Introduction

With the increased emphasis in recent years on interdisciplinary treatment, deficiencies associated with traditional methods of diagnosis and treatment planning have become more evident and problematic. Historically, the treatment plan was dictated primarily by information provided by study casts that were mounted on a sophisticated articulator in centric relation. However, with the advent of new treatment modalities, a more systematic approach was needed to diagnose and treatment-plan complex interdisciplinary dental patients with a common language that can be used by the orthodontist, periodontist, oral and maxillofacial surgeon, and restorative dentist.

Q: What is the “Global Diagnosis” system that you use in your practice and teach to other dentists?

A: When I first started practicing more than 40 years ago, complex dentistry was treatment-planned on an articulator, with an emphasis on the condylar position. This system of treatment planning started to become antiquated as the emphasis on esthetics increased. In the early 1980s, Drs. John Kois and Frank Spear changed the paradigm with their concept of facially generated treatment planning. Their starting point was the incisal edge position of the maxillary anterior teeth rather than the condylar position. I loved the concept and was an early adopter. During those early years, I became interested in the etiology and treatment of the gummy smile. I didn’t create the differential diagnosis for the gummy smile, but I did create a system for evaluating these patients. In the mid-1990s, Dr. Jeff Rouse and I became speaking partners and expanded our understanding of this group of patients. It was at this point that we realized that the differential diagnosis for the gummy smile patient dovetailed perfectly with the facially generated concept. As a result, our emphasis changed from the gummy smile patient to the diagnosis and treatment planning of the interdisciplinary dental patient. This was the genesis of the Global Diagnosis system that we teach today. What sets our system apart from other diagnostic systems is our emphasis on the gingival positions. In fact, that is how we define an interdisciplinary patient: one whose gingiva is in the wrong place (Figs 1 & 2).

J. William Robbins, DDS, MA, will be presenting at AACD 2016 in Toronto on Thursday, April 28, 2016, regarding a new concept of interdisciplinary dental diagnosis and treatment planning for the complex dental patient. In this interview, Dr. Robbins discusses the “Global Diagnosis” system for treatment planning.
Q: What are the differential diagnoses that you use in your Global Diagnosis concept?
A: Our system is straightforward and easy to understand. We believe that there are only 4 “Global Diagnoses” that dictate all interdisciplinary treatment planning. These diagnoses are as follows:
1. Length of the upper lip and upper lip mobility. This is measured from repose to full smile.
2. Length of the clinical crowns.
3. Dentoalveolar extrusion. This occurs when the teeth move into incorrect positions, commonly due to lack of opposing teeth or attrition. The gingival position is the key diagnostic parameter when diagnosing dentoalveolar extrusion.
4. Facial proportions and symmetry.

As dentists, there are only 5 things that we can “fix”:
1. The landscape, with an emphasis on the lip positions (Diagnosis 1).
2. The teeth (Diagnosis 2).
3. The gingiva (Diagnoses 2 and 3).
4. The alveolar bone (Diagnoses 2 and 3).
5. The facial bones (Diagnosis 4).

This is why the 4 Global Diagnoses dictate all interdisciplinary treatment planning.

Q: How do you recommend that dentists implement this system into their practices?
A: We have created a simple one-page diagnostic form that leads the dentist through the process (Fig 3). We recommend that the form, which requires no more than five minutes to fill out, be completed on any patient that has a gingival discrepancy. This is easy to add to the comprehensive examination of the new dental patient. However, dental practices are full of patients with tremendous dental needs that are never diagnosed. Therefore, the dental hygienist is the key team member to implement use of the form into a dental practice. The hygienist can collect the data and share the findings with the dentist during the periodic exam. This opens the door for the dentist to bring the patient back for a comprehensive exam to discuss their unmet needs and desires.

Q: How do you sustain such passion for your profession after so many years?
A: There obviously are many answers to that question, including the ability to provide a wonderful service to our fellow passengers on the planet, the friendships that are created, the financial rewards, etc. But for me, the passion comes in the creation. I believe that dentistry is the best blend of art and science in all the healing professions. As a general dentist, I do a great deal of single tooth dentistry. However, that is not where my passion lies. Being able to lead an interdisciplinary patient through the diagnostic process, coordinate and sequence the specialty referrals, and ultimately restore the patient—that’s what keeps me coming back!

The AACD invites readers to attend the 32nd Annual AACD Scientific Session in Toronto, Canada, April 27-30, 2016. The program will raise the bar on AACD’s already high education standards in comprehensive cosmetic dentistry. Register now at www.AACD.com for this innovative event.

**Figure 3:** Global Diagnosis form to aid in the diagnosis of gingival discrepancy cases.

Dr. Robbins maintains a full-time practice in San Antonio, Texas, and is a clinical professor in the Department of Comprehensive Dentistry at the University of Texas Health Center School of Dentistry at San Antonio. He is also a diplomate of the American Board of General Dentistry.

Disclosure: The author did not report any disclosures.