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VA DENTAL JOURNAL

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EXPANDED! NOW WHAT?

VDA CONTINUES TO SUPPORT PROGRESS FOR EXPANDED MEDICAID DENTAL BENEFIT

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DR. AMY DAVID

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CLASSIFIEDS

The Silver Scroll is awarded to the editor whose publication demonstrated the most overall improvement over the prior year of publication.

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THREE PILLARS

ADVOCACY, PRACTICE SUCCESS, AND PROFESSIONAL DEVELOPMENT

Dr. Frank Iuorno, Jr.

The VDA Board has been hard at work meeting nearly every month since the start of the pandemic. Your Board of Directors has put in endless hours of reading and discussion about all-things COVID-19 and as the light at the end of the pandemic tunnel seems to glimmer in the distance it is now time to focus our efforts on more internal affairs and attack the business of the VDA. A big part of this effort has been the development and roll out of the VDA's strategic plan, so without further ado…

The VDA's Strategic Plan 2025… Advancing Dentistry and Empowering Members, stands on three pillars—Advocacy, Practice Success, and Professional Development.

Advocacy includes legislative initiatives currently centered around dental practice and third-party payers. Looking toward 2022, I believe it is time for the VDA to take an unprecedented, aggressive stance and bring forth a comprehensive legislative package to address our most common member concerns. The Council on Government Affairs is currently working on a legislative initiative which would help level the playing field between providers and third-party payers while bringing reimbursement into the 21st century. Advocacy also includes enhancing our relationships with the state Board of Dentistry and the VCU School of Dentistry. Additionally, COVID-19 has allowed us to exploit the strength of organized dentistry and elevate the VDA brand. Never before have we seen such comprehensive public exposure in all forms of media across the state. Finally, many of our advocacy efforts are tied closely with our PAC and given the absence of in-person meetings, PAC funding is significantly down for 2020 and again in 2021. Please keep this in mind when paying dues and responding to upcoming fund drives.

Practice Success and the Virginia Dental Services Corporation (VDSC) go hand in hand. We will work to enhance services offered for practice, provider, and staff! Keep your eyes peeled for valuable offers that can save you money and support the VDA at the same time. Another vital component of practice success, especially for growing practices and practices in transition, are our new dentists and our bright, eager dental students. The VDA will be spearheading a more robust, tangible relationship between our members and the students that hopes to open the channels of communication to aid in practice transition opportunities.

Finally, Professional Development includes continuing education and once again, COVID-19 has shown us another silver lining. Our on-demand CE library has grown exponentially, and we will continue to add resources for members (many free and some at a much-reduced rate) for continuing education. Feel free to let us know what you would like to see added to this library for future development. Another key element of professional development is leadership development. In conjunction with our bylaws revision, we will put in place a system for formal leadership development that inspires our VDA Fellows to become effective leaders at the local, state, and national level.

Clinical practice has taught us treatment success comes with a well-developed treatment plan. Advancing Dentistry and Empowering Members is our plan for the next 5 years, and I am confident that if we adhere to the plan, the VDA will be even stronger in 2025. Please take the time to thank your Board of Directors for their time and dedication to the VDA's success and we in-turn thank you for your support of the VDA and your continued dedication to the profession.

Are you interested in getting involved with the VDA in a leadership position?
Then you're in luck! We currently have openings in the following positions:

- President Elect – 2022, then President – 2023
- ADA Delegate (2022-2024) – 4 positions available
- ADA Alternate Delegate (2023-2024) – 5 positions available

Learn more about the open positions and how to apply at **www.vadental.org/about-us/leadership-opportunities** or contact Lynn Wisman at **wisman@vadental.org**

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THE TIME OF OUR LIVES

Dr. Richard F. Roadcap

Recently I made a series of phone calls, and I spoke to a pediatric dentist in another state. She told me she planned to retire last year and had reached an agreement for the sale of her practice. As the COVID-19 pandemic bore down in March 2020, the buyer backed out. She was in the process of clearing out her office when we spoke. Prior to the call, I wondered why her Google listing said "Closed".

"Not only has the cost of seating patients increased, many of our patients have not returned to routine dental care for fear of contracting the virus."

It's been a year since dental offices closed for two months or more, either voluntarily or to meet state mandates. Dentists no longer practice in the manner they did at the start of last year. Some changes are for the interim, and others will be permanent. I'm unable to foresee how the delivery of dental care will evolve in response to the pandemic. Despite the dread and trepidation that greeted the arrival of SARS-CoV-2, no one dared to predict that over half a million would die in the US alone.[1] The wait at a local hospital for the Moderna vaccine (doses 1 and 2) brought back childhood memories of the lines for the Salk and Sabin polio vaccines.

So, what has changed in your practice in the last year? What further changes do you expect? The use and distribution of PPE has become of paramount importance. Face shields, N95 or ASTM Level 3 masks, protective eyewear (ever more important as the virus can colonize the eyes[2]), and disposable Tyvek® gowns are now everyday attire. Staff in many offices now sport brightly colored head coverings. I don't foresee a time when dentists can revert to wearing nothing but Level 1 face masks, gloves, and multi-day clinic jackets. The modes of transmission of the virus that causes COVID-19 are many, and not well understood.

The preceding twelve months has brought change to dentists' lives in three arenas: clinical, business, and personal. Some of the changes can be quantified, but many are subjective and hard to define. I've already mentioned the new wardrobe which we may be wearing for an indefinite period of time. Our heightened awareness of aerosols and their role in the transmission of pathogens will help us adapt, even if we never embrace the new protocols. Our waiting rooms have been transformed from luxe to spartan. Gone are the stacks of periodicals and scattered newsprint, communal seating, and amenities such as the ubiquitous Keurig machine, and pitchers of lemon-infused ice water. Now it's temporal thermometers and Covid-19 disclaimers. Operatory design will bend to the new realities. Open bay treatment areas will yield to the more traditional 100 square foot dental operatory, although there's no research that condemns the former. Dentists are seeking new methods to improve indoor air quality,[3] hoping to reduce the number of airborne virus particles. Hygienists now use ultrasonic scalers as a last resort, giving preference to hand instrumentation. I find myself at times hoping to avoid the use of air driven handpieces in tooth preparation.

Changes in our business practices have been profound. Increased expenditures for PPE are necessary but are not being reimbursed by third-party payers. For example, I use a face shield designed to accommodate loupes and an LED headlamp. In limited quantities, they cost $5.00 each, and are labeled "single use only". Some of us received checks last summer for random amounts, a sop from insurance carriers embarrassed by 60 days freedom from paying claims. We were told the payments were based on a formula, the basis of which remains hidden to practicing dentists. Dentists are forbidden from charging directly for these expendables, and must raise the fees charged for each procedure to compensate. Not only has the cost of seating patients increased, many of our patients have not returned to routine dental care for fear of contracting the virus. The dental profession's record in patient safety is exemplary, but many practices are operating at 75-80% of pre-pandemic levels. The ADA's Health Policy Institute estimates that spending on dental care will decline 20% in 2021.[4] As I write, only one in eight Americans has received both doses of the Pfizer or Moderna vaccines.[5] It's not hard to imagine a public, where 85% are not immune to the virus, being reluctant to schedule a prophy appointment.

Finally, there's the personal aspect of confronting a world where our plans have been knocked askew. We've become conditioned to expect each year to be an improvement over the one before. Dentists pride themselves on their independence and self-reliance, yet the events of the year just past make us feel vulnerable. Previously we could rely on the camaraderie and friendly banter of face-to-face meetings. Technology used

>> CONTINUED ON PAGE 14

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VIRGINIA DENTAL ASSOCIATION

REACH OUT AND TOUCH

Gary D. Oyster, DDS; ADA Trustee, 16th District

I hope each of you, your staff, and family are dealing successfully with the continuing COVID pandemic. It seems the majority of patients feel safe when coming to our offices for care. Many of us have been adversely affected by schools being virtual and staff members' schedules being disrupted, and look forward to a return to normalcy.

COVID had an enormous impact on the ADA in 2020 - $13 million in lost revenues and a net loss of 2,100 members. Our market share decreased 1.7%. Thus, 2021 is focused on both financial and membership recovery. The ADA needs to jumpstart stagnant membership growth and work is underway. The ADA can only offer ideas and strategies; you, the member, must be a part of bringing dentists who have dropped their membership and new members into the fold. Peer to peer involvement has always been the most successful recruitment tool.

We need to institutionalize our focus on diversity and health equity. A new Diverse Dental Society which is composed of members of the NDA, HAD, and SAID has been formed. We believe DDS will make our communications with these entities easier and more effective, and hopefully will increase their membership in the ADA.

We must recruit and welcome DSO (Dental Service Organization) dentists into membership at all levels of the tripartite. We need to end the perspective that DSO dentists are or should be somehow apart from membership. Due to the large amount of debt that dental students are graduating with, many are working for a DSO in hopes of later establishing their own practice. That is where ADAPT, ADA's Practice Transitions, can be an effective tool in keeping private practices open, especially in small towns and rural areas. This tool matches a practice owner looking for an associate or selling the practice with a dentist looking to associate or buy. It is cheaper than a broker and has an advantage of reaching out to the whole ADA membership.

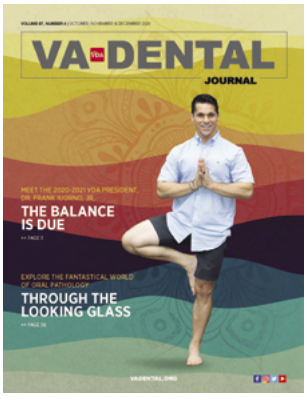
We have a great story to tell about our efforts for dentistry in Washington, DC. Keeping dental offices open, liability protection during the pandemic, PPE procurement, PPP loans and forgiveness, and repealing the federal antitrust exemption for dental insurers happened only because of ADA efforts. No single dentist or state could have achieved these results. Dental insurers now must play by the same rules as others in the market and many commentators believe the repeal increases the chances of antitrust enforcement actions. Dental insurance reform efforts are also continuing in many states, with ADA assistance.

ADA membership has remained relatively stable over the last few years, but we are falling behind the growing dental market. We need to recruit more successfully in growing market segments where our membership is lagging, especially among young dentists, minority dentists, women dentists and dentists working in DSOs. When we return to in-person meetings, we all need to REACH OUT AND TOUCH NON-MEMBERS.

RESILIENCE AND INNOVATION IN THE FACE OF CHALLENGE

Dr. Robert A. "Bob" Levine

I commend our colleague, Dr. Al Rizkalla, on his thought-provoking article regarding the enhanced safety measures taken in his dental practice operatories as a result of this pandemic. I am always amazed at the resilience and innovation shown by our members when we are challenged. Dr. Rizkalla described what he determined to be the best course of action for his office at the early onset of this current health crisis. The initiative and resourcefulness in charting his own path when protocols and products were of limited supply is greatly appreciated. Thank you Dr. Rizkalla for doing and sharing.



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https://bit.ly/37VEMgP

EXPANDED! NOW WHAT

OVERDUE – VIRGINIA ADULT MEDICAID EXPANSION

Ryan Dunn, VDA Executive Director

An Adult Medicaid Benefit was approved by the General Assembly this year and will go into effect July 1, 2021. By now, you should have received additional information on the implementation and rates that will be associated with that benefit as it launches. There are articles in this edition of the Journal that explain more about the process, and the VDA will continue to share information about it on our HUB, along with opportunities to provide direct feedback with officials on how the program can be improved.

I want to particularly thank Dr. Cindy Southern and Dr. Roger Palmer for their close involvement in representing VDA member concerns in the development and implementation of this benefit. The candid feedback they shared throughout the process has helped state officials develop a clear-eyed view of the barriers dentists face in becoming Medicaid providers and the limitations of piecemeal solutions to truly addressing access-to-care issues in Virginia. The Adult Medicaid Benefit is a first step, and an important one, towards doing that.

However, at the same time, it is unacceptable that the dental Medicaid reimbursement rates have not been increased in over 15 YEARS! We are 15 years overdue for an adjustment in the rates and now the program will add hundreds of thousands of adults to an already dated and inadequate reimbursement structure.

This expansion takes place in a broader context across insurers of stagnant reimbursement rates at the same time that costs are increasing for our members across the board, from PPE, supplies, real estate, complying with federal and state mandates and a host of other costs, while safety protocols have resulted in lower patient capacity. This challenge is going to be the VDA's focus for the coming year as we develop our agenda for the 2022 General Assembly session and beyond.

The VDA's Board adopted a long-term strategic plan that prioritizes forcefully advocating for our members around third-party payer issues and developing stronger relationships with third-party payers to ensure dentists have a seat at the table. We are working with the ADA, the Health Policy Institute and others to lay out in clear terms where Virginia stands around third party payer issues and where legislative action should be taken.

> *"The program will add hundreds of thousands of adults to an already dated and inadequate reimbursement structure."*

We will be asking for all members to be involved in this effort, from gathering actionable data to reaching out to your state representatives in the months ahead. Please stay tuned and thank you for all who have worked on this effort.

VDA CONTINUES TO SUPPORT PROGRESS FOR EXPANDED MEDICAID DENTAL BENEFIT

EXPANDED MEDICAID DENTAL BENEFITS AND YOUR PRACTICE

Dr. Zachary P. Hairston; Dental Consultant; Department of Medical Assistance Services (DMAS)

Virginia has been a national leader in our Medicaid ***Smiles For Children*** program and in providing a robust dental benefit for pregnant women enrolled in Medicaid. As of July 1, 2021, Virginia has the exciting opportunity to continue to expand the Medicaid dental program by offering comprehensive adult dental benefits for approximately 750,000 Virginians!

There are many areas we will need to address in providing these needed services. There is a natural altruism we are willing to extend to provide services to the children we see in our offices. As I speak with you individually across the state, some have shared with me any number of reasons why you have hesitation to see adults. Having practiced for almost forty years, I admit sharing ownership with the very statements I hear. I respectfully ask that you rethink some of those reasons and walk with me on this journey.

Engage your staff and achieve buy-in with them to be a leader in treating these members. We will also need to engage many of our fellow dentists that are not pediatric dentists to support this cause. Ask your colleagues to step forward and treat these adults, to ensure positive oral health and overall health gains for thousands of Virginians.

While the Department of Medical Assistance Services has been a drum major for this action for some time, there are many sister agencies and stakeholders that have been just as influential. It is the combined efforts of all of these groups that will help ensure the success of the adult program, and will assure the program will grow and thrive. I will ask for and offer thanks for this joint effort to continue. It will take a village. Please allow me to speak for the many beneficiaries that will receive our skills as clinicians. Many may not thank you directly. They at times have stronger relationships with the staff members and tell them and that's okay. The appreciation they enjoy will leave your front door and go back to be shared in their neighborhoods and communities, family members, and places of worship. You are now a resource for the patient who previously had no other option than to seek help at the emergency department. Your benevolence can in turn grow your practice immensely.

If you have questions, or would like additional information on these new services, please do not hesitate to reach out to me for any way I might be of further assistance.

Thanking you in advance for helping make Virginians have happy and healthy smiles!

IMPLEMENTATION ROLLOUT

Sarah Bedard Holland; CEO, Virginia Health Catalyst

We're already in the second quarter of 2021, a year that holds high expectations after what we saw in 2020. There is good reason for hope – many Virginians (including dental providers) have received the COVID-19 vaccine, and the rollout in preparation of the adult dental benefit in Medicaid is well underway. Adults in Virginia's Medicaid program will soon benefit from comprehensive dental care coverage starting July 1, 2021. This means that nearly 800,000 Virginians will be able to access and afford oral health care, especially important during a pandemic.

States that currently have an adult dental benefit in Medicaid have seen improvements at both the clinical and community levels. In every state with a comprehensive adult dental benefit, the number of dentists participating in Medicaid has increased and practices report an increase of $15,000 on average in annual revenue. Medicaid beneficiaries using the dental benefit have seen improved chronic disease outcomes, positive employment implications, and fewer trips to the emergency department for oral health concerns.

What will the benefit look like?

Leadership at Virginia's Department of Medical Assistance Services (DMAS) has outlined the types of services that will be covered. It is similar in nature to the dental benefit for pregnant women, with some limitations and is designed to ensure providers are able to offer true comprehensive services to their patients. Please see the table on the next page provided by DMAS explaining the services covered by specialty area.

Virginia Health Catalyst partnered with DMAS and DentaQuest, the dental benefit administrator, to share the latest information and answer your questions in a webinar on February 3; you can find the recording at **https://vimeo.com/508080886**.

Credentialing

If you are already a Medicaid provider, you do not have to do anything; you will automatically be a provider for the newly-eligible adults. If you are interested in becoming a Medicaid provider, simply visit the DentaQuest Enrollment webpage (**https://dentaquest.com/state-plans/regions/virginia/dentist-page/**) and click on **VA Smiles For Children Application** or call 866-853-0657.

Reimbursement

Medicaid reimbursement rates for the newly-enrolled adults will be the same as the rates for pregnant patients and children, an issue that advocates like Catalyst and the VDA will address with members of the legislature in the 2021 general assembly session.

Stay involved in the benefit rollout

Catalyst will continue to host a monthly adult dental implementation update webinar to ensure a smooth rollout and provide up-to-date information. The webinars will be recorded and are posted on the Catalyst event webpage (**https://vahealthcatalyst.org/event-calendar/**) – please add these to your calendar!

Check back regularly to the Catalyst webpage (**https://vahealthcatalyst.org/adultdentalbenefit/**) where we will post new resources and information. There, you can find a general flyer about the dental benefit to post in your clinic or office. If you want other resources that are more specific to your needs, please let us know and we would be happy to work with you.

The upcoming adult dental benefit is a huge success as a result of advocates like you, your colleagues, and your community members. It will ensure that more Virginians are able to access care that many have never received before. However, we know that access to care does not necessarily equate to care utilization, so an important part of the rollout is educating patients and referrers about the benefit. Please feel free to contact me directly at **sholland@vahealthcatalyst.org** with any questions or ways that we can support you.

DMAS Table of Benefits

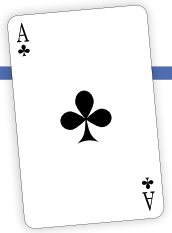
Specialty Area	Description	Services Covered	Limitations
Diagnostic and Preventive Care	Services that are used to detect and recognize caries and periodontal disease. Up to three routine cleanings may be permissible	Exams, Routine cleanings, X-rays	Non-routine X-rays such as imaging and cone beam technology would require prior authorization
Restorative Care	Specialty allows dentists to restore teeth to proper function	Fillings and crowns	Crowns are covered when a root canal is done while member is under the adult dental program Bridges
Endodontics	Specialty allows dentists to perform root canals on teeth that have sound below the gum structure (root) yet the above gum structure is compromised (decay or trauma)	Root canals Pulpal Debridement	Endodontic retreatment and surgical procedures that have a questionable success rate
Periodontics	Specialty focuses on keeping gums and the bone below the gums healthy.	Scaling and Root Planing Gingivectomies Periodontal maintenance procedures	Periodontal flap procedures, crown lengthening procedures, bone replacement grafts
Dentures and Partials	Specialty focuses on replacing teeth with removal appliances	Dentures, Partials, and Repair procedures	Partials are covered as a part of a definitive treatment plan
Oral Surgery	Specialty routinely extracts teeth and performs extractions requiring surgical methods such as removing bone	Extractions Alveoplasty	Non-tooth extraction procedures Surgery necessitated by trauma Implants
Adjunctive General Services	This area while not a specialty is important in that it allows coding for anesthesia services and many other dental procedures not listed elsewhere.	Anesthesia Services	Non-anesthesia services may require prior authorization

THROUGH THE LOOKING GLASS

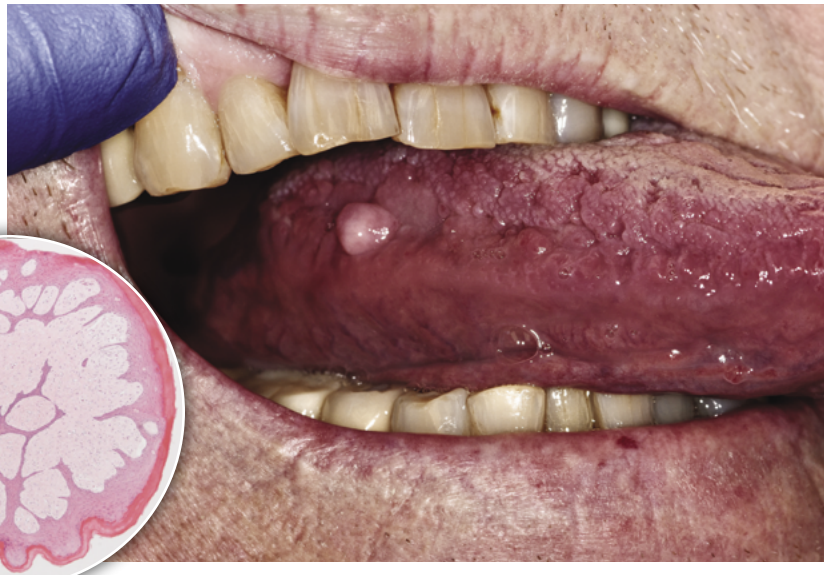
WITH DR. SARAH GLASS

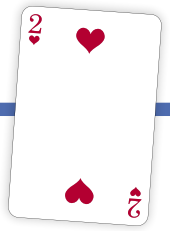
EXPLORE THE FANTASTICAL WORLD OF ORAL PATHOLOGY

Editor's Note: Dr. Sarah Glass is a board certified Oral and Maxillofacial Pathologist. She works as an assistant professor at VCU School of Dentistry, and her job responsibilities include teaching, working in the biopsy service, and seeing oral medicine patients.

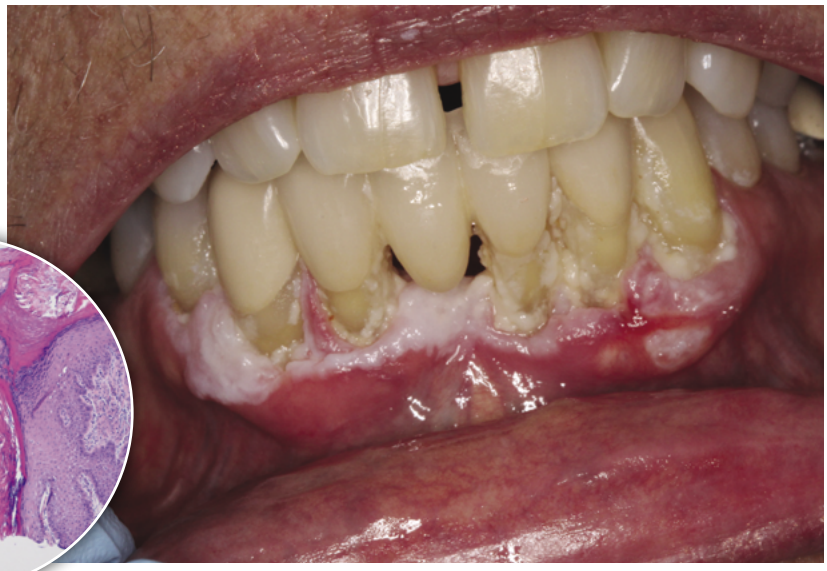


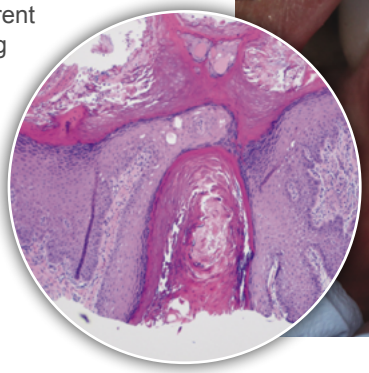
You find this lesion on your 43-year-old male patient during a routine head and neck exam and perform a biopsy. What is the diagnosis?

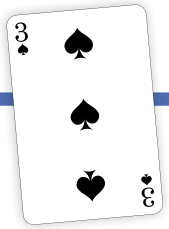




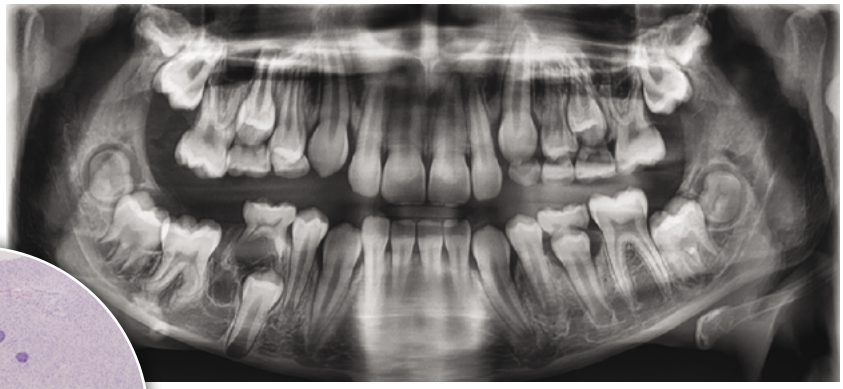
A 75-year-old female patient reports being managed by her dermatologist for a long-standing diagnosis of lichen planus, but her current lesions are not responding to topical steroids. Her clinical presentation and biopsy results make you think what?

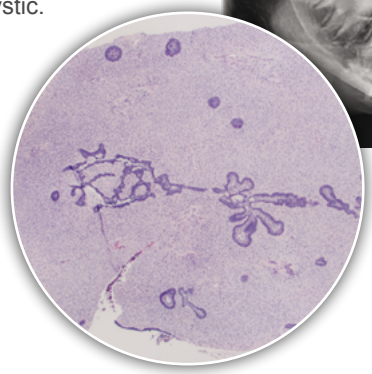






A mandibular lesion is seen on a panoramic image of an 11-year-old female. On surgical removal, the lesion does not appear cystic. What is the diagnosis?





>> ANSWERS ON NEXT PAGE

>> CONTINUED FROM PAGE 5

to communicate remotely is often cold and impersonal. It's hard to discuss that big case that went south in a chat room or Zoom meeting.

The twelve months that began in March 2020 were what none of us expected. My colleague in another state certainly didn't expect to be sorting through the remains of a dental practice. Can young dentists get a loan to buy a practice? Can retiring dentists find a qualified buyer? Bankers and brokers remain chipper. Later in life we'll remember these times as changing us forever.

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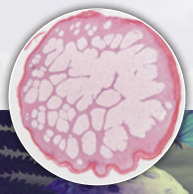
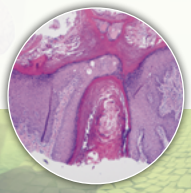
>> THROUGH THE LOOKING GLASS ANSWERS CONTINUED FROM PAGE 13

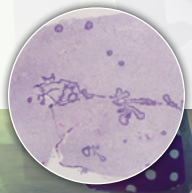
1. The histopathology shows some plump stellate fibroblasts diagnostic of a **giant cell fibroma**. These neoplasms are similar to the routine fibroma but are often not associated with chronic irritation. The treatment is the same.



2. Although lichen planus can have areas of white plaques, the mucosal changes here are not lichen planus but rather a specific type of leukoplakia – **proliferative verrucous leukoplakia (PVL)**. This potentially malignant oral disorder has a high risk of malignant transformation.



3. The radiolucency associated with an unerupted tooth in this radiograph is an **ameloblastic fibroma**. These uncommon tumors tend to occur in the posterior mandible of younger patients. Conservative excision is recommended with follow up as ameloblastic fibromas can recur.



EFFICACY AND SAFETY OF POSTOPERATIVE MEDICATIONS IN REDUCING PAIN AFTER NONSURGICAL ENDODONTIC TREATMENT: A SYSTEMATIC REVIEW AND NETWORK META-ANALYSIS

Zanjir M, Sgro A, Lighvan N, Yarascavitch C, Shah P, da Costa B, Azarpazhooh A. J Endod. 2020; 46(10):1387-1402.

Patients undergo nonsurgical root canal treatment (NSRCT) to relieve pain, yet 21%-40% of patients report immediate postoperative pain which results from inflamed periapical tissues. Pharmacotherapeutic agents are the primary means of reducing postoperative pain after endodontic treatment. Modalities of treatment after NSRCT include analgesics, NSAIDs, corticosteroids, and opioids.

Most randomized controlled trials on the effectiveness of various medications on post-operative pain typically use pair-wise meta-analyses for statistical analysis, which only allow the comparison of 2 interventions at a time. Due to this statistical design, these studies are unable to rank the effectiveness of the different classes of drugs, and do not determine the most efficacious drug type. A network meta-analysis (NMA) is a method that allows the comparison and ranking of any number of treatments for a particular condition at the same time and can estimate the relative effect of the various interventions. This study aimed to review medications used in managing postoperative pain in patients who underwent NSRCT using a NMA approach to determine the most efficacious and safe medication.

The systematic review included randomized controlled trials (RCTs) of NSRCT on adults which administered pharmacologic intervention for post-operative pain and measured pain on a verbal or visual-analog scale. Two authors independently reviewed the selected studies and evaluated the risk of bias using Cochrane's risk of bias assessment tool. A Bayesian NMA was performed. Treatment effects were estimated as mean differences with a 95% confidence interval at 6-8 hours, 12, 24, and 48 hours. The surface under the cumulative ranking curve was also calculated to simplify the information about the effect of each treatment, rank its effectiveness, and identify the best treatment.

From an initial search of 969 records, 11 RCTs met the inclusion criteria, encompassing a total of 706 patients. Eight groups of medications were included: NSAIDs, corticosteroids, opioids, acetaminophen, placebo, NSAIDs + acetaminophen, NSAIDs + benzodiazepines, and NSAIDs + opioids. All included patients who underwent NSRCT up to either the canal instrumentation or canal obturation stages. Pain values were either reported as or converted to a 0-100 scale. Five studies were graded as low risk of bias, 5 as moderate, and 1 as high.

At 6-8 hours, NSAIDs + acetaminophen and NSAIDs alone provided the greatest reduction in pain. At 12 hours and 24 hours, NSAIDs alone provided a significant amount of pain relief. All other groups listed above were not found to provide a statistically significant reduction in pain in comparison to the placebo based on 95% credible intervals. At 48 hours, no intervention resulted in significant pain reduction when compared to the placebo.

NSAIDs and NSAIDs + acetaminophen were the most efficacious pharmacologic modalities for pain relief at 6-8 hours post-operatively. After 8 hours, NSAIDs + acetaminophen did not provide greater pain relief than NSAIDs alone, which suggests proper initial pain management may eliminate pain up to 24 hours. No study analyzed investigated the effect of acetaminophen + opioids, but the combination remains recommended to treat moderate to severe pain in patients who could not take NSAIDs. Corticosteroids were not found to significantly reduce pain, however, the quality of evidence in the available literature was not high. Some limitations of this NMA included a relatively low number of studies compared with the interventions analyzed, levels of evidence ranging from moderate to very low, and limited findings regarding the safety of various medications. This NMA finds NSAIDs to be the first line therapy for post-operative pain after NSRCT, with the addition of acetaminophen for severe pain not managed by NSAIDs alone.

Inderpal S. Sappal, D.D.S.; Resident in Endodontics, Virginia Commonwealth University

DIAGNOSTIC ACCURACY OF CONE BEAM COMPUTED TOMOGRAPHY USED FOR ASSESSMENT OF APICAL PERIODONTITIS: AN EX VIVO HISTOPATHOLOGICAL STUDY ON HUMAN CADAVERS

Kruse C, Spin-Neto R, Evar Kraft DC, Vaeth M, Kirkevang LL. Int Endod J. 2019;52(4):439-450.

The use of cone beam computed tomography (CBCT) is ever increasing in dental care and its use has been shown to have better diagnostic accuracy to detect apical periodontitis (AP) when compared to traditional periapical radiograph (PA).

The aim of this study was to further assess the diagnostic accuracy of CBCT using ex vivo histopathology of the corresponding tooth as the reference standard for detection of true AP in human cadavers. A total of 553 teeth were selected and PA radiographs and CBCT scans were taken. Using the 2-dimensional PA image, information regarding tooth number, number of visible roots, root canal treatment status, existing post, type of coronal restorations, caries, marginal bone level and finally the periapical status was recorded. Periapical status was assessed via CBCT using 0.085mm voxel size and observers could freely manipulate the images and the grade of AP was given based on probability index set by Reit and Grondahl (1983). Finally, histologic sections including the apical foramen and adjacent sections of each tooth were prepared and examined by an oral histopathologist. The sections were graded based on inflammation and given a score of (i) no inflammation, (ii) mild AP, (iii) moderate AP, (iv) intense AP (v) inflammation not related to AP.

Upon examination of the results, it was found that when CBCT examination gave a score of “mild AP” of non-root filled teeth there was a sensitivity of 0.95 when detecting AP and 1.00 when detecting “no AP” when compared to the actual histological condition. Conversely, teeth with root canal fillings with score of “mild AP” on CBCT had sensitivity of 0.63 when detecting AP and 0.91 when detecting “no AP” when compared to the actual histological condition.

This study highlights the high level of sensitivity and specificity that CBCT provides when assessing a non-root filled tooth. The clinician may be confident in diagnosing apical periodontitis in non-root filled teeth based on CBCT without fear of over-diagnosis and over-treatment. In endodontically treated teeth however, the sensitivity and specificity were less encouraging. The risk of diagnosing apical periodontitis in root-filled teeth was higher than that of non-root filled teeth when in fact, the histological condition did not show AP. Thus, the risk of over diagnosis and over treatment of an endodontically treated tooth may be higher.

This study is the first to demonstrate that the endodontic status of a tooth should be considered when using CBCT to diagnose apical periodontitis as CBCT was shown to have decreased accuracy in endodontically treated teeth. The ability to diagnose apical periodontitis is limited to radiographic imaging as well as the clinical testing, both of which are known be subject to the clinician’s judgment, prior experience and training. The authors of this study suggest that a wait-and-see approach may be warranted when an endodontically treated tooth shows no clinical signs or symptoms of pathology but there is doubt when interpreting the radiographic data.

Jeremy Hargrove, DMD, Resident in Endodontics, Virginia Commonwealth University

“FERRULE COMES FIRST. POST IS SECOND!” FAKE NEWS AND ALTERNATIVE FACTS? A SYSTEMATIC REVIEW

Naumann M, Schmitter M, Frankenberger R, Krastl G. J Endod 2018;44(2):212-9.

Over the past decades, many studies have been conducted to answer the question of which post-and-core technique/material should be used to increase the survival rates of endodontically treated teeth (ETT) and restorations. The role of an endodontic post and the ferrule effect have been studied for many years. However, the clinical impact of posts compared with post-free restorations in the presence or absence of ferrule support has not been systematically reviewed so far.

The aim of the present systematic review was to look for a high-level of clinical evidence comparing post placements versus no-post placement in endodontically treated teeth in the presence or absence of ferrule support to help distinguish the impact between the post and the ferrule effect. The null hypothesis was that post placement is superior to post-free restorations irrespective of the presence of a ferrule for restoration and/or tooth survival.

The specific PICO criteria were as follows: Patients - adults with an endodontically treated tooth requiring a core or post; >

THE INFLUENCE OF IRRIGANT ACTIVATION, CONCENTRATION AND CONTACT TIME ON SODIUM HYPOCHLORITE PENETRATION INTO ROOT DENTINE: AN EX VIVO EXPERIMENT

Virdee SS, Farnell DJJ, Silva MA, Camilleri J, Cooper PR, Tomson PL. Int Endod J. 2020; 53(7): 986-997

Apical periodontitis is a condition that develops in response to bacterial invasion of the root canal system. The goal of root canal therapy is disinfection of the root canal system and sealing of the canals in order to achieve healing of the periapical tissues. Sodium hypochlorite (NaOCl) is the irrigant of choice used to kill bacteria and remove organic debris. Due to the complex anatomy of root canal systems and the fact that bacteria can reside in dentinal tubules up to 420 µm, it is a challenge to eliminate 100% of bacteria. This could negatively affect the prognosis of root canal therapy if bacteria are able to persist in dentinal tubules leading to periradicular disease later on. Cleaning and shaping of the canals leads to deeper needle penetration allowing NaOCl to disinfect the main canal near the apex, however conventional needle irrigation (CNI) only allows NaOCl to infiltrate the dentinal tubules up to 250 µm into root dentine possibly leaving some deeper bacteria untouched. Manual dynamic activation, passive ultrasonic irrigation, and sonic irrigation are techniques used to overcome the shortcomings of CNI. Manual dynamic activation (MDA) is a technique using a well-fitted gutta percha (GP) point into the canal and using it to manually pump the irrigant into the canal system. Passive ultrasonic irrigation (PUI) uses oscillating files at ultrasonic frequencies to generate acoustic cavitation of the irrigant. Sonic irrigation (SI) is the oscillation of a plastic file at subsonic frequencies creating a hydrodynamic phenomenon within the canal system known as acoustic streaming.

The primary aim of this study was to find out if MDA, PUI, and SI improved the tubular penetration of NaOCl into root dentine. The secondary aim was to determine if higher concentrations of NaOCl and/or increased contact time improved the effects of the aforementioned irrigant activation techniques.

Eighty-three extracted human maxillary permanent canines were prepared to an apical size 40 preparation. The root dentine was stained with crystal violet and embedded in silicone. Eighty teeth were randomly distributed into 16 groups according to the irrigant activation technique, NaOCl concentration (2% or 5.25%), and the irrigant contact time (10 min or 20 min). Three teeth were not exposed to NaOCl and were used as negative controls. After the irrigating techniques were completed in each group, the teeth were then sectioned and evaluated under a light microscope. The depth of penetration of NaOCl was measured using an average width of bleached dentine.

The NaOCl penetration ranged from 38.8 to 411 µm with MDA, PUI, and SI consistently resulting in significantly deeper tubular infiltration than CNI. The MDA technique with 5.25% NaOCl used for 20 minutes had the deepest measurement of dentinal tubule penetration of the irrigant. The CNI technique with 2% NaOCl for 10 minutes had the lowest penetration of NaOCl into the tubules. Increased irrigant concentration and increased irrigant contact time resulted in greater penetration of NaOCl into the dentinal tubules across all groups.

According to this study it was recommended to use 5.25% concentration with either MDA, PUI, or SI over conventional needle irrigation in order to maximize penetration of NaOCl into the dentinal tubules.

Benjamin Brown, DMD; Resident in Endodontics, Virginia Commonwealth University

Intervention - posts with or without a ferrule present; Comparison - no posts with or without a ferrule present; Outcomes - tooth/ restoration survival rates.

A Medline search (via PubMed) and hand search were performed. The following terms were used to identify potential studies comparing the success/survival of dental restorations using posts or no posts in endodontically treated teeth: “post” OR “posts” OR “dowel” OR “dowels” OR “screw” OR “screws” OR “core” OR “post-retained” OR “no-post” OR “post-free” OR “endocrown” OR “buildup” OR “buildups” OR “build-up” OR “build-ups”. Clinical trials and studies published in dental journals were included. Only prospective clinical studies reporting information on the remaining tooth structure and comparing the success/survival rate of teeth restored with or without posts in the presence or absence of ferrule support over a minimum observation period of 5 years were considered.

Regarding the quality assessment of the included studies, the critical appraisal skills program (CASP) and Cochrane checklist (version 5.1.0) were used.
Seven randomized controlled trials and one prospective clinical trial were included. Five studies demonstrated a high risk of bias according to the Cochrane rating. Two of three studies were in favor of the ferrule-effect concept. Seven of eight demonstrated no post effect.

Conclusion: Presence of a ferrule and maintaining cavity walls are the predominant factors that influence tooth and restoration survival of endodontically treated teeth.

Lolwa Alyahya , BDS; Resident in Endodontics, Virginia Commonwealth University

SUCCESS OF DIRECT PULP CAPPING USING MINERAL TRIOXIDE AGGREGATE AND CALCIUM HYDROXIDE IN MATURE PERMANENT MOLARS WITH PULPS EXPOSED DURING CARIOUS TISSUE REMOVAL: 1-YEAR FOLLOW-UP

Suhag K, Duhan J, Tewari S, Sangwan P. J Endod 2019;45(7):840-7.

Direct pulp capping is a procedure performed when the pulp is exposed due to caries, trauma, or mechanical exposure. The exposed pulp should be covered with a biocompatible, nontoxic, and antibacterial material. This treatment aims to maintain a healthy pulp by protecting it from bacteria and inducing formation of a dentin bridge at the exposure site.

Calcium hydroxide had been considered the standard of care for direct pulp capping until Mineral Trioxide Aggregate (MTA) was introduced in 1990. It has antibacterial properties, and it can release bioactive molecules that help in repairing pulp and dentin remineralization. The success rates for using calcium hydroxide for direct pulp capping procedures ranged between 13% to 97%. Calcium hydroxide does have some disadvantages which include: having a poor seal, presence of tunnel defects inside the dentin bridge, and nonadhesive dissolution over time. MTA, which was introduced by Torabinejad and Chiven, is the material of choice now. It induces dentin bridge formation, is biocompatible, sustains a high pH for a longer duration, and provides a better seal to prevent microleakage. The success rates with using MTA in direct pulp capping procedures range from 67% to 97%.

The aim of this study was to evaluate the success and to assess the incidence of postoperative pain after direct pulp capping with calcium hydroxide and MTA in mature mandibular molars with carious pulp exposures. Sixty-four teeth were included in this study. They were randomly divided after caries excavation into two groups (MTA and Calcium hydroxide). All the cases had deep caries in mature permanent first and second molars with a closed apex. Teeth were diagnosed with a reversible pulpitis. Caries was removed with a slow speed round carbide bur and spoon excavator. Sodium hypochlorite (2.5%) was used to disinfect the exposed pulp with a syringe and cotton pellet. The cotton pellet was left in the cavity for 10 minutes to achieve hemostasis. In the calcium hydroxide group, calcium hydroxide was mixed with saline and placed over the exposure site. Teeth were restored with resin-modified glass ionomer and composite. In the MTA group, MTA was mixed and applied to the exposure site with a sterile carrier. A wet cotton pellet was placed over the MTA and restored with a temporary restoration. After 24 hours these teeth were restored similarly to the calcium hydroxide group with resin-modified glass ionomer and composite. A periapical radiograph was taken after each case. Pain was recorded preoperatively, and at 6-, 12- and 18-hours post-treatment and 1, 2, 3, 4, 5, 6 and 7 days after the procedure using the visual analog scale. Follow-up examinations were completed at 1 week, 3 months, 6 months, and 12 months.

At the 12-month follow-up, the overall recall rate was 87.5% and the overall success rate was 80.4%. In the MTA group, the success rate was 93% while the success rate for the calcium hydroxide group was 69%. There was no significant difference between the groups regarding pain intensity at 6 and 12 hours. However, lower pain scores were found in the MTA group after 18 hours.

In this randomized clinical trial study, direct pulp capping of teeth with carious exposures and reversible pulpitis were found to have a favorable outcome. MTA had a higher success rate when compared to calcium hydroxide.

Abdullah Alawadhi, DDS;
Resident in Endodontics, Virginia Commonwealth University

THE INFLUENCE OF MISSED CANALS ON THE PREVALENCE OF PERIAPICAL LESIONS IN ENDODONTICALLY TREATED TEETH: A CROSS-SECTIONAL STUDY

Baruwa AO, Martins JNR, Meirinhos J, et al. J Endod 2020;46(1):34-9.

It is generally accepted that a small percentage of endodontically treated teeth do not respond favorably to root canal treatment. Outcome studies have documented factors such as persistent bacterial infection, inadequate root filling, untreated canals, improper coronal seal, improper coronal restoration, and procedural errors as variables with possible associations with the persistence of apical periodontitis. In particular, the absence of disinfection and shaping of a root canal may result in the presence of a reservoir of bacteria, which can lead to a persistent apical periodontitis and may have an impact on the treatment outcome. An untreated canal in an endodontically treated tooth could be a result of an operator's limited knowledge of tooth anatomy, complexities in canal configuration, or procedural errors such as inadequate access design.

Previous studies on post endodontically treated teeth and persistent apical periodontitis have used conventional radiographs to evaluate pathosis. The two-dimensional nature of a periapical radiograph presents a limitation when searching for missed canals. This limitation can now be overcome with the introduction of cone-beam computed tomographic (CBCT) imaging. The use of CBCT can improve visualization of pulpal anatomy by providing a more accurate three-dimensional representation of the tooth in question. The aim of this study was to evaluate the prevalence of untreated canals in endodontically treated teeth and their association with periapical lesions.

This study was conducted by obtaining 1160 CBCT scans from preexisting patient records from 8 different private dental clinics from several regions over a 12-month period from January-December 2018. The study was approved by the ethics commission at Faculdade de Medicina Dentaria, Universidade de Lisboa, Lisbon, Portugal. CBCT scanners from multiple manufacturers were used in producing the studied volumes, inclusion criteria required full arch images, and five independent observers were used in the assessment process. Tooth number and specific root, presence or absence of periapical pathology, and presence or absence of missed canals were all recorded. Periapical pathology was defined according to the CBCT periapical index score presented by Estrela et al.

From the total sample of 20,836 teeth, 2,305 endodontically treated maxillary or mandibular teeth were selected for further examination in order to determine the prevalence of periapical radiolucency and missed canals. The overall proportion of missed canals was 12.0%. The prevalence of missed canals was highest in maxillary first molars with 59.5%, followed by maxillary second molars with 40.0%, mandibular first molars with 11.2%, and mandibular second molars with 9.5%. The prevalence of periapical lesions in endodontically treated teeth with at least one missed canal was 82.6%. The root presenting with the highest percentage of missed canals was the mesiobuccal root of the maxillary first molar with 62.8%. This root was also associated with a periapical lesion 75.2% of the time if a canal was missed. The mesiobuccal root of the maxillary second molar presented a missed canal in 49% of cases, which was associated with a periapical lesion 68% of the time.

The present study found that endodontically treated teeth with missed canals were 4.4 times more likely of being associated with periapical lesions than endodontically treated teeth without missed canals. Thus, an untreated root canal should be considered as an important factor that may influence the continuation or development of posttreatment disease. Clinicians should be fully aware of tooth anatomy, root canal configurations, and possible variations before the start of root canal therapy procedures in order to minimize the possibility of missing canals during treatment.

Christina Martin, DMD; Resident in Endodontics; Virginia Commonwealth University

INVASIVE CERVICAL RESORPTION-DISTRIBUTION, POTENTIAL PREDISPOSING FACTORS, AND CLINICAL CHARACTERISTICS

Jeng PY, Lin LD, Chang SH, Lee YL, Wang CY. J Endod 2020;46(4):475-482.

Invasive cervical resorption (ICR) is a significant defect of the root surface where the hard dental tissues are undermined and become translucent due to the resorptive granulomatous tissue. This resorptive process is mainly detected on radiographs. ICR is a localized resorption process originating from the external cervical root surface. Cases of ICR have been noted after internal tooth bleaching. The effect of bleaching on periodontal tissue, dental tissue, and osteoclastic/odontoclastic cells has also been investigated. The mechanisms that trigger ICR are not entirely clear. Internal bleaching procedures have been improved in recent years; thus, ICR after bleaching in now rarely reported. Cases with prior bleaching accounted for only a low percentage of the total ICR cases. This indicates that the etiology of ICR is relatively complicated and requires further investigation.

The purpose of this study was to investigate the distribution, predisposing factors, and clinical characteristics of invasive cervical resorption. This study was approved by the Research Ethics Committee of National Taiwan University Hospital, Taipei City, Taiwan. Cases between July 2009 and June 2019 were collected at National Taiwan University Hospital. Patients over 10 years of age who were diagnosed with ICR by the visiting staff were included in the study. The affected tooth was required to have radiographs taken at different angulations to confirm the location and size of the lesion. All collected cases were screened by 1 endodontic master student and 2 board-certified endodontic specialists to confirm the presence of ICR. In cases of disagreement, the 3 observers reached a consensus through discussion.

Initially, 67 teeth were retrospectively diagnosed as being affected by ICR. Four teeth were excluded after screening by the 3 observers. Ultimately, 31 patients with a total of 63 ICR-affected teeth were included in the final analysis. An average of 2.03 teeth were affected by ICR per patient. Among the 31 patients, 45% were men and 55% women. No significant difference was found in sex distribution. The average age of the patient population was 45 years and the distribution among each age group showed a marginally significant difference. The majority of the patients displayed only one affected ICR tooth. The most commonly affected teeth were maxillary canines (21%) and central incisors (16%). Maxillary lateral incisors, maxillary first premolars, and mandibular first molars were equally affected (11%). This was followed by maxillary second premolars (9.5%), mandibular canines and maxillary first molars (each 4.7%), and mandibular second molars (3.2%).

The potential predisposing factors of ICR were categorized into 2 groups: a systemic condition and dental-related factors. Most patients denied all major systemic diseases. The most common dental-related factors were dental/orofacial trauma (33%), periodontal treatment (27%), restoration/crown (17%), and orthodontic treatment (16%). Previous studies have shown that 29% of ICR-affected teeth had a history of dental trauma. Most teeth showed no percussion/palpation pain, no probing depths >3mm, no abscess formation, no sinus tracts, and no periapical lesions. The pulp status was generally vital (73%). The presence of percussion pain and probing depths differed significantly among Heithersay ICR classification groups.

Maxillary anterior teeth were the most affected tooth type in the studied population. Traumatic injury, periodontal treatment, and orthodontic treatment were the significant predisposing factors. Furthermore, affected teeth typically lacked clinical signs and symptoms. Radiographic examination is critical for early diagnosis of ICR and regular radiographic follow-up should be performed for early detection of new ICR lesions in these patients. In more advanced cases, deep pockets and abscess formation were seen. The findings of this study may be helpful for the diagnosis of ICR and for developing further effective treatments.

Brian Hone, DDS; Resident in Endodontics, Virginia Commonwealth University

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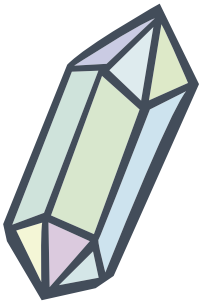


20 ORAL SURGERY "GEMS" LEARNED AFTER DENTAL SCHOOL

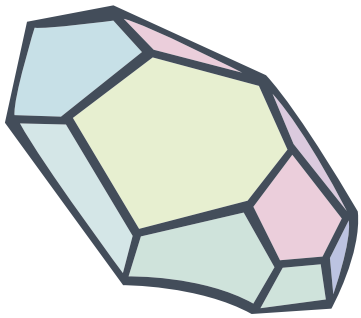
Harold G. Speer, Jr., D.D.S. and Grace E. Speer, D.D.S.

We received a first-rate dental education at the University of Tennessee Dental School in Memphis and graduated in 1981. Our exposure to oral surgery during our UT school years was extensive, and we felt very competent in this area upon graduation. Nevertheless, after we sold our general practices and bought practices dealing primarily with oral surgery and dentures, we learned a plethora of new "tricks" that make our oral surgery procedures much easier. As proponents of mentoring younger dentists, we'd like to take this opportunity to share these twenty "gems" for extracting teeth.

THE ORAL SURGEON IS STILL YOUR BEST FRIEND!

After struggling significantly during several extractions of impacted wisdom teeth early in our career, we attended a dental seminar where the Oral Surgeon lecturer stated that he spent seven minutes extracting each impacted wisdom tooth. We quickly realized that referring the patient to someone with this level of expertise benefited both the patients and us. Somewhat later, we had the opportunity to watch a young, talented Oral Surgeon extract impacted wisdom teeth, and he spent about three minutes (after anesthesia was obtained) extracting each tooth, including about three seconds to develop a flap and eight seconds for buccal bone removal with the surgical handpiece. While we may never reach this level of efficiency, it is helpful to know the maximum efficiency timeframes. Mentoring can provide all kinds of learning opportunities for a young dentist interested in improving his or her skills. We also had the opportunity to observe a gifted general dentist who had expertise in wisdom tooth extraction, and we learned that: a) the lingual nerve can be as close as 2 mm from the top of the lingual ridge around a lower wisdom tooth; b) the bone covering the occlusal surface of an impacted wisdom tooth can be so soft that it can be scraped away with a periosteal elevator; c) an uncovered impacted wisdom tooth can be quickly elevated by placing the tip of a Cryer elevator into a small hole drilled into the tooth; and d) an IM shot of prednisone in the buccinator muscle can relieve post-op pain.

Finally, we learned that observing procedures that you're never going to perform can be a wonderful opportunity to understand the parameters of oral surgery. During an externship program with the Oral Surgery department at the University of Tennessee in Knoxville, participating UTCHS students had the opportunity to observe an Oral Surgeon perform many procedures, such as maxillary Le Fort fracture repairs, mandibular sliding osteotomies, mandibular bone augmentation with harvested ribs, insertion of disc implants in orbital floors, and wire fixations of the maxilla, mandible, zygomatic arch, and orbital rim. Experiences like these increase the dentist's judgment in deciding when to refer to an Oral Surgeon. For example, many dentists would refer patients to Oral Surgeons for biopsy of suspicious lesions, management of conditions with sinus involvement, and management of uncontrolled bleeding.



ANESTHESIA IS YOUR FRIEND.

Our job is quicker and less stressful if we obtain good anesthesia because the patient is less likely to move, moan, or raise their hands into our working space. Our technique for lower teeth involves using a 30-gauge short needle for the Inferior Alveolar Nerve block with a carpule of 3% Mepivacaine (Carbocaine) plain without epinephrine first, followed by a carpule of 2% Lidocaine with 1:100,000 epinephrine. The smaller gauge short needle and the absence of epinephrine in the first carpule allows for a less painful injection. This anesthesia can be supplemented with buccal and lingual infiltrations of 4% Articaine (Septocaine) with 1:100,000 epinephrine (similar to a periodontal ligament injection), which works very well with so called "hot teeth." Our technique in the maxilla involves simple infiltration with 4% Septocaine with 1:100,000 epinephrine.

There are some additional "gems" concerning local anesthesia: a) frequently, patients have varied and extra innervation, which requires extra infiltration on the distal ridge of upper posterior teeth and in the distal retromolar pad area of lower wisdom teeth, b) intra-canal injection may also help in "hot teeth," or shattered teeth with exposed pulp tissue that is sensitive to the cold air and water produced by the surgical handpiece c) injection into the swollen collared gingiva in very mobile

periodontally involved teeth usually eliminates patients' complaints of pain d) the degree of divergence of the lateral angle of the ramus is also an important factor in successful inferior alveolar anesthesia and e) in full mouth extraction cases, it is imperative to keep in mind the maximum local anesthetic carpule limits based upon factors such as the patient's age, sex, and weight. For a 160-pound patient, the maximum limits are 11 carpules of 2% Lidocaine with 1:100,000 epinephrine, 7.5 carpules of 3% Mepivacaine (Carbocaine) plain, 8 carpules of 4% Articaine (Septocaine) with 1:100,000 epinephrine, 5.5 carpules of 4% Prilocaine (Citanest) plain, 10 carpules of .5% Bupivacaine (Marcaine) with 1:200,000 epinephrine.[1]

THE PATIENT'S TREATING PHYSICIAN IS ALSO YOUR FRIEND, AND A GOOD MEDICAL HISTORY CAN BE THE BEST INDICATOR FOR YOUR REFERRALS.

Our primary concerns involve bleeding complications, bisphosphonate use and the concomitant risk of osteonecrosis of the jaw (BRONJ), and immunity issues that could affect healing. So, we consult with treating physicians concerning bleeding issues. We find that most patients do well after having been taken off their blood thinners three to seven days prior to extraction procedures. Of course, some patients cannot be taken off Coumadin or Warfarin. We refer those patients to an Oral Surgeon for their extractions. We find that we can generally manage the extractions of patients who are still taking their Plavix, although we may perform the extractions over multiple visits, and we start slow with anterior teeth and evaluate the clotting process. As for BRONJ (bisphosphonate related osteonecrosis of the jaw), we make sure that the patient is adequately informed about potential complications before proceeding with treament. Finally, we find that patients who have been through chemotherapy or radiation treatment in the last year may have immunity issues that delay healing; therefore, we refer these patients to an Oral Surgeon for their extractions and post-op management.

ANTI-ANXIETY MEDICATIONS, SUCH AS XANAX, CAN BE YOUR FRIEND, ESPECIALLY IN YOUNGER PATIENTS.

We find that younger patients consistently overestimate their ability to tolerate a longer full mouth extraction procedure. They are still young enough to have the unrealistic expectation that life can be lived without experiencing any discomfort, and they tire easily towards the end of the procedure. We find that prescribing Xanax before the procedure and requiring a driver have made these visits more manageable for all concerned. We obtain a separate informed consent when we prescribe anti-anxiety medication.

PACKING THE THROAT WITH GAUZE IS THE BEST WAY TO PREVENT THE PATIENT FROM ASPIRATING A CROWN OR A PIECE OF TOOTH.

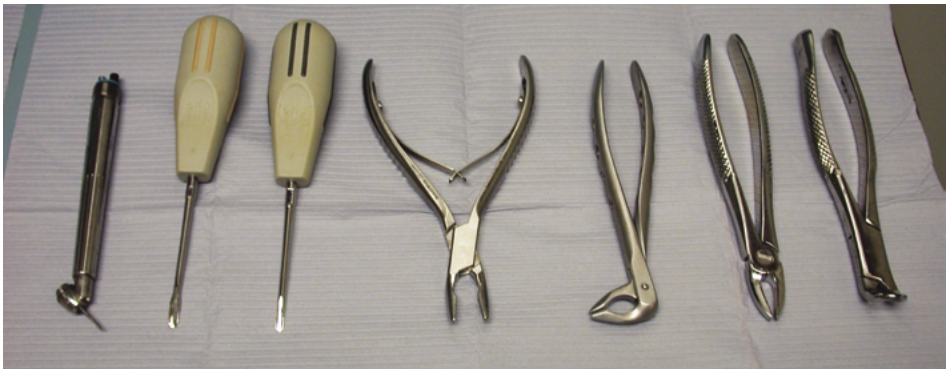
Crowns on teeth will often pop off in their entirety or in pieces during an extraction. Thus, having a gauze in the throat will prevent a lot of anxious moments and prevent the patient from aspirating dental fragments.

STARTING WITH THE UPPER ANTERIOR TEETH HAS HELPED US IN FULL MOUTH EXTRACTION CASES.

These teeth are generally extracted easier and quicker (unless you're dealing with a tooth that has lost its crown and post). You relieve the anxiety of the patient by extracting these teeth first and the patient is more likely to follow through to the end of the procedure. If you start with a complicated molar which requires additional time and sectioning, the patient might become apprehensive that each following extraction will require the same effort and time. Finally, bleeding is more easily controlled in the anterior region; if you start with a molar, you will be dealing with blood trickling down the patient's throat from the time of the first extraction – which can be a problem in a "gagger."

THE LUXATOR (DIRECTADENTAL OR JS DENTAL) IS ONE OF YOUR BEST FRIENDS.

A mentoring dentist recommended luxators to us. We use mostly a long 3 mm straight (L3S – Directa) or a long 5 mm straight (L5S – Directa). Their tips are thinner than elevators, and once you learn to ease the tip between the bone and the tooth and start twisting, they are amazingly effective in popping out teeth and root tips. They should not be used as elevators, with strong mesial-distal pressure, although you can exert some limited buccal and lingual pressure. Generic luxators may be cheaper, but, in our experience, their tips break easily. We frequently avoid flaps by using luxators with our sense of feel, especially in subgingival roots.[2] The picture below shows some of our basic armamentarium.



Basic armamentarium, mentioned in #7.

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THE 45-DEGREE ANGLE PALISADE DENTAL HANDPIECE CAN BE YOUR FRIEND.

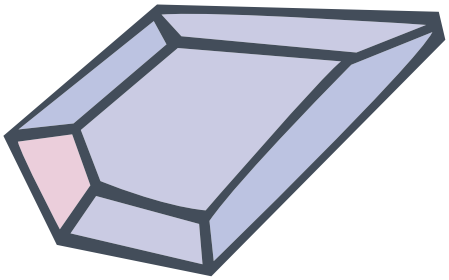
This handpiece is most frequently used to section upper and lower molars. It is also used to remove buccal bone on cuspids and place a small ½ to 1 mm trough between bone and a remaining root tip in order to get the luxator or root tip elevator initially inserted. We occasionally use this handpiece to cut a vertical line in crowns, in order to assist their removal. Use of this handpiece reduces the likelihood of air emphysema, since the air is propelled out the back of the handpiece.[3]

THE SURGICAL BONE FRICTION GRIP CARBIDE BUR 541A (HENRY SCHEIN ITEM 102-2417) IS DEFINITELY YOUR FRIEND.

Before another dentist recommended this bur to us, we occasionally broke 558 burs and were concerned about where the burs went. Since we couldn't be sure if the evacuation system had sucked them up, we tried to find them on x-rays. We have not broken any burs since we began using the surgical bone friction grip carbide bur 541A bur.[4]

THE # 1 ENGLISH PATTERN MAXILLARY ANTERIOR FORCEP WORKS GREAT.

Its head is square and provides a sure feel when placed on the tooth. The anterior tooth comes out easily with a twisting movement after apical pressure.



THE A. TITAN X-TRAC BIRD-BEAK LOWER ANTERIOR FORCEP (BENCO ITEM 4314-430) WORKS GREAT.

This forcep has extended beaks that can get lower on the tooth, thereby giving you more leverage and making easier an extraction to the buccal. We even use this forcep for lower bicuspids with a twisting movement, which results in less root tip breakage. We feel confident that we can remove any tooth with a forcep if we get 1 ½ to 2 mm of tooth structure on which to place the beaks of the forcep. This sometimes calls for removal of a small amount of lingual bone with the handpiece. Sometimes rongeurs or a serrated tipped forcep (150AS or 151AS) are necessary to get a firm grip on the 1 ½ to 2 mm of exposed root surface. Often, before we attempt extraction with the forcep, we place the luxator in a lingual trough and give it a twist, which causes the tooth to be displaced out of the socket towards the buccal.

USE OF THE LOWER COWHORN FORCEP (# 23) IS A FINE ART AND THIS FORCEP CAN ACCOMPLISH SECTIONING IN MANY INSTANCES.

A pumping motion with this forcep causes the tips to go lower and lower, and the tooth will come up out of the socket or will cause a badly decayed tooth to come out in sections. East-West Cryer elevators are great assists in certain lower molar cases to remove a small portion of interseptal bone and extrude the remaining root tip. We also use a pumping and figure eight motion when using the upper cowhorn forceps (# 88R and #88 L).

SMALL TIP EVACUATION TIPS, ROOT TIP ELEVATORS, AND THE DENTAL HANDPIECE ARE GREAT ASSISTS IN ROOT TIP EXTRACTION.

Our removal of small root tips is quicker if we can see a clear field. This is where the assistance by an experienced dental assistant comes in handy. Small root tip evacuation for just a fraction of a second clears the blood so that the doctor can see the line of separation between the tooth and bone, at which point the doctor will place the luxator, root tip elevator, or surgical bur. Special care should be taken in order to prevent pushing an upper root tip into a sinus. There are, of course, other ways to accomplish removal of a root tip or difficult tooth. We once observed an older Oral Surgeon who used a surgical mallet and chisel to make an insertion groove for his luxator on upper cuspids.

TWISTING AND FIGURE EIGHT MOVEMENT CAN BE BETTER THAN BUCCAL TO LINGUAL MOVEMENT.

We were taught in dental school to exert pressure buccally and lingually when extracting teeth. However, we've noted that much less breakage of root tips occur when twisting and a figure eight movement are utilized. Many times, you can feel which way the bone is expanding and then you can direct your force more in that direction. Lingual bony tori on lower bicuspids often prevent lingual expansion, thus, a twisting movement is even more important in that case. Occasionally, twisting movements "finish the job" on extraction of upper or lower molars. Also, don't be shy about using two hands on the forcep to assist your twisting movement, especially in upper cuspids.

LINGUAL PRESSURE CAN BE PREFERABLE ON UPPER PREMOLARS THAT ARE ENCASED IN VERY STRONG, NON-EXPANDING BUCCAL BONE.

Although the normal mode of extracting upper bicuspids involves pressure in a buccal direction, there are those cases when a lingual path may be preferable. In cases where the buccal bone is dense and non-expanding, we have many times had success by exerting lingual pressure and extracting the bicuspids in a lingual direction.

"Continuing education is a must, especially in the newer fields that go hand-in-hand with oral surgery, like implant dentistry, including their placement and removal."

ANTERIOR TEETH WORN GREATLY BY ATTRITION STAND A GOOD CHANCE TO BE CLINICALLY ANKYLOSED TO BONE.

One of the few instances when we use an elevator now involves anterior teeth that are worn by attrition. We usually find the bone surrounding these teeth dense and enlarged, as if the bruxism has increased the amount of bone around these teeth. Thus, we try to use elevators more, so that we don't have to use as much force with the forcep. Nevertheless, we find that the bone is clinically ankylosed to these teeth in many cases, necessitating the use of the bone file and rongeurs to smooth up the rough edges.

REMOVAL OF BRIDGES, CUSPIDS, AND ROOT CANAL TREATED TEETH CAN BE TRICKY.

Rarely, maybe once or twice a year, we need to completely cut off a bridge. Usually, applying pressure on each abutment separately will cause the crown to break free from one abutment tooth. Once it has broken free, the removal of the abutments is easy. If one crown won't break free, we cut a vertical slot in the buccal portion of the crown, and then we pry it off. As for root canal treated teeth, they are brittle and much more apt to break into pieces. Many times, we end up removing bone with a handpiece when extracting these teeth. Similarly, with cuspids, we may need to remove bone on the buccal, mesial, and distal, or in the full mouth extraction case, remove the adjoining teeth first then grip the forcep on the mesial and distal of the cuspid after removal of some interproximal bone.

GELFOAM, HELIPLUG, SUTURES, AND PATIENT'S BITING PRESSURE ON GAUZE OR A WET TEA BAG ARE GREAT ASSISTS TO CONTROL BLEEDING.

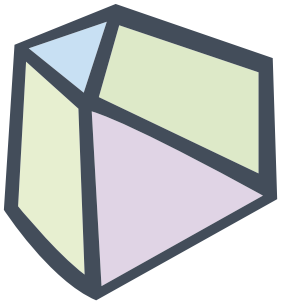
Early into our career we found that a significant number of our after-hour phone calls involved bleeding questions following extractions. So, we modified our post-op instructions to strongly stress an explanation of the clotting process, a discouragement against continuous spitting, and a direction to bite strongly on wet tea bags for thirty minutes when bleeding concerns arise. Tea has tannic acid, an aide to the clotting process. We also use Gelfoam, and more rarely, Heliplug, to assist clot formation when necessary. We use single interrupted 3-0 catgut sutures, or less frequently, a continuous horizontal mattress suture, when necessary to control bleeding. We frequently use these adjuncts to control bleeding on patients who have been on blood-thinners.

DRY SOCKET PASTE AND PERIDEX ARE FRIENDS FOR POST-OP COMPLICATIONS.

Occasionally, a patient will not form a good blood clot in the extraction socket, and a dry socket will result. Studies have shown that dry sockets are more common in the mandibular third molars, in smokers, and in women.[5] We have found that placing a small amount of dry socket paste (Alvogyl from Septodont) in the socket (without using local anesthetic) usually helps relieve the patient's pain. We have also found Peridex (chlorhexidine gluconate) to be a good aide to healing, especially with the pesky mandibular molar lingual dehiscence.

APPROPRIATE POST-OP MEDICATION CAN PREVENT ADDICTION ISSUES.

The dentist's choice of pain medication to prescribe has really narrowed down in the last few years. Mepergan Fortis and Darvocet are two drugs that are no longer produced. Thus, Hydrocodone and Oxycodone are two of the dentist's most frequently prescribed drugs for pain management. However, these drugs have high addiction potentials. Most states require that the prescribing dentist run a drug screen for patients to whom they are prescribing a narcotic pain medication. This has cut down on both over-prescribing by doctors and doctor shopping by drug addicts. Toradol is an alternative in those patients who are allergic to Hydrocodone or Oxycodone. However, Toradol carries gastro-intestinal bleeding risks and it is limited to short term use (five days) by a Black-box warning.[6]



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FINAL REMARKS

A dentist should always remain open to learning new things, regardless of his or her years of experience. As you can tell, we have always been willing to observe other dentists with more expertise. Continuing education is a must, especially in the newer fields that go hand-in-hand with oral surgery, like implant dentistry, including their placement and removal. Keeping abreast of technological advancements, such as, computerized tomography and the use of loupes with lights, is a must. We hope that you can use these "gems" to make your oral surgery quicker and more efficient.

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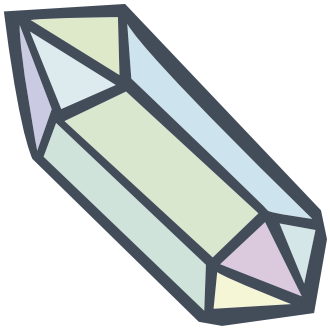
ABOUT THE AUTHORS

Harold Glenn Speer, Jr., D.D.S., F.A.G.D., J.D. and Grace Elizabeth Speer, D.D.S., J.D. graduated from the school of dentistry at the University of Tennessee Center for the Health Sciences in Memphis, in June 1981. They both obtained their Juris Doctor degree at the University of Memphis Law School in 1987. They have been married for 39 years and have practiced dentistry and law in middle and west Tennessee.



AWARD NOMINATIONS

The Board of Directors Awards Subcommittee selects recipients for VDA awards which are presented at the Governance Meeting in September. In order to select those who are most deserving of these honors, we would like to ask for your help in identifying potential recipients. Nominations for awards may be made by individual members of the VDA or by components. Please go to **https://www.vadental.org/about-us/member-team-recognition** and submit your nomination by July 1, 2021.

Nominations are accepted for the following awards (more information on website)

- **Dental Team Member Award**
- **New Dentist Award**
- **Special Service Award**

DENTAL DETECTIVE SERIES - WELLNESS

WORD SEARCH

Dr. Zaneta Hamlin

G T K K G M S M N Y K A W W M D D K F S E V S L H Z D Y O S
T S M W W N T J A T O X J A P T E E S D O C W I C P T Y E K
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ACCESS
ACCOUNTABILITY
ALTRUISM
AUTONOMY
BENEFICENCE
CODE
COMMUNITY
COMPASSION
COMPETENCE
CRITERIA
DECISION
EMPATHY
ETHICS
EXPERTISE
FICTICIOUS
INTEGRITY
INTENT
LICENSURE
LIFELONG
NARRATIVE
OBLIGATION
PLEAD
PRESTIGE
PRINCIPLE
PROFESSIONAL
REFLECTION
RESPECT
RESPONSIBILITY
STANDARD
TANGIBLE
UNIQUE
VERACITY

>> ANSWERS ON PAGE 56

CYBER ATTACKS:

PREVENTION MAY BE THE CURE FOR RANSOMWARE

Robert McDermott; President/CEO, iCoreConnect

Just as you wash your hands regularly so you don't get sick, it's critical to adopt good habits of 'digital hygiene' to prevent cyber attacks on your practice. The 'illness' threatening your practice is called malware. Malware is an umbrella term for any malicious software criminals use to steal your or your patients' data.

Ransomware, a particularly sinister malware, burrows into your system and begins encrypting all your data so you can't access it. Then a cybercriminal holds your data for ransom, demanding you pay a large sum of money, often ranging from $300,000 to more than $1 million, before they will give you access to your own files.[1] Attacks skyrocketed in 2020, with one research group estimating the total cost to healthcare providers at nearly $21 billion. The number of compromised patient records in the 2020 attacks totaled nearly 18 million.[2]

"Just like a human virus can lie undetected, malware can be in your computer system long before you realize it. By the time you see the symptoms, it's too late."

Just like a human virus can lie undetected, malware can be in your computer system long before you realize it. By the time you see symptoms, it's too late. Cyber criminals are continually developing sophisticated methods for infecting computers and servers without you catching on. Let's look at the two primary ways malware gets into your system and how to prevent these attacks from infecting your practice.

Hacking

If you're old enough to remember the 1983 movie, WarGames, then you might imagine hackers as unsuspecting teenage whiz kids finding 'backdoors' into computer systems, sparking an unintended world war. Unfortunately, hackers today are sophisticated and keenly aware that they are in a booming, billion-dollar business.

Hackers secretly tap into your data by exploiting weaknesses in your IT security. Outdated, unmaintained systems often make smaller, older practices particularly easy targets. For example, if your practice is still running on Windows XP or an older version of Windows, you are at greater risk of attack. Microsoft no longer provides security updates for those older versions, making them susceptible to hacking.

Do you occasionally check emails from the coffee shop on Friday using your work laptop? If the Wi-Fi network doesn't require a password, it's an open door to all the files on your computer. Look for the padlock icon in the web browser address bar to see if you are connected to a secure network. You're better off treating public Wi-Fi security with a healthy dose of skepticism. Avoid entering your practice login, passwords etc. while on an unsecure public Wi-Fi network.

Working with a proactive team of IT experts, known as Managed IT Services Providers or MSP, is an important layer of defense against attacks. These folks can save you money, time and headaches over the long run. They detect threats early to eliminate or reduce damage well before it gets out of hand.

Phishing

Email is often a particular vulnerability. Phishing occurs when a criminal tricks people into thinking an email comes from a trustworthy source, then convinces them to click a corrupt link or provide sensitive information directly (like a credit card number or password).

Use only a fully HIPAA-compliant, cloud-based email system that protects your information whether it's sitting in your inbox or sending to another doctor's inbox. There are big differences between an encryption-only email for general security and a truly HIPAA-compliant, protected email that fulfills every HIPAA security requirement. These requirements range from verifying recipient identity to making sure no email is altered.

For your Gmail, Hotmail, Yahoo, or other non-secure email accounts, awareness is key for doctors and staff. The most common phishing ploy is known as 'deceptive phishing'. You might receive an email that comes from a company or person with whom you are familiar. The fraudulent sender will often use a sense of urgency to get you to click on an attachment or link, or to call a number. They are looking to steal personal data, login credentials or otherwise access the business server. If the sender is unknown, claims to be your IT person, or someone in your office, yet asks you to click an unusual link or take a secure action, verify the email first with the actual person on your team.

Attackers are preying on a lack of awareness on the part of you or a staff member. No one is immune, but we can

be one step ahead. Educate your whole team to recognize suspicious messages, links and other weak spots, to avoid falling victim. Ongoing security awareness training for everyone in your practice will help keep you all on top of the latest scams and vulnerabilities within your systems.

Take Steps

Act now by working with a qualified dental IT services provider to assess, boost and maintain your IT immune system. They can work directly with your team to understand what to look for and how to prevent these types of criminals from getting in the door. Healing from an attack is much more difficult and costly than preventing it in the first place.

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DR. CLARA M. SPATAFORE NAMED INTERIM DEAN OF THE VCU SCHOOL OF DENTISTRY

Clara M. Spatafore, D.D.S., M.S., has been named interim dean of the Virginia Commonwealth University School of Dentistry.

As the current chair of the VCU School of Dentistry's Department of Endodontics and Oral Diagnostic Sciences, Dr. Spatafore comes to her new role with experience as an oral health and dental education insider.

"Dr. Spatafore is highly qualified to lead the school at this pivotal moment in its history," says Arthur Kellermann, M.D., professor and senior vice president for VCU Health Sciences and CEO of VCU Health System. "For more than three decades, she has been an active member of the American Association of Endodontics and has held a variety of leadership roles with the organization's board including President. She is a Diplomate of the American Board of Endodontics and has served on multiple committees. Currently she is a director on the American Board of Endodontists and is on the Journal of Endodontics Scientific Review Board.

In addition to her national leadership within the endodontics specialty, Dr. Spatafore is a member of numerous dental associations representing local, state, and national interests. She lectures nationally and internationally on all facets of dentistry.

As interim dean, Kellermann says, Dr. Spatafore is fully empowered to exercise the office's authorities and responsibilities in support of the VCU School of Dentistry's students, staff, and faculty, and to advance the school's strong education, research, and clinical service programs.

A native of Clarksburg, West Virginia, Clara Spatafore earned an undergraduate degree in medical technology and her D.D.S. from West Virginia University. After three years in general dentistry private practice in Pittsburgh, Pennsylvania, she returned to West Virginia University to earn a master's in Endodontics.

"Nothing could make me happier than to lead the VCU School of Dentistry into an integrative future of collaborative care for our students, faculty, staff and, of course, our patients," Spatafore says. "It is truly an honor to serve the dental school in this manner."

Before becoming chair of the Department of Endodontics, Dr. Spatafore was in private practice in the specialty of Endodontics for 25 years after serving in the United States Navy as an endodontist. She left the Navy at the rank of Lt. Commander. She and her husband Philip Bartling have four children.

Dr. Spatafore replaces David C. Sarrett, D.M.D, who announced his return to the school's full-time faculty and clinical practice on Jan. 27. Sarrett will continue to serve as associate vice president for Health Sciences, Faculty Affairs, a position he has held since 2003.

Editor's Note: Press released from the VCU School of Dentistry.

Dr. Clara M. Spatafore

VCU School of Dentistry

THE BLIND SIDE

Vanessa Sturz, Associate Editor; Class of 2022, VCU School of Dentistry

Much like we adjusted to practice changes dictated by COVID-19, we face the surprising and large-scale changes that are still fresh in the halls and clinics of VCU School of Dentistry community. Unfortunately, with the School of Dentistry not moving into the new outpatient building, we will not be sharing a space with medicine teams. We are also no longer moving to the EPIC dental platform, so we are not sharing a virtual space. As a student body, we wait for the dust to settle and let the new administration find its footing, and we can't help but feel like pawns in some sort of power struggle. Throughout all the changes and disappointments, the students remain vigilant and focused on the goals of graduation and matriculation.

In all the change and chaos, I sat back and wondered, who is protecting the school's blind side? Once I am in practice, who will protect mine? Dr. Clara Spatafore, the interim Dean, recently sent out a schoolwide email that asked of the faculty, staff and students, "If you see something, say something." As a practice owner, you may have measures in place to protect your blind side. Do you have an open communication policy with your team and take a similar approach of "If you see something, say something?" During times of chaos, confusion, and disappointments, how do you protect your blind side? It is easy to pay attention to the things like a pandemic and changes in leadership only to ignore other housekeeping items that could cause more of an unexpected, and greater, issue. One item that I came upon during a treatment planning course was from research on interproximal contact loss (ICL) between single unit implant crown and natural tooth. The big-ticket items mentioned in the research included:[1-4]

"As a student body, we wait for the dust to settle and let the new administration find its footing, and we can't help but feel like pawns in some sort of power struggle."

1. 33%-66% of single unit implant crowns lost interproximal contact,
2. Some studies showed as much as 78%+ of the ICL occurs on the mesial
3. ICL has been shown to appear 3 months following crown placement; however, it occurred more often in implant crowns that were placed 5-10 years ago.
4. Maxillary molar implant crowns seemed to have the biggest risk of interproximal contact loss, while premolar implant crowns in both arches seem to fair better.
5. Over 40% of the time the patients are aware of ICL and food impaction
6. The concerns are
   - a) increased prevalence of interproximal decay
   - b) increased clinical attachment loss (CAL) and probing depths on the natural tooth
   - c) potential unexpected costs to patient included replacement of implant crown and/or composite
7. While the causes are not entirely known, it has been hypothesized that increased Frankfort mandibular plane angle, craniofacial growth into adulthood, and occlusal forces are all possible contributing factors.

After evaluating the literature, I read through our implant crown consent forms and realized that they did not include verbiage of this most recent (publications beginning in 2016) and widely known issue that can develop with implant crowns. I brought this to department chair's attention. The next round of consent updates will include language regarding these risks.

An article published in 2014 in The Journal of Family Medicine Primary Care, addressed consents (most important, written and signed), uses and importance as they should be viewed as a preventive mechanism that could potentially save a practitioner trips to the courtroom.[5] Consents

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should be reviewed and updated yearly to ensure they remain in accordance with changing laws and practices.

So, as you finish reading this article, ask yourself, “Do I foster an office environment where my staff members are proactive and feel comfortable to speak up and protect my blind side, and am I listening?”

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DID YOU KNOW?

A SERIES FROM THE VIRGINIA BOARD OF DENTISTRY

Knowing Signs of Abuse and Neglect

Did you know that a dentist is responsible for conducting his practice in a manner that safeguards the safety, health, and welfare of his patients and the public by knowing the signs of abuse and neglect and reporting suspected cases to the proper authorities consistent with state law?

18VAC60-21-60 (A) (6) of the Regulations Governing the Practice of Dentistry

Financial Responsibilities

Did you know that a dentist is responsible for conducting his financial responsibilities to patients and third party payers in an ethical and honest manner by making a full and fair disclosure to his patient of any financial incentives he received for promoting or selling products?

18VAC60-21-60 (B) (4) of the Regulations Governing the Practice of Dentistry

Retention of Advertising

Did you know that a prerecorded or archived copy of all advertisements shall be retained for a two-year period following the final appearance of the advertisement? The advertising dentist is responsible for making prerecorded or archived copies of the advertisement available to the board within five days following a request by the board.

18VAC60-21-80 (D) of the Regulations Governing the Practice of Dentistry

Minimal Sedation Equipment Requirements

Did you know that a dentist who utilizes minimal sedation or who directs the administration by another licensed health professional shall maintain the following equipment in working order and immediately available to the areas where patients will be sedated and treated and will recover: Blood pressure monitoring equipment, source of delivery of oxygen under controlled positive pressure, mechanical (hand) respiratory bag, suction apparatus, and pulse oximeter?

18VAC60-21-280 (D) (1-5) of the Regulations Governing the Practice of Dentistry

VIRGINIA BOARD OF DENTISTRY NOTES

MARCH 19, 2021

Ursula Klostermyer, DDS, PhD

This meeting was held in a virtual setting.

Dr. Dag Zapatero was welcomed as a new board member by Dr. Augustus Petticolas.

Public comments:
Trey Laurence, Vice President for Advocacy and General Counsel of the American Association of Orthodontists handed in a written comment on behalf of the American Association of Orthodontists, American Academy of Pediatric Dentists, and the American Association of Oral and Maxillofacial Surgeons to express concerns regarding the new for-profit corporate sponsorships instituted by the American Association of Dental Boards (AADB) and the potential conflicts of interest these appear to have created.

Kannan Ramar MD, President of the American Association of Sleep Medicine (AASM), expressed his concerns regarding a recently published position issued by the American Academy of Dental Sleep Medicine (AADSM). This statement encourages the use of home sleep apnea tests by dentists for the diagnosis of obstructive sleep apnea. He argues that ordering, administering and the interpreting home sleep apnea tests is outside the scope of practice for dentists, and requests that the BOD protect both patients and dentists in Virginia by adopting a policy to clarify this fact.

In a live comment, Jessica Bui, Executive Director of the Southern Regional Testing Agency (SRTA), reassured the BOD that the SRTA is currently still administering dental and dental hygiene examinations and operating as usual. There was a motion to only accept the ADEX exams for dental and dental hygiene qualification. This was approved by the exam committee members. Based on the information provided by SRTA, these exams do meet the requirements for licensure in Virginia. SRTA continues to provide a comprehensive and conjunctive scoring methodology for both the dental and dental hygiene clinical exams. They use the same manikin manufacturer and model for teeth and hygiene testing as ADEX. If this motion were to pass, it could potentially cause issues for prospective applicants to obtain a license within Virginia, especially with an SRTA exam taken out of state. SRTA continues to administer examinations in Tennessee and West Virginia. Although VCU students take the ADEX exam, SRTA would like to encourage the BOD to reconsider and continue accepting the SRTA examinations.

Brett Seigel, VCU ASDA President Elect, addressed the concern and the negative impact of using human subjects in clinical licensing examinations by candidates seeking a dental license, which the ASDA is convinced is flawed and unethical. The ASDA would support alternatives to the current process of using human subjects.

Dr. Thomas Walker, the SRTA president, commented briefly that competition amongst testing agencies is preferable and that students should be able to decide their test medium.

Dr. Bruce Horn commented regarding the Western Regional Examining Board, WREB, examination records and that they should be accepted for licensure in Virginia. Incoming licensees that come from other schools, especially the ones with more military presence, could fall under hardship including their military spouses. Dr. Horn requests that candidates who use the WREB exam be permitted to come to Virginia with those results.

Dr. Jack Beeregg, the General Council of WREB, discussed the possible non-acceptance of WREB exams. He kindly asked the BOD for a meeting to discuss the scoring system and the equality of the WREB exam, and compare it to the ADEX exam. He as well stated the difficulty for especially military personnel, being first licensed in Texas and California, to obtain licensure.

Dr. Erika Mason asked the Board to consider revoking dentist's permission to prescribe home sleep tests. The letter, which was sent out by the AADSM, did not clearly state that home tests might not always provide an accurate result. Dentists might not be qualified to diagnose OSA home tests. Home sleep tests should be diagnosed by a licensed sleep physician. The use of the test should be focused on the patient and the patient's well-being. Further assessment is necessary before regulations can be proposed.

Dr. Alexander Vaughan of 'Virginia Total Sleep' states that the letter written by the AADSM is not clear in the interpretation of home testing and that medical sleep medicine should not restrict the Academy of Dental Sleep Medicine.

Approval of Minutes:
The minutes of the meetings in December 11, 2020, January 7, 2021 and February 26, 2021 were accepted.

Dr. David Brown, Director of the Department of Health Professions, reported that Virginia got a "pushback" regarding the legalization of marijuana. A new legal agency to control recreational and medical marijuana should be created. Therefore, Virginia might become the first Southern state to legalize marijuana. Communities of color will benefit from the business aspects of legalization. While marijuana remains illegal, arrests for possession and use continue.

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WHAT INVESTORS TEND TO GET WRONG ABOUT RISK

Jimmy Pickert, CFA®, CFP®, CRPS®; Portfolio Manager

How much risk are you taking with your investment portfolio? This is arguably the most important financial question to ask, yet many investors tend not to know. Even if you think you know—perhaps based on how much stock market exposure you have—chances are that you, too, are not completely answering the question. The concept of risk in our financial lives need not be complicated, but it is multi-faceted. This article aims to provide investors with a better framework through which to assess how much risk they're actually taking.

The first misconception to address is the risk of permanent versus temporary loss. Examples of permanent loss are illustrated by a gambling scenario. If you walk up to a roulette wheel and put all your chips on red, you are risking the permanent loss of that money in the event the ball lands on black or green (a 52.6% probability). By contrast, investing usually involves temporary losses. If you buy 100 shares of a company's stock and that stock subsequently declines in price, you don't realize (make permanent) that loss unless you decide to sell the shares. This is not to suggest your stock won't fall to $0 per share or that it will necessarily recover to a level above where you bought it; this is why it's important to diversify your portfolio with many types of investments. Practically speaking, history has demonstrated that a diversified portfolio does not experience permanent loss unless the investor sells their investments at a loss.

Having made the distinction between permanent and temporary loss, managing the risk of temporary loss in one's portfolio is still a critical exercise for every investor. You may be comfortable with the notion of your portfolio temporarily losing 40% of its value in a severe bear market, but if you are currently retired, about to retire, or have some imminent need for money from your portfolio, you may have no choice but to sell some of your investments at a loss in order to generate liquidity. Because of this possibility, the amount of temporary loss you should be willing to risk (most commonly described as volatility and measured in terms of standard deviation) is primarily influenced by your portfolio's time horizon. The longer until you'll need money from your portfolio, the longer your time horizon. It can be helpful for investors to segregate their portfolio by various goals; perhaps the time horizon for your retirement accounts is longer than the time horizon for your savings account, which you plan to use to in the near future for a down payment on a house. Just as the time horizons vary, the amount of risk taken for each goal should likely be different.

The above may be obvious to some, but there are other misconceptions of financial risk even more insidious. Too often investors implement a hyper-aggressive portfolio strategy during their career, followed by a hyper-conservative portfolio during their retirement. This approach gets the concept of risk and time horizon right in broad strokes, but its lack of nuance fails to address other sources of financial risk: inflation risk, interest rate risk, and longevity risk.

Inflation risk should be a consideration of every investor, but particularly for those who are in or near retirement. While inflation has been largely muted during the past several years there is no guarantee it will remain so. Even if it remains at approximately 1.6% per year (the average over the past decade, based on Core Consumer Price Index data), that means the cost of living in 30 years will still be 60% higher than it is today. Thus, a recently retired investor may feel confident having reduced his or her portfolio's risk downward, only to

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be unknowingly subjecting themselves to a much higher degree of inflation risk. It is critical for investors to include investments in their portfolio that hedge inflation, such as stocks, real estate, and commodities. While this inclusion may increase a portfolio's risk of temporary loss, it will reduce the risk posed by inflation.

"There is much more to one's financial risk than just the volatility of portfolio investments. The goal of the investor should be to find the right balance between the various sources of risk."

Interest rate and inflation risk are closely connected due to the interest rate movement. Longer-dated bonds that mature several years from now are primarily influenced by inflation, and as inflation increases (or the expectation of inflation), so do long-term interest rates. Because the price of a bond is inversely correlated with interest rate movements, this poses a problem for bond investors. In 2020 the interest rate on the 10-Year Treasury Bond fell from 1.91% to 0.92% (falling as low as 0.32% during the early stages of the COVID-19 crisis), and bond investors benefited: the main bond index, the Bloomberg Barclays Aggregate Bond Index, gained 7.51% for the year.

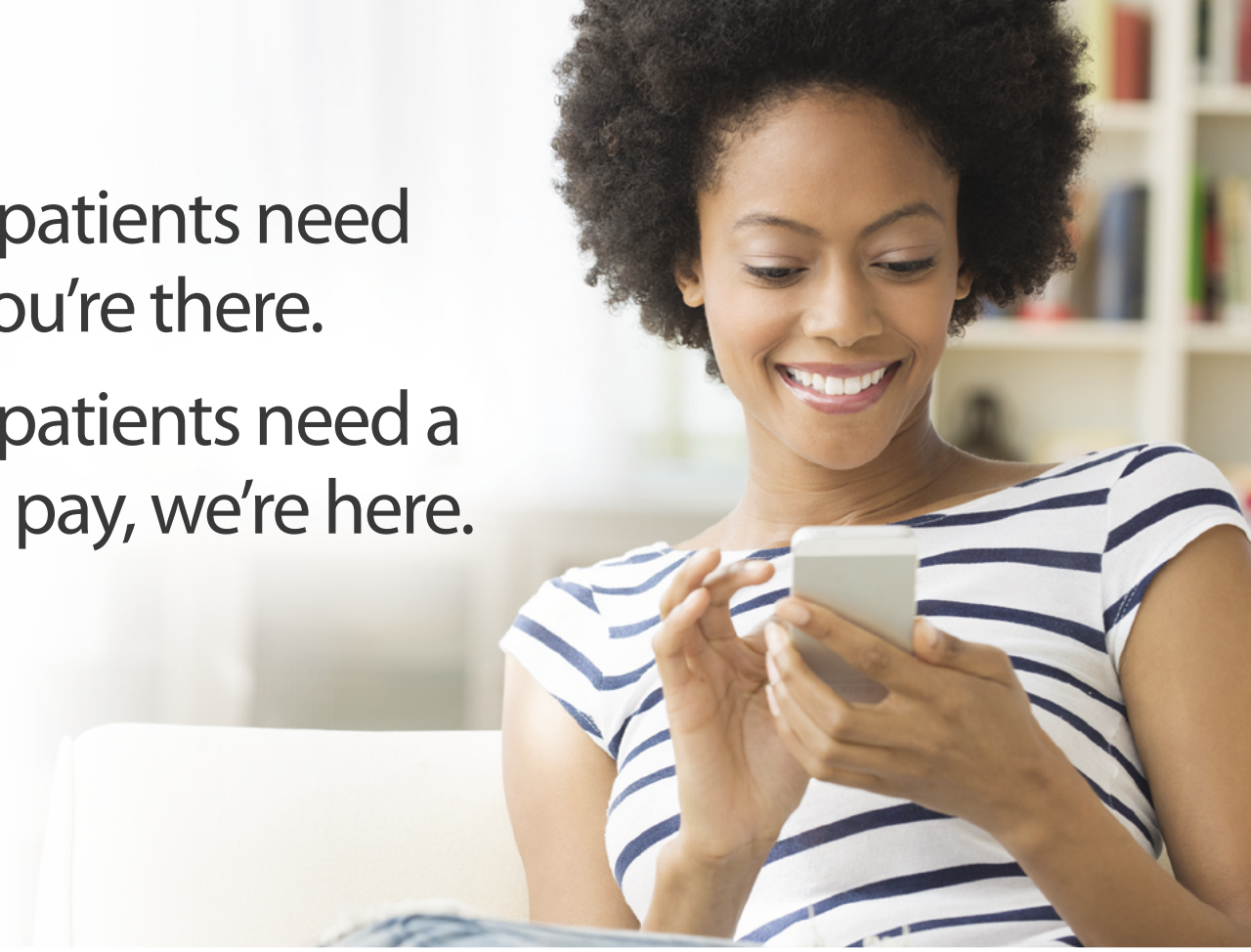
Conversely, the yield on the 10-Year Treasury Bond has risen to 1.45% during the first two months of 2021, and that same bond index has lost 2.15% over the same time frame. An investor who believes he has limited his portfolio risk by shifting all his stocks into bonds may be surprised at the impact of rising interest rates.

Lastly, the threat of longevity risk is often overlooked by investors. Should you live longer than expected, and neglect to plan and invest appropriately, you may become a financial burden to others at the end of your life. Similar to inflation and interest rate risk, this too can be mitigated by including growth-oriented investments into your portfolio. While this may increase your portfolio's risk, it should help reduce the possibility of you outliving your assets.

There is much more to one's financial risk than just the volatility of portfolio investments. The goal of the investor should be to find the right balance between those various sources of risk described above. This exercise involves making well-informed tradeoffs and should be approached as scientifically as possible with the use of statistically-based financial planning tools, a disciplined investment strategy, and a trusted financial advisor.

When patients need care, you're there.

When patients need a way to pay, we're here.



As patients come in for preventive care and needed dentistry, many may be more cost conscious. Being able to pay over time with the CareCredit credit card may make it easier for them to move forward with recommended care.

Contactless Applications and Online Payments

By sharing your Custom Link, your patients can use their own device to learn about and apply for the CareCredit credit card — eliminating the need to pass a paper application or a credit card back and forth. If approved, your patient can use their card immediately.

Download your Custom Link at **www.carecredit.com/mycustomlink.**

Already accept CareCredit?
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VADJ2021DA

ETHICS: FOUNDATION OF A PROFESSION

Dr. William J. Bennett

Wikipedia defines a profession as "an occupation founded upon specialized educational training, the purpose of which is to supply disinterested objective counsel and services to others for a direct and definite compensation, wholly apart from expectation of other business gain". Professionals undergo prolonged training, formal qualification and adhere to legal and ethical standards. Legal standards have varied over time, but basic ethical standards remain. Ethical behavior is the cornerstone and foundation of all honorable professions.

"Dentistry has gained much public trust. It takes courage and commitment from all members of the dental profession to maintain this high level, no matter the working environment."

As professional dental health care providers and members of the American Dental Association, pride should be taken that the ADA's Principles of Ethics and Code of Professional Conduct are widely regarded as the world's Gold Standard. Great strides have taken place to move dental care from a barbershop or blacksmith's barn to a respected healthcare profession. It has taken leaders with courage and integrity and dental care providers holding to ethics as their moral philosophy. To maintain ethical standards over time is not just a personal commitment of what you do but is also what professionals do as a whole.

Ethical behavior is critical to being a professional and a respected profession. Ethical behavior is basically what is morally right or wrong – good or bad. It also involves Honesty, Integrity, Empathy, Compassion, Attentiveness, Respect, Selflessness, and Loyalty. As a dental health care provider ethics that also requires Objectivity, Fairness, Concern for others, Confidentiality, Value sensitivity, Effectiveness, Fidelity, Trustworthiness, Competency and Responsibility to the profession as a whole.

The public should be assured and trust that a profession is properly regulated. Dentistry has gained and generally holds much public trust. It takes courage and commitment from all members of the dental profession to maintain this high level, no matter the working environment.

Doctors who have practiced for a period of time know that dental practice laws and regulations have changed. For example, more specialized providers now exist, acceptable promotional activity has been enlarged, acceptable locations for a practice have expanded, and more auxiliaries and advanced procedures are available. Also, there is managed care, as well as insurance and corporate ownership.

Professional behavioral norms may evolve as dental practice changes. To do so while maintaining fundamental professional ethical standards requires everyone to agree to the goals of the profession and adhere to acceptable behavior. A part of this is taking a courageous position regarding improper professional behavior. To disregard this aspect is not beneficial to the public or the profession. Often a colleague is simply unaware any issue exists.

The VDA has gained a national reputation and awards from the ADA for properly addressing ethical concerns. If you wish information or advice each component has an ethics representative or contact the VDA office directly. The VDA does not desire our members, or any dental professional, to have to address the Board of Dentistry. It does not enhance the dental profession for that to occur.

Ethics is an interesting topic with abundant literature and positions. Internet searches can provide you hours of learning while at home due to the pandemic. Of course, the ADA (**www.ada.org**) has information on Ethics and professional behavior. The American College of Dentists (ACD) is dedicated to Ethics in Dentistry (**www.dentalethics.org**). The ACD has courses available to anyone on ethics and CE credits can be obtained. A web search can uncover more ethics information.

As ADA members we have agreed to abide by the ADA standards. Those standards are enforced, if necessary. Laws do change but basic ethical guidelines and behavior should remain constant. The public expects and the law demands a certain level of conduct. Should we not promote the ADA and our practices for our high level of ethical commitment? Should we not educate our patients, our staffs, and ourselves on the values and need for ethical behavior? Being an ADA member exhibits your firm commitment to ethics for yourself, your patients and the dental profession. Have pride in your commitment for ethical standards and mentor others in the benefits to patients and dentistry.

EVERYONE HAS A RISK NUMBER. **WHAT'S YOURS?**

TAKE THE GUESSWORK OUT OF YOUR FINANCIAL FUTURE.

Use ACG's Riskalyze Quiz to pinpoint your
ideal level of investment risk and reward.

Take the 5-minute questionnaire by
scanning the QR code below.

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HOW SOCIAL ARE YOU?

Theresa Stenger; Marketing Director, Leadership by Design

In its most basic form, social media fuels an innate human desire to connect with others; to build relationships; be part of a community.

Social media is like the digital "front porch" of your business. Think of it as a welcoming place for people to gather and converse in plain sight while others walk by. As "neighbors" pass by, they get curious about what's going on, realize that there's something interesting and eventually get drawn onto the porch to get to know their neighbors – your social media community.

When implemented at its best, the right social media mix can deliver multiple benefits for a dental practice – from relationship-building and connection, elevating brand awareness, increasing scheduled appointments, fostering referrals, attracting new patients, and giving back to the community you're serving.

Facebook

Facebook attracts a large segment of your community and features finely tuned targeting technology. Your Facebook community takes notice of the information you share because it is coming from a trusted source. If your practice is active in the community – such as visiting schools to educate children on dental health or hosting events like community food drives – Facebook is a great platform to get your business in front of individuals connected with those schools and non-profits you are supporting.

Facebook is also an ideal place to highlight special occasions, health awareness campaigns, fun contests, community fundraisers, and giveaways. A strategic content library that's developed and includes team photos often yield the most engagement and can go a long way in creating that fun, welcoming "front porch" experience.

When used to reach new, targeted audiences, Facebook advertising can be highly effective with ads running across a wide range of digital platforms. Paid advertising has a low cost per click rate and gives your practice a powerful means to provide the right message to the right audience at the right time. This type of strategy equals high conversion.

Instagram

A growing number of people are finding (and purchasing) new products and services on Instagram. If you already have a Facebook page, adding Instagram to your social media strategy can be easy and provides an added point of connection. Keep in mind that visual content and hashtags are key for capturing interest and engagement on Instagram. If you have a dramatic before-and-after case to showcase, wonderful! Keep HIPAA in mind, though, and get all necessary permissions in place before sharing any patient information. The best scenario is when patients are so excited about their smile makeover, they can't wait to share the big reveal across their own social media networks. So, listen carefully for if and when a patient says, "Wow, I can't wait to show-off my new smile!" and have your (simple) release form ready.

Twitter

Twitter may not seem like a natural fit, but it works well for sharing quick, focused communications to a large audience. Short messages of up to 140 characters can be broadcast in seconds through tweets. If you have a blog page with

monthly articles, Twitter can be a good place to point potential patients to your articles (and website!).

YouTube

Video marketing can be a powerful tool to attract new patients and is great for telling your story. You can use YouTube to post videos or take it a step further by presenting a steady stream of quality high value content. A behind-the-scenes office tour can give prospects an insight into how well you and your team care for your patients. A "Meet the Team" video can help people get to know the doctors on a personal level - and even encourage greater connection if viewers find they share similar interests or hobbies. Short video testimonials from happy patients often provide the most powerful video content and yield some of the most impressive ROI in the healthcare and dental industries.

News or Blog Website Page

While a blog or news page on your website is not considered an actual social media platform, it is an important aspect of your social media strategy. Articles on your website generate cross traffic between your website and social sites. Adding a blog is inexpensive and as long as the information is informative and interesting, it only adds value to your marketing efforts.

Content quality and consistency

Social media for businesses is not something that can or should be left to chance. It is an important tool to be developed strategically like any other system designed to support business growth. If weeks or months go by without a quality post, then how do you think this "inattentive" page will reflect on your business? Commit to an annual plan or quarterly strategy at minimum so you can streamline the process. This also allows time to develop the relevant messages and campaigns based on established needs and goals. In terms of communication "style", social media calls for a more personal friendly tone, conversational in nature. Posts are not meant to talk AT the audience, but to talk WITH them.

Maintain brand consistency across all your social platforms. Use your dental practice logo when appropriate, incorporate your fonts and colors, and remember that the social experience should mirror (to some extent) the in-office experience. Having recognizable colors, fonts, and visuals simply enhance the digital and in-person experiences. Quality and consistency communicate comfort and trust.

How do I get started on social media?

While the dentist and team members have a collaborative role, the DIY approach is not the most effective way to utilize social media marketing. This strategy requires your initial time to identify the right partner, develop a budget, and discuss needs, goals, and even vision. But, once your social media partner and plans are in place, the primary role of a dentist is oversight – allocating time to review quarterly initiatives and the professionally created content calendar that is specifically designed for your practice.

When you first get started, invite employees, colleagues (who aren't competitors), friends, and your patients to follow your accounts. You can do this through an email blast to patients, in-office signage, patient appointment notices, and many other means.

Don't get lost in the weeds with your social media strategy. Plan to meet with your social media consultant or digital firm on a monthly or quarterly basis, depending on what works best for you. Consider using that time to discuss practice updates, any "wow" moments with team members or patients, and review reports. Remember, even though social media is compared to the "front porch" of your businesses, it should still demonstrate measurements of success and growth for your practice.

Editor's Note: Interested in learning more? Contact Leadership by Design, a dental consulting firm that supports the needs of dental professionals in areas of dental marketing, dental recruitment, leadership development/growth plans, and practice acquisitions and sales. Find out more at **www.lbdtransitions.com** or contact Theresa directly at **Theresa@lbdtransitions.com**.

COMPARING CONE BEAM TOMOGRAPHY IMAGES WITH PERIAPICAL RADIOGRAPHS TO DIAGNOSE VERTICAL ROOT FRACTURES

Hernandez E, Méndez C, Jimenez PM. J Translat Sci Res. 2020; DOI:10.24966/TSR-6899/100012

Aim: To compare the accuracy of periapical radiographs (PRs) with Cone Beam CT (CBCT) in detecting vertical root fractures in endodontically treated teeth.

Method: The systematic review included both prospective and retrospective clinical diagnosis studies. Based on questions being asked, regarding the effectiveness of CBCT, both study designs exam patients with suspected vertical root fractures in endodontically treated teeth. The inclusion criteria include at least one endodontically treated permanent tooth suspected of having a vertical root fracture on the basis of existing clinical signs and symptoms. These symptoms included sensitivity to pain on biting and release, percussion and/or localization of periradicular bone loss and pocket depths. In order to further determine the accuracy of CBCTs, vertical root fractures with grossly distracted root fractures were eliminated. In order to be included in the study, the fracture plane must not be visualized on periapical radiographs.

Two review authors independently evaluated and selected studies from the search results and extracted the data using a piloted data collection form. The descriptive statistical data, including sensitivity, specificity, and positive and negative predictive values (PPV and NPV) and to plot data on the receiver operating characteristic (ROC) plane, which is a plot of sensitivity as a function of 1 – specificity, were calculated using the software Meta- Disc. The four included studies were clinically heterogeneous, so an a priori decision was made to conduct a systematic review, rather than a meta-analysis.

Results: Out of the 4 studies that were included in the systematic review, the results showed a reported range in values. These values included 40%–90% for vertical root fracture prevalence, which demonstrates the probability of a vertical root fracture before the CBCT. The sensitivity was varied from 60-61% in PRs and 80% in CBCT, and determines the ability to positively identify a vertical root fracture that is present. There was a range of 71% to 90% for positive prediction value, meaning those that tested positive for a fracture actually have a fracture. The negative predictive value was 55% to 100%, which is the ability to be accurate in subjects that had both a negative result and actually did not have the disease. With the introduced bias into the study being high risk and the imprecise range of the statistical data a conclusion cannot be drawn on the accuracy of CBCT or PRs in detecting vertical root fractures in endodontically treated teeth.

Conclusions: Due to the relatively inconclusive data collected from this systematic review, there is not enough evidence to suggest that a CBCT or PR is an accurate test for detecting vertical root fractures in endodontically treated teeth. They, however, can be used as a diagnostic tool with operators' knowledge and expertise. Any clinical "takeaways" might only include utilizing CBCT and PRs as a helpful, but non-determinant diagnostic tool for vertical root fractures. Still the best tool for detecting vertical root fractures is clinical exam prior to CBCT examination. This includes recognizing and identifying the signs and symptoms that are associated with vertical root fractures.

Nicole Griffith, DDS; Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

UTILITY OF MEASURING ANTERIOR-POSTERIOR SPREAD TO DETERMINE DISTAL CANTILEVER LENGTH OFF A FIXED IMPLANT-SUPPORTED FULL-ARCH PROSTHESIS

Walter L, Greenstein G. J Am Dent Assoc. 2020; 151(10): 790-795

Purpose: Historically, anterior-posterior (AP) spread measurements were the only factor used in determining distal cantilever length for implant-supported fixed full-arch restorations. It is defined as the distance between a line connecting the distal of the most distal implants and a line through the center of the most anterior implants. An arbitrary distal cantilever length that has been used is 1.5 times the AP spread. There have not been any systematic reviews evaluating this measurement. Although AP spread is one factor that can determine distal cantilever length, it is not the only one to be considered. Other factors that should be analyzed are differences in cantilever size in the mandible versus maxilla, number and distribution of placed implants, final prosthetic materials, and framework design.

Methods: Articles that were included in this analysis related to AP spread and the biomechanics of cantilevers searched on numerous databases. Eleven human clinical trials were included and critiqued.

Results: Multiple factors were considered of the 11 human clinical trials.

AP spread to determine distal cantilever length
There is inconsistency in the data that relates AP spread to distal cantilever length. Some suggest less than 1, 1.5, 2, and 2.5 times AP spread, while others suggest less than 15 mm, 15-20 mm, and 20 mm.

Class 1 lever system related to AP spread
As the length of the effort arm increases, tensile, compressive, and shear forces increase stress on the prosthesis. In order to counteract this, a large resistance arm is needed. Clinically, anterior implants should be placed as anteriorly as possible.

Cantilever lengths associated with full-arch reconstruction: maxilla versus mandible
The articles have inconsistencies in cantilever length in the maxilla and mandibular arches. However, they all suggest that mandibular cantilevers can be longer than in the maxilla due to the increased strength of mandibular cortical bone.

Number of implants supporting a cantilevered prosthesis
Authors have concluded that there is no linear relationship between AP spread and cantilever length. Instead, cantilever length is dependent on the number and distribution of implants between the most anterior and posterior implants.

Spacing of implants, cross-arch stabilization, and arch form
- Correct distribution of implants reduces the load per implant and facilitates constructing a larger cantilever.
- One study found that a rigid-cross arch fixed prosthesis would distribute loads to several implants more effectively than a similar prosthesis without cross-arch stabilization.
- A tapered or ovoid arch form allows for a more favorable AP spread of implants than a square arch form.

Bone loss due to cantilevered prosthesis
- This is a debatable topic. Studies have found either no difference in the amount of bone resorption associated with cantilevers or more bone loss in anterior implants when supporting a fixed prosthesis in the mandible.
- Researchers from two studies have found no additional bone loss with short unilateral cantilevers.

Cantilever design related to beam theory
- Studies suggest that cantilevers should be limited in size or as small as possible because a beam will flex, increasing stress on the prosthesis.
- Adequately bulking the material distal to the posterior abutment as well as around each cylinder may accommodate the flexing. A contrasting study suggested that the height of the connector instead of the bulk played a role in the success of the cantilever.
- Multiple studies concluded that the I-beam (framework cross-sectional design) was the most effective cross-section design to withstand occlusal forces when there is minimal restorative height available.

Impact of materials used to construct prostheses
- The more rigid the prosthesis, the more evenly distributed the forces. The cantilever is more resistant to deformation and can be longer.
- There was a greater prosthetic complication rate with an interim acrylic prosthesis than with the definitive metal prosthesis, regardless of AP spread.

Conclusions: Cantilever length should be determined on a case-by-case basis. The following factors should be taken into consideration: biomechanics, AP spread, bone quality, number and distribution of implants, prosthetics design, and prosthetic material. The following steps in determining distal cantilever length for fixed implant supported full arch prosthesis have been suggested:

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RESIN-BONDED FIXED DENTAL PROSTHESES WITH ZIRCONIA CERAMIC SINGLE RETAINERS SHOW HIGH SURVIVAL RATES AND MINIMAL TISSUE CHANGES AFTER A MEAN OF 10 YEARS OF SERVICE

Naenni N, Michelotti G, Lee WZ, Sailer I, Hämmerle CH, Thoma DS. Int J Prosthodont. 2020;33(5):503-512

Problem: The replacement of a single missing anterior tooth can be achieved in multiple ways. If space allows, a single unit implant crown is an ideal treatment modality. However, there is often a lack of space for implants, and alternative treatments must be considered. Conventional fixed dental prostheses (FDP's) are another option, but incur the additional preparation of adjacent teeth. A minimally invasive treatment such as resin-bonded fixed dental prosthesis (RFDP) with two metal wings attached to both adjacent teeth has been used successfully in the past. Recent research, however, indicates that single winged resin bonded bridges with a cantilevered pontic are another predictable treatment option for replacing single anterior teeth. Additionally, more advanced and esthetic materials are available on the market today, and many clinicians have switched to zirconia frameworks for RBFDP's. Replacing a single anterior tooth presents a challenge to clinicians, as the treatment choice must satisfy both functional, and esthetic needs of the patient.

Purpose: The current study assessed the clinical outcomes of single-retainer resin bonded fixed dental prostheses made with zirconia frameworks. Furthermore, the study investigated prolifometric changes of pontic sites. Both of these criteria were evaluated after a mean of 10 years.

Materials/Methods: Ten patients (mean 32.4 years old) received an RBFDP with zirconia framework, replacing a single anterior tooth. All patients had healthy adjacent teeth, which were free of caries and periodontal concerns. Additionally, all patients included in the study had no medical concerns, and were considered non-bruxers. All patients received removable prostheses in order to shape the pontic site before beginning definitive treatment, and 5 of these patients received a sub-epithelial connective tissue graft at the pontic site due to a deficiency in ridge profile. Abutment teeth were all prepared identically, and conventional impressions were made of the prepared teeth with A-silicone impression material. Frameworks were fabricated out of zirconia, were manually veneered with zirconia ceramic, and were then adhesively bonded per manufacturer's instructions.

Probing depth (PD), bleeding on probing (BOP), plaque accumulation, gingival recession, width of keratinized gingiva, and intraoral photographs/radiographs were all assessed at 7-10 days after insertion, and then after mean follow up times of 4 years and 10 years. Additionally, patient satisfaction surveys were recorded.

Results: The survival rate after at least 10 years was 100 percent. No fractures of framework or chipping of the ceramic veneer were observed. No marginal gaps were present between restorations and abutment teeth. PDs and BOP reflected stable and healthy periodontal conditions at 10 years. All test teeth were vital, and no radiographic or clinical caries were detected. Profilometric analysis of pontic sites showed minimal changes.

Conclusions: In order to optimize esthetic results, metal frameworks have started to be replaced by ceramic materials. Among the ceramic materials, studies have indicated that zirconia resulted in higher survival rates than other types of ceramics. Using zirconia frameworks allows for reduced minimal material thickness for both the connector and retainer, and improves esthetic outcomes. RBFPD's with zirconia frameworks have become a predictable option for replacing single teeth in the anterior esthetic zone. The current study showed high survival rates of zirconia framework RBFDP's with minimal complications, and stable soft tissue dimensions in the pontic area.

David Smiley, DDS; Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

DIGITAL VS CONVENTIONAL IMPLANT IMPRESSIONS: A SYSTEMATIC REVIEW AND META-ANALYSIS

Papaspyridakos P, et. al. J Prosthodont. 2020; 29(8): 660-678.

Aim: This meta-analysis served to review the 3D accuracy of digital versus conventional implant impressions for complete and partially edentulous patients by reviewing in vitro and clinical studies.

Methods: The PICO (population, intervention, control, outcomes) question was as follows: "In partially and completely edentulous patients, do digital scans/impressions demonstrate similar accuracy outcomes compared to conventional implant impressions?"

For the search of studies, only English articles from January 1, 1990 to March 15, 2020 were included using a reference manager software program in addition to manually searching the following keywords: (digital implant impression OR digital impression OR digital scan OR intraoral scan) AND (partially edentulous OR completely edentulous) AND (conventional impression OR conventional implant impression). Studies that were included were clinical studies and in vitro studies; however, case reports/series were not included. After the search, 10 articles discussing completely edentulous impressions and 8 articles discussing partially edentulous impressions were selected for meeting the inclusion criteria.

The following data was extracted from the studies: authors, study design, publication year, implant brand and type of connection, location and type of edentulism, impression techniques, number of implants per patient, conventional impression material, accuracy of evaluation method, scanning strategy, brand of scanner, material of scan body, superimposition technique, and accuracy of impression results.

A meta-analysis was performed and heterogeneity was assessed using Chi2 and I2 tests and the significance level was .05. Sensitivity analysis was not performed, and publication bias was evaluated with funnel plots and Begg's and Egger's tests.

Results: In terms of 3D accuracy for completely edentulous impressions, digital scans had better accuracy when compared to conventional impressions and accuracy was not affected by angulation or type of connection. For impressions involving less than three implants, conventional impressions proved to be more accurate than digital impressions. When the impression involves four implants, digital scans are more accurate. However, when the cases involve more than four implants, neither technique is superior. The only scanner that showed statistically significant less accuracy than conventional impression was iTero, while the Trios and CEREC impressions were not statistically different from conventional impressions.

Conclusions: For completely edentulous jaws, digital impressions showed a nominally better accuracy than conventional impressions, and conventional impressions were nominally better for partially edentulous jaws. More clinical studies need to be conducted before recommending digital impressions for partial and full arch implant rehabilitations.

Alice Xiang, DDS; Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

>> CONTINUED FROM PAGE 43

- Consider the occlusal load when determining the size, number, thread design, and surface area of implants to be placed and place enough implants to distribute the occlusal forces
- Maximize implant distribution to reduce the load per implant
- Maximize the AP spread
- Use a cross-arch splint design when working with a full-arch design
- Use rigid material for the framework
- Use an I-beam in cross-section for the framework
- Minimize cantilever length, especially in the maxilla

Kimberly Amanda Kaneshiro, DDS; Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

REPEAL OF THE ANTITRUST EXEMPTION FOR HEALTHCARE INSURANCE

WHAT DOES THAT MEAN FOR ME?

Bruce R. Hutchison, DDS; Chair, VDA PAC

The McCarran-Ferguson Act, passed in 1947, exempted insurance companies from some of the federal anti-trust laws that most businesses in the United States must follow. In January 2021, President Trump signed into law the Competitive Health Insurance Reform Act of 2020, which repealed this exemption for health insurance companies, including dental insurance companies.

What does that mean, and how did it happen?

For over 12 years, the ADA has fought to overturn this antiquated law that placed obstacles in the way of investigating and enforcing possible anticompetitive practices and activities of health care insurers. Dentists met with their legislators, ADA lobbyists continued to educate lawmakers, ADA members responded to requests from the ADA to contact their legislators about the importance of this bill, and ADPAC helped elect legislators who would listen to our story. It was a long, drawn out war against the insurance companies fighting repeal, as the McCarran-Ferguson Act provided them protection against investigations and enforcement by the Department of Justice (DOJ) and the Federal Trade Commission (FTC). Now, with that protection removed it is believed that DOJ and FTC will be more likely to challenge possible anti-competitive practices and activities of insurers. Dentists taking action made a huge difference in making this happen.

According to information provided by the ADA, this is unlikely to have an immediate impact on insurance carriers, but in the long run should improve transparency and competition in the health care insurance marketplace. If dental plans are compelled to compete fairly and transparently, we should see increased innovation and choice for customers and providers.

Consumer Reports, which has long advocated for the reform legislation, praised the passage of the bill as being good for both consumers of health care services and providers. On December 22, 2020, they wrote "the antitrust exemption has essentially allowed health care insurers to act as a monopoly, making demands in lockstep on the terms they will offer consumers and healthcare providers. The resulting squeeze puts pressure on providers to cut corners on services in order to increase the profits the health insurers can extract."

Enactment of this legislation should begin to change that detrimental pressure. It should open up more opportunities for new insurance companies to enter the market and compete in offering better and more affordable coverage to consumers and better terms for doctors, hospitals, and providers. Existing insurance companies will have to start finding ways to offer those choices. Ultimately these choices will mean a better product for consumers, and a better arrangement for all who seek to provide healthcare to them.

The U.S. Department of Justice agreed, writing that "where there is effective competition, coupled with transparency, in a consumer-friendly regulatory framework, insurers will be spurred to compete against each other by offering plans with lower premiums, reducing copayments, lowering or eliminating deductibles, lowering out-of-pocket maximum costs, managing care, improving drug coverage, offering desirable benefits, and making their provider networks more attractive to potential members."

This is a big win for our patients, for choice and for dentistry. It all happened because of many dedicated people, dentists and ADA staff, fighting persistently for 12 years. If you answered those calls for help, visited your legislators in Washington, DC or back home, supported candidates who support dentistry, or contributed to ADPAC and the VDA PAC then THANK YOU! Your efforts have been rewarded. If you weren't among those who did participate, I ask why not? Do you want to have a say in the future of our profession? It's not too late to contribute to VDA PAC and ADPAC, and get on board with VDA and ADA's texting and email legislative alerts. This shows what we can do as a group, be part of that solution and help keep dentistry the great profession it is.

> ***"If dental plans are compelled to compete fairly and transparently, we should see increased innovation and choice for our customers and providers."***

We have been blessed to have such a wonderful profession. But there will always be challenges. Without everyone being involved, we risk others deciding where our profession will go. Let's stay strong, stay involved, contribute to our PACs and make our profession even better. DO IT TODAY!

To make it easy, use this link to contribute: **www.vadental.org/advocacy/vda-pac**

2021 GENERAL ASSEMBLY SESSION REVIEW

Chuck Duvall and Tripp Perrin, VDA Lobbyists

The nearly all virtual 2021 Virginia General Assembly adjourned "Sine Die" on Monday, March 1st. Despite limited face-to-face access to legislators and their staffs, significant legislation was considered that included: the legalization of recreational-use marijuana; social and legal justice reform; consumer data privacy; environmental justice; mandatory paid sick leave; school re-opening plans and; vaccine distribution. With the Democrats fully in charge of both the House and Senate for the second consecutive year, there was a plethora of progressive-minded proposals, many of which have made it to Governor Northam's desk for consideration.

Not unlike most advocacy organizations, the VDA took the opportunity during this short, virtual session to play mostly defense on important issues to dentistry. This was especially prudent given how engaged the leadership and lobbying team was with legislators and the administration in the months leading up to session on a myriad of issues related to the pandemic. And, on the defensive front, there were plenty of big-ticket items to say grace over:

- Our team played a valuable role in defeating or amending dentistry out of several bills aimed at forcing employers to pay for annual sick/ family leave benefits.
- The VDA opposed and defeated a bill that would have forced dentist offices to pay workers time-and-half during any declared state-of-emergency.
- The VDA teamed up with the Medical Society of Virginia to kill legislation that would have increased the medical malpractice cap as the measure would have most certainly increased premiums for dentists around the Commonwealth. We would anticipate this issue is going to be discussed in the off-season (VDA will participate) and it definitely will be back in future sessions.
- You may recall the budget that passed during the 2020 legislative session had an adult dental benefit incorporated into it. Unfortunately, with budget constraints and competing priorities, the budget negotiators only allocated $17 million for implementation, which makes the benefit design vital. Your lobbying team and VDA leadership continues to be very proactive on this front. It is an issue on which we will need to manage expectations with legislators and others in the months ahead.

The VDA team also played a key role in legislation that has passed and been signed by the Governor that removes red tape on the vaccine's distribution and administration front. This includes ensuring dentists are front and center in any larger vaccine effort at community health clinics and other locations. Legislation also passed that charges a select group to review and come up with recommendations for comprehensive campaign finance reform. These recommendations could potentially include limits on individual donations and some constraints on PACs. Virginia remains probably the most expensive state in the country in which to run a campaign and at least part of the goal could include ratcheting that spending downward. We will, of course, be following this issue closely especially as it relates to VDA PAC operations – any recommended changes would need to be passed by a future General Assembly.

The legislature came back to town on April 7th for the standard "veto session" where they are considering amendments and vetoes to select legislation. Otherwise, all eyes and energies now turn to November elections where all 100 seats in the House of Delegates are up for grabs as are the offices of Governor, Lt. Governor & Attorney General. Will the blue wave continue or with Trump now out office will the Republicans be able to make some headway after not being competitive in the last couple of cycles? Time will tell and your lobbying team will keep you in the loop but, no matter what, it has never been more important for every single member of the VDA to engage in the political process in the months ahead!

VDA HOSTS VIRTUAL LOBBY DAY IN MIDST OF PANDEMIC

Laura Givens, VDA Director of Legislative and Public Policy

The VDA Annual Legislative Reception and Lobby Day are events that we look forward to every winter during the VA General Assembly Session. These were unfortunately cancelled due to the COVID-19 pandemic. Even though we were not able to gather in Richmond, VDA member dentists and VCU dental students were invited to the event this year in a virtual format. This allowed everyone to attend from the comfort of their homes or offices.

During our Virtual Lobby Day, VDA member dentists and VCU dental students heard from VDA President Dr. Frank Iuorno, Jr. and our government affairs team about Virginia General Assembly actions that impact dentistry. This activity included the medical malpractice cap, dentists serving as vaccinators and the adult dental Medicaid benefit. Following the virtual presentation, the VDA provided attendees with tools to easily contact their state legislators and advocate for dentistry. We thank everyone who participated! An update on the outcome of the 2021 General Assembly session from VDA lobbyists can be found in this edition of the Journal.

Although we were thrilled to be able to bring you legislative updates virtually, the VDA looks forward to getting together in-person in Richmond next year. The 2022 VDA Legislative Reception and Lobby Day are scheduled for January 20-21 at the Omni in downtown Richmond so please mark your calendars. The hands-on, face-to-face interaction with legislators at these events is priceless. See you at the Capitol next year!

HOW DOES YOUR COMPONENT STACK UP?

VDA PAC CONTRIBUTION UPDATE

Laura Givens, VDA Director of Legislative and Public Policy

Thank you very much to so many of you for your support of the Virginia Dental Association Political Action Committee (VDA PAC). Although our PAC remains strong, it is important to note that only 33% of the VDA membership has contributed to the VDA PAC this year. This means that 33% of VDA members are doing 100% of the important political action work done by the VDA PAC. All 100 seats in the House of Delegates are up for grabs in November, which makes our participation critical in 2021 and beyond.

If you have not yet contributed to the VDA PAC for the 2021 year, please do your part and make a contribution today. Your profession and your patients deserve nothing less! Contributions can be made through the VDA website at **www.vadental.org/advocacy/vda-pac**. Please contact Laura Givens at **givens@vadental.org** or 804-523-2185 with questions.

Component	% of 2021 Members Contributing to Date	2021 VDA PAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	36%	$45,500	$28,640	$286	63%
2 (Peninsula)	37%	$27,500	$16,425	$298	60%
3 (Southside)	32%	$14,000	$7,822	$301	56%
4 (Richmond)	26%	$67,750	$46,530	$308	69%
5 (Piedmont)	34%	$30,000	$20,290	$286	68%
6 (Southwest VA)	42%	$25,250	$13,885	$295	55%
7 (Shenandoah Valley)	30%	$30,000	$21,335	$307	71%
8 (Northern VA)	28%	$135,000	$64,287	$228	48%
TOTAL	**33%**	**$375,000**	**$219,214**	**$289**	**58%**

TOTAL CONTRIBUTIONS: $219,214

MUST RAISE $155,786 TO REACH GOAL

2021 GOAL: $375,000

Join the Tooth Party!

Advocate for Your Profession and Patients

DREAMS REALIZED

Julie Ericksen, Donated Dental Services

Dr. Kalpana Kaleswaran was a practicing dentist in India before coming to this country. In addition to tending to her young family, her dream was to practice dentistry in the US. As one with a passion for both dentistry and giving back to her community, she came to the VDA Foundation in September 2015 and volunteered her services in the office. She worked closely with me for a year performing administrative tasks, making phone calls to dentist offices, patients, applicants, and inquirers to the Donated Dental Services program. She was a quick study, so consequently I gave her more involved work to do as time progressed. Beyond part time work at our office, she volunteered for a Mission of Mercy event, Give Kids a Smile Day, and with Dr. Dickinson at the Virginia Home for the severely disabled – demonstrating a true commitment to our Foundation and to serving for those in need as well as her passion for all things dentistry!

We loved working with this bright, capable and enthusiastic woman (and in awe of her colorful Indian clothing). We encouraged her as she applied to US dental schools and supported her by writing recommendations, citing her competence, passion for dentistry, and her compassionate nature. We became friends! As she fell in love with the work we do through Donated Dental Services, she dreamed about returning to us, not as an office volunteer but a volunteer dentist in practice, supporting our Donated Dental Services program. In her own words:

"It has been my honor to work with the VDA Foundation over the years. When I first began, I was able to volunteer with the process connecting patients to the dentist. It was amazing to me to see how this small act of connecting people positively changed lives forever. From that moment, I thought 'when I become a dentist, I am going to help people for the VDA Foundation'. For me, this has been a dream come true and I am grateful for the opportunity to change lives for the better."

R-L: Dr. Kalpana Kaleswaran and Myrtle - PRE-COVID-19

We were thrilled when she was accepted into dental school in Colorado and wished her well as she took off for the wild west, where she spent two years completing her degree to become a US dentist. Meanwhile, in the midst of all of this, her second child was born!

Dr. Kaleswaran and her young family did indeed return to our area in 2019, where she joined Lifetime Dentistry (near the VDA) in the Short Pump area. As a brand new US dentist, she convinced the management to allow her to take on Donated Dental Services patients. Kalpana Kaleswaran, DDS saw her first patient in January of 2020; the dream we held together came full circle.

Her patient "Myrtle", a 58 year old female, had been on our waiting list for almost two years before we connected her with Dr. Kaleswaran in January 2020. Myrtle had COPD, was in remission from Thyroid Cancer, and in fragile health. Through Donated Dental Services (and despite COVID delays), with Dr. Kaleswaran's guidance, we were able to connect Myrtle with specialists for additional care she needed to complete her dental work. Dr. Charles Gaskins, a periodontist, and Dr. Monroe Harris, an oral surgeon, have provided Donated Dental Services to our applicants for many years. Fitz Vital Dental Lab, another dedicated Donated Dental Services donor, agreed to donate the lab work for her case.

Every time I spoke with the patient she expressed her overwhelming gratitude for the care and compassion she received from all of her Donated Dental Services dentists. Even better, Dr. Kaleswaran has agreed to keep Myrtle as an onging Donated Dental Services patient to maintain her remaining teeth. I am looking forward to the next case we complete with our new dentist volunteer! Myrtle has received over $9,000 in donated dental care so far from three dentists and a lab, which included two partial dentures, restorations, extractions, and periodontal treatment.

On a daily basis, I am amazed and humbled at the generosity of Virginia dentists and labs. If you would be interested in joining us for this rewarding work, call me at (804) 523-2182 and we'll give you the opportunity to make a difference in the life of a deserving patient.

Virginia Dental ASSOCIATION

Strategic Plan 2025

Advancing Dentistry and Empowering Members

The VDA Board of Directors is pleased to share our newly adopted strategic plan. This long-term plan will serve as the VDA's guide to supporting members in the areas that matter most to you and to the dental profession. As the VDA advances its goals under Advocacy, Practice Success and Professional Development to meet your needs, we will be tracking and reporting our progress. We hope you'll get involved. Please share your feedback on the strategic plan and volunteer today to be part of the VDA's work on these important initiatives by visiting **vadental.org/about-us/get-involved**.

Member Focused

The VDA's Strategic Plan will be supported by specific programs and initiatives under each of the plan's three focus areas.

Advocacy

- Dental Practice
- Third Party Payers
- Virginia Board of Dentistry
- Political Action Committee
- Member Engagement
- Public Relations
- Student Engagement

Practice Success

- Business Resources
- Exclusive Savings
- Practice Staff Success
- Career Support

Professional Development

- Education
- Networking and Philanthropy
- University Relations
- Leadership Development

About the VDA's Long-Term Strategic Plan

In October of 2019, the VDA Board of Directors met for two days to begin the long-term strategic planning process. This strategic planning session was facilitated by Bob Harris, a nationally recognized expert on association management who has worked with dental associations across the country, including the ADA. The strategic planning process continued throughout 2020. On January 15, 2021, the Virginia Dental Association's Board of Directors reviewed and unanimously approved the 2021-2025 Strategic Plan.

Powerful Advocacy

Serve as the preeminent organization representing the dental profession and oral health in Virginia

- Advance and protect the practice of dentistry in the Commonwealth by increasing the VDA's influence as the Voice of Dentistry
- Forcefully advocate for the profession around third party payer issues and develop better working relationships
- Collect and analyze data from our members to improve payment models
- Strengthen relations with the Board of Dentistry and identify opportunities for VDA members to volunteer and serve
- Grow and maintain influence and relevance through a strong Political Action Committee (PAC)
- Educate, motivate and activate dentists, their staff and component societies around policy and regulatory issues
- Cultivate relations with the media and influencers to elevate the voice of VDA members
- Collaborate with VCU's School of Dentistry, faculty and students to effectively advocate and advance dentistry

Practice Success

Provide dental professionals with the tools, savings and opportunities needed to start, grow and transition a successful dental practice in the Commonwealth

- Make the VDA the most relevant and essential organization for success throughout the entire dental career
- Elevate member awareness and enrollment in VDA programs and offerings
- Identify and create benefits to address unmet member needs
- Create new solutions for member needs
- Position the VDA as the most apparent and relevant source of success for dental students as they transition out of school

Professional Development

Support education, training and a strong community network essential for professional growth

- Grow and expand the VDA offerings to benefit the entire dental team through CE, networking and certifications
- Be the leading provider of Continuing Education both in-person and online
- Provide dynamic networking opportunities through premiere events
- Offer unique philanthropic opportunities to give back to the community
- Foster a pipeline from VCU School of Dentistry to organized dentistry through the VDA

WELCOME NEW MEMBERS

THROUGH MARCH 1, 2021

Tidewater DENTAL ASSOCIATION

Dr. MaryKate Conboy – Virginia Beach – University of Connecticut School of Dental Medicine 2015

Dr. Dana Kim – Virginia Beach – New York University College of Dentistry 2015

Dr. Clayton Willinger – Virginia Beach – Louisville College of Dentistry 2020

Peninsula DENTAL SOCIETY

Dr. Matthew Eppright – Williamsburg – New York University College of Dentistry 2011

Dr. Patra Eppright – Williamsburg – New York University College of Dentistry 2011

Southside DENTAL SOCIETY

Dr. Bansari Patel – North Chesterfield – University of Colorado Denver School of Dental Medicine 2020

Richmond DENTAL SOCIETY

Dr. James Cunningham – Richmond – University of Alabama School of Dentistry at UAB 2018

Dr. Anne Hefele – Ashland – Tufts University School of Dental Medicine 2020

Piedmont DENTAL SOCIETY

Dr. Jacob Hadley – Roanoke – University of Michigan School of Dentistry 2020

Dr. Ellyn Harper – Roanoke – West Virginia University School of Dentistry 2020

Dr. Luis Lecleres Diaz – Roanoke – University of Puerto Rico School of Dentistry 2015

Dr. Jonathon Williams – Daleville – West Virginia University School of Dentistry 2020

Southwest Virginia DENTAL SOCIETY

Dr. Joehoon Jung – Blacksburg – Nova Southeastern University College of Dental Medicine 2020

Shenandoah Valley DENTAL ASSOCIATION

Dr. Johanna Huijssoon – Madison – Washington University School of Dental Medicine, St. Louis 1998

Dr. Kathleen Lamontagne – Lexington – University of New England College of Dental Medicine 2020

Northern Virginia DENTAL SOCIETY

Dr. Alireza Aram – McLean – Florida Institute for Advanced Dental Education 2017

Dr. Mitra Davaninejad – Vienna – University of Maryland Dental School, Baltimore College of Dental Surgery 2017

Dr. Maidah Farooq – Woodbridge – Howard University College of Dentistry 2020

Dr. Karen Harriman – Fairfax – New York University College of Dentistry 1994

Dr. Helina Hussain – Sterling – Howard University College of Dentistry 2020

Dr. Urvi Kulkarni – Arlington – Howard University College of Dentistry 2020

Dr. Bach Nguyen – Annandale – Howard University College of Dentistry 2020

Dr. Kourosh Seifolahi Bazarjani – Fairfax – Florida Institute for Advanced Dental Education 2020

Dr. Mohamed Masoud – Falls Church – Howard University School of Dental Medicine 2006

Dr. Christopher Spears – Fairfax – University of California School of Dentistry 2016

Dr. Rabecca Vanevenhoven – Fairfax – Marquette University School of Dentistry 2017

Dr. Rebecca Yang – Sterling – Loma Linda University School of Dentistry 2019

IN MEMORIAM: DR. LINDSAY M. HUNT JR.

Dr. Lindsay M. Hunt Jr. passed away on December 18, 2020. He obtained his undergraduate degree from the University of Oklahoma in 1961 and then received his D.D.S. in 1965 from Baylor College of Dentistry. Dr. Hunt served in the United States Navy Dental Corps from 1965-1967. He returned to Baylor University Graduate School and earned his PhD in Physiology in 1971. He then joined Emory University School of Dentistry, serving as a professor and administrator until being named Dean of the School of Dentistry, Virginia Commonwealth University, in 1985. He served as Dean of the School until 1998. During his tenure he placed great emphasis on professionalism and ethics. His contributions included spearheading extensive renovations to the school's physical facilities as well as a redesign of the clinical curriculum. Improvements included the VCU Philips Institute of Oral and Craniofacial Molecular Biology and extensive enhancements in clinical operations and infection control protocols. He was named the Harry Lyons Professor in 1993. He served as President of the American Association of Dental Schools as well as a member of the American Dental Association's Commission on Dental Accreditation and the Council on Dental Education. Locally he was a member of the Virginia Dental Association and the Richmond Dental Society serving on the Board of Directors for each organization.

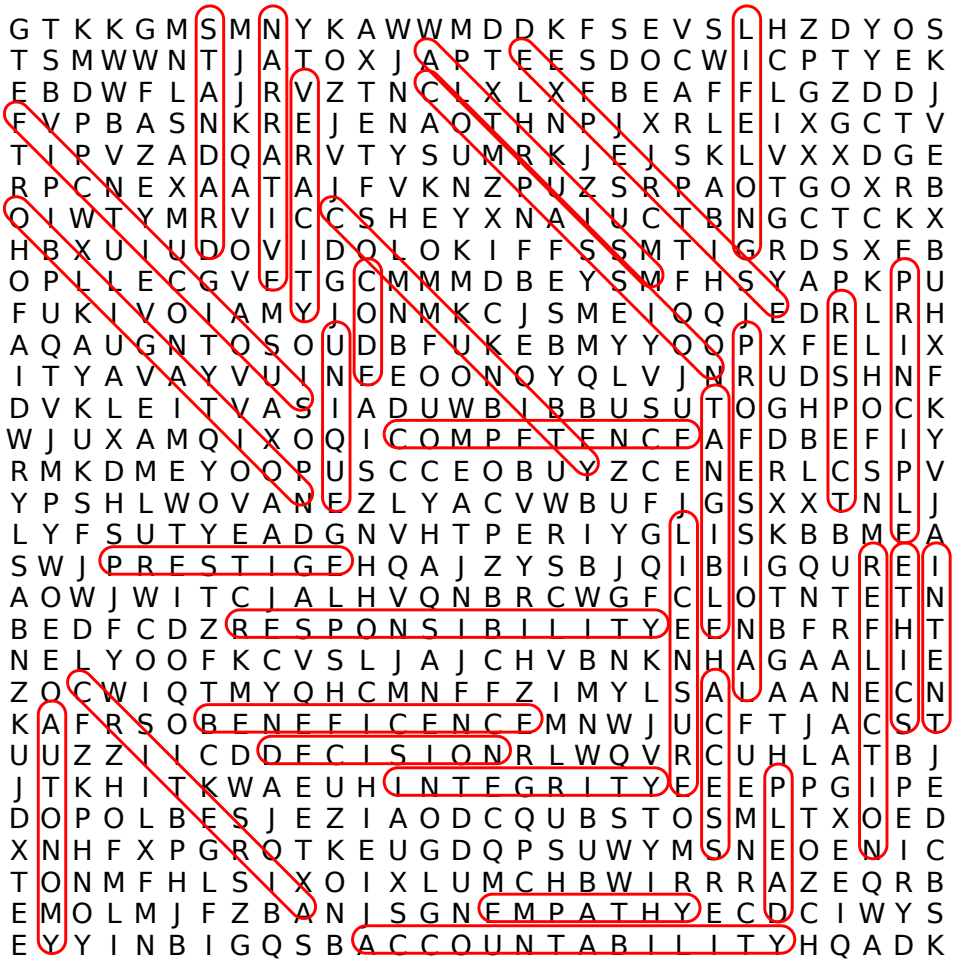
Memorial gifts may be made to the School of Dentistry's Philips Institute. Please send your donation made payable to the MCV Foundation, 1228 East Broad Street, PO Box 980234, Richmond, VA, 23298 and please note your donation for the Philips Institute.

Dr. Lindsay M. Hunt Jr.

IN MEMORY OF:

Name	City	Date	Age
Dr. Odilon Presley Delcambre	Norfolk	9/15/19	94
Dr. Paul D. Harvey	Appomattox	10/19/20	68
Dr. Lindsay M. Hunt	Midlothian	12/18/20	81
Dr. Joseph B. Johnson	Oxford, FL	9/18/18	90
Dr. J. Darwin King	Staunton	10/11/20	90
Dr. J. Everett Lewis	Richmond	11/26/12	66
Dr. William Bragg Russell	Petersburg	9/15/16	96
Dr. Charles P. Thomas	Newport News	2/8/21	59
Dr. Thomas Leon Walker	Forest	10/11/20	67

>> WORD SEARCH ANSWERS CONTINUED FROM PAGE 27



ACCESS
ACCOUNTABILITY
ALTRUISM
AUTONOMY
BENEFICENCE
CODE
COMMUNITY
COMPASSION
COMPETENCE
CRITERIA
DECISION
EMPATHY
ETHICS
EXPERTISE
FICTICIOUS
INTEGRITY
INTENT
LICENSURE
LIFELONG
NARRATIVE
OBLIGATION
PLEAD
PRESTIGE
PRINCIPLE
PROFESSIONAL
REFLECTION
RESPECT
RESPONSIBILITY
STANDARD
TANGIBLE
UNIQUE
VERACITY

Classifieds

VIRGINIA DENTAL ASSOCIATION

VDA Classifieds allows you to conveniently browse and place ads on the VDA website and in this publication. VDA Members can advertise with VDA Classifieds for FREE. Nonmembers are also welcome to place ads for a fee. Please visit vdaclassifieds.org for details on advertising with us.

JOBS: Dentists

6917 - Associate Dentist Opportunity
Sterling
Our 17-year-old established practice is seeking a general dentist. Our three doctors with two locations bringing 35 years of combined experience. The dentist must be proficient with comprehensive restorative treatments, endodontics, periodontal therapy, and extractions. The dentist must have exceptional communication skills practice teamwork, bring humor and fun to work. We provide mentorship and training to the right candidate to practice advanced dental treatments. The dentist must have three years of experience in general practice or have completed advanced education.
Contact: Michelle 703-444-9900
jobs@ridgetopdental.com

6929 - Dental Director
Wytheville
Nestled in the foothills of the Appalachian Mountains, Bland Ministry Center has tended to the spiritual and physical needs of the surrounding community for forty years. Our organization is searching for a compassionate dental director to serve the residents of Wythe County, Virginia, at Big Walker Dentistry as well as oversee dental operations at its sister clinic in Bland. This facility is a new, state-of-the-art complex, with 5 operatories. This position offers a 4-day work week, competitive salary and a healthcare stipend. Interested applicants should contact the below Special Projects Coordinator.
Contact: Ms. Susan Keene
skeene@blandministrycenter.org

6934 - Dentist
Bland
Bland County Medical Clinic, a Federally Qualified Health Center, in partnership with the Bland Ministry Center and Dental Clinic, is seeking a full-time dentist. This graduate of an accredited U.S. dental school will oversee the operations of a three operatory, fully staffed and up-to-date dental office in the scenic and beautiful county of Bland, Virginia. While being paid a competitive salary and benefits, this individual will be able to see years of training put to use in a way that changes lives. This opportunity offers a unique chance for personal and professional growth. To apply or for more information, contact the below.
Contact: CEO Susan Greever
276-688-0445 **sgreever@blandclinic.net**

6943 - Excellent Associate Opportunity
Danville
Lawrence A. Hayes DDS is seeking a motivated, quality-oriented associate dentist. Danville is an easy commute from Greensboro/Burlington/Martinsville/Durham/Chapel Hill. The ideal candidate would have 2+ years of experience or completed a GPR AEGD residency. Strong consideration given to clinicians proficient in Endo and or Extractions. High earning potential @ $300,000 +/ per annum. (Much more if proficient in Molar Endo.) $800 minimum daily guarantee and numerous great paid benefits. Future path to ownership/partnership (if desired) Flexible Clinical hours that support a healthy work-life balance. Laid back atmosphere with complete autonomy over treatment planning. Full patient schedule right out of the gate. Discretion over dental supplies. Amazing and competent staff.
Contact: Lawrence Hayes
lahayes17@yahoo.com

6778 - Associate Dentist
Hampton
Busy office is actively looking for a full-time/part-time Dental Associate that provides excellent general dentistry. This candidate must be a friendly, outgoing and a motivated General Dentist with at least 2 years of experience, a team player and ready to work! Great earning potential!
Contact: Regina 757-838-5999
familydentistry11@yahoo.com

6860 - Associate Dentist
Falls Church
A patient centered dental practice is searching for a general dentist to join our team. PT and/or FT. The candidate must have at least 2 years of private practice experiences, good chairside manners, and desire to deliver high quality dentistry to our patients. Please submit your resume for consideration.
Contact: Iris
bestdentist4you@gmail.com

6865 - Associate Dentist
Dental Health Associates is a rapidly growing doctor owned and managed multi-office group practice in the heart of Virginia. We strive for excellent comprehensive full mouth Dentistry. We have a strong commitment to CE, training and mentorship. Seasoned Dentists, AEGD/GPR graduates or new Dentists are welcome to come grow with us. Opportunities throughout the Shenandoah Valley in Lexington, Staunton, Harrisonburg, Dayton and Fishersville. Excellent commission-based compensation with a $500 per day guarantee and the potential to earn $200 to $300k annually. We offer an excellent benefit package including Malpractice, Medical, 401K matching and CE stipend. A route to ownership/partnership is available. Qualified candidates submit your resume and cover letter to the below email.
Contact: Dr. Dennis Calvano
540-569-2523 **drcalvano@mydha.net**

6969 - Calling All Dentists!
Williamsburg
Our practice is growing! Morrison Dental Group is looking for a motivated Doctor interested in unlimited earning potential to work with experienced Staff in Williamsburg, Virginia. The ideal candidate would have 2+ years' experience and/or GPR or AEGD Residency. Established patient base-

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be busy right away! Salary guarantee vs. commission; Health Benefits, CE allowance, Malpractice paid, 401K.
Contact: Alison Morrison 757-719-2237
amorrison@morrisondentalgroup.com

6971 - Associate Dentist
Rocky Mount/Roanoke
Willis & Associates Family Dentistry is seeking a motivated, quality-oriented associate dentist for our offices. We provide the ultimate in quality general dentistry to the entire family in a modern, technologically advanced setting with experienced support staff. Average compensation of full-time dentists in excess of $220,000/ per annum. Benefits include health insurance, malpractice insurance, retirement plan, continuing education, and more! Visit our website at **www.willisdentistry.com**.
Contact: Justin Gilbert 540-487-4871
justin@willisdentistry.com

6764 - Dental Associate
Virginia Beach
Full time with solid benefits package. Please email resume.
Contact: Dr. Anthony L. Martin
martindentistry@gmail.com

6974 - Associate Dentist
Charlottesville
Looking to hire a Full Time Associate Dentist. Our two state of the art buildings are located in the heart of town. We are looking for a highly motivated Dentist. We have a strong patient base with continued growth. There is a potential for a future buy in or purchase opportunity. Our company provides a great benefit package included (Health, Dental, Vision, Bonus, Vacation, and 401K). We look forward to hearing from you!
Contact: Brad Swisher 434-566-9868
brad@swisherdentistry.com

6982 - Beautiful Blue Ridge Practice Hiring NOW
Roanoke/Salem
Now seeking a caring and competent dentist for our well-established practice in the Blue Ridge Mountains. Our practice is minutes from the Appalachian Trail for hiking, Carvin's Cove for mountain biking, and the Roanoke River for kayaking. We are just a short drive from Smith Mountain Lake or Claytor Lake for boating. We are also near some of the best schools with great Music, Arts, Special Education, and Athletic programs. The practice accommodates two doctors, and we have the latest technology. This is also a great opportunity as the incoming dentist will have the opportunity to earn their way into a partnering position which includes bonuses and ownership. We would love to show you around, whether in person or virtually.
Contact: Tanya Johnson
swvadental@gmail.com

6986 - Associate Dentist
Virginia
The Smile Group is seeking ethical and efficient Associate Dentists to join our growing team. If you are interested in a practice with partnership and mentoring opportunity, without the management nightmare, this is the opportunity for you. The Smile Group consists of four successful dental offices and a Call Center located in the Hampton Roads/Tidewater areas. We focus on Patient's Health, customer service and professional, personalized care. We are preparing to expand to more locations from Central Virginia to Northern Neck down to the Outer Banks. To learn more about The Smile Group and the Associate opportunity please send your CV to our Chief Operating Officer to the below.
Contact: Amy Eveland 757-229-1224
amy.eveland@smilesofwilliamsburg.com

6987 - Richmond General Dentist Opportunity!
Richmond
Morrison Dental Group is looking for a motivated Doctor interested in unlimited earning potential to work with experienced Staff in Richmond, Virginia. The ideal candidate would have 2+ years experience and/or GPR or AEGD Residency. Established patient base- be busy right away! Enjoy working with a dedicated team in an all-digital office including digital patient records, Extra-oral radiography, I-Tero, CEREC and more! Salary guarantee vs. commission; Health Benefits, CE allowance, Malpractice paid, 401K. We look forward to meeting you!
Contact: Alison Morrison 757-719-2237
amorrison@morrisondentalgroup.com

6991 - Associate to Traditional Private Practice
Hampton Roads
Atlantic Dental Care has multiple opportunities for General Dentists. We are a unique group 100% owned by our dentists, preserving the private practice of dentistry. Our 130 dentists have a shared vision of delivering quality care in the communities (Williamsburg to Virginia Beach) we serve through our 80 locally owned offices. We are a group practice for dentists by dentists. Tired of working for someone else? Come join us and begin your pathway to ownership of your own practice. Benefits include 401k, health insurance, and HSA. Tired of working for someone else or a recent graduate, ADC is designed to provide you with the clinical and business mentoring to ensure your success. Meet us at **https://youtu.be/D1LBEvGglu8** and **http://www.atlanticdentalcare.net/**. Confidentiality Assured.
Contact: Marina 757-455-5554
atlanticdentalcare@cox.net

6994 - Associate Dentist
Stafford
We are looking for an Associate Dentist who will fit our philosophy of taking care of patients according to their needs and wants, not according to the dictates of their insurance. We like to produce quality dentistry over quantity. The ideal candidate for this position has worked with patients of all ages, is proficient in performing regular checkups and complex dental procedures and is committed to the highest patient care quality. Those who are qualified and in search of a career opportunity in a cutting-edge practice are encouraged to apply today. Diagnose and provide appropriate dental treatment to patients. Prescribe medications as necessary,carefully document all medications, diagnoses, treatments, and consultations. Bilingual (Spanish) is a Plus.
Contact: AQUIA DENTAL CARE
540-720-8630 **normagdds@gmail.com**

6996 - Community Dental Clinic Dentist
Martinsville
As the clinic dentist for the Martinsville Community Dental Clinic, you'll enjoy a stable and rewarding opportunity providing care for patients who are truly in need of your skills and expertise. The Piedmont Virginia Dental Health Foundation Dental Clinic provides an opportunity for professional growth and development while meeting the dental health needs of a diverse population. As an Adjunct Faculty Member of Virginia Commonwealth University School of Dentistry overseeing dental students, you will have an impact on the future of our profession. Great Salary and Benefits SIGNIFICANT Virginia Dental Loan Repayment is also available. View our website at Piedmont Virginia Dental Health Foundation http://www.piedmontdental.org Send resume/CV to the below email address.
Contact: Dr. Mark Crabtree 276-632-9266 **DrCrabtree@piedmontdental.org**

7015 - Associate Dentist
Waynesboro
Associate dentist needed to take place of doctor entering retirement in group practice. New graduates or experienced dentist welcome. Well established busy practice with excellent staff and relaxed atmosphere. Benefits include health and retirement plans, CE allowance, license fees, and malpractice. Please send CV to the below email address.
Contact: Rachel 540-943-2723
Magnoliadent@gmail.com

1716 - Associate Dentist
Midlothian
Midlothian Family Dentistry is looking for an eager associate dentist who wants to expand his or her knowledge and experience by helping patients in a state-of-the-art environment. Initially, services would include but would not be limited to prophylaxis and restorative dentistry, and there would be opportunity to learn from experienced doctor owners. We will consider candidates will minimal or no experience in practice. If you'd like to find out more information or be considered for this role, please send an email with your resume to the below email address.
Contact: Rula 804-878-7831
support@dentistrichmond.com

7018 - General Dentist
Fairfax
State of the art dental practice is in search of an experienced General Dentist who is looking to join an established team with multiple locations in Northern Virginia. Minimum of 2 years experience is required. The ideal candidate must have excellent interpersonal skills and aim to provide their patients with the highest standard of care.
Contact: **dnltctr@gmail.com**

7020 - Dental Associate
Fredericksburg
General Dentist Provide high quality efficient oral health care which includes all phases of general dentistry. Our patient base has the ability to keep four dentists busy. Currently, 2 providers are sharing the workload. You will walk into an established practice with a full schedule from day one. Your salary will be based on a commission basis and is negotiable. We are looking for someone proficient with endo, oral surgery, implants. If you do not possess all these skills it is not a disqualifier. Confident, passionate provider with strong communication and customer service skills who can multitask in a fast-paced environment. Ideal candidate should have completed a 1 yr GPR or has 2 years of experience private practice.
Contact: Joseph Fusaro 540-898-8616
fdcjfusaro@gmail.com

7021 - Associate Dentist
Verona
Dental Health Associates is a rapidly growing Dr. owned and managed multi-office group practice in the heart of the Shenandoah Valley in Virginia. We strive for excellent comprehensive full mouth Dentistry. We have a strong commitment to CE, training and mentorship. Seasoned Dentists, AEGD/GPR graduates or new Dentists are welcome to come grow with us. Opportunities throughout the Shenandoah Valley. Excellent commission-based compensation with a $500 per day guarantee and the potential to earn $200 to $300k annually. We offer an excellent benefit package including Malpractice, Medical, 401K matching and CE stipend. A route to ownership/partnership is available.
Contact: Dennis Calvano 540-569-2523
drcalvano@mydha.net

7022 - Associate Dentist
Chantilly
Award winning well established cosmetic and family practice in Loudoun looking for skilled Associate Full Time. The right candidate will join our dynamic Team with a commitment to excellence and practice growth. We are a privately owned practice with attention to detail, customer service, and community involvement. Our Team uses a comprehensive approach to dentistry and believes a beautiful, functional smile is an essential part of one's overall oral and physical health. Only PPO insurance and FFS reimbursement accepted. A competitive full benefits package includes health insurance, malpractice and CE allowance, 401k, and more! Five years experience required as you will hit the ground running with a full schedule while checking hygiene. Experience with endodontics, oral surgery and a AEGD/GPR residency program is welcome.
Contact: Send resume and cover letter to **dentistryinloco@gmail.com**.

7024 - Living the Dream
Newport News
Living the dream... great location, caring-supportive staff, great hours and friendly patients. We are continuously growing with a perfect opportunity for expanding. Looking for a Dental Associate with potential for partnership and possibility for ownership. If you would like to share in living this dream please call and schedule for an interview. I invite you to visit our website and read what our patients have to say about us, you won't be disappointed.
www.thecaringdentist.com
Contact: Sharon 757-875-2273
sharon@thecaringdentist.com

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Practice Transitions

6912 - Dental Practice for Sale
Richmond
A once in a lifetime opportunity to win a vibrant successful dental practice from a retiring dentist. The practice was founded in 1993. Over a million in collections in 2019. In 2020, despite COVID shutdown of 2+ months collections were 1 million. Great upgrade of the equipment within the last 2 years. The patient population is diverse and loyal. A tremendous number of new patients a month. A large portion of FFS. A great opportunity for a dentist with plenty of room to grow the practice. The staff is well trained and very efficient. The office includes a long-term lease. The seller is willing to stay on part-time to ensure a smooth transition. Partial financing available by the seller for the right candidate. Contact the below.
Contact: Steve
richmondva102@gmail.com

6941 - Montgomery County General Practice for Sale
Montgomery County
If you've been searching for the ideal general practice in southwest Virginia, this is the one! 5 operatories with expansion opportunity for 2 additional plumbed ops. Collections of $1.13 million and Seller's Discretionary Earnings of nearly $600,000. 1,700 active patients and 17 new patients per month. To learn more about this practice and to review the prospectus, please email the below or give us a call. We look forward to speaking with you!
Contact: Kaile Vierstra 719-694-8320
kaile@professionaltransition.com

6942 - Busy Virginia Beach General Practice for Sale
Virginia Beach
Newly on the market is a general practice in VA Beach that you're going to want to see! Located in a free-standing building with 4,000 square feet; the practice was recently remodeled as well. 7 fully equipped operatories with an expansion opportunity for one additional, plumbed op. Nearly 2,800 active patients. Collections of $1.2 million, SDE of $445,000 and Adj EBITDA $167,000.
Contact: Kaile Vierstra 719-694-8320
kaile@professionaltransition.com

6866 - Dental Practice for Sale
Rocky Mount
Serving Southwest Central Virginia area dental patients for over 65 years, profitable General Dentist practice plus real estate for sale. Dentist retiring. Awesome opportunity for new grads and experienced dentist. Located in Rocky Mount, 22 minutes south of Roanoke. Serving Greater Roanoke, Salem, Martinsville, Danville and more. Outdoor recreation paradise. Beautiful turnkey, 4 plus 1 opperatories, Paperless, Windows 10, Eagle Soft 21, computer stations all ops, cameras, monitors, panorex. Newly renovated interior with over 2800 Sq. Ft. New parking lot serving main level dental clinic. Lower-level apartment can be repurposed for additional income from professional business, or residential living. Has own parking lot and private entrance. Unbelievable potential!
Contact: James Cornick, DDS
540-721-5250 **jkcornick@yahoo.com**

6738 - Williamsburg Dentist
Williamsburg
Active general dentistry practice 1700 sq. ft. dental office. Five treatment rooms - expandable (plumbed) to eight if needed. Opportunity to purchase 6800 sq. ft. building for rental income in addition to practice. Owner will finance over years with proper financials. Seller will transition to new dentist over a limited period of time. No onerous buyout agreement of patients just take over practice and enter into rental agreement with owner dentist. High quality practice with no aggressive treatment of patients.
Contact: Send Resume/CV to PO Box 1199 Williamsburg, VA 23187.

6992 - Private Practice Ownership
Hampton Roads
Atlantic Dental Care has multiple purchase opportunities for general dentists. ADC is a group practice 100% owned by its dentists. Our 130 dentists have a shared vision of delivering quality care in the communities (Williamsburg to Virginia Beach) we serve through 80 locally owned offices. We are a group practice for dentists by dentists. Tired of working for someone else? Come join us and begin your pathway to ownership as we preserve traditional private practice. Benefits include 401k, health insurance, 125 plan, and HSA. Whether you're tired of working for someone else, a recent graduate or student ADC has opportunities for outright purchase as well as mentorships. Meet the dentists of ADC at **https://youtu.be/D1LBEvGglu8** and **http://www.atlanticdentalcare.net/**. Confidentiality Assured.
Contact: Marina 757-455-5554
atlanticdentalcare@cox.net

6896 - Practice and Real Estate for Sale
Hampton
Great satellite, start-up opportunity or your new forever practice home practice located on a busy 4 lane roadway, with a highly visible corner lot. Practice owner wants to sell the real estate with the practice. Owner is flexible with financing both the practice and real estate. Also, willing to rent with option to purchase. Dental office is located on a large lot with room for expansion. Practice has been in this location for the last 31 years. Please email inquiries to the below.
Contact: Wayne Oplinger 570-760-1069
familydentistryusa@yahoo.com

6997 - Dentist Retiring
Chesapeake
Family Practice, 13 yo, 2100 sq ft, 6 operatories, 4 chairs, digital X-rays and CBCT, excellent visibility in family-oriented community, $607K in 2019 and on track to exceed that in 2021 with no marketing. Very busy, Excellent opportunity for grafting and implants. Excellent boating and fishing, 35 min to beach, asking $325K. Will negotiate soft turnover and implant mentoring if desired.
Contact: **zubabolje9@gmail.com**

7023 - General Practice - Fantastic Opportunity
Virginia Beach
Fantastic opportunity to own a long established, 6 operatory (4 equipped) practice collecting $500K+ yearly. This office has recently been remodeled and boast a spacious floorplan. Excellent opportunity for growth as the current

doctor refers out most specialty work, advertises on an extremely limited basis and has not negotiated insurance fee schedules. Excellent, dedicated staff. Seller is excited to make it a solid transition for the new owner.
Contact: Todd and Sheryl Garfinkel 443-422-9509 **sgarfinkel@ddsmatch.com**

JOBS: Office Staff

6908 - Registered Dental Hygienist
Scottsville
$5,000.00 sign on bonus!!! Scottsville Family Dentistry is seeking a full or part time Registered Dental Hygienist. If you are dedicated to providing the highest quality dental care, we would invite you to consider joining our team! Experience with Eaglesoft, digital radiographs, and intra-oral camera preferred, but not required. New graduates are welcome to apply! Full PPE provided and COVID protocol in place. Benefits include very competitive pay, health/prescription drug insurance, paid time off based on tenure, paid holidays, simple IRA retirement plan, free dental services for you and your dependents. Visit our website at **www.scottsvilledds.com.** Please provide resume/CV.
Contact: Justin Gilbert 540-487-4871
justin@willisdentistry.com

6915 - Dental Hygienist Needed
Charlottesville
We are seeking a dental hygienist to complement our team. Great working environment, progressive pay scale and benefits. Patient dedicated individuals please apply.
Contact: Shanna 434-293-8944
shanna@getaperefectsmile.com

6935 - Dental Program Manager
Wytheville
The Bland Ministry Center and Dental Clinic is searching for a Dental Program Manager for its school-based dental program. We are searching for a compassionate dental hygienist to serve in this introductory role. The successful candidate will be responsible for the implementation and management of a school-based program that identifies children with limited access to care.
Contact: Susan Keene 276-688-4701
skeene@blandministrycenter.org

6947 - Dental Office Manager
Arlington
Experienced office manager familiar with Dentrix is needed
Contact: Reza 425-435-5166
rezatahernia@yahoo.com

6953 - Full Time Hygiene Position
Virginia Beach
Dental Hygiene position available for part time or full time. Offices in Virginia Beach and Norfolk. $40+ hr salary. We provided advanced air cleaning to reduce and eliminate aerosols in all our hygiene rooms. Full time benefits including medical, holiday, and paid time off. Come join a growing practice that offers a unique low stress atmosphere. Dexis Software and Digital Xray system. Check out the power of our air cleaning system on Instagram #partnersindentalhealth Learn more about the practice at **www.partnersindentalhealth.com**
Contact: Jason 757-499-0389
drmkent@partnersindentalhealth.com

6794 - Dental Assistant
Hampton Roads
Needed ASAP to join our fabulous and growing team. DENTAL EXPERIENCE REQUIRED. The duties include but are not limited to, assisting the dentists and hygienists, taking x-rays, going over the patient's medical history, answering phones, scheduling appointments, computer experience, attention to detail, multi-tasking, insurance coordination and customer service. Full time and Part time hours available. Compensation depends on experience. If you're interested, please email your resumes to the email address or call the phone number below ASAP! Applicants must possess the ability to work in a progressive environment. This candidate must be friendly, outgoing and motivated.
Contact: Regina 757-838-5999
familydentistry11@yahoo.com

6795 - Dental Insurance Coordinator
Hampton Roads
Needed ASAP to join our fabulous and growing team. DENTAL EXPERIENCE REQUIRED. The duties include but are not limited to, assisting the dentists and hygienists, taking x-rays, going over the patient's medical history, answering phones, scheduling appointments, computer experience, attention to detail, multi-tasking, insurance coordination and customer service. Full time and Part time hours available. Compensation depends on experience. If you're interested, please email your resumes to the email address or call the phone number below ASAP! Applicants must possess the ability to work in a progressive environment. This candidate must be friendly, outgoing and motivated.
Contact: Regina 757-838-5999
familydentistry11@yahoo.com

6796 - Dental Hygienist
Hampton Roads
Busy office is actively looking for a full-time or part-time Dental Hygienist that provides excellent general dentistry. This candidate must be a friendly, outgoing and a motivated Hygienist with at least 2 years of experience, a team player and ready to work! Great earning potential! Must have an active Virginia License. Please email your resumes to the email address or call the phone number below ASAP!
Contact: Regina 757-838-5999
familydentistry11@yahoo.com

6967 - Temporary Dental Hygienist
Glen Allen
Looking for a temporary dental hygienist to cover maternity leave from end of May to mid-August. 3-4 days a week.
Contact: Manik Khisti 804-874-5005
manik_khisti@yahoo.com

6970 - Dental Office Manager
Scottsville
Scottsville Family Dentistry is seeking a full time experienced dental office manager to oversee daily operations. Eaglesoft experience preferred. Benefits include very competitive pay, health/prescription drug insurance, paid time off based on tenure, paid holidays, simple IRA retirement plan, free dental services for you and your dependents.
Please email resume to
justin@willisdentistry.com
Contact: Justin Gilbert 540-487-4871
justin@willisdentistry.com

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6973 - Hygienist Needed
Lynchburg/Forest
State of the art dental office looking for a FT (4-5 days) hygienists. Paperless office with digital x-ray. Office and equipment all less than 5 years old. We are a family friendly office focusing on patient health and education. Looking for an energetic person who wants to work in a friendly environment. Need a motivated individual with great communication skills. Please email CV.
Contact: **cvadentist@gmail.com**

6976 - Dental Receptionist Needed
Midlothian
Fantastic opportunity for an experienced Dental Receptionist to join our team. Team oriented, light-hearted, fun atmosphere. 32ish hours per week, no weekends, M-TH, occasional Fridays. PTO, 401k, 6 paid holidays, life insurance. 1-2 years experience required. Cross trained a plus. Show a strong desire for learning and continuing education. If you are: -a people person who exudes sincerity, warmth, and confidence -motivated to achieve results with our team of professionals -an expert with details while staying focused on our valued patients -able to leap tall buildings in a single bound We want to talk to you now. We offer an incredible work environment, continuing education opportunities, and competitive salary.
Contact: Dr. Randazzo 804-897-2900
drrandazzo@jrdentistry.com

6977 - Dental Assistant Needed
Midlothian
Fantastic opportunity for an experienced Dental Assistant to join our team. Team oriented, light-hearted, fun atmosphere. 32ish hours per week, no weekends, M-TH, occasional Fridays. PTO, 401k, 6 paid holidays 1-2 years experience required and current X-ray certification. Cross trained a plus. Show a strong desire for learning and continuing education. If this sounds like something for you, send your resume and cover letter with an answer to either of the below questions: What do you feel is important for us to know about you? What brings you to the job market right now?
Contact: Dr. Randazzo 804-897-2900
drrandazzo@jrdentistry.com

6980 - Dental Hygienist
Amelia
Our three-dentist practice has an opening for a PT/FT Registered Dental Hygienist. We are located 20 minutes West of Woodlake on 360 in Amelia. AFD has been growing for 4 decades and we need a dedicated provider to serve our amazing patients. We are looking to fill 3 or more days per week. We are fully digital with Dentrix, Dexis, Nomad units and in the process of transitioning to all electronic records. Our new team-member must be personable, reliable, hard-working, and a team player with a bedside manner focused on patient care, comfort and education. Must be able and willing to communicate with patients, doctors, and dental team with respect and understanding and a common patient centered goal in mind.
Contact: Christa Morris 804-357-6735
dr.morris@amfamdent.com

7008 - Modern Practice Seeking Dental Hygienist
Richmond - West End
DrWhyteSmile is a private owned dental practice specializing in caring for patients in a safe and comfortable environment while offering state of the art dental care with a focus on easing patient anxiety along with a plan to maintain their smiles for a lifetime. We are seeking dental hygienists to join our growing team. DrWhyteSmile provides flexible hours, CE, paid time off, health benefits and competitive wages. Ideal candidates would have a current RDH license, current BLS, and be an effective communicator. Being a team player and having an abundant mindset with an openness for growth is a must. Qualified and interested professionals may submit a resume for consideration.
Contact: Dr. Mike Whyte 804-366-3027
DrW@DrWhyteSmile.com

Office Space: Sale/Lease

6916 - Beautiful Office in Ballston for Sale
Arlington
Beautiful three ops office for sale. It's a turnkey office. Everything you need is there. Originally plumbed to have 4 ops but we use the other room for the PANO machine. It's in very good condition. 1,180 SF. If interested contact me.
Contact: Dr. S
a.alsalim1981@gmail.com

6936 - Five Chair Dental Office for Sale or Lease
Charlottesville
Office condo in Charlottesville available. 1480 sq feet space is equipped with five treatment rooms is ready to go. Choose your software and X-ray system. Hardwired for secure data transmission. This office provides a quiet space in a busy place, Rio and 29 north.
Contact: Alan 434-242-1848
alan.bream@gmail.com

6938 - Office Condo for Sale
Midlothian
11301 Polo Place Ste C
Office condo for sale, 1600 square feet, 4 ops, lab, 10 years old, large waiting room, business area, ample parking.
Contact: Daniel Leahy 804-794-3966
dleahybuckeye@outlook.com

6864 - Dental/Orthodontic Office Condominium for Sale
Manassas
Condominium office for sale in well maintained Manassas office complex. Approximately 1,700 sq. ft. Excellent, centralized location with easy access to Rt. 66. Turnkey operation for primary or satellite office. New equipment including state of the art 3D digital Pan/Ceph unit. Currently set up for orthodontic practice with five chairs and plumbed for two additional. Office could easily be transitioned to treat patients for a general practitioner or specialist of any type with some minor modifications. All furniture, equipment, and supplies are negotiable for sale, as well as the real estate. Great

opportunity for a quick practice start!
Contact: **toothuniverse@gmail.com**

7011 - Office for Sale or Rent
Williamsburg
Williamsburg building for sale or rent: Office building will be available at the end of April 2021. It is 3,600 square feet with an additional 477 square feet of storage space. It is presently a dental office equipped with 11 operatories. The building could be divided into 3 separate 1,200 sq. ft. offices or one of 2,400 square feet and 1,200 square feet, if desired. The present dental practice is expanding and relocating into a larger space. Most of the cabinets and plumbing etc. will remain. So, little modifications would be required. 5 operatories are on one side of the building and the other 6 are on the opposite side. The layout could allow two practices to operate in the building.
Contact: Bill Bennett 757-880-0906
seaplane@cox.net

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There is good news to report regarding Covid-19 vaccinations in Virginia. Some restrictions were loosened. There are in-person graduations planned and hopefully soon in-person meetings can resume. But still caution is indicated. Currently cases are still higher than last summer. However, the number of deaths is much lower compared to last year. Regarding the variants / mutations of the virus, the vaccines seem to be effective in reducing hospitalizations.

Dr. Allison Bryant reported from the Covid-19 front: 1C category for vaccination is open now in Virginia, and by May1 every adult, who wants the vaccine – should be able to get it. Right now 1 out of 5 adults are fully vaccinated. We can be satisfied with the numbers of vaccinated people so far and how the testing process is coming along.

Dentists and dental hygienists are eligible to become vaccinators. This does not mean that dentists can give the vaccine in their own practice settings. Dentists have to register with the VDH. The Virginia Health Agency will be able to send volunteers into public health vaccination settings.

There is still a need for vaccinators, as the ones working right now may need support. New vaccinators should sign up on the VDA website.

The dental scope of practice of sleep apnea concerns was discussed. A legal definition could be developed by the Board of Dentistry. The BOD is considering action.

Dr. Zapatero stated that sleep home test should not be interpreted by dentists as this would be beyond their scope of expertise.

Sandra Reen, Executive Director of the Board of Dentistry, remarked that a dentist can refer patients for a sleep study. Then a medical doctor reads the study, diagnoses it and will then prescribe either by a CPAP treatment or refer back to the dentist for an oral sleep appliance. It was made clear that dentists can refer to a sleep physician, but not make the diagnosis themselves. Ms. Elaine Yeatts confirmed dentists can refer to a sleep physician who can then take care of the interpretation and diagnosis of OSA.

Dr. Perry Jones remarked that a take-home sleep study might be a reasonable approach but that this should be further discussed and all Board members agreed to refer this to the legislative committee

Dr. Nathaniel Bryant presented the Exam Committee Report. The Exam Committee has thoroughly investigated acceptance criteria for the ADEX Dental Exam for licensure by examination. The ADEX exam is accepted for initial licensure in 48 of 50 states, but not in New York and Delaware. It is administered by CITA and CDCA and the Board is a member of ADEX and CITA. Therefore, the Board will be informed of any changes in the exam ahead of time and will also be a part of the discussion of any changes. The ADEX exam covers the required components which the Board wants in an exam (Diagnostic Skills Examination, Endodontics, Fixed Prosthodontics, Periodontics and Restorative). It utilizes Conjunctive Scoring methods only.

Every candidate must pass each individual component with only conjunctive scoring and no compensatory scoring with a minimum passing score of 75% to receive the license in Virginia. The motion above was accepted by the BOD unanimously.

The recommendation for the BOD to continue accepting the passage of exams by all 5 testing agencies for dental applicants by endorsement with the following requirements written in regulation, guidance document and/or application – each candidate must pass each individual component with a minimum passing score of 75% the Diagnostic Skill exam (ADEX= CDCA and CITA) or comprehensive treatment planning (WREB). SRTA and CRDTS do not have an exam component that is equivalent to the Diagnostic Skills Examination or the Comprehensive Treatment Planning. Endodontics, Fixed Prosthodontics, Periodontics and Restorative exams as well as having been in a continuous clinical practice in another jurisdiction of the United States or in Federal civil or military service for five out of six years immediately

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preceding application for licensure pursuant to this section. Active patient care in another jurisdiction of the United States as a volunteer in a public clinic, as an intern, or in a residency program may be accepted by the board to satisfy this requirement. One year of clinical practice shall consist of a minimum of 600 hours of practice in a calendar year as attested by the applicant. Motion of the above unanimously carries.

Dr. Rick Archer stated that moving forward there will be a grace period until January 1, 2023 so that a potential licensee – if applicants took e.g. the WERB instead of ADEX exam, can still apply for licensure. VCU has exclusively used the ADEX exam for several years. Motion: BOD accept only ADEX for dental licensure as addressed above - motion carries.

Regarding the Dental hygiene examination, the motion was to only accept ADEX exam (CITA and CDCA testing agency).

The Dental Hygiene Exams across all 5 testing agencies seems to be equivalent in exam components and scoring. The minimum passing score to be 75% in treatment clinical Examination and Computer simulates clinical Examination. The motion passes after the vote, with Aye 5, Nay 4.

Ms. Reen stated Virginia BOD can only have one voice in one testing agency. Virginia can only have a decisive voice in one testing agency. That is the decisive argument for the ADEX participation.

The Dental hygiene licensure after endorsement - continue to accept the 5 testing agencies. The motion passed (Aye 9).

Acceptance date: January1, 2023 as the effective date of only ADEX exam applying by examination. Motion: passes (Aye 9)

Dr. Bryant went over the general recommendations including the Clinical Competency Exam, the compensatory scoring, the conjunctive scoring, and the substantially equivalent. This should be clearer for applicants and make decisions for the exam committee easier and prevent confusion. Motion: carries (Aye 9).

There was a motion regarding scoring cards. The Board should require an original and detailed score card or report from the testing agency documenting passage of a clinical competency examination. Candidate's score cards are not acceptable. All score cards must be requested by the applicant. For the WREB an IPR detailed report is necessary. Score cards must show conjunctive scoring of the clinical competency exam components. The score cards must show a pass (equivalent to at least 75%) or a fail. The motion carries (Aye 9).

Dr. Bryant stated the need to have the just accepted changes to be addressed in a guidance document with application instructions. Motion carries (Aye 9).

Ms. Reen stated that regarding the Board of Health Professions there is nothing which would have an immediate impact for the BOD right now.

And the Regulatory Legislative Committee reported to remove the pulp capping from the scope of practice of the Dental Assistants II. Ms. Yeatts suggested to grandfather the ones who are doing the pulp capping until the new legislative review is in process – this could be a 2-year process though. This matter will be sent back to legislative committee. Motion carries (Aye 9).

Dr. Petticolas requested one board member to attend –in person- the CITA annual meeting in October 2021 in Florida.

Ms. Yeatts informed about the status report on regulatory of actions: the anesthesia report which became active 2 days ago. New regulations regarding the DA II are effective March 31, 2021. The amendment to regulations creates a pathway for dental assistants with 5-10 years of experience to take the Certified Restorative Functions Dental Assistant exam and have the employing dentist observe and approve of their capabilities to be a dental assistant II. This was discussed by the Board and comments regarding qualifications to become a DA II included the need for additional education and training. The motion carries (Aye 8, Nay 1).

The Deputy Executive Director Report was given by Ms. Jamie Sacksteder. The Disciplinary Report shows for the year 2020 there were 441 received cases. The year ended with 443 cases closed with no violations (some cases were from 2019), 54 cases were closed with violations – for a total of with 497 closed cases.

Presently we have 6,067 Dental Hygienists, 7,694 Dentists, 252 Oral Surgeons, 38 Dental Assistant II, 11 Mobile Dental Facilities licensed and working in Virginia.

Ms. Reen presented the Executive Director Report. She mentioned it was questioned how the AADB represents our Commonwealth in Virginia and how this could be handled.

In addition, Ms. Reen introduced a document from 2014: "When a dentist dies: A guidance document from New York State." In a situation like this lawyers and family members are confused and need help and guidance, especially when it is an unexpected death. It would be helpful, if the Virginia Board would develop a similar guidance document. This would be a great starting place for family members and lawyers and would help to protect the public in matters such as records. It was agreed upon to initiate the development of a similar guidance document.

The meeting adjourned after 4 hours at 2:09 p.m.

Editor's Note: Dr. Klostermyer, a VDA member, practices prosthodontics in Richmond. Information is presented here for the benefit of our readers, and is deemed reliable, but not guaranteed. All VDA members are advised to read and comprehend all Board of Dentistry regulations and policies.

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