consider it to be one of the best baseball movies. It's one of those movies that never fails to get me weepy every time, especially the scene (spoiler alert) between John Kinsella, (played by Dwier Brown), and Ray Kinsella, (portrayed by Costner.) Never. Ever. Fails.

The Greater Houston Dental Meeting was first held at the AstroWorld Hotel in 1972. Founded by Dr. Burt Kunik, the GHDM was seen as a new benefit of membership for GHDS members. Member registration was complimentary and members were encouraged to bring their teams to the meeting. Over the ensuing years, the popularity of the meeting, along with attendance, grew and necessitated moving the meeting to larger and more desirable venues such as the Shamrock Hilton, the downtown Hyatt Regency Hotel and then the Westin Galleria. Fun movie fact: The Shamrock Hilton was the inspiration for the fictional Emperador Hotel in the 1957 Oscar-winning best picture *Giant*.

It was at the Westin Galleria in 1996 that I first began volunteering at the GHDM. I succeeded Dr. Lee Clitheroe as Sign Chairman and would continue in that capacity through 1998. In 1998, the Greater Houston Dental Meeting, with Dr. Jerry Long serving as Chairman, moved to the George R. Brown Convention Center. "Downtown at the Brown" was the rallying cry. The Westin Galleria had served us well. Unfortunately, the allure of the Galleria became a distraction and pulled attendees away from attending courses and visiting exhibitors. Other large dental meetings in other metropolitan areas were being held in convention centers. So, the next logical location would be the George R. Brown. If you're old enough to remember the cramped exhibitor space of the Westin Galleria, you could better appreciate the larger offerings of the GRB. As with any new change, there was uncertainty as to whether or not the meeting success would continue. And did it ever. Attendance our first year at the GRB would surpass six thousand attendees. And in 1999, the Greater Houston Dental Meeting became the Star of the South. Attendance would peak in 2009 under the stewardship of Dr. Victor Rodriguez with close to 7,000 attendees.

Since 2012, the SOTS has experienced a steady drop in attendees from 6,756 in 2012 to 2,223 in 2021. I've come to refer to anything happening before 2020 as "BC" or "Before COVID". Post-COVID the Star saw our attendee numbers drop precipitously. In early 2022 the Star was back at the Westin Galleria and attendance that year was 1,400. Then in the Fall of 2023 SmileCon was held in Houston and GHDS, was obligated to not hold a competing meeting. In July of 2024 the SOTS moved to the Downtown Marriot and attendance ticked up slightly to 1,492. In 2025, the Star's returned to the George R. Brown with attendance dropping to 1,194 registrants.

GHDS is experiencing what other professional organizations are experiencing: navigating a "new normal." This new normal is characterized by a slow recovery to pre-COVID numbers, travel hesitancy, changing event formats and dentists prioritizing time in the office. High inflation in audio-visual, food, and decorator expenses contribute to significant financial pressures. As a result of this new normal in attendance trends and rising costs, the American Dental Association made the decision to sunset SmileCon in 2026 and beyond. Declining attendance along with a decrease in exhibitors and sponsorships has led to financial losses for the GHDS.

Should the Star also ride off into the proverbial sunset? That possibility was within the scope of a task force assembled to review the performance of the Star and make recommendations to the Board whether the event should be restructured, significantly changed, or potentially discontinued. I am writing to report to you there is no immediate plan to sunset the Star. The Star will still continue to be a membership benefit uniting dentists of the Greater Houston district, promoting and maintaining high professional and moral standards as well as advancing the science of dentistry through research and collaboration. The Star of the South will take place this September 25-26 and will be held at the Norris Conference Center in City Centre. This year's Council, chaired by Dr. Adriana Salinas, along with the GHDS Central Office team, has developed a new and exciting meeting format with educational tracks designed for dentists, hygienists and auxillary team members. Be sure and check the GHDS website for meeting information. If we build it, will you come?

We hope to see you all at the Star!

2026 GREATER HOUSTON DENTAL SOCIETY

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May 14, 2026 | Brennan's of Houston

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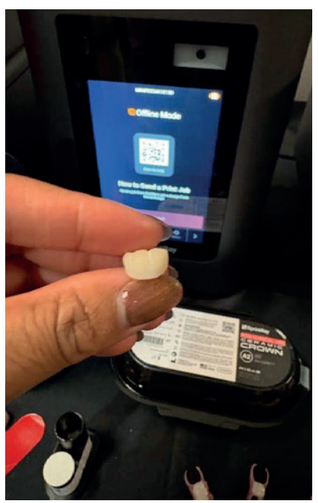


It was a great night of networking and learning!

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JOIN US
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Message from the Chair

We're thrilled to invite you to two days of learning, collaboration, and inspiration designed specifically for the dental team—dentists, hygienists, and dental assistants.

This year's streamlined program focuses on strengthening clinical expertise, enhancing team connection, and equipping attendees with practical strategies and innovative approaches that elevate patient care. Engage in cutting edge continuing education and insights you can apply immediately. The conference will offer opportunities for both professional growth and meaningful engagement.

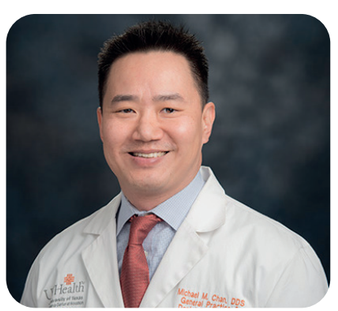
You'll have the chance to learn from leading experts, connect with colleagues and event partners, and explore new ideas shaping the future of dentistry.

We are excited to announce our NEW location, Norris Conference Center, located in Houston CityCentre, a popular Houston destination. Free parking will be available.

Thank you for your continued support of organized dentistry. Your commitment drives our profession forward and helps improve the oral health of the communities we serve. We look forward to welcoming you to Houston for an inspiring and impactful experience.

Adriana Salinas, DDS

2026 Star of the South Council



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What to Expect

- A simplified, streamlined dental conference format offering a thoughtfully curated scientific program for dentists, hygienists, and dental assistants.
- Premier Event sponsors enthusiastically supporting our dental community offering the latest in new products and technologies for you and your practice.
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Speakers and Topics

Janessa Bock, RDH	Photobiomodulation 101: Integrating Red Light Therapy into Dental Practice
Chun-Yeh Chien, DDS	Digital Planning in Contemporary Prosthodontics
Manish Garala, DDS / Biraj Patel, BDS	From Guesswork to Guided Precision: The Evolution in Endodontics
Theresa Groody, EFDA, CDA	ABC's of Restorations and Next Level Dental Assisting
John Kacher, DDS	Pediatric / Young Adult Oral Pathoses and Efficiency in the Dental Office
Katrina Klein, RDH, CEAS, CPT	Hygiene Assessments that Influence Case Acceptance, Precision Scaling, and Dental Magnification
Anna Munne, DDS	Advanced Suturing Techniques for Dental Surgery: Hands-on Workshop
Rodrigo Neiva, DDS	Saving Teeth in the Era of Pulling Teeth and Ridge Preservation Procedures: Why, When and How Hands-on Workshop
Victoria Patrounova, RDH	Obesity, Ozempic, and Oral Health and Xerostomia Solutions in Cancer Care
Xavier Saab, DDS	A New Solution for Full Arch Implant Rehabilitation
Hal Stewart, DDS	Epigenetics in Craniofacial Development and Airway Remodeling
Jill Yeager	Infection Control

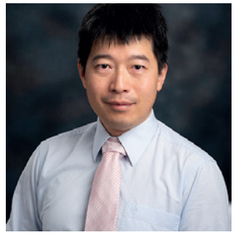
Register by August 28, 2026 to receive the Early Bird discount rate!

Visit staroftheSouth.org for full details!

2026 Star of the South Dental Conference

MEET THE SPEAKERS


Janessa Bock, RDH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John Kacher, DDS


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Salvaging Maxillary Form and Function After Free Tissue Transfer Failures:

Successful Use of an IPS® Custom Subperiosteal Implant

DIEGO M. QUIRARTE[1,2], JULIAN J. GONZALES[1,2]
SERGIO ORTEGON[3,4] , AND EDWARD P. BUCHANAN[1,2]

Abstract

Background

Maxillary defects resulting from tumor resection or trauma can lead to substantial functional and esthetic impairment, including malocclusion, impaired mastication, disordered speech, and loss of midface projection. Free tissue transfer has become the primary method of reconstruction for large maxillary defects, yet flap failure and patient-specific contraindications can limit its use. Custom patient-specific implants have emerged as a potential alternative for patients who are unable to undergo or have previously failed traditional reconstruction.

Case Presentation

We present the case of a 23-year-old man who acquired severe maxillary bone loss following childhood fibrous dysplasia treated with hemi-maxillectomy. Over 7 years, he underwent multiple reconstructive attempts at our institution, including 2 fibula free flaps that ultimately failed, prompting consideration for reconstructive alternatives. This patient was selected for custom maxillary reconstruction with a digitally planned, titanium subperiosteal implant using the IPS Implants® Preprosthetic system. The implant was successfully placed in a single-stage procedure, providing immediate, stable structural support for definitive prosthetic rehabilitation.

Conclusions

This case highlights the role of custom patient-specific implants as a viable reconstructive option for patients with extensive maxillary loss who are poor candidates for free tissue transfer. Patient-specific subperiosteal implants may provide durable skeletal support and reliable dental rehabilitation for complex cases in which traditional methods have failed.

Keywords

maxillary reconstruction, patient-specific implant, subperiosteal implant, computer-aided design, dental rehabilitation

Introduction

The maxilla is a crucial osseous component of the face, providing support for structures including the ocular globes, paranasal sinuses, nasal cavity, hard palate, and alveolar ridge.[1] Maxillectomies may lead to substantial morbidity due to the wide range of facial structures that the maxilla supports. Sequelae of maxillectomies include, but are not limited to, malocclusion, deficiency of the nasolabial/midface projection, and disorders of mastication, swallowing, and speech.[2-5]

Historically, prosthetic rehabilitation had been the principal approach for managing maxillary defects.[2,6] Over time, the approach to maxillary reconstruction has evolved alongside surgical refinement and innovation. As advancements in microsurgery have developed, free tissue transfer (FTT) has been adopted as the primary reconstructive option for complex midface defects, particularly in maxillary reconstruction.[2] Like any surgical procedure, FTT is not always successful, and when it fails, alternative reconstructive techniques are required.

Virtual surgical planning (VSP) and computer-aided design and manufacturing (CAD/CAM) are technological innovations that are advancing the landscape of maxillary reconstruction with custom patient-specific implants (PSI).[3,4] Herein, we report a case of a 23-year-old male with a history of pediatric fibrous dysplasia treated with hemi-maxillectomy and subsequent failed FTT reconstruction who presented to our institution for custom PSI maxillary reconstruction.

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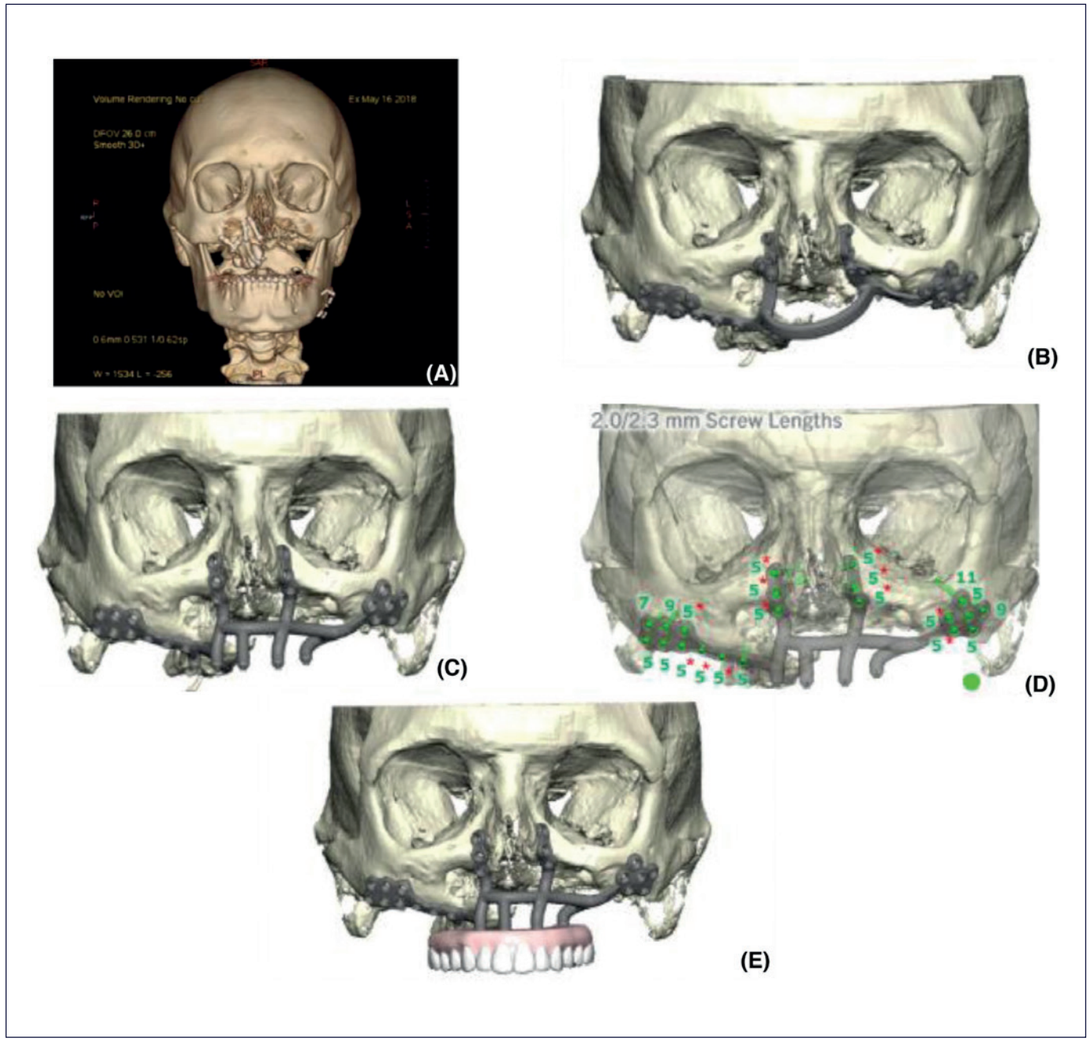

Figure 1.

(A) Preoperative CT Scan, May 2018, (B) custom cutting guide, (C) custom IPS Implants® Preprosthetic system, (D) screw guide, and (E) final custom implant with simulated custom prosthodontic placement.

CASE

Clinical History

IB is a 23-year-old male with a past medical history of fibrous dysplasia, previously treated at an outside hospital with left hemi-maxillectomy and latissimus flap reconstruction of the palate at age 13. He subsequently presented to our institution, where he has undergone multiple reconstructive procedures. The patient initially presented to our institution at age 15 with an acquired maxillary defect following a left hemi-maxillectomy, resulting in a malpositioned residual maxilla and class III malocclusion. At that time, surgical options were discussed, and operative planning began. The patient returned one year later for orthodontic adjustments and finalization of the surgical plan (Figure 1A).

At age 16, the patient underwent his first major reconstructive procedure in June 2018: a hemi LeFort I osteotomy with maxillary fixation, left fibula free flap reconstruction, and left saphenous vein graft. Although initial flap viability was confirmed postoperatively, complications soon arose. By post-operative day (POD) 6, intraoral wound breakdown suggested flap compromise, leading to a takeback surgery the following day. Necrotic fibula was debrided, and soft tissue coverage was achieved with buccal mucosal flaps.

Over the next several months, he underwent a series of additional procedures. In August 2018, he had 2 surgeries using buccal mucosa advancement to close an oronasal fistula. Both attempts were unsuccessful, resulting in a persistent defect. In December 2018, a radial forearm flap was used as a free flap to close the oronasal fistula, with postoperative evaluations in early 2019 showing stability. Dental reconstruction was attempted with an oral and maxillofacial surgeon 18 months later in July 2020, but a nonviable fibula was recognized intraoperatively. Dental reconstruction was therefore aborted, and no dental implants were placed.

In October 2020, a second fibula free flap with dental implants was performed. Surgery was initially successful, and the patient was discharged home on POD 8. However, follow-up exams revealed bulky tissue, plate displacement, and eventual failure of the reconstruction, with bone and implant exposure by early 2021. This necessitated the removal of the reconstruction in January 2021. Therefore, no additional operations were required, shifting care toward prosthodontic options.

By May 2023, following years of multiple reconstructions and flap failures, the patient had a stable intraoral environment and was considered a candidate for a custom implant based maxillary reconstruction with full upper arch restoration. With a history of multiple graft complications and a thrombophilic family history, the patient was evaluated by hematology/oncology in August 2024 to rule out the presence of an underlying clotting disorder. Laboratory evaluation was found to be significant for an elevated Anti-Cardiolipin IgG, suggesting an underlying blood dyscrasia.

Custom Implant-Based Maxillary Reconstruction

Our craniofacial surgeon (E.B.) and maxillofacial prosthodontist (S.O.) decided to proceed with a patient-specific implant in collaboration with the KLS Martin group, IPS Implants® Preprosthetic (KLS Martin Group, Tuttlingen, Germany). A digitally backward planned subperiosteal implant was designed for one-step reconstruction of the maxilla (Figure 1B-E). In January 2025, 7 years after the patient's initial reconstruction, the custom implant was placed.

Through an upper gingivobuccal incision, the zygomas and nasomaxillary region were exposed. A premade guide was used to align drill holes (Figure 1B) followed by introduction of the custom implant (Figure 1C). The implant was secured in place with 6- and 7 mm screws (Figure 1D). Access holes were created for the five posts, the palate was closed with Vicryl sutures, and caps were placed without difficulty. The patient was discharged the following day.

At early follow-up, the implant remained stable with minor mucosal sloughing. By POD 8, all posts were visible and no oronasal fistula was noted. Shortly after, the patient was evaluated by our maxillofacial prosthodontist and reported the sensation of a fistula in the upper right area. Examination showed palatal tissue now covering 2 implants as well as the presence of a new soft tissue defect.

At his third postoperative visit in March 2025, 4 out of the 5 posts were visible, and a small anterior oronasal fistula was confirmed. The patient underwent an additional operation for fistula closure and exposure of the fifth post. The nasal oral lining was closed using 4-0 Vicryl® suture in interrupted fashion, and the fistula was repaired with an adjacent tissue transfer. Tissue overlying the left posterior post was debrided for full exposure, and the patient was discharged on the same day of surgery with no concerns. Screw-retained temporary prosthetics were applied the following week. Due to the prosthesis intaglio and contours not matching with the soft tissues, the distal abutment was not engaged, and only three support posts were used (Figure 2A and B).

In May 2025, the right posterior post became accessible, allowing a four-post temporary prosthetic. The left posterior post remained inaccessible due to partial coverage by the buccinator muscle. A new screw-retained prosthesis was then placed using the four available posts. In October of 2025, the upper screw-retained teeth were delivered to the patient's satisfaction (Figure 2C-F), and the patient was scheduled to follow up with S.O. in six months.

Discussion

Objectives of maxillary reconstruction include support of midface soft tissues, separation of oral and nasal cavities, and establishment of bony support for dental implants.[2] Soft tissue and bone augmentation procedures, often by FTT, still remain the standard for maxillary reconstruction of large defects.[2,4,7-9] The free fibula flap provides excellent versatility, combining sufficient bone for structural support with a long pedicle and flexible soft tissue for contouring.[2,7]

Not all patients are ideal candidates for maxillary reconstruction with FTT and bone augmentation. We presented the case of a patient who acquired severe maxillary bone loss and suffered two failed fibula flaps. Sweeny et al found that 84% of free flap failures in head and neck reconstruction were attributed to vascular compromise involving the arterial and or venous systems.[10] Due to the history of multiple flap losses, our senior author E.B. recommended hematologic workup for the patient which revealed elevated anti-cardiolipin IgG antibodies, suggestive of an underlying clotting disorder. Our patient's course prompted consideration of available options for patients needing major maxillary reconstruction who cannot undergo or have failed free tissue transfer.

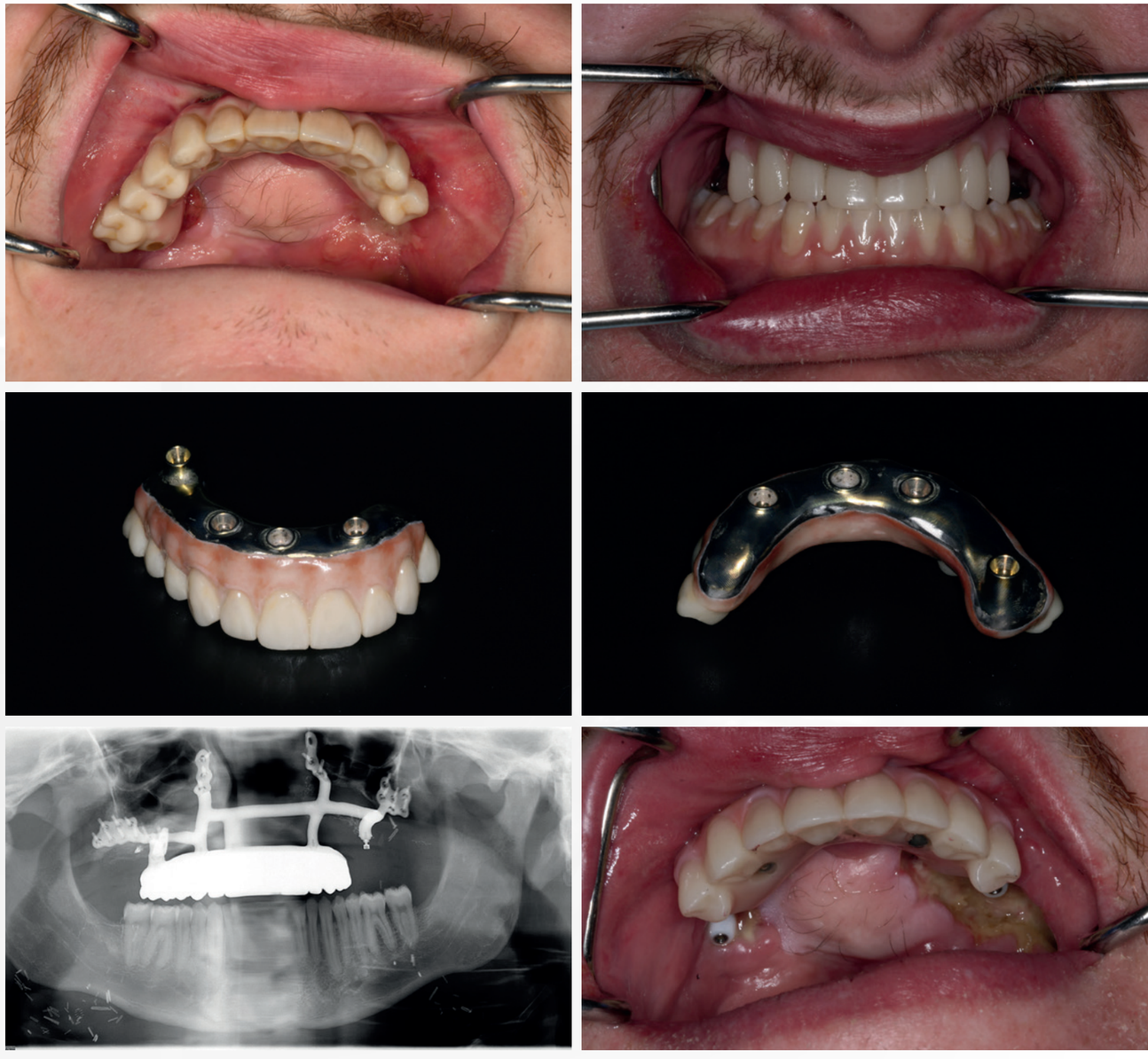

Figure 2.

(A and B) KLS provisional connection to MUA abutments, March 2025, (C and D) final fixed prosthesis, August 2025, (E) final panoramic x-ray, August 2025, and (F) Final fixed restorations with titanium substructure and zirconia suprastructure, August 2025.

Subperiosteal implants for dental rehabilitation have been described in the literature for over 80 years.[11-13] This technique has been replaced by FTT as the primary option for complex maxillary reconstruction and implant dentistry. With advances in VSP and CAD/CAM, new strategies for complex facial reconstruction have emerged.[3,4,12] These tools allow refinement of older techniques such as subperiosteal implants, although current planning still prioritizes bony contours over soft-tissue thickness, which can limit postoperative access to implant components. In our patient, this contributed to a post that remained buried beneath the palatal flap, limiting postoperative accessibility. These challenges underscore the importance of precise preoperative planning and frame the rationale for selecting a customized patient specific implant.

Through collaboration between our craniofacial surgeon and maxillofacial prosthodontist, a custom patient-specific implant was selected. The team used the IPS Implants® Preprosthetic system (KLS Martin Group, Tuttlingen, Germany). The design protocol, known as "IPS-Dental," was described by Gellrich et al[12-14] Planning begins with high resolution CT imaging and wax-up models used to define ideal dental position and occlusion. The data is then converted into stereolithographic (STL) files for digital reconstruction of the defect. The skeletal framework and prosthodontic connection system are planned individually then merged into a single titanium implant produced by laser melting, resulting in a substantial 1-piece implant. To ensure accurate placement, this large implant requires wide exposure with appropriately sized incisions to allow precise fixation along stable bony buttresses and facilitate single-stage placement. In this case, access was achieved through an upper gingivobuccal incision, as other approaches would not have provided adequate exposure. However, in cases with severely hypoplastic maxillary bone stock, additional surgical approaches may be necessary.

Applying IPS Implants® for maxillary reconstruction has multiple benefits when compared to existing surgical techniques. Korn et al hypothesized that since the posts are not anchored to bone but rather part of the subperiosteal framework itself, there is a reduced risk of peri-implantitis and local infection.[12] Additionally, the rigid fixation is completely customizable to the patient's anatomy, with emphasis of fixation onto the buttresses of the maxilla.[14] In the past, the use of non-rigid subperiosteal implants often resulted in progressive bone loss due to movement of the framework.14 In contrast, the rigid fixation in IPS Implants® provide the stability needed to prevent the occurrence of bone loss. The denture connection system is built into the implant, and this integrated unit passes through the overlying soft tissues on the day of surgery, thus eliminating the need for 2 procedures.[13] These properties offer meaningful advantages in reconstructive efficacy and complication reduction when compared to conventional approaches.

While the integrated design aims to eliminate the need for a second procedure, select cases may necessitate a staged intervention. Surgeons who consider performing this operation must therefore balance adequate soft-tissue clearance to allow the posts to emerge, without over-resection that increases fistula risk. In cases requiring concomitant free tissue transfer, IPS Preprosthetic reconstruction may be staged to preserve flap viability, with initial burial of posts and delayed exposure after vascular integration. In such cases, careful staging is essential. At our institution, we favor performing soft tissue reconstruction first, allowing for confirmation of negative margins and complete intraoral healing prior to implant placement through the gingivobuccal incision. Immediate placement at the time of free flap reconstruction should be approached cautiously, as the reliability of residual bone for anchorage is variable and dependent on factors such as tumor characteristics, required margins, and the ablative surgery. Surgeons and patients should be counseled accordingly, as staged intervention may be required even when single-stage reconstruction is the intent.

Conclusions

IPS Implants®, particularly in patients who have significant contraindications to or have previously failed FTT for maxillary reconstruction, provide an exciting new treatment modality. This promising surgical option may provide a new opportunity for maxillary reconstruction and dental rehabilitation in patients who have exhausted conventional approaches. Our case builds upon previous reports by Gellrich and Korn showing that patient-specific implants are a reliable and stable option for prosthodontic restoration in patients with large maxillary defects.[12,13,15] This case also illustrates the essential role of coordinated care between the craniofacial surgeon and maxillofacial prosthodontist in guiding both surgical planning and prosthetic rehabilitation. Future studies are warranted to focus on the long-term outcomes and stability of subperiosteal IPS Implants® in patients with large maxillary defects. Notably, current FDA approval restricts use of this system to patients 18 years of age and older, which may limit access for younger patients who could otherwise benefit from intervention.

Because maxillary growth typically completes in mid-to-late adolescence, select skeletally mature patients younger than 18, including those with craniofacial syndromes, oncologic defects, or severe maxillary deficiency, may be appropriate candidates. Therefore, broadening the approved age indication to include skeletally mature adolescents could allow for earlier definitive reconstruction in this population.

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Ethical Considerations
Our institution does not require ethical approval for reporting individual cases or case series.

Consent to Participate
Informed consent for information published in this article was not obtained because all patient information was de-identified and patient consent was not required.

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Declaration of Conflicting Interests
The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data Availability Statement
Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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Learning *Twice:*

Why Teaching as a Junior Dental Faculty has been impactful

In academic dentistry, junior faculty often stand at a crossroads—no longer trainees, but not yet fully seasoned educators. Within this space lies a powerful, often underappreciated opportunity: teaching dental students not only shapes the next generation of clinicians, it fundamentally transforms the teacher.

For early-career faculty, teaching is not a detour from clinical growth—it is an accelerator. Explaining a treatment plan, defending a material choice, or guiding a student through a difficult procedure forces clarity of thought. What once felt intuitive must be articulated, justified, and often revisited. In this way, teaching becomes a form of deliberate practice. You don't just know dentistry—you learn it again, more deeply, and in a different way to be able to teach it back.

This "learning twice" effect is especially visible in clinical settings. When a student asks "why," it disrupts autopilot. It pushes faculty to engage with evidence, reflect on decision-making, and remain current. The result is not only better teaching, but better clinical care.

But the IMPACT extends beyond technical knowledge. Teaching accelerates the development of communication skills—how to give feedback that is honest but constructive, how to adapt explanations to different learners, and how to maintain composure when things don't go as planned. These are not just teaching skills; they are core competencies of effective, successful clinicians.

At the same time, junior faculty are undergoing their own transformation: from provider to educator, from individual contributor to role model. This shift can feel uncomfortable. Many grapple with imposter syndrome, particularly when supervising students not far removed from their own training. Yet, this proximity is also their strength. They remember what it feels like to struggle with hand skills, to question clinical decisions, to seek reassurance, to seek value and belonging. That insight fosters empathy—and often, stronger connections with students.

Students notice more than we think. They observe how faculty handle uncertainty, communicate with patients, and navigate pressure. Junior faculty, in particular, help define the tone of the learning environment. When they create spaces where questions are welcomed and mistakes are treated as part of growth, they don't just teach dentistry—they model professionalism and humanism.

Still, the role is not without its challenges. Balancing clinical responsibilities, teaching expectations, and scholarly productivity can be overwhelming. Many junior faculty receive little formal training in education, yet are expected to teach effectively from day one. Add to this the weight of student evaluations and unclear institutional expectations, and it's easy to see why burnout is a real concern in today's academic industry.

If academic dentistry values teaching—and it should—then supporting those who teach early in their careers is not optional. Mentorship, time for personal growth, opportunities for scholarly activities, and meaningful faculty development are not luxuries; they are necessities. Investing in junior faculty is, ultimately, an investment in students, in patients, and in the future of the profession.

Teaching as a junior faculty member is not simply a responsibility to fulfill. It is a defining experience—one that sharpens clinical judgment, strengthens communication, and shapes professional identity. In guiding students, junior faculty do something remarkable: they become better clinicians, better educators, and, in many ways, better versions of the professionals they set out to be.

And in the process, they remind us of something simple but profound—dentistry is not just learned once. It is learned, refined, and rediscovered every time we teach it. So come be transformed as a faculty member, become a student again in this profession of life long learning, and create impact within the next generation of professionals.

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